



**Medicaid Transformation
Accountable Communities of Health (ACH)
Project Plan Template**

*Revised
October 18, 2017*

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PROJECT PLAN TEMPLATE OVERVIEW

Sub-Section	Response Format	Suggested Word Count
Regional Health Needs Inventory	Narrative	4,000 words
ACH Theory of Action and Alignment Strategy	Narrative	1,500 words
	Attachment: Logic model(s), driver diagrams, tables, and/or theory of action illustrations that visually communicate the region-wide strategy and the relationships, linkages and interdependencies between priorities, key partners, populations, regional activities (including workforce and population health management systems), projects, and outcomes	n/a
Governance	Narrative	1,000 words
	Attachment: Visual/chart of the governance structure	n/a
Community and Stakeholder Engagement and Input	Narrative	1,000 words
	Attachment(s): Evidence of how the ACH solicited robust public input into project selection and planning (more details in template below)	n/a
Tribal Engagement and Collaboration	Narrative	1,000 words
	Optional Attachment(s): Statements of support for the ACH from ITUs in the ACH region	n/a
Funds Allocation	Narrative	3,000 words
	Attestation	n/a
	Supplemental Data Workbook: Funds Distribution Tabs	n/a
Required Health Systems and Community Capacity (Domain I) Focus Areas for all ACHs	Narrative	2,000 words
Project Selection & Expected Outcomes	Narrative	2,000 words

Sub-Section	Response Format	Suggested Word Count
Implementation Approach and Timing	Supplemental Data Workbook: Implementation Approach Tabs	n/a
Partnering Providers	Supplemental Data Workbook: Partnering Providers Tabs	n/a
	Narrative	500 words
Regional Assets, Anticipated Challenges and Proposed Solutions	Narrative	1,000 words
Monitoring and Continuous Improvement	Narrative	500 words
Project Metrics and Reporting Requirements	Attestation	n/a
Relationship with Other Initiatives	Attestation	n/a
Project Sustainability	Narrative	500 words

PROJECT PLAN SUBMISSION INSTRUCTIONS

Word Count. ACHs are strongly encouraged to be both responsive and concise. Suggested word count by sub-section are provided as guidance only and ACHs will not be penalized for responses that exceed the suggested word count.

Response Boxes. ACHs must clearly respond to questions in the Project Plan Template response boxes. Tables and graphs may be inserted into the narrative response boxes.

Attachments. If including additional attachments beyond those that are required or recommended, label and make reference to these attachments in the responses. Additional attachments may only substantiate, not substitute for, a response to a specific question. HCA reserves the right not to review attachments beyond those that are required or recommended. Suggested word counts do not pertain to attachments.

File Format. Each ACH will submit Project Plan applications to the Independent Assessor (IA) through a web-based document repository, the Washington Collaboration, Performance, and Analytics System (WA CPAS). The IA will provide a user guide with instructions for user registration and uploading of documents. Additionally, the IA will provide Help Desk support should users have questions.

Deadline. Submissions must be uploaded no later than 3:00 pm PT on November 16, 2017. Late submissions will not be accepted.

Questions. Questions regarding the Project Plan Template and application process should be directed to medicaidtransformation@hca.wa.gov.

SECTION I: ACH-LEVEL

ACH	Greater Columbia Accountable Community of Health (GCACH)
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Regional Health Needs Inventory

Under the Demonstration, ACHs will use data to support project selection and design. As part of this data-driven planning effort, ACHs conduct an assessment to identify regional health needs, disparities in care, and significant gaps in care, health, and social outcomes. Data used in the regional health needs analysis may include data sources provided by the state and other public sources, as well as regional and local-level data sources, and existing reports or other assessments (e.g. community, hospital). It is expected that the regional health needs inventory will be conducted in collaboration with regional stakeholders, partners, and providers who have knowledge of local data and conditions.

Describe how the ACH has used data to inform its decision-making, from identifying the region's greatest health needs, to project selection and implementation planning. This section should serve as a summary description of how data were used. Additional data relevant to specific projects should be referenced in each project description and justification in Section II of the Project Plan Template.

Address the following:

- Describe how the ACH has used data to inform its project selection and planning.
- Describe the data sources the ACH has acquired or gathered to inform its decision-making, noting where data were provided by partnering providers (Managed Care Organizations (MCOs), providers, Community Based Organizations (CBOs), etc.).
- Provide a high-level summary of the region's health needs relevant to Demonstration project planning. Highlight key sub-regions or sub-population groups if/as appropriate. For each identified topic, cite the data sources and the processes/methods used:
 - Medicaid beneficiary population profile, including number of beneficiaries, geographic, demographic and socio-economic characteristics, and prevalence of adverse social determinants of health
 - Medicaid beneficiary population health status, including prevalence of chronic conditions, vital statistics, and other measures of health
 - Existing healthcare providers serving the Medicaid population (e.g., hospitals, federally qualified health centers, primary care providers, mental health and substance use disorder treatment providers) available across the care continuum in the community, and how these healthcare providers are currently serving the Medicaid population
 - Existing community-based resources available to the Medicaid beneficiary population (e.g., supportive housing, homeless services, legal services, financial assistance, education, nutritional assistance, transportation, translation services, community safety, and job training or other employment services), and how those community-based organizations are currently serving the Medicaid population

- Medicaid beneficiary population’s level of access or connection to care, and their greatest barriers to accessing needed health care and supportive services
- Outline any identified capacity or access gaps between the Medicaid population’s identified health care and health care access needs, and the services (or service capacity) currently available from identified providers and CBOs.

ACH Response

Greater Columbia Accountable Community of Health (GCACH) Demographics

The GCACH region is largely rural, covering nine counties and 15,000 square miles, and has a population of approximately 710,000 people. The Yakama Indian Reservation has approximately 11,700 people and is within

Greater Columbia ACH Differentiations		
Characteristics	Statewide	GCACH
Rural	18%	23.3%
Hispanic/Latino	11.2%	26.4%
American Indian/Alaska Native	1.2%	14.3%
Less than high school graduate	10%	19.2%
Non Citizen	7.1%	10.0%
Limited English proficient	7.9%	13.5%
Migrant Seasonal Farmworker	4.1%	19.6%
Uninsured	13.5%	18.2%
Medicaid Insured	26%	34.7%
Below Poverty	12.9%	19.5%

Yakima County. Compared with the rest of Washington State, the GCACH population is more rural (23%), has higher rates of poverty (19.5%), has a higher percentage enrolled in Medicaid (35%), and has a higher uninsured rate (18%). The region is culturally and racially diverse, with higher proportions of Hispanic (26%) and American Indian/Native American (14%) than the statewide average, as well as a large migrant seasonal farmworker population (20%) as displayed in Figure 1. The Hispanic and American Indian/Native American populations generally reside in geographic pockets.

Yakima and Franklin Counties are near or above 50% Hispanic. The city of Sunnyside in Yakima County is more than 73% Hispanic. Yakima County has a concentration of Native-American Indians that is more than three times the statewide average. (Figure 2)

Figure 1: Regional Health Improvement Plan, 2016 (source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates, <http://www.factfinder.census.gov>)

		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%

Figure 2: County Demographics, GCACH, (source: RWJF County Health Rankings)

Demographics, Medicaid population 2015 (RHNI)				
Regional Health Needs Inventory				
	GCACH		WA State	
	#	%	#	%
Overall	259,762	13.7%	1,892,696	100.0%
Gender				
Male	122,175	47.0%	897,598	47.0%
Female	137,587	53.0%	995,094	53.0%
Race/Ethnicity				
American Indian/Alaska Native	8,423	3.2%	53,735	3.0%
Asian	2,696	1.0%	86,535	5.0%
Black	4,621	1.8%	135,494	7.0%
Native Hawaiian/ Pacific Islander	2,158	0.8%	55,211	3.0%
White	123,930	47.7%	1,071,745	57.0%
Multiracial	1,796	0.7%	23,714	1.0%
Other	91,362	35.2%	278,040	15.0%
Unknown	24,596	9.5%	188,222	10.0%
Ethnicity				
Hispanic	130,890	50.4%	401,292	21.0%
Not Hispanic	98,132	37.8%	1,139,314	60.0%
Unknown	30,740	11.8%	352,090	19.0%
Age (bins tbd)				
Adult (19+)	120,932	46.6%	1,029,869	54.0%
Child (<19)	138,830	53.4%	862,827	46.0%
Language				
English	162,205	87.6%	1,588,222	83.9%
Spanish	9,294	5.0%	172,807	9.1%
Other	714	0.4%	49,201	2.6%
Unknown	12,777	6.9%	82,466	4.4%

Figure 3: Demographics of GCACH compared to WA State (source: HCA Quick Start Guide)

Of note is the reversal of children and adult demographics between GCACH and Washington State as shown in Figure 3. Whereas the population of GCACH is 53.4% children and 46.6% adults, Washington State population is 54% adults and 46% children. Yakima’s expansive population pyramid helps to explain why children outnumber adults!

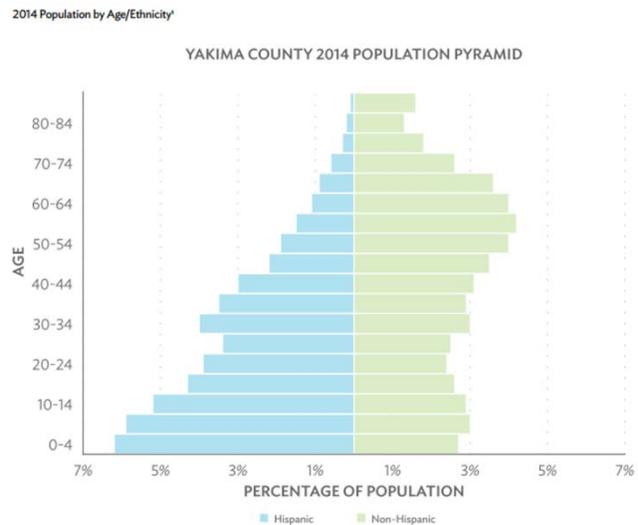


Figure 4: Yakima County 2014 Population Pyramid (source: Yakima Community Health Needs Assessment)

Five of nine GCACH counties are above the statewide average of rural geography; Garfield County is considered 100% rural with no major metropolitan area. Compared to Washington State, the GCACH counties have lower average income, higher unemployment and a greater percentage of children living in poverty. The GCACH has pockets of high homelessness and higher levels of physical inactivity and fewer exercise opportunities. In terms of healthcare coverage, there is a greater portion of uninsured, mainly due to ineligible and undocumented immigrants. The GCACH Medicaid population is more than 50% Hispanic.

Despite poverty, the overall homelessness rate is below the statewide average. However, pockets of high homelessness exist within some of its counties, including Asotin and Yakima counties as shown in Figure 5.

Snapshot of Homelessness in Washington State for January 2016

Based on Total Basic Food Population

Includes recipients, denials, closings, and associated household members

Unstably Housed and Homeless Persons, by Household Type and County

County / State	Total Homeless	Child Only	Parenting Teens	Youth (18-24) w/o Children	Adults (25+) w/o Children	Single Parent with Children	Two Parents with Children	Unknown	Population (4/1/2016 estimate)	Homeless Rate Per 1000	Graph
Asotin	725	-	-	107	377	176	65	-	22,150	32.7	
Benton/Franklin	3,822	*	*	708	1,790	947	366	*	279,170	13.7	
Columbia	77	-	-	11	28	24	14	-	4,050	19.0	
Garfield	37	-	-	*	17	*	*	-	2,200	16.8	
Kittitas	526	*	-	90	278	108	49	-	43,710	12.0	
Walla Walla	1,122	*	-	189	543	290	99	-	60,730	18.5	
Whitman	284	*	-	45	119	95	24	-	47,940	5.9	
Yakima	6,774	*	-	1,024	3,310	1,720	706	*	250,900	27.0	
GCACH	13,367	N/A	N/A	2,174	6,462	3,360	1,323	N/A	710,850	18.8	
Washington State	141,464	248	41	20,630	77,014	31,028	12,481	22	7,183,700	19.7	

Source: <http://www.commerce.wa.gov/wp-content/uploads/2015/11/hau-hmis-snapshot-homelessness-1-2016.pdf>

Source: http://www.ofm.wa.gov/pop/april1/ofm_april1_population_final.pdf

Figure 5: Homelessness in GCACH, 2016 estimate

Arrest rates for the Medicaid population with mental health service needs in the GCACH region are also higher than Washington State and for those of every other ACH (DSHS RDA) as shown in Figure 6. These arrest rates may offer opportunities to address the opioid public health crisis through trauma informed training to our local government partners in public safety and criminal justice.

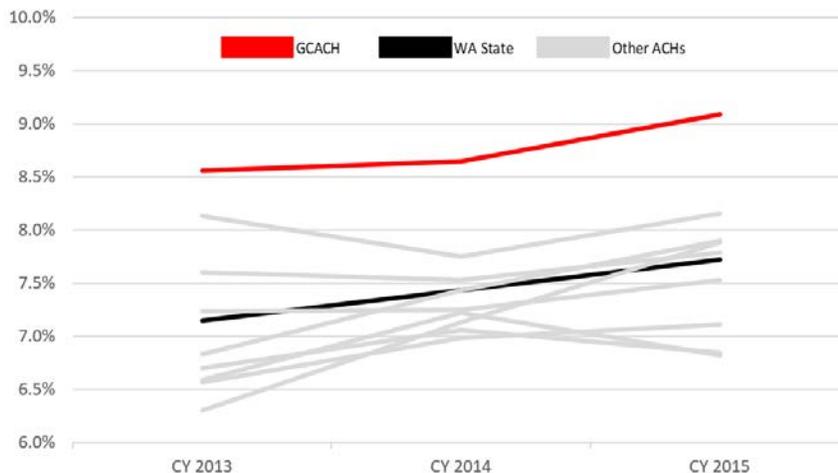


Figure 6: Arrest Rates for the Medicaid Population with Mental Health Service Needs (source: DSHS RDA)

Regional Health Needs Planning Process in GCACH

GCACH has a strong history in using data and evidence-based processes to evaluate regional health needs and inform decision-making around project selection and planning. The GCACH Executive Director (ED), formerly of the Benton-Franklin Community Health Alliance (BFCHA), had led a Community Health Needs Assessment in partnership with the Benton-Franklin Health District using the Mobilizing for Action through Planning and Partnerships (MAPP) process in 2012, and developed the bi-county Community Health Improvement Plan in 2013. The MAPP process is a community-driven assessment that prioritizes public health issues in a community, and identifies resources to address them. As the leader of the newly forming Accountable Community of Health, the ED used the MAPP process in 2014 to bring together the

partners, conduct the four assessments, identify strategic issues, and formulate goals and strategies as illustrated in Figure 7. This work was foundational to the regional assessment conducted for GCACH.

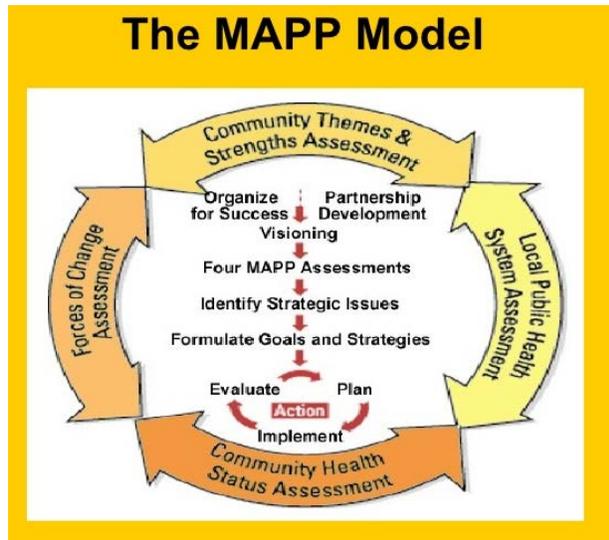


Figure 7: MAPP Model, Foundation for Regional Assessment (source: National Association of County Health Officials)

Dr. Patrick Jones, Executive Director of Eastern Washington University’s Institute for Public Policy and Economic Analysis, was hired to facilitate the steering committee, and lead the Community Health Needs Assessment given his expertise in data, research and policy development. During the next eighteen months, Dr. Jones led the steering committee - which included local public health, behavioral health, health action councils and more - through an iterative process to evaluate national, state and local data, and population statistics, and to discuss community priorities and health issues.

Building on the work of 2014, and the priorities determined at a ten-county retreat in December, Dr. Jones presented an extensive power point on local health improvement indicators on August 20, 2015 using data from the following sources:

- Healthy People 2020:
- Washington State County Health Rankings:
- Washington State Local Public Health Indicators:
- American Community Survey: Small Area Health Insurance Estimates from the US Census
- Small Area Income & Poverty Estimates
- Benton-Franklin Trends
- Walla Walla Trends

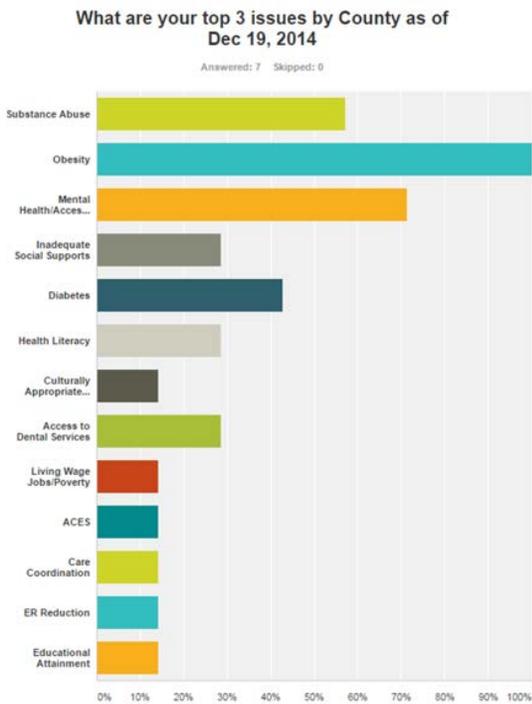


Figure 8: Top Health Issues in GCACH; December 2014 (source: December 18th, 2014 GCACH Survey Retreat Results)

The data confirmed the survey results from the December 2014 retreat, and led to the formalization of five priority areas for planning work as shown in Figure 8: Behavioral Health, Obesity/Diabetes, Care Coordination, Healthy Youth and Equitable Communities, and Access to Dental Services. Five Priority Committees were formed around these areas in September of 2015 to review data, resources and initiatives in the region, and to start collaborating across disciplines.

The GCACH's 2016 Regional Health Improvement Plan (RHIP) built on the 2014-15 work of Dr. Jones and GCACH stakeholders. The RHIP used the RWJF's Culture of Health framework to identify strategies and goals to address the five priority areas.

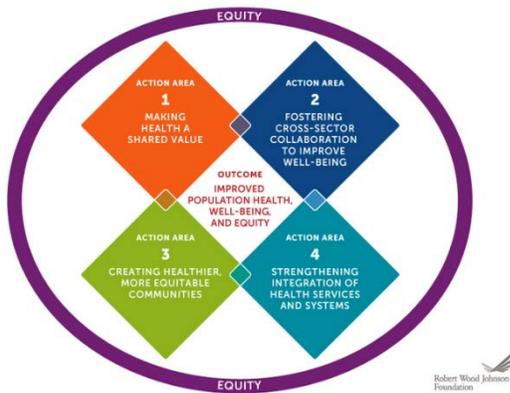


Figure 9: RWJF Culture of Health Framework (source: RWJF Culture of Health)

According to the Robert Wood Johnson Foundation, a Culture of Health is broadly defined as “one in which good health and well-being flourish across geographic, demographic, and social sectors.” As shown in Figure 9, the framework has four action areas that, when connected, lead to improved population health.

The Framework takes an innovative approach to improve population health. It relies on four action areas: Making Health a Shared Value, Fostering Cross-Sector Collaboration, Creating Healthier, More Equitable Communities, and Strengthening Integration of Health Services, and numerous strategies to drive change. (See Figure 10) The **Action Areas** are high-level objectives which lead to health improvement, well-being and equity. Drivers are activities or strategies that support each action

area. The Outcomes result from goals and strategic actions.

ACTION AREAS	DRIVERS			OUTCOMES
Making Health a Shared Value	Mindset and Expectations	Sense of Community	Civic Engagement	Enhanced Individual and Community Well-being
Fostering Cross-Sector Collaboration to Improve Well-Being	Number and Quality of Partnerships	Investment in Cross-Sector Collaboration	Policies That Support Collaboration	
Creating Healthier, More Equitable Communities	Built Environment Physical Conditions	Social and Economic Environment	Policy and Governance	Managed Chronic Disease and Reduced Toxic Stress
Strengthening Integration of Health Services and Systems	Access	Consumer Experience and Quality	Balance and Integration	Reduced Health Care Costs

Figure 10: Action Areas, Drivers, Outcome Measures, (source: RWJF Culture of Health)

GAP ANALYSIS (SELECTED)

Key:
Boldface = strategies
Red = measures for which at least half of the counties in the region had outcomes worse than the state
Blue = measures for which all of the counties in the region had outcomes worse than the state
Yellow = strategies prioritized by the SIC

	WA	Asotin	Benton	Columbia	Franklin	Garfield	Kittitas	Walla Walla	Yakima
Access to exercise and healthy foods									
Access to exercise opportunities	88	73	82	66	55	74	72	76	69
Physical inactivity	18	24	18	25	19	30	16	20	24
Walk to or from school at least 3-4 days a week	6.8	8.4	6.0	3.7	6.2	10.5	5.8	9.0	8.7
Food environment index (access to healthy foods, food insecurity)	7.5	5	4	10	12	36	10	7	5
Limited access to healthy foods (low-income and do not live close to a grocery store)	5	5	4	10	12	36	10	7	5
Food insecurity (lack of access to food)	15	15	13	16	10	14	17	14	12
Families living in poverty served by WIC	63	71	64	56	69	64	59	66	66
Infants served by WIC	45	25	55	56	67	14	41	58	78
Healthy community design									
Alcohol Retail Licenses, per 1,000 persons (all ages)	2.16	1.83	1.85	6.02	1.49	3.02	3.7	2.19	1.95
Tobacco Retail and Vending Machine Licenses, per 1,000 persons (all ages)	0.96	0.6	0.75	2.49	0.81	1.6	1.37	0.68	1.05
Complete Streets		0	0	0	0	0	0	0	0
Walking or biking to work	4.4	4.2	2.5	12	1.8	7.1	11.2	9.9	1.9
Population Not Registered to Vote, per 100 adults (age 18 and over)	27.64	22.43	28.51	20.25	47.52	15.15	36.76	32.09	39.27
Registered And Not Voting in the November Election, per 100 adults (18 & over)	39.1	40.05	39.2	27.43	42.68	25.85	34.56	38.12	46.41
Public libraries		3	7	1	6	1	4	7	18
Economic environment									
Children in poverty	18	24	21	26	25	21	19	21	30
Median household income	61400	44055	58750	45465	55006	46404	48127	49819	44342
Students Eligible for Free or Reduced Price Lunch, per 100 students enrolled	45.18	49.82	49.77	56.66	71.02	47.3	42.38	56.4	74.91
Supplemental Nutritional Assistance Program (SNAP), per 100 persons (all ages)	20.45	28.8	22.25	22.84	28.97	18.42	17.03	22.27	35.21
Temporary Assistance to Needy Families, Child Recipients, per 100 children	9.29	14.42	9.95	11.27	12.95	9.64	8.19	9.76	16.87
Children in single-parent households	29	37	30	30	35	23	26	29	40
Unemployment	6.2	6	7.7	7.7	8.5	6.8	7.1	6.5	8.9
Income inequality	4.5	4.4	4.5	4.3	4.1	3.4	5.5	4.7	4.2
Education									
3 and 4 year olds enrolled in nursery/preschool	40	45	34	0	24	36	41	43	28
Annual (Event) Dropouts, percent of students	4.77	6	3	1	6	0	7	2	5
High school Cohort (Cumulative) Dropouts, percent of students	13.19	19	11	5	16	1	18	9	18
High school graduation	78	70	78		72		77	76	72
Protective Factor: Extended Graduation, percent of students	79.69	73	81	89	75	95	76	87	74

Figure 11: Crosswalk of Metrics Related to Strategies to Improve Population Health (source: RHIP)

The GCACH formed a Strategic Issues Committee (SIC) to develop the RHIP. The SIC was cross-sector, cross-geography, and included representatives from the five priority areas. The SIC met weekly between April and July of 2016 to review data and metrics to determine which strategies aligned with the priorities and goals of GCACH. For example, in Figure 11, **Healthy Community Design** metrics indicated measures for which at least half of the counties in the region had outcomes worse than the state average. Theoretically, addressing policies that created healthier communities would result in enhanced community and individual well-being.

The SIC also reviewed several Washington State health care strategic plans. Some of the fifty strategies that appeared most frequently in these plans included access, social services support, environment, collaboration, engagement, integration, systems, and capacity. Data used in the RHIP originated from US Census Bureau, Robert Wood Johnson Foundation, Health Care Authority, US Department of Health and Human Services, Community Commons, Indian Health Services, University of Wisconsin Population Health Institute, WA State Department of Health, WA State DSHS, WA School-based Health Alliance, WA Health Alliance and more.

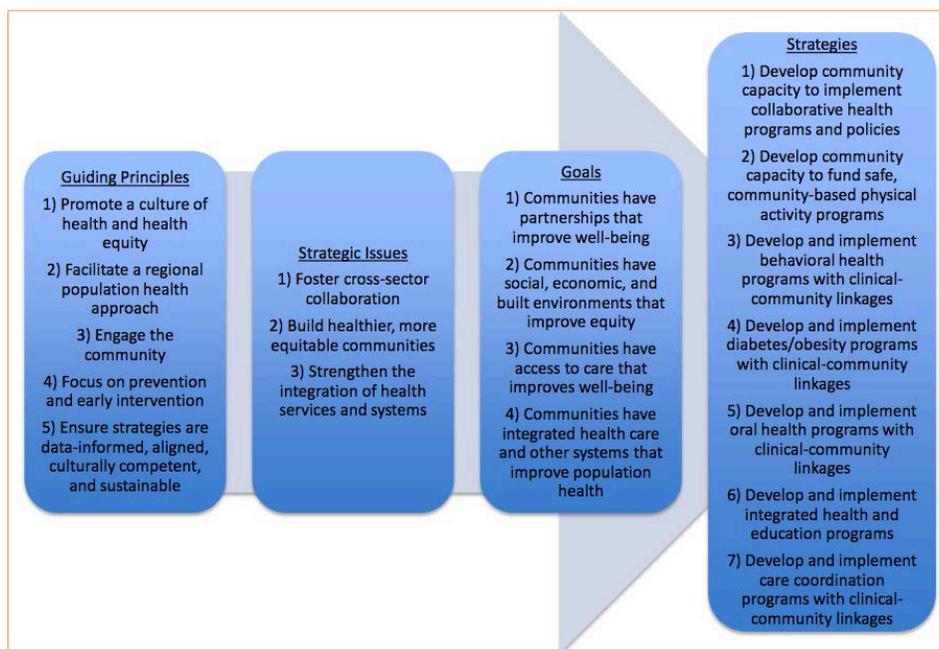


Figure 12: Regional Health Improvement Plan Logic Model
(source: Deb Gauck, Consultant for RHIP)

Based on the data and assessments, the Strategic Issues Committee developed guiding principles, strategic issues, goals, and strategies as seen in the Logic Model in Figure 12. The Guiding Principles and Strategic Issues have provided the cornerstones for developing the GCACH project plan application.

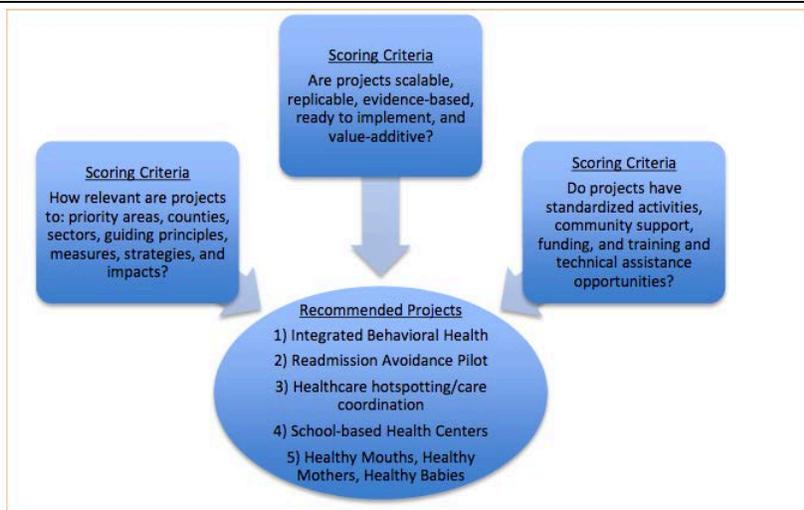


Figure 13: Scoring Criteria for RHIP Pilot Project (source: Deb Gauck, Consultant for RHIP)

The RHIP was also developed to demonstrate our theory of action. Several potential projects that used the strategies, guiding principles, and drivers identified in the plan, were submitted as a pilot project. The Strategic Issues Committee reviewed each project using the scoring criteria shown in Figure 13, and recommended the Hospital Readmission Avoidance Pilot (RAP) as its State Innovation Model (SIM) project. The goal of the RAP project was to reduce avoidable hospital readmissions within thirty days of discharge. The pilot adapted a hospital

discharge planning tool that used social determinants of health measures to predict future readmissions, a care coordination team that was cross-sector, relied on clinical and community resources, and stressed prevention.

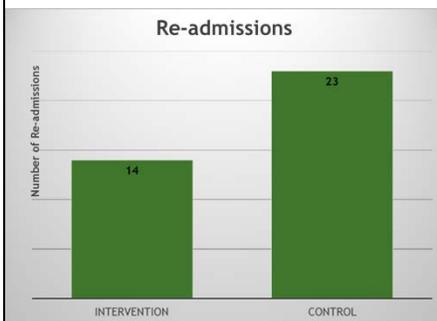


Figure 14: Readmissions Avoidance Pilot (RAP) Results (source: Findings from GCACH RAP SIM Project)

The results from the RAP project were remarkable as shown in Figure 14. The intervention group had significantly lower readmission rates than the control group. Of notable findings: 83% of the patients in the RAP pilot had some degree of a cognitive deficit based on standardized testing in the home after discharge, and there was a high correlation between social determinants and readmissions. Patients with Medicaid coverage were more likely to re-admit, consistent between control and intervention groups, and 64% lived alone. It was found that early intervention in the home by a nurse care coordinator, post-discharge, and early collaboration by other programs was important in reducing readmissions.

Medicaid Transformation Demonstration Project Teams and RHNA

On January 9, 2017, Washington State received word from the Centers for Medicare & Medicaid approving their request for a five-year Medicaid demonstration project. In April of 2017, the five Priority Work Groups had transitioned into the eight Medicaid Transformation Project Teams as shown in Figure 15.

GCACH Priority Work Group	Medicaid Transformation Project Team
Behavioral Health	Bi-Directional Integration of Physical and Behavioral Health
	Addressing Opioid Use Crisis
Care Coordination	Community-Based Care Coordination
	Transitional Care
	Diversions Interventions
Healthy Youth & Equitable Communities	Reproductive and Maternal/Child Health
Oral Health	Access to Oral Health Services
Diabetes/Obesity	Chronic Disease Prevention and Control

Figure 15: Transformation of Priority Work Groups into Project Teams
(source: GCACH)

Accompanying this, GCACH internal staff prepared a large data report and analysis and presented it at a Spring Board retreat, and subsequently to the Leadership Council. The report synthesized multiple data sources, and presented data in a digestible manner that compared GCACH to statewide performance. It highlighted variation across the nine counties in the region, and allowed ready identification of health indicators with worse outcomes.

To evaluate regional health needs, GCACH members reviewed national, state, and local data sources, including:

- **HCA Medicaid eligibility and claims data:** e.g. key Medicaid providers in the GCACH network, aspects of ED utilization across network hospitals, high-volume opioid prescribers, and co-occurring behavioral health and chronic care statistics
- **DSHS RDA data analysis:** e.g. Statistics on employment, arrest and homelessness rates; all-cause and psychiatric re-admissions; mental health treatment and SUD treatment penetration, Community Risk Profiles, ED utilization by county, and % disability
- **DSHS Washington Tracking Network:** Various maps
- **Robert Wood Johnson Foundation County Health Rankings:** e.g. statistics on county demographics, social and economic factors, health behaviors, clinical care and outcomes
- **Community Partner Data:** e.g. mapping of community paramedic programs across the ACH, Community Asset Inventory listing healthcare and social service agencies
- **Managed Care Organization data:** e.g. plan enrollment by program type and county
- **Providence CORE (aggregated from various sources):** e.g. statistics on % uninsured, disease prevalence, dental service penetration, sexual health, and opioid abuse prevalence
- **Healthier WA Dashboard:** e.g. statistics on disease prevalence, immunization rates, and hospital care including ED utilization and readmissions
- **US Census Bureau:** e.g. county demographic data

- **Washington Health Alliance:** e.g. statistics on access to care, potentially avoidable care, behavioral health, chronic disease management, medication management, and preventive care
- **Community Commons:** e.g. socio-economic and demographic statistics
- **WA State Office of Financial Management:** e.g. homeless counts by category and county.
- **Local Health Jurisdictions:** e.g. County Community Health Needs Assessments and Community Health Improvement Plans
- **Community Hospital Partners:** e.g. ED utilization data
- **ACH Partners:** e.g. number-needed-to-treat data across P4P metrics and counties
- **WA State Department of Health:** e.g. BRFSS data and hospital statistics
- **WA State Health Workforce Sentinel Network:** e.g. workforce requirement data
- **Washington State MONAHRQ:** e.g. hospital ED utilization and wait time data
- **University of Wisconsin Neighborhood Atlas:** neighborhood Area Deprivation Index scores relating to the social determinants

These data were either provided by the state (ACH RHNI “Starter Kit” datasets, Healthier Washington Dashboard, DSHS data), or obtained from local or national sources.

Summary of Regional Health Care Needs

The large data analysis, performed at the Spring Board retreat, identified high level areas of health concern for the GCACH:

- Potentially avoidable Emergency Department visits
- Opioid abuse among chronic users (>30 days) across genders, ages and ethnic groups
- Mental health and chemical dependency/substance abuse treatment penetration
- Well-child visits
- High teen pregnancy and STD rates
- Preventable inpatient hospital days

The eight Project Teams then engaged in an in-depth review of this regional health data, and used the data report file in their analysis of projects. The GCACH tasked Project Teams with objectives to evaluate the regional health needs data in each project area and to develop proposed projects targeting these needs consistent with the Healthier Washington Toolkit, and a community asset inventory.

GCACH provided ongoing staff support to address data-related questions and other issues, and the Project Teams met more than 60 times between May and June to populate a Project Team Report based on a standardized template. At the June 22, 2017 Leadership Council meeting, the Project Teams presented their reports, and received feedback from the broader Leadership Council regarding the proposed evidence-based project approaches. This feedback was incorporated into the Project Team Reports, and given to the Technical Advisory Committee (TAC).

The Board has benefited from the use of the TAC, which is made up of Governor John Kitzhaber, Dr. Hugh Straley of the Bree Collaborative, Mike Bonetto of Tenfold Health Consulting, Bob Burden of Kaiser Permanente, and Dr. Lee Ostler, a national expert on the link between oral-systemic health. This group has been a key strategic advisory group, providing the board with highly informed and impartial insights and guidance on key decisions, such as on the selection of project areas and approaches initially chosen by the Project Teams. The TAC also received the supporting master data report, Regional Health Improvement Plan, the Regional Survey of GCACH providers, and access to all the minutes and materials posted to the GCACH website in their review of project proposals.

At the GCACH August 2017 Board meeting, the Board elected to move forward with six project areas, with the intention to integrate Maternal and Child Health and Oral Health Access into other project areas. The strategic considerations for selecting the project portfolio were based on:

- Feedback from the Technical Advisory Committee and their scoring of projects
- ROI in 3-5 years and investments that outlast the Demonstration
- Ability to move the project metrics throughout the life of DSRIP
- Available infrastructure to measure project process and outcomes
- Provider participation, local leadership and energy around project proposals, and willingness to share data
- Common target populations and addressing health inequities
- Alignment with community needs and synergies with other project areas
- Clinical-community linkages, especially those tied to the social determinants of health
- Common denominators around performance metrics
- The risk of choosing projects with many outlier metrics
- Guidance from Health Management Associates (HMA), the program consultant during the initial project year
- The ability to integrate Maternal and Child Health and Oral Health Access into the other project areas

Once the project areas were selected, GCACH began an intensive process to determine target populations and alignment across project areas. The Project Team Facilitators, known as the Project Advisory Committee (PAC) collectively, continued to work with their committee structures to determine initial target populations given a template developed by Cascade Pacific Action Alliance, another ACH. HMA condensed these findings into a matrix cross walking target population with measures. GCACH staff also did background research into high-cost, high-utilizing patient populations, the starting point of any population-health driven initiative. This latter research incorporated findings from the Healthcare Transformation Task Force (a national organization tied to VBP transformation), AHRQ, and research linking the social determinants of health with healthcare outcomes and mortality. The research into high-cost, high-utilizing patients and the matrix cross-walk, which was used as a strawman, were presented at a PAC retreat on September 19th.

Retreat participants actively engaged in discussion of target populations for each project and shared populations across projects. They identified key target populations for the project portfolio:

- Medicaid beneficiaries with Severe Persistent Mental Illness (SPMI) and other co-morbidities (for example, diabetes)
- Medicaid beneficiaries with 6 or more ED visits in past 12 months
- Medicaid beneficiaries with an ED visit and a MH, alcohol or drug abuse diagnosis
- Medicaid beneficiaries with preventable ED visits even if they don't have 6 or more in a year (3D will address patient education)
- People with social determinant needs across projects

Key areas of alignment across all project areas include:

- Population health information (HIT/HIE) and workforce (esp. Community Health Workers and their counterparts) are foundational across projects
- Care coordination, such as through social service and healthcare pathways, are also foundational and serve as a connection point across projects, whether an electronic pathway tool is utilized
- Screening for social determinants, behavioral health needs as well as patient engagement (e.g. Patient Activation Measure) directly affect outcomes
- Trauma-Informed Care
- Equity needs to be a meaningful consideration in project planning and projects need common means of defining, measuring and tracking race/ethnicity and language
- Projects need GCACH to provide a shared infrastructure / TA for building business case and measuring ROI

At the October 26th Leadership Council and Board Meetings, the decision was made to move from 6 projects to 4 projects. Some of the key considerations for this decision were:

- Budget cuts due to decreased matching funds from the Designated State Health Program, and potential funding cuts in future years
- Deeper, target investments could allow for more strategic use of limited dollars
- A more flexible and targeted approach to Care Coordination and ED utilization across the region
- Understanding that many of the same P4P metrics are addressed in the chosen project areas

Further refinement of the target populations will include continuing interviews with key stakeholders and partners who serve these target populations, and evaluating strategies that can support the project portfolio, especially in the areas of care coordination, workforce, population health management, and value-based payment.

Data Sources to Inform Decision-making

Our analysis of this data has shaped our project selection and allowed for focused interventions. It is not the intention of the program to deploy each program within every county of the region. This points to the need for projects that are aligned with common measures and interventions that cut across project areas.

Provider Access and Beneficiary Needs

There are large provider access issues as shown in Figure 16, owing to lower provider-to-population ratios for primary care, dentistry, and behavioral health. Primary care access for Medicaid patients in Yakima county and adult dental access across the GCACH are very limited. Adult dental access is also driven by low reimbursement rates. FQHCs provide a true life-line for this population, providing primary care, behavioral health, dental and sometimes vision and maternal support services. However, they have long appointment lead-times for scheduling across every clinical specialty. Limited primary care capacity and long appointment lead times are a major driver in increasing ED utilization. Accordingly, there is a lower percentage of individuals with personal providers compared to the state overall (RWJF County Health Rankings):

	Asotin	Benton	Columbia	Franklin	Garfield	Kittitas	Walla Walla	Whitman	Yakima	WA State	Graph
Clinical Care	Uninsured	11%	11%	12%	18%	9%	12%	14%	10%	11%	
	Primary care physicians ratio	1,057	1,413	996	3,252	2,215	1,575	798	1,511	1,432	
	Dentists ratio	2,211	1,475	1,315	2,537	2,219	2,704	1,341	2,834	1,595	
	Mental health providers ratio	381	570	563	925	2,219	709	434	753	431	
	Preventable hospital stays	33	47	38	41	37	47	25	43	45	
	Diabetes monitoring	84%	86%	86%	87%	86%	90%	88%	88%	88%	
	Mammography screening	66%	65%	43%	61%	77%	62%	63%	60%	59%	
Outcomes	Premature death	6,714	5,239	8,170	4,898	N/A	5,106	6,530	4,868	7,106	
	Poor or fair health	16%	14%	16%	21%	14%	15%	16%	16%	24%	
	Poor physical health days	4.2	3.5	4.0	4.0	3.7	3.7	3.9	4.1	4.5	
	Poor mental health days	3.8	3.5	3.9	3.9	3.7	3.8	3.6	4.1	4.1	
	Diabetes prevalence	13%	10%	12%	7%	14%	8%	10%	7%	10%	

Worse than average Better than average

Figure 16: Provider Access Issues (source: RWJF County Health Rankings)

Despite this, there appears to be adequate testing of diabetics for blood sugar, kidney disease and eye disease (WA Health Alliance Community Checkup) as shown in Figure 17 except for Yakima which has notable primary care access issues:

Washington Health Alliance Community Check-Up, 2016 Medicaid Plans		Asotin	Benton	Columbia	Franklin	Garfield	Kittitas	Walla Walla	Whitman	Yakima	GCACH	WA State										
Chronic Disease Management	Blood sugar (HbA1c) testing for people with diabetes	61%	Average	59%	Average	N/A	N/A	62%	Average	N/A	N/A	61%	Average	65%	Average	63%						
	Eye exam for people with diabetes	82%	Better	65%	Average	N/A	N/A	58%	Average	N/A	N/A	81%	Better	64%	Average	67%	Average	66%	Average	65%	Average	63%
	Kidney disease screening for people with diabetes	82%	Average	75%	Average	N/A	N/A	72%	Average	N/A	N/A	60%	Average	57%	Average	67%	Average	70%	Average	70%	Average	71%
	Managing medications for people with asthma	N/A	N/A	59%	Average	N/A	N/A	60%	Average	N/A	N/A	56%	Average	64%	Average	N/A	N/A	51%	Worse	55%	Average	60%
	Spirometry testing to assess and diagnose COPD	N/A	N/A	39%	Better	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	24%	Average	28%	Average	22%
	Statin therapy for patients with cardiovascular disease	N/A	N/A	19%	Average	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	11%	Worse	15%	Average	20%
	Staying on antidepressant medication (12 weeks)	N/A	N/A	55%	Average	N/A	N/A	56%	Average	N/A	N/A	49%	Average	55%	Average	N/A	N/A	52%	Average	54%	Average	58%
	Staying on antidepressant medication (6 months)	N/A	N/A	38%	Average	N/A	N/A	38%	Average	N/A	N/A	N/A	N/A	48%	Average	N/A	N/A	35%	Worse	38%	Average	42%

Figure 17: Diabetes Management across GCACH (source: Washington Health Alliance Community Checkup)

For mental health, the percentage of adults reporting poor mental health, is about average. However, mental health treatment penetration and SUD treatment penetration are both below the statewide average (see Figure 18). Despite this, the psychiatric re-admission rate is lower than average (DSHS RDA):

	GCACH	WA State
HCBS and Nursing Facility Utilization Balance	93%	92%
Mental Health Treatment Penetration - Broad Definition	41%	43%
Percent Arrested	7%	6%
Percent Employed	57%	50%
Percent Homeless - Broad Definition	9%	12%
Plan All-Cause 30-Day Readmission	13%	16%
Psychiatric Inpatient 30-Day Readmission	11%	13%
Substance Use Disorder Treatment Penetration	24%	27%

Figure 18: Mental Health Treatment Penetration (source: DSHS RDA)

The GCACH also contains large (rural) and small (urban) pockets of socio-economic deprivation. This was assessed through the Singh Area Deprivation Index (ADI), (see Figure 19) a geographic, area-based measure comprised of census measures relating to poverty, housing, employment, education, and more. Research indicates that a high ADI (most disadvantaged) correlates with increased inpatient admissions/re-admission, ED utilization, pre-mature mortality, disease prevalence and more. In reviewing this geographic data with some of our community stakeholders (e.g. Yakima Valley Farmworkers Clinic), they confirmed a correlation between high ADI and high healthcare utilization. This supports the concept that addressing healthcare utilization in isolation of addressing social service needs is unlikely to be sustainable:

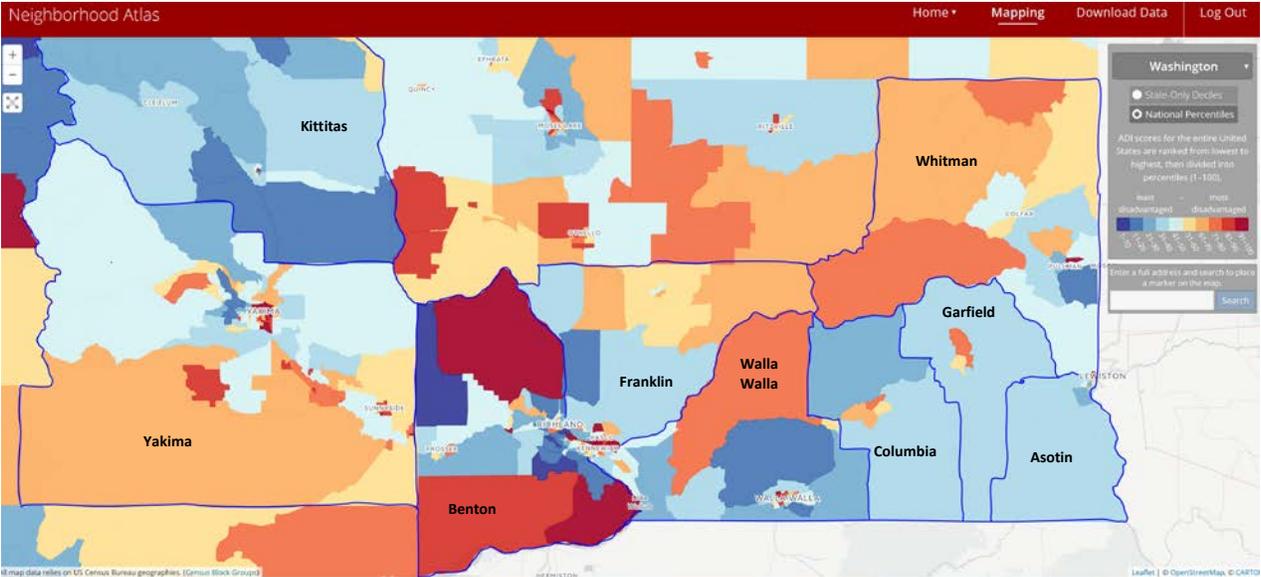


Figure 19: Area Deprivation Index, GCACH (source: University of Wisconsin)

Opioid abuse is a significant problem for the GCACH. Benton County, per square mile, has a high concentration of opioid deaths. Per-capita, Asotin also has a high number of opioid-related deaths as shown in Figure 22:

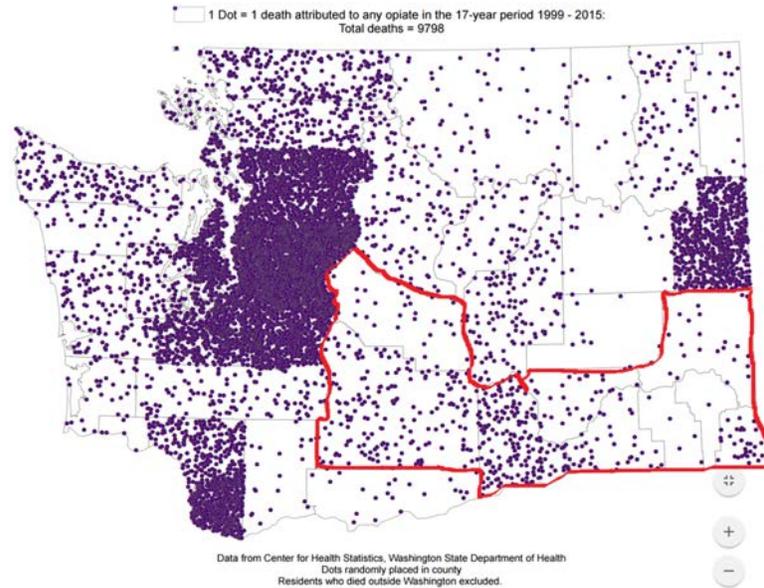


Figure 22: Opioid Deaths across GCACH

There is a high number of chronic opioid users (>30 days use) across age, gender, and ethnicity. However, use of Medication Assisted Treatment with buprenorphine across all these demographic groups appears to be at rates above the statewide average (HCA Regional Health Needs Inventory Report) (see Figure 23):

Opiate Abuse: Medicaid only population with full medical eligibility, Medicaid eligible excluding dual Medicare eligibles, third party liability and partial medical eligibility - 2016	% Heavy Opioid Users		% Users of opiates for >30 days		% Receiving Medication Assisted Treatment with Buprenorphine (%)		% Receiving Medication Assisted Treatment with Methadone(%)	
	GCACH	WA State	GCACH	WA State	GCACH	WA State	GCACH	WA State
Overall	19%	20%	20%	18%	16%	10%	5%	17%
Gender								
Female	19%	20%	20%	18%	13%	10%	5%	17%
Male	19%	20%	21%	19%	19%	10%	5%	16%
Age								
Ages 0-9	NA	1%	NA	1%	0%	0%	0%	0%
Ages 10-19	16%	17%	1%	1%	NA	2%	0%	5%
Ages 20-29	20%	20%	9%	7%	23%	13%	5%	15%
Ages 30-39	20%	20%	21%	17%	20%	13%	5%	19%
Ages 40-49	20%	20%	33%	27%	12%	8%	5%	16%
Ages 50-59	20%	21%	40%	36%	8%	5%	5%	16%
Ages 60-69	20%	22%	44%	40%	NA	3%	7%	18%
Ethnicity								
Non Hispanic White	20%	20%	27%	22%	18%	10%	5%	17%
Non Hispanic AI/AN	13%	18%	17%	20%	NA	15%	6%	15%
Non Hispanic Black	18%	20%	21%	15%	NA	4%	NA	18%
Hispanic	18%	20%	12%	11%	12%	10%	6%	14%
Other/UNK	21%	21%	18%	12%	12%	7%	NA	13%

Figure 23: % Receiving Medication Assisted Treatment with Buprenorphine in GCACH (source: HCA RHNI)

Probably the single largest healthcare utilization issue and outlier for the GCACH revolves around emergency department (ED) visits and potentially avoidable ED visits. The GCACH, on average, has the highest overall ED utilization rate of any ACH in Washington State. This is true across all Medicaid classifications (see Figure 24-25). This calls out the need to target populations across project areas that have high utilization of downstream intensive resource use, including ED utilization and inpatient utilization. High ED utilization is also apparent across different age groups (see Figure 24):

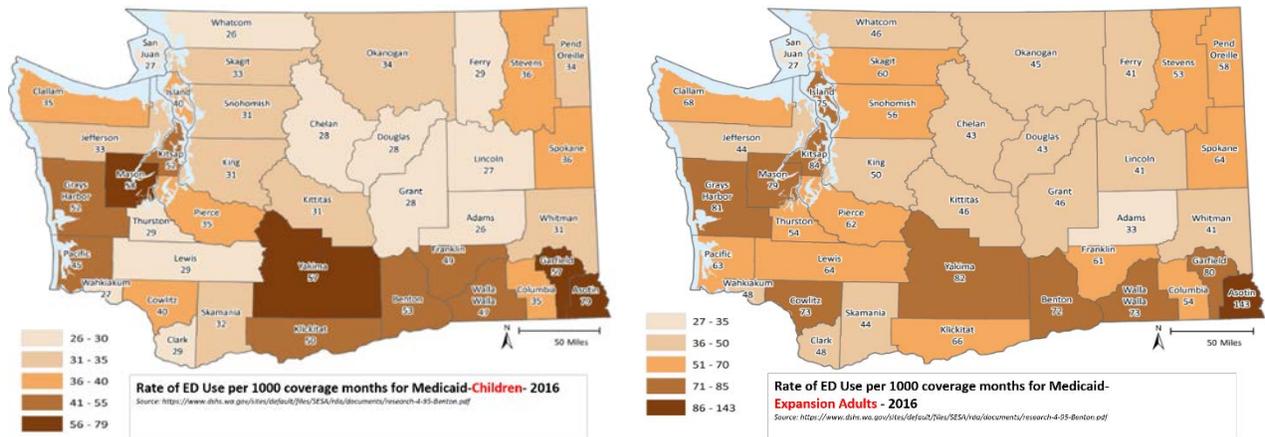


Figure 24: ED Utilization - Medicaid Children & Expansion Adults (source: DSHS)

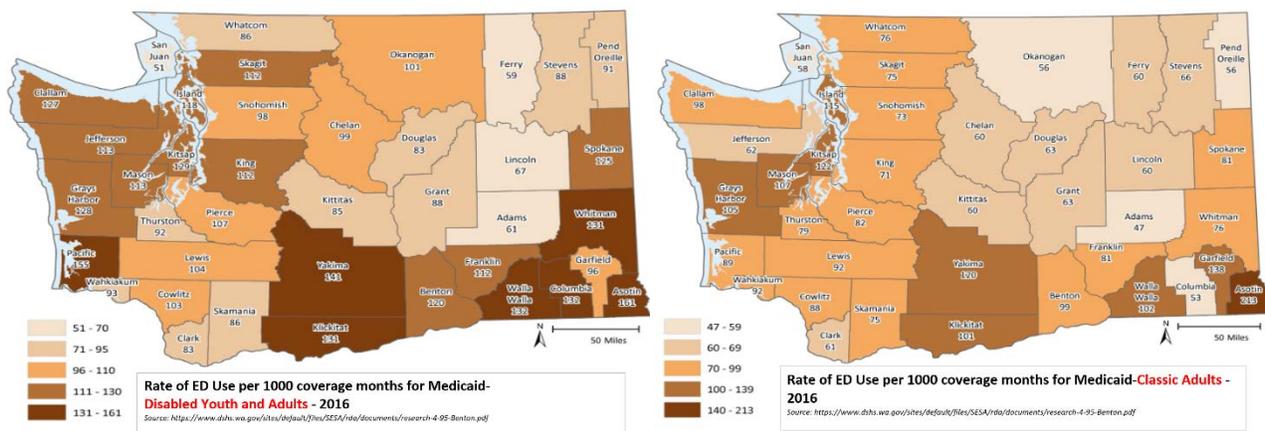


Figure 25: ED Use, Disabled Youth, Medicaid Classic Adults (source: DSHS)

Healthier Washington Dashboard

Worse than average Better than average

		Asotin	Benton	Columbia	Franklin	Garfield	Kittitas	Klickitat	Walla Walla	Whitman	Yakima	GCACH	WA State
		%	%	%	%	%	%	%	%	%	%	%	%
Hospital Care	Emergency Department Utilization per 1000 MM - Medicaid	124	67	51	55	72	41	57	65	43	72	67	5100%
	Emergency Department Utilization per 1000 MM, age 0-17 - Medicaid	79	53	34	48	58	31	41	48	31	56	52	3600%
	Emergency Department Utilization per 1000 MM, age 18+ - Medicaid	162	84	64	69	84	50	72	85	52	95	86	6600%
	Potentially Avoidable ED Visits Percent - Medicaid	21%	18%	11%	21%	21%	16%	15%	16%	16%	19%	19%	15%
	Potentially Avoidable ED Visits Percent, age 1-17 - Medicaid	31%	24%	N/A	25%	30%	22%	18%	20%	24%	24%	24%	20%
	Potentially Avoidable ED Visits Percent, age 18+ - Medicaid	17%	15%	12%	16%	15%	13%	13%	13%	13%	15%	15%	13%

Figure 26: GCACH Emergency Department Utilization Rates (source: HCA Healthier Washington Dashboard)

There are several hypotheses for high-frequency ED utilizers. Some are unbonded to a primary care medical home. For these individuals, education on alternatives (e.g. urgent care) might benefit. Some of those who are bonded to a primary care provider might find their practitioner does not instill confidence, so the ED becomes more convenient. Long appointment lead times may exacerbate this. For others, the ED is a convenient access point for obtaining pain medications or being treated for domestic violence. Finally, some individuals go to the ED because of mental health conditions. Low accessibility to the primary care medical home will also exacerbate utilization. The management of each of these types of clients might differ, depending on the driver of utilization. Interventions might range from education and health coaching to 1-on-1 case management. Community wide education will also play a role in curbing unnecessary utilization. This could include ED handouts in multiple languages, posters, billboards, articles in local press, TV, and partnerships with private industry, schools, community centers, and churches.

The causes of high ED use are multi-factorial, relating to socio-economics, culture, generational habit, clinical characteristics, deliver access and capacity, workplace policy (i.e. requiring a doctor's note to return to work) and more. Accordingly, a single broad strategy, no matter how well intended, may not succeed. The GCACH will require a strategy to reduce avoidable visits through education to the community, and care coordination for medium-high utilizers. A comprehensive approach to ED utilization will be a strong focus for the Strategic Planning Workgroup during 2018.

Provider Access

The GCACH is served by many Federally Qualified Healthcare Centers with multiple locations throughout our service area as shown in Figure 27, and served by many of hospitals and health systems as shown in Figure 28.

Community Health Centers in GCACH

Clinic	Operator	Services	City	County
Ellensburg Dental Care	Community Health of Central Washington	Dental	Ellensburg	Kittitas
Ellensburg CHCW	Community Health of Central Washington	Medical,Pharmacy	Ellensburg	Kittitas
Highland Clinic	Community Health of Central Washington	Medical, Pharmacy,Behavioral Health,Urgent Care,Women's Health,Pediatrics,OB /	Tieton	Yakima
Naches Medical Clinic	Community Health of Central Washington	Medical	Naches	Yakima
Children's Village	Yakima Valley Farmworkers Clinic	Medical,Dental,Behavioral Health	Yakima	Yakima
Lincoln Avenue Medical-Dental Center	Yakima Valley Farmworkers Clinic	Medical,Dental	Yakima	Yakima
Central WA Family Medicine - CHC Central WA	Community Health of Central Washington	Medical,Behavioral Health	Yakima	Yakima
Yakima Pediatrics	Community Health of Central Washington	Medical , Pediatrics	Yakima	Yakima
YNHS @ Central Washington Comprehensive Mental Health	Yakima Neighborhood Health Services	Medical, Behavioral Health	Yakima	Yakima
Community Health of Central Washington	Community Health of Central Washington	Administrative	Yakima	Yakima
Senior Smiles	Community Health of Central Washington	Dental	Yakima	Yakima
Senior and Residential Care	Community Health of Central Washington	Medical services to nursing home visits only	Yakima	Yakima
Neighborhood Connections	Yakima Neighborhood Health Services	Medical, Dental,Behavioral Health	Yakima	Yakima
YNHS @ The Depot	Yakima Neighborhood Health Services	DSHS Eligibility Worker , Behavioral Health , Health Home , Homeless Outreach , Patient Navigators , Housing Services , HEN, CHG	Yakima	Yakima
YNHS 8th Street Campus	Yakima Neighborhood Health Services	Administrative , Basic Needs Assistance ,Medical,Dental,Pharmacy,WIC , Behavioral Health; Mental Health , HCA Eligibility worker , Homeless Outreach ,Pediatrics , HEN Benefits	Yakima	Yakima
Yakima Medical-Dental Clinic	Yakima Valley Farmworkers Clinic	Medical,Dental	Yakima	Yakima
YNHS @ Southeast Community Center	Yakima Neighborhood Health Services	Medical , Behavioral Health , Mental Health , Nutrition services	Yakima	Yakima
Yakima Behavioral Health Services	Yakima Valley Farmworkers Clinic	Behavioral Health	Yakima	Yakima
YV Tech Dental Clinic	Yakima Valley Farmworkers Clinic	Dental	Yakima	Yakima
Wapato Mobile Medical & Dental Services	Yakima Valley Farmworkers Clinic	Medical,Dental	Wapato	Yakima
Wapato Mid-Valley Family Medicine	Yakima Valley Farmworkers Clinic	Medical,WIC	Wapato	Yakima
Yakima Valley Farm Workers Clinic	Yakima Valley Farm Workers Clinic	Administrative	Toppenish	Yakima
Neighborhood Health Services Granger	Yakima Neighborhood Health Services	Medical, Behavioral Health, Outreach, HCH, HBE Enrollment Assistance	Granger	Yakima
Neighborhood Health Services Sunnyside	Yakima Neighborhood Health Services	Medical,Dental,Pharmacy , Vision , WIC , Behavioral Health , Mental Health , Homeless outreach , Pediatrics, Housing , HEN Benefits , Basic Needs Assistance	Sunnyside	Yakima
Community Dental Care	Yakima Valley Farmworkers Clinic	Dental, Ortho	Sunnyside	Yakima
Neighborhood Health at Walmart Plaze	Yakima Neighborhood Health Services	WIC , Patient Navigators , Outreach & Enrollment , Housing , HEN , CHG , Referral & Linkage , Basic Needs Assistance	Sunnyside	Yakima
Sunnyside Immediate Care	Yakima Valley Farmworkers Clinic	Urgent Care	Sunnyside	Yakima
Grandview Medical-Dental Clinic	Yakima Valley Farmworkers Clinic	Medical,Dental,Behavioral Health,Pharmacy	Grandview	Yakima
Grandview Mountainview Women's Health Center	Yakima Valley Farmworkers Clinic	Medical	Grandview	Yakima
Valley Vista Medical Group	Yakima Valley Farmworkers Clinic	Medical,Pharmacy	Prosser	Benton
Connell Family Clinic	Columbia Basin Health Association	Dental,Medical, Eye Care,Pharmacy	Connell	Franklin
Richland Medical	Tri-Cities Community Health	Medical, Behavioral Health	Richland	Benton
Kennewick Medical and Behavioral Health	Tri-Cities Community Health	Medical, Behavioral Health	Kennewick	Benton
Kennewick Medical	Tri-Cities Community Health	Medical / OB/GYN / Pediatrics / Dental	Kennewick	Benton
Amistad School Based Clinic	Tri-Cities Community Health	Pediatric	Kennewick	Benton
Minne Pesina Clinical Service Building	Tri-Cities Community Health	Dental / Behavioral Health / WIC and First Steps / Womens Health / Counseling	Pasco	Franklin
Urgent Care	Tri-Cities Community Health	Ugent Care	Pasco	Franklin
Tri-Cities Community Health Center	Tri-Cities Community Health	Medical / Dental / Administrative / Pharmacy / Pediatrics / Eye Clinic / OB/GYN /	Pasco	Franklin
Ochoa School Based Clinic	Tri-Cities Community Health	Pediatrics	Pasco	Franklin
Family Medical Center	Yakima Valley Farmworkers Clinic	Medical, Dental	Walla Walla	Walla Walla
Lewis and Clark Dental Clinic	Community Health Association of Spokane	Dental	Clarkston	Asotin

Figure 27: Federally Qualified Healthcare Centers in GCACH service area

WA DEPARTMENT OF HEALTH CHARS REPORTING SYSTEM
Payer Census & Charge Comparison From 01/01/2016 To 12/31/2016
Medicaid Utilization and Charges

Hospital	County	City	Bed Count	Critical Access	Discharges	Patient Days	Total Charges	Mean Length of Stay	Mean Charge/Discharge	Mean Charge/Day	Case-Mix Adj Charges Per Discharge	CaseMix
Dayton General Hospital	Columbia	Dayton	25	Y	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Garfield County Hospital District	Garfield	Pomeroy	25	Y	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Kadlec Regional Medical Center	Benton	Richland	270		1,591	7,072	\$ 51,160,119.13	4.45	\$ 32,155.95	\$ 7,234.18	\$ 38,570.19	0.8337
Kittitas Valley Community Hospital	Kittitas	Ellensburg	25	Y	60	117	\$ 524,448.54	1.95	\$ 8,740.81	\$ 4,482.47	\$ 20,454.50	0.4273
Lourdes Medical Center	Franklin	Pasco	25	Y	285	899	\$ 8,498,556.78	3.15	\$ 29,819.50	\$ 9,453.34	\$ 31,519.18	0.9461
Prosser Memorial Hospital	Benton	Prosser	25	Y	129	244	\$ 1,723,873.95	1.89	\$ 13,363.36	\$ 7,065.06	\$ 36,831.69	0.3628
Providence St. Mary Medical Center	Walla Walla	Walla Walla	87		1,018	3,059	\$ 22,609,392.60	3	\$ 22,209.62	\$ 7,391.11	\$ 33,902.07	0.6551
Pullman Regional Hospital	Whitman	Pullman	25	Y	84	168	\$ 446,255.22	2	\$ 5,312.56	\$ 2,656.28	\$ 16,513.34	0.3217
Sunnyside Community Hospital	Yakima	Sunnyside	25	Y	1,261	2,719	\$ 26,258,739.86	2.16	\$ 20,823.74	\$ 9,657.50	\$ 45,304.82	0.4596
Toppenish Community Hospital	Yakima	Toppenish	63		1,123	2,202	\$ 17,053,197.34	1.96	\$ 15,185.39	\$ 7,744.41	\$ 37,941.81	0.4002
Trios Health	Benton	Kennewick	111		1,555	3,634	\$ 21,155,834.37	2.34	\$ 13,605.04	\$ 5,821.64	\$ 31,219.59	0.4358
Tri-State Memorial Hospital	Asotin	Clarkston	25	Y	78	211	\$ 1,602,439.75	2.71	\$ 20,544.10	\$ 7,594.50	\$ 20,416.48	1.0063
Walla Walla General Hospital	Walla Walla	Walla Walla	72		336	768	\$ 6,415,878.00	2.29	\$ 19,094.88	\$ 8,354.01	\$ 34,017.38	0.5613
Whitman Hospital and Medical Center	Whitman	Colfax	25	Y	98	253	\$ 2,072,857.65	2.58	\$ 21,151.61	\$ 8,193.11	\$ 32,224.33	0.6564
Yakima Regional Medical and Heart Center	Yakima	Yakima	150		750	2,559	\$ 40,284,686.19	3.41	\$ 53,712.91	\$ 15,742.35	\$ 52,929.22	1.0148
Yakima Valley Memorial Hospital	Yakima	Yakima	222		1,491	5,362	\$ 25,242,332.22	3.6	\$ 16,929.80	\$ 4,707.63	\$ 34,672.11	0.4883
					9,859							

Figure 28: Hospitals in GCACH service area

GCACH Professional Services Summary Report
2016 Top Professional Medicaid Services Providers

Provider Name	Claims Count	LOI Rec'd
Comprehensive Healthcare	235,635	Yes
Yakima Valley Farm Workers	220,299	Yes
Kadlec Regional Medical Center	157,042	Yes
Lourdes Health Network	121,782	Yes
Trios Health	98,637	No
Virginia Mason Memorial Hospital	91,644	Yes
Tri-Cities Community Health	62,476	Yes
Community Health Of Central Washington	51,172	Yes
Ideal Option	41,247	Yes
Yakima Neighborhood Health Services	39,733	Yes
Sunnyside Community Hospital	46,405	Yes
Providence St Mary Medical Center	29,000	Yes
Yakima Valley Council On Alcoholism	26,750	No
Walla Walla Clinic	23,595	No
Yakima Hma Physician Management	20,033	No
Pinnacle Pain Center	18,344	No
Planned Parenthood Of Greater Washington	17,654	No
Valley Alcohol Council	17,221	No
Kennewick School District	15,918	No
Yakima School Dist 7	15,879	No
Palouse River Counseling	15,867	Yes
Yakama Nation	15,430	No
Adventist Health	14,721	No
Tri-State Memorial Hospital	11,986	Yes
Mid-Valley Community Clinic	11,537	No
Kittitas Valley Healthcare	11,406	Yes
Whitman Hospital & Medical Center	11,261	No
Asotin County Mental Health Center	10,568	Yes
Prosser Public Hospital District, B	10,109	Yes

*Highlight denotes that they have been engaged in GCACH work.

Figure 29: Top Medicaid Healthcare Providers in GCACH

The healthcare providers serving the largest numbers of Medicaid clients across the GCACH were analyzed through data acquired from healthcare claims. Not surprisingly, the top providers include the FQHCs, hospital systems, and large behavioral health providers. Through our pending Partnering Provider process, we seek to form relationships with as many of these Top provider organizations as possible (see Figure 29). Fortunately, eleven of our top twelve providers have already submitted Letters of Interest to participate with the GCACH in its Transformation work

The nine county GCACH is also served by numerous community-based and social service agencies which serve low-income and Medicaid clients, based upon eligibility requirements (see Figures 30-37)

Housing Assets

AGENCY NAME	Entity Type	Primary Sector	Service Name	Site Cour
Fair Street Apartments		Housing	Fair Street	Asotin
Housing Authority of Asotin County	government	Housing	Public Housing Section 8 Housing Voucher Program Fairhaven Homes	Asotin
Lewiston Clarkston Habitat for Humanity	non-profit	Housing	Home Ownership	Asotin
Brentwood Apartments		Housing	Low Income Apartments	Benton
Elijah Family Homes		Housing	Housing	Benton
Habitat for Humanity - Tri Cities	non-profit	Housing	Self-Built Housing INACTIVE - 6/8/16 - Critical Home Repair	Benton
Housing Authority of the City of Kennewick	government	Housing	Public Housing Program Section 8 Housing Choice Programs	Benton
Luther Senior Center, Inc		Housing	Low-income Senior Housing	Benton
McMurray Park Apartments		Housing	Affordable Housing	Benton
Prosser Manor		Housing	Low Income Apartments	Benton
Quail Ridge Apartments		Housing	Low Income Housing	Benton
Benton Franklin Community Action Connections		Housing	Supportive Housing	Franklin
Franklin County Planning and Building Department	government	Housing	Burn Line Code Enforcement	Franklin
Housing Authority of the City of Pasco & Franklin County	government	Housing	Affordable Apartments Public Housing	Franklin
Briarwood Commons		Housing	Senior and Disabled Housing	Kittitas
Crestview Terrace		Housing	Low Income Apartments	Kittitas
Hampton Court Apartments		Housing	Subsidized Housing	Kittitas
Housing Authority of Kittitas County	government	Housing	Low Income Rental Housing	Kittitas
Huntington Court Senior Apartments		Housing	Senior Apartment Complex	Kittitas
Huntington Court Senior Apartments		Housing	Senior Apartment Complex	Kittitas
Kittitas County Habitat for Humanity	non-profit	Housing	Self Built Homes New Home Construction and No-Interest Loans for Low Income Critical Home Repair Loans for Low Income Home Owners ReStore	Kittitas
Pennsylvania Place Apartments		Housing	Low Income Disabled and Senior Housing	Kittitas
Pine Terrace Apartments		Housing	Affordable Housing	Kittitas
Housing Authority of the City of Walla Walla	government	Housing	Section 8 Housing Choice Voucher Program Affordable Housing and Rental Assistance	Walla Walla
Catholic Charities Housing Services	non-profit	Housing	Single Family Homeownership Program	Yakima
Commons, The		Housing	Low Income Apartments	Yakima
Harmony Park		Housing	Low Income Apartments	Yakima
Housing Authority of Yakima		Housing	Housing Authority	Yakima
Mabel Swan Manor		Housing	Low Income Housing	Yakima
Next Step Housing		Housing	Administration Office	Yakima
Northridge Apartments		Housing	Northridge Apartments	Yakima
Orchard Lane Apartments		Housing	Low Income Apartments	Yakima
Park Village and Selah Park Apartments		Housing	Low Income Apartments	Yakima
Rivard Apartments		Housing	Low-Income Apartments	Yakima
Rivard Apartments		Housing	Low-Income Apartments	Yakima
Sandalwood Apartments		Housing	Low Income Apartments	Yakima
Selah Square Apartments		Housing	Low Income Apartments	Yakima
Sun Tower		Housing	Senior Housing	Yakima
Sunnyside Housing Authority	government	Housing	Housing for Seniors and Disabled Adults	Yakima
Triumph Treatment Services		Housing	Transitional Substance Abuse Housing	Yakima
Willow Park Apartments		Housing	Low Income Apartments	Yakima
Yakima County Asset Building Coalition		Housing	Administration	Yakima
Yakima Valley Partners Habitat for Humanity	non-profit	Housing	Home Building	Yakima
Yakima Valley Partners Habitat for Humanity	non-profit	Housing	Habitat Store	Yakima
USDA Rural Development - Central Southeastern Washington	government	Housing	Farm Labor Housing, Home Improvement Loans & Grants, Home Ownership Loans	Yakima +

Figure 30: GCACH Housing Assets

Despite the number of housing units for low-income families, GCACH lacks supportive housing for people with behavioral health issues. This is especially true in Yakima, Benton, Franklin, Walla Walla, Columbia, and Asotin Counties. Addressing this issue will require a strong involvement from our local government partners. Supportive housing is often seen as a political issue, which will require public support. The GCACH will look to other successful housing initiatives that have addressed this issue (see Figure 30).

Fortunately, GCACH has developed strong partnerships with Community Action Agencies that provide a variety of services for individuals with low incomes; including housing, energy assistance, weatherization, child care, child nutrition, employment training, and more. GCACH will work closely with our partner action agencies, local health improvement networks, and community based organizations to reduce the barriers to needed healthcare and supportive services.

Community Action Agencies

AGENCY NAME	Service Name	Site Count
Benton Franklin Community Action Connections	Low Income Home Energy Assistance Eviction Prevention Assistance Low-income Prescription Assistance Information, Referrals and Advocacy Diaper Program Project Warm Up Childcare Support Services Clothing Crisis/Emergency Services Supplemental Housing SHIBA Weatherization and Minor Home Repair	Benton
HopeSource	Door to Door Transportation Energy Assistance Rent Assistance/Eviction Prevention Transitional Housing Youth Recreation Scholarship Central Transit Community Christmas Basket and Toys Support Services for Veterans and Their Families	Kittitas
Blue Mountain Action Council	Adult Literacy Volunteer Attorney Program Job Training Division Senior - Disabled Utility Discount Commodity Supplemental Food Program (CSFP) Minor Home Repair Weatherization Special Needs Housing Rapid Re-Housing AmeriCorps Employment And Training Energy Assistance Program Emergency Utility (not water) Assistance Pacific Power Rate Reduction Affordable Housing Options HEN - Housing and Essential Needs Supportive Services for Veteran's Families Permanent Supportive Housing for Homeless Families	Walla Walla
Northwest Community Action Center	Energy Assistance Program Homeless Assistance Rental & Shelter Aid Home Weatherization Seasonal Childcare Supplemental Education Services Ready to Learn Safe Haven Coordinated Approach to Child Health Adult Employment Programs Academic Youth Employment Programs	Yakima
OIC of Washington	WIOA Youth Education & Employment Training Migrant Seasonal Farmworker Program Home Weatherization Services Low Income Home Energy Assistance Program Emergency Food Assistance Program WIOA Youth Program The Prosperity Center YouthBuild Yakima	Yakima
Community Action Center	Crisis Housing Affordable Housing Energy and Heating Food and Nutrition Support Services Weatherization	Whitman

Figure 31: Action Agencies in GCACH

Legal Services

AGENCY NAME	Service Name	Site Count
Benton Franklin Legal Aid Society	Unemployment Law Project	Benton
Columbia Legal Services - Kennewick	Legal Aid Services	Benton
Northwest Justice Project - Pasco	Legal Aid Services	Franklin
Northwest Justice Project - Walla Walla	Legal Counseling Relicensing Assistance	Walla Walla
Columbia Legal Services - Yakima	Legal Counseling	Yakima
Northwest Justice Project - Yakima	Legal Counseling	Yakima
Whitman County Legal Services	Legal Aid Services	Whitman

Figure 32: Legal Services for Low Income

Financial Assistance

AGENCY NAME	Service Name	Site Count
DSHS Region 1 - Clarkston Community Services Office	Financial Assistance Medicare Savings Programs Washington Basic Food Program Working Connections Child Care Washington State ID Card Assistance	Asotin
DSHS Region 1 - Kennewick Community Services Office	DSHS - Community Service Office - Basic Food Program DSHS - Community Service Office - Financial Assistance DSHS - Community Service Office - ID Card Assistance DSHS - Community Service Office - Medicare Savings DSHS - Community Service Office - Working Connections	Benton
DSHS Region 1 - Ellensburg Community Services Office	Financial Assistance Medicare Savings Programs Washington Basic Food Program Working Connections Child Care Washington State ID Card Assistance	Kittitas
DSHS Region 1 - Goldendale Community Services Office	Financial Assistance Medicare Savings Basic Food Program Working Connections ID Card Assistance	Klickitat
DSHS Region 1 - White Salmon Community Services Office	DSHS - Community Service Office - Financial Assistance DSHS - Community Service Office - Basic Food Program DSHS - Community Service Office - Working Connections DSHS - Community Service Office - ID Card Assistance DSHS - Community Service Office - Medicare Savings	Klickitat
DSHS Region 1 - Walla Walla Community Services Office	Financial Assistance Medicare Savings Basic Food Program Working Connections ID Card Assistance	Walla Walla
DSHS Region 1 - Sunnyside Community Services Office	Financial Assistance	Yakima
DSHS Region 1 - Toppenish Community Services Office	Financial Assistance	Yakima
DSHS Region 1 - Yakima Community Services Office	DSHS - Community Service Office - Financial Assistance	Yakima

Figure 33: Financial Assistance Agencies in GCACH Region

Education (excludes government primary, secondary or tertiary education)

AGENCY NAME	Entity Type	Primary Sector	Service Name	Site Count
Lewis Clark Early Childhood Program		Education	Early Childhood Education	Asotin
Benton Franklin Head Start	government	Education	Head Start Early Head Start	Benton
Benton Franklin Head Start	government	Education	Head Start	Benton
Children's Reading Foundation of the Mid Columbia Communities In School of Benton-Franklin		Education	Promotion of Childhood Literacy Academic Assistance Enrichment Program Life Skills Program	Benton
Community Development Institute Head Start (EPIC)		Education	Early Childhood Education and Assistance Program (ECEAP)	Benton
Benton Franklin Head Start		Education	Head Start	Franklin
Benton Franklin Head Start	government	Education	Head Start	Franklin
Boys and Girls Clubs of Benton and Franklin Counties	non-profit	Education	Discovery Preschool	Franklin
Region 2 - Tri-Cities Office of Department of Early Learning	government	Education	Child Care and Early Learning	Franklin
Bright Beginnings for Kittitas County	government	Education	Head Start & Early Head Start Program Early Childhood Education and Assistance Program (ECEAP) Early Intervention Program Ages & Stages Questionnaire	Kittitas
OIC of Washington		Social Services	WIOA Youth Education & Employment Training	Kittitas
Mid-Columbia Children's Council	government	Education	Head Start, Early Head Start and ECEAP	Klickitat
Mid-Columbia Children's Council	government	Education	Head Start, Early Head Start and ECEAP	Klickitat
Mid-Columbia Children's Council			Head Start, Early Head Start and ECEAP	Klickitat
Mid-Columbia Children's Council			Head Start, Early Head Start and ECEAP	Klickitat
Children's Home Society of Washington - Southeast Region	government	Education	Early Head Start Farm Labor Homes Summer Recreation Program Volunteer Parents as Teachers	Walla Walla
The Star Project		Social Services	General Case Management Housing Education Employment	Walla Walla
Catholic Family and Child Service of Yakima		Social Services	Outpatient - Counseling Services VIP - Valley Intervention Program Foster Care/Adoption Services Foster Grandparents Program - Elder Services Foster Teen Programs Senior Companion Program Respite Care (Specifically for the Memory Challenged) Parents as Teachers (PAT) Kinship Navigator Carroll Children's Center Early Childhood Intervention & Prevention Services (ECLIPSE) ECEAP (Early Childhood Education Assistance Program) Child Care Aware of Central WA	Yakima
Community Development Institute Head Start (EPIC)	government	Education	Administration	Yakima
La Casa Hogar		Education	Spanish Classes ESL Pre-General Education Diploma (GED) Preparation Basic Computer Literacy Driving Classes Early Learning Center Summer Programs	Yakima
Northwest Community Action Center		Social Services	Energy Assistance Program Homeless Assistance Rental & Shelter Aid Home Weatherization Seasonal Childcare Supplemental Education Services Ready to Learn Safe Haven Coordinated Approach to Child Health Adult Employment Programs Academic Youth Employment Programs	Yakima
Nuestra Casa	non-profit	Education	English as a Second Language (ESL)	Yakima
OIC of Washington			WIOA Youth Education & Employment Training Migrant Seasonal Farmworker Program Home Weatherization Services Low Income Home Energy Assistance Program Emergency Food Assistance Program WIOA Youth Program The Prosperity Center YouthBuild Yakima	Yakima
Region 2 - Yakima Department of Early Learning	government	Education	Department of Early Learning	Yakima
Yakama Nation	government	Education	Head Start	Yakima

Figure 34: Education & Academic Assistance, GCACH

Nutrition Programs

AGENCY NAME	Service Name	Site Count
Asotin County Food Bank Association	Food Pantry	Asotin
Jericho Road Ministries	Evening Food Bank and Learning Center Professional Clothing Closet	Benton
Jubilee Ministry of Prosser	Food pantry	Benton
Second Harvest Tri-Cities	Food Donation Program	Benton
Senior Life Resources NW	Home Delivered Meals for age 60+ Administration Fundamental Home Delivered Meals for Under Age 60	Benton
Tri-Cities Food Bank	Food Pantry	Benton
Trios Health	Nutrition Services	Benton
Yakima Valley Farm Workers Clinic	Primary Care Medical Services WIC/ Nutrition Services	Benton
Connell Food Bank	Food Bank	Franklin
Golden Age Food Share Program	Senior Food Pantry	Franklin
Pasco, City of	Meals on Wheels	Franklin
Riverview Seventh-Day Adventist Church	Food Pantry	Franklin
Salvation Army Mid Columbia	Food and Clothing Bank	Franklin
Senior Life Resources NW	Home Delivered Meals for age 60+ Senior Dining Center Meals Fundamental Home Delivered Meals for Under Age 60	Franklin
Tri-City Union Gospel Mission	INACTIVE - 11/23/15 - Thanksgiving Boxes INACTIVE - 12/04/15 - Christmas Food Baskets	Franklin
Community Food Bank of Dayton	Food Bank	Columbia
Dayton Food Bank		Columbia
Project Timothy	Food/Utilities/Rent/Emergency/Transitional Housing	Columbia
Garfield County Food Bank	Food Pantry	Garfield
Allied People Offering Year-Round Outreach	Food Pantry	Kittitas
Ellensburg, City of	Senior Nutrition Program	Kittitas
Elmview	Senior Nutrition Meals on Wheels	Kittitas
FISH Food Bank	Fish Food Bank The Diner at FISH Bread Room	Kittitas
HopeSource	Food Bank	Kittitas
Goldendale Food Bank	Food Pantry	Klickitat
Klickitat County Senior Services	Nutrition Program	Klickitat
Washington Gorge Action Programs	Nutrition Services	Klickitat
Blue Mountain Action Council	Commodity Supplemental Food Program (CSFP)	Walla Walla
Center at the Park/Walla Walla Senior Citizens Center, The	Senior Round Table - Meals on Wheels & Nutrition Services	Walla Walla
Christian Aid Center	Meals and Food Distribution	Walla Walla
Round Table Senior Center	Meals & Socialization	Walla Walla
Salvation Army - Walla Walla	Food Bank	Walla Walla
St Vincent de Paul - Walla Walla	INACTIVE - 11/27/2015 - Christmas Food Boxes INACTIVE - 11/24/2015 - Thanksgiving Dinner	Walla Walla
Yakima Valley Farm Workers Clinic- Family Medical Center	Nutrition Counseling WIC/ Nutrition Services	Walla Walla
Catholic Family and Child Service of Yakima	Child Care Nutrition Program	Yakima
Fairview SDA Church Food Pantry	Food Pantry	Yakima
Grandview Seventh-Day Adventist Community Services	Food and Clothing Bank	Yakima
Granger Food Bank	Food Pantry	Yakima
Northwest Harvest	Food Distribution Center Volunteer Opportunities	Yakima
OIC of Washington	Emergency Food Assistance Program	Yakima
People for People	Meals on Wheels	Yakima
Rod's House	Food Pantry	Yakima
Salvation Army of Yakima	Food Pantry	Yakima
Selah Food Bank	Food Pantry	Yakima
St Michael's Food Pantry	Food Pantry	Yakima
Sunnyside Seventh-Day Adventist Church	Food Pantry	Yakima
Sunrise Outreach Center	Food and Clothing Bank, Soup Kitchen	Yakima
Tieton Food Bank	Food Bank	Yakima
Toppenish Community Chest Food and Clothing Bank	Food & Clothing Bank	Yakima
Wapato Food Bank	Food Pantry	Yakima
White Swan Food Bank	White Swan Food Bank	Yakima
Yakama Nation	Food Bank	Yakima
Yakima Rotary Food Bank	Food Pantry	Yakima
Zillah Food Bank	Food Pantry	Yakima

Figure 35: Food Assistance Agencies, GCACH

Transportation

AGENCY NAME	Service Name	Site Count
Asotin County PTBA	Local Bus Services	Asotin
Interlink, INC.	Wheelchair Ramps Transportation Yard Work Minor Home Repair and Safety Modification	Asotin
Ben Franklin Transit	Fixed Route Bus Service Dial-A-Ride Night & Sunday Service Prosser/Benton City General Demand Response Vanpool Taxi Feeder Service Travel Training	Benton
Columbia County Public Transportation	Public Transportation	Columbia
Garfield County Rural Transportation	Garfield County Transportation	Garfield
HopeSource	Door to Door Transportation Energy Assistance Rent Assistance/Eviction Prevention Transitional Housing Youth Recreation Scholarship Central Transit Community Christmas Basket and Toys Support Services for Veterans and Their Families	Kittitas
HopeSource	Food Bank Energy Assistance Rent Assistance/Eviction Prevention Transitional Housing Youth Recreation Scholarship Door to Door Transportation Community Christmas Basket and Toys	Kittitas
Hospice Friends	Equipment and Supplies Transportation Bereavement Support Volunteer Support Comfort Therapies	Kittitas
Klickitat County Senior Services	Information and Assistance for Seniors Case Management In-Home Services Nutrition Program Mt Adams Transportation	Klickitat
Klickitat County Senior Services	Information and Assistance for Seniors Case Management In-Home Services Nutrition Program Mt Adams Transportation	Klickitat
Jonathan M Wainwright Memorial VA Medical Center	Veteran's Medical Care Outpatient Substance Abuse Treatment Transportation	Walla Walla
Valley Transit	Fixed Route Public Transportation Dial-A-Ride Evening and Saturday Flex Route Service Job Access	Walla Walla
Pahto Public Passage	Fixed Transit Routes	Yakima
People for People	Community Connector General Transportation Employment/Employment Services Transportation	Yakima
Yakima Transit	Bus Service	Yakima

Figure 36: Transportation Services, GCACH

Employment Services

AGENCY NAME	Service Name	Site Count
Benton Franklin Legal Aid Society	Unemployment Law Project	Benton
Columbia Industries	Employment Services Pre-Vocational/Group Supported	Benton
DSHS Region 1 - Kennewick Community Services Office	DSHS - Community Service Office - Working Connections	Benton
DSHS Region 1 - Kennewick Office of Developmental Disabilities Administration	Early Intervention Services Administration Employment and Day Program Services Individual and Family	Benton
Goodwill Industries of the Columbia, Inc	Community Jobs Program	Benton
WorkSource Columbia Basin	Job Center Unemployment Information Dislocated Worker Program Youth Program Adult Program Veterans Program	Benton
Elmview	Employment Services	Kittitas
Entrust Community Services	Individual Supported Employment Transition Program	Kittitas
OIC of Washington	WIOA Youth Education & Employment Training	Kittitas
People for People	Employment Training	Kittitas
WorkSource Area Office #9	Job Finding Assistance Veterans Services	Kittitas
DSHS Region 1 - White Salmon Community Services Office	DSHS - Community Service Office - Working Connections	Klickitat
WorkSource Area Office #9	Job Finding Assistance Veterans Services Migrant Seasonal Farm Worker Program	Klickitat
WorkSource Area Office #9	Job Finding Assistance Veterans Services	Klickitat
Blue Mountain Action Council	AmeriCorps Employment And Training	Walla Walla
DSHS Region 1 - Walla Walla Community Services Office	Working Connections	Walla Walla
DSHS Region 1 - Walla Walla Office of Division of Developmental Disabilities	Employment and Day Program Services	Walla Walla
Lillie Rice Center, Inc	Employment Training and Support for the Disabled	Walla Walla
The Star Project	Employment	Walla Walla
Valley Transit	Job Access	Walla Walla
Walla Walla Community College	Transition to Work Courses	Walla Walla
WorkSource Walla Walla	Skills and Employment Background Assessment Veterans Services Dislocated Worker Program Youth Services Employment and Training Unemployment Information	Walla Walla
Entrust Community Services	Individual Supported Employment Group Supported Employment Transition Program Ticket-to-Work	Yakima
Northwest Community Action Center	Adult Employment Programs Academic Youth Employment Programs	Yakima
OIC of Washington	WIOA Youth Education & Employment Training	Yakima
People for People	Employment/Employment Services Transportation	Yakima
South Central Workforce Development Council	Workforce Development	Yakima
WorkSource Area Office #9	Job Finding Assistance	Yakima
Yakima Specialties	Employment for People with Disabilities	Yakima
Yakima Work Opportunity Center, Division of Tacoma Goodwill	Vocational Services for Disabled	Yakima

Figure 37: Employment Services in GCACH regional service area

All the service providers included here, and many more, play a large role in addressing the social determinants of health. The goal of the GCACH will be to coordinate these organizations with Medicaid providers and Medicaid clients in a holistic way, which is discussed elsewhere in the Project Plan proposal. This will go toward better outcomes and lower costs.

Data has been used by GCACH leadership, staff and Project Teams to explore populations to inform the theory of action; identify health care needs, gaps, and disparities; select projects and estimate potential project impact; identify priority populations for projects; identify potential partnering providers and organizations; understand community needs; engage stakeholders; design and plan projects; and assess workforce capacity and gaps.

The GCACH has had a Data Committee for several years, which met sporadically. The committee was recently reconstituted and rebranded as the Data Management and HIE committee, whose goals are to support data-driven decision-making through the review and interpretation of available information, to identify data gaps and needs, and to making recommendations regarding issues of strategic importance to the organization.

The DMHIE committee is also tasked with identifying system and integration needs for the overall GCACH transformation work. This includes the possible implementation of an online resource tool that might provide a robust, user friendly, consumer facing web resource, like www.1degree.org, which makes it easy for consumers, CHWs, non-profits, Medicaid providers and more to access and possibly self-manage their use of community-based resources.

GCACH's DMHIE includes representation from MCOs, FQHCs, large hospital providers, Qualis, a regional care coordination agency, social service providers and more. These partners bring sector-specific content expertise to the DMHIE to assess community needs and review available information to make recommendations regarding project and population selection.

The DMHIE The GCACH is already working with community partners to determine integrative systems needs to support project goals. For example, the need for a HIPAA compliant secure messaging service for providers across different systems has been discussed. As well, the idea of creating an Expedia-like platform that reports out available residential treatment facility beds for individuals requiring short stays for SUD recovery has also been talked about. This latter system could be shared across all providers and would increase access, decrease wait times, and would reduce provider frustration in managing these clients.

GCACH has contacted Providence CORE to determine future data and analytic support around both P4P and P4R performance monitoring. It has also executed a contract with HMA to assist with modeling funds flow and project impact. GCACH has also contact King County relating to potential data analytic and support

Analytic gaps that still need to be filled include analysis around the targeted populations chosen by the Project Teams. More detail will be collected around the numbers each targeted sub-population (e.g. patients with severe and persistent mental illness) by county. There is also the issue of timeliness of data. With claims lags around P4P data, it provides little capacity for rapid cycle improvement. The formulation of proxy measures is an additional area where work can be done.

The GCACH has also collaborated with King County, leading to the formation of an online Performance Gap Analysis tool: (https://public.tableau.com/profile/apde.datarequest#!/vizhome/GC_PerformanceGapAnalysis/Readme), which has been used to identify numbers-needed-to-treat across project measures and counties. This highly useful tool has been successfully presented to the Project Teams, Leadership Council, Board and community partners. GCACH has also been participating in group discussions with all ACH leaders about HIT/HIE needs and has participated in a review process of at least one possible CRM platform.

ACH Theory of Action and Alignment Strategy

ACHs are encouraged to think broadly about improving health and transforming care delivery beyond the Medicaid program and population. Advancing a community-wide vision and approach will be critical in ensuring the sustainability of health system transformation.

The term “health equity,” as used in this Project Plan Template, means reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.¹

Describe the ACH Theory of Action and Alignment Strategy. In the narrative response, address the following:

- Describe the ACH’s vision for health system transformation in its region; include a vision statement and a discussion of how the vision addresses community needs, and the priorities of the whole population.
- Define the ACH’s strategies to support regional health and healthcare needs and priorities.
- Indicate projects the ACH will implement (a minimum of four).

Project Plan Portfolio	
Domain 2: Care Delivery Redesign	
<input checked="" type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input checked="" type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversions Interventions
Domain 3: Prevention and Health Promotion	
<input checked="" type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input checked="" type="checkbox"/>	3D: Chronic Disease Prevention and Control

¹ Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What Is Health Equity? And What Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017. Accessible at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf437393

- Describe the process the ACH followed to consider and select projects as part of a portfolio approach.
 - What were the criteria for selecting projects?
 - Describe how the ACH applied its whole-population vision for health system transformation to inform its project selection and planning.
 - Which interventions, resources, and infrastructure will be shared throughout the project portfolio, and how will they be shared?
- Describe how, through these projects, the ACH plans to improve region-wide health outcomes.
- Describe how, through these projects, the ACH plans to improve the region-wide quality, efficiency, and effectiveness of care processes.
- Describe how, through these projects, the ACH plans to advance health equity in its community.
- Describe how, through these projects, the ACH plans to demonstrate a role and business model as an integral, sustainable part of the regional health system.
- Discuss how the ACH addressed any gaps and/or areas of improvement, identified in its Phase II Certification, related to aligning ACH projects to existing resources and initiatives within the region.
- Submit logic model(s), driver diagrams, tables, and/or theory of action illustrations. The attachments should visually communicate the region-wide strategy and the relationships, linkages, and interdependencies between priorities, key partners, populations, regional activities (including workforce and population health management systems), projects, and outcomes (*submit as ACH Theory of Action and Alignment Strategy – Attachment A*).

ACH Response

GCACH's vision for health system transformation

GCACH's regional vision is that we are a vibrant, healthy community in which all individuals, regardless of their circumstances, can achieve their highest potential. To achieve this vision, GCACH's mission is to advance the health of our region-wide population by decreasing health disparities, improving efficiency of health care delivery, and empowering individuals and communities through collaboration, innovation, and engagement.

GCACH's vision for health system transformation is a health system focused on prevention, person-centered, culturally-competent, integrated care that addresses a full range of individual clinical and social needs impacting health, and accountability to improving health and reducing costs through measurable outcomes. As reflected in our mission, GCACH's vision for health system transformation is based on four foundational concepts that work together in our theory of action (see figure 38, and Attachment A for full-size image):

1. Collective impact through strong cross-sector partnerships and collaboration;
2. Health system integration and care coordination, including clinical and community linkages;
3. Health equity with a focus on social determinants of health; and
4. Individual and community empowerment to create a culture of health throughout the region.

Greater Columbia ACH Theory of Action

Adapted from RWJF Culture of Health Framework

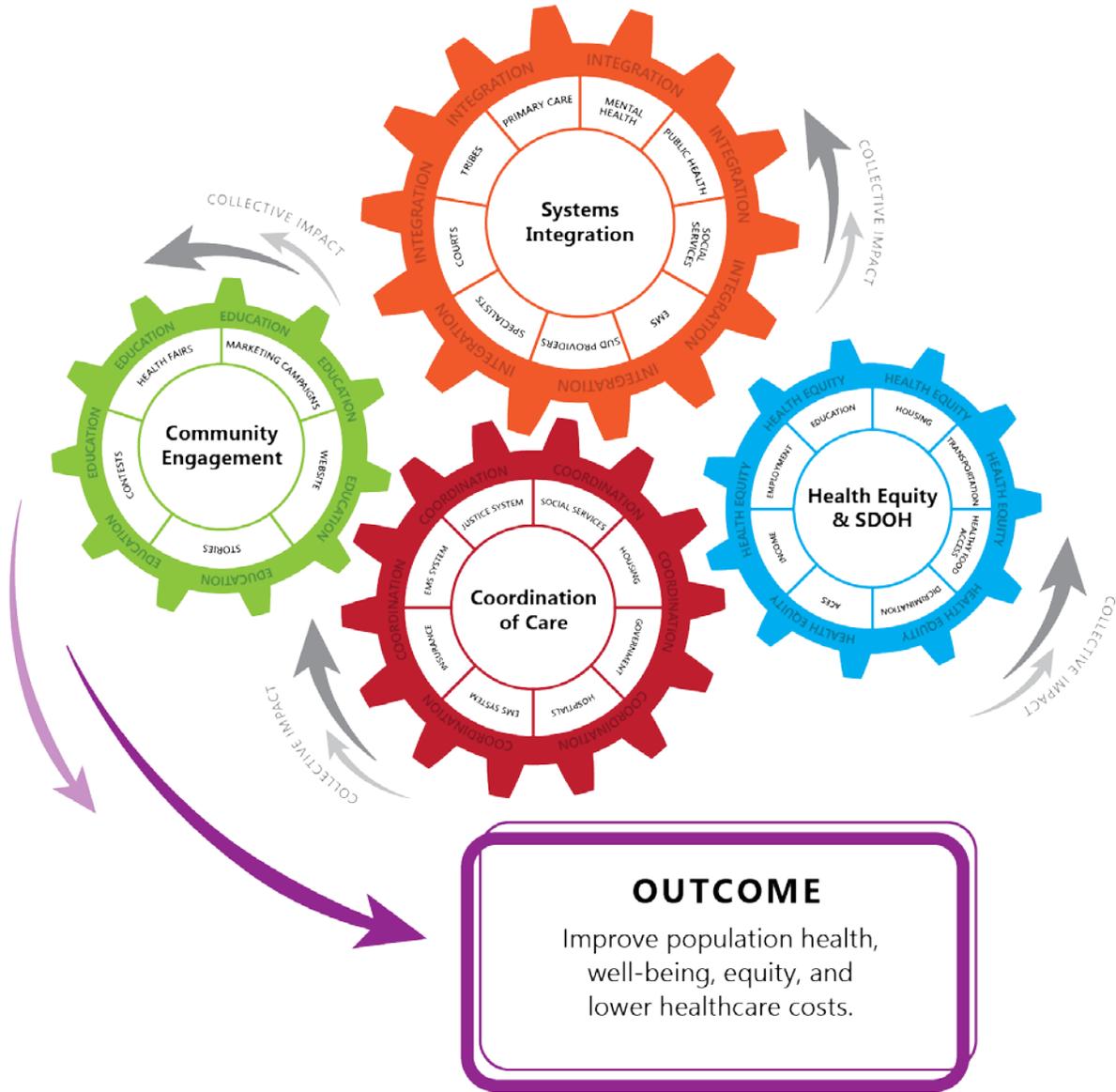


Figure 38: GCACH Theory of Action

This approach to transformation will support community-wide and system-level changes to address our regional health needs and priorities. We note that this vision aligns with the Robert Wood Johnson Foundation’s Culture of Health Framework, reinforcing that our approach to health system transformation is supported by national thought leaders in this field.

Strategies to support regional health and healthcare needs and priorities

Since 2014, GCACH has employed a two-pronged strategy to support a robust regional health needs assessment:

1. Data- driven evaluation of regional and county-level health needs, and
2. Broad cross-sector, region-wide collaboration and engagement to develop solutions addressing these needs. See Figure 39 below:

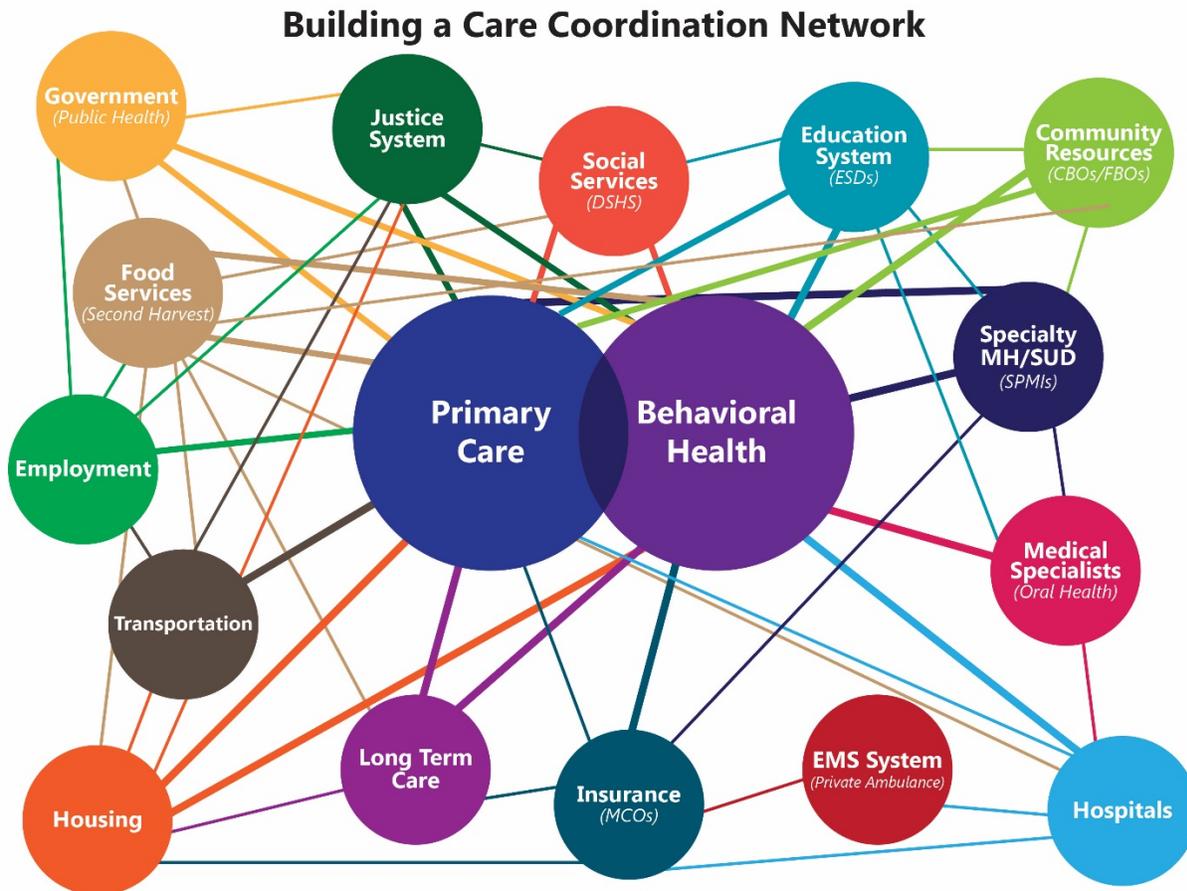


Figure 39: GCACH Care Coordination Network

With the approval of Washington’s Medicaid 1115 waiver, the original five Priority Work Groups evolved into eight Project Teams (PTs) based on the project areas in the Healthier Washington Toolkit.

Table 1. Proposed "Re-formation" of Priority Work Groups to Project Teams (April 2017)

GCACH Priority Work Group	Medicaid Demonstration Project Team
Behavioral Health	Bi-Direction Integration of Care & Primary Care Transformation (2A)
	Addressing Opioid Use Public Health Crisis (3A)
Care Coordination	Community Based Care Coordination (2B)
	Transitional Care (2C)
	Diversion Interventions (2D)
Healthy Youth & Equitable Communities	Reproductive and Maternal/Child Health (3B)
Oral Health	Access to Oral Health Services (3C)
Diabetes/Obesity	Chronic Disease Prevention and Control (3D)

Each Project Team (PT) formed out of the GCACH Leadership Council (LC), a multi-sector, representative group of subject matter experts. Subject matter and clinician experts were brought in to form Reproductive and Maternal/Child Health, Addressing Opioid Use Crisis, and Bi-Directional project teams as the original work groups had not focused specifically in these areas. In early May 2017, each PT further evaluated regional health data and engaged in a collaborative process to develop a proposed project plan in each of the eight project areas, with a focus on evidence-based models and achieving measurable improvements in health outcomes. Each of the PTs was led by one or two Project Facilitators. The Project Facilitators from each PT participate on the Project Advisory Committee (PAC), formed to identify areas of alignment and synergy across the projects. The committee also provided bi-directional communication between the Board and the Leadership Council. Figure 40 below shows these relationships:

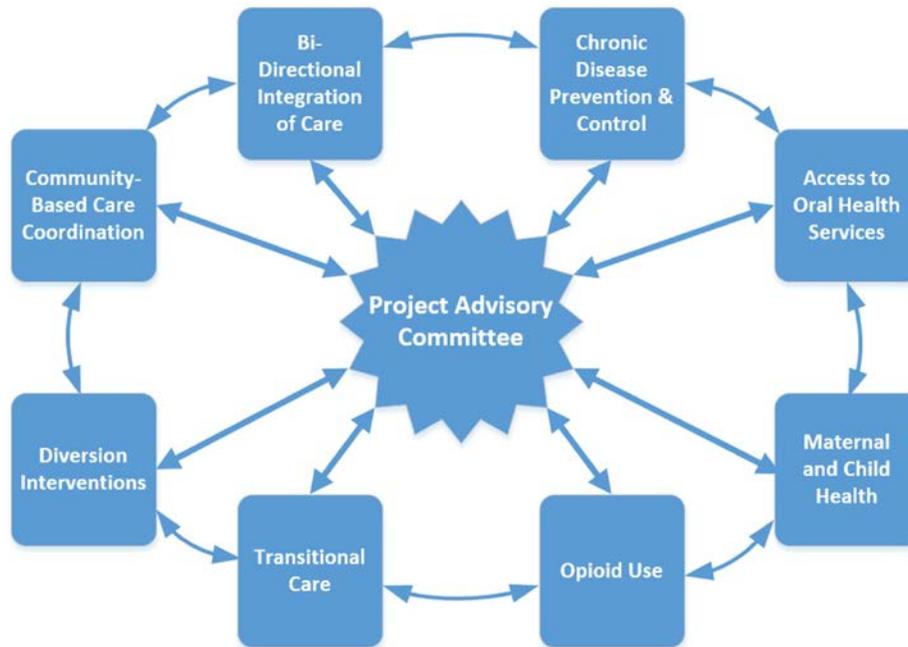


Figure 40: Project Advisory Committee Structure

GCACH Project Portfolio

On October 26th, the Board chose four projects for the project plan based on input from the Technical Advisory Committee, the Leadership Council, common understanding of the themes expressed through community engagement. The projects included in the Portfolio are:

- Bi-directional integration
- Transitional Care
- Opioid crisis
- Chronic disease

Although the GCACH Board selected these four areas for the Portfolio, Board members expressed support for all eight project areas in the MDT toolkit and directed GCACH staff to incorporate elements of these into the Portfolio or other ACH activities. Community-based care coordination and emergency department utilization were highlighted as priorities for the region. ED utilization will also require a broad-based community strategy to address pervasive and long-standing ED abuse. GCACH previously considered moving forward with the Pathways Hub model but after further community conversations with partnering providers, has opted to investigate and develop strategies to support community-based care coordination that are a better fit with the region.

GCACH Project Portfolio Selection Process

At the October Board meeting, the GCACH Board made a formal determination to move forward with four of the eight project areas under consideration for purposes of further developing projects for the Project Plan application. This decision was based on review of the project plans presented by each PT, recommendations by an independent Technical Advisory Committee (TAC), recommendations by the GCACH LC, community and stakeholder input, and based on strategic considerations regarding alignment and accountability for project metrics and the DSRIP project funding. The GCACH project

selection process ensured that the Board’s decision was based on a data-driven regional health needs identified assessment and incorporated broad cross-sector and community input.

Project selection criteria: GCACH formed an independent TAC is comprised of five clinical and subject matter experts to make recommendations to inform the Board’s project selection decisions. The TAC evaluated the eight project plans based on 10 criteria aligned with our mission and vision, our strategic plan for improving population health, and Healthier Washington priorities (See Attachment C) for project selection criteria and scoring form):

1. Community support for the project
2. Impact/synergy with other projects
3. Sustainability
4. Likelihood of return on investment
5. Scalability
6. Health equity
7. Alignment with community needs
8. Measurement infrastructure
9. Workforce capacity
10. Adoption of Toolkit/evidence-based models

Selection based on whole-population vision for health system transformation: Projects selected provide the opportunity to advance health system transformation for all populations in the GCACH region. By focusing on projects that start with high-needs, complex populations, the project portfolio emphasizes fundamental system changes that can be scaled and will benefit our regional population at large. The delivery of these projects aligns with GCACH’s mission, and our high-level objectives of coordinating care, integrating health systems, building community partnerships, and empowering patients.

Interventions, resources and infrastructure shared the project portfolio:

GCACH’s initial assessment of project alignment has identified potential shared interventions and infrastructure needs across projects. These include:

- Region -wide care coordination and data sharing infrastructure will serve as a shared regional resource to align and optimize care coordination and outreach to target populations. GCACH has allocated \$790K over the course of the Demonstration to support care coordination, data sharing, and building a robust website designed with both stakeholders and consumers in mind. Data sharing agreements will be required of our participating providers to measure and monitor performance.
- Workforce – Mental Health Counselors, Behavioral Health Specialists, Primary Care Providers, Nurses, Social Workers, and Community Health Workers, were identified by several project areas and in a regional survey as key workforce needs. A Workforce Committee has been chartered to review the GCACH Provider system workforce needs and develop a recommended target state for the region. Funding in the amount of \$672K has been set aside for capacity development, recruiting, training and retention activities.
- Performance measurement and Health Information Exchange (HIE) infrastructure will be critical as a population health management tool, and to share electronic health information between the participating providers. GCACH will try to find a system that can integrate social determinants and behavioral health into medical data within EHRs, and ask participating

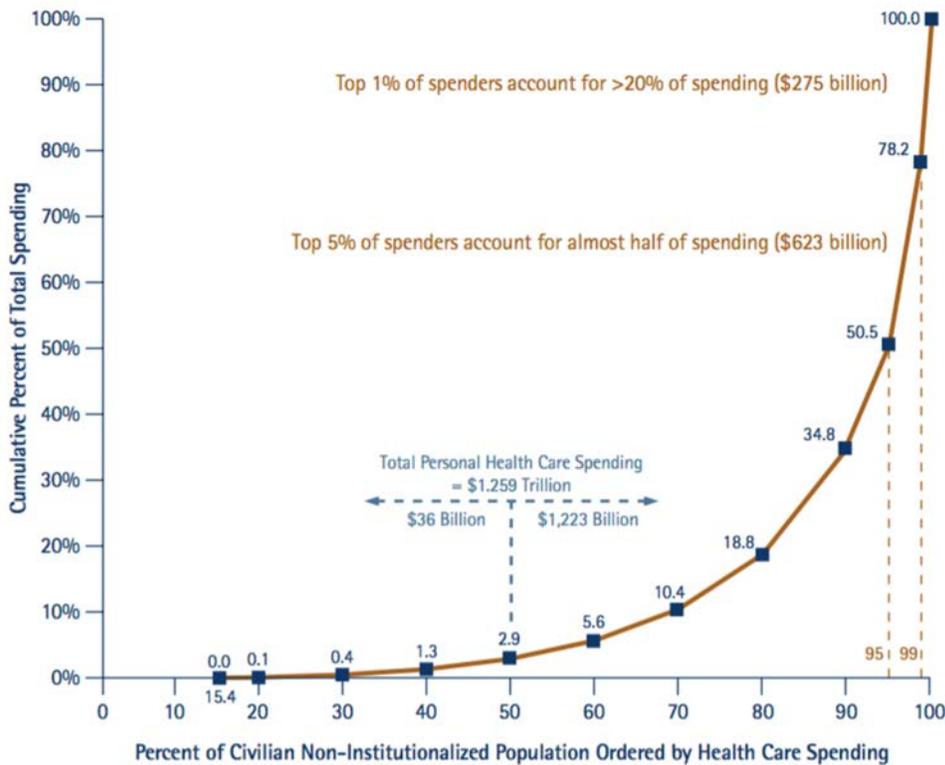
providers to engage in health information exchange. GCACH is dedicating approximately \$1M to initiative such a system of sharing.

- Community engagements efforts will be shared across projects to gather community input, build consumer councils, and engage collective action. Funding from Design funding in the amount of \$900K will be used to support Local Health Improvement Coalitions, a user-friendly and modern website, education and training.

How GCACH project portfolio will improve region-wide outcomes and quality and efficiency of care

GCACH has chosen to focus on high-cost, high-utilizing patients, particularly those with co-morbidities of behavioral health and chronic disease, as its primary target population. People with complex needs often receive health care that is not coordinated, and not connected to a system of social supports, often the result of social determinants. Addressing the health needs of this vulnerable population will require new models of coordinating medical care and community based social services. Cross-sector collaboration between partners will be essential to share information and coordinate person-centered care which will improve the quality and effectiveness of our regional system, and result in better patient outcomes.

Cumulative distribution of personal healthcare spending in the U.S. in 2009



Source: Schoenman, Julie A. "The concentration of health care spending." NIHCM Foundation Data Brief, National Institute of Health Care Management, Washington, DC (2012). (Formatted by www.OurWorldInData.org)

Figure 41: Distribution of personal healthcare spending in US, 2009

The GCACH Project Portfolio will prioritize reducing avoidable emergency department utilization. Emergency department utilization has been traditionally higher in our region than the state average.

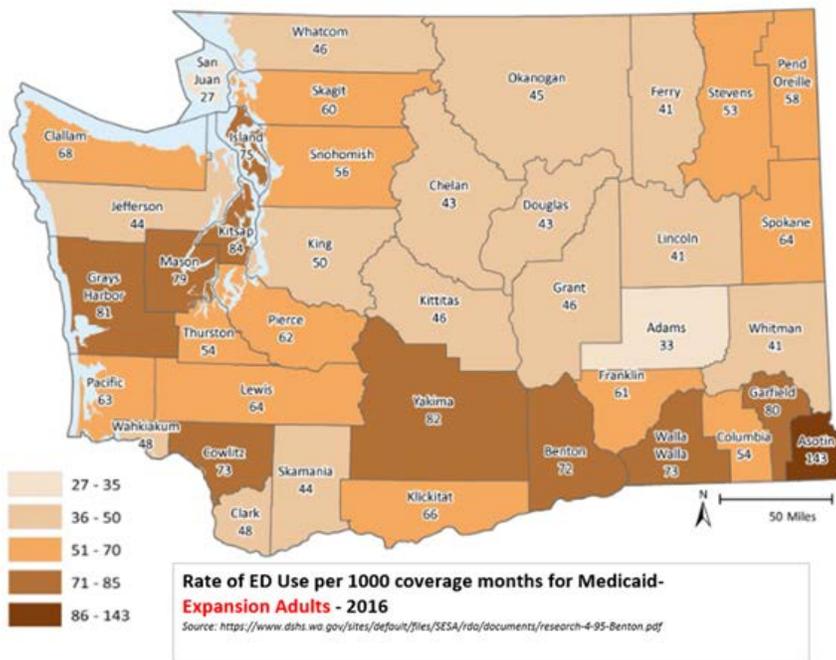


Figure 42: Rate of ED Utilization - 2016

Almost 40% of emergency department super utilizers (EDSU) have one or more chronic conditions, a higher percentage than non-EDSU. GCACH’s Project Portfolio is designed to address core areas of need for this population and build a strong foundation for long-term transformation of the health care delivery for everyone in the region, not just Medicaid beneficiaries. Our bi-directional integration of care project will result in improvements in coordinated, whole-person care and help break down the silos between provider types. Integration of services is an important strategy to address persistently high cost patterns among patients with complex care needs, multiple chronic conditions such as diabetes and heart disease, and psychological and social barriers to care. Serious mental health and substance use diagnoses are among the most significant drivers of cost. Per capita costs are double or triple for Medicaid patients with a co-morbid mental health diagnosis or with evidence of substance abuse. Bi-directional integration of physical and behavioral health is a person-centered, cost-effective strategy that yields better patient outcomes. The Transitional Care Project will improve support for at-risk enrollees at care transitions by strengthening and broadening existing person/family-centered interdisciplinary/interagency (ID/IA) collaborative initiatives across the region. Improved case management and community-based care coordination for these individuals can also address their mental, physical, and social determinant needs. Addressing the opioids use crisis will improve health outcomes for the most vulnerable in our region through increased prevention, treatment, overdose prevention and long-term recovery support. And addressing chronic disease, particularly for people who also experience behavioral health issues, through both prevention and improvement management of care (including improved access to primary care) will make significant improvements in health outcomes.

How GCACH project portfolio will advance health equity in the region

Creating healthier, more equitable communities

Knowing which neighborhoods lack access to healthy options, whether exercise opportunities or nutritious food will be a part of the action agenda of the Local Health Improvement Networks (LHINs). These networks are being formed specifically to advance the health of community populations and conditions. There is a strong causal link between individual socio-economic status and the neighborhood in which we live. The Area Deprivation Index (ADI) is an index that represents a geographic area-based measure of the socioeconomic deprivation experienced by a neighborhood. Higher index values represent higher levels of deprivation. Higher levels of deprivation have been associated with an increased risk of adverse health and health care outcomes.

For heart failure patients, living within a high-ADI U.S. neighborhood is significantly associated with 6-month all-cause readmission even after adjusting for other patient-level factors. GCACH will provide funding to LHINs to advance health in their own communities, specifically addressing health disparities for the target populations they feel are in most need. Because these determinations will be made at the local level, neighborhoods experiencing high disparities can be identified and addressed.

Finally, making health a shared value emphasizes the importance of all individuals, families, and communities in shaping a Culture of Health. When everyone treats health as a priority in public policy and personal decision-making, we'll see a comprehensive cultural shift in America.

How GCACH project portfolio will demonstrate a role and business model for GCACH as an integral, sustainable part of the regional health system

We believe there is an ongoing role for GCACH as a neutral convener and a facilitator of alignment across health care transformation efforts across the region, in building stronger connections between social determinants of health providers and clinical providers. GCACH will also play a leadership role in the region in identifying and helping to develop and support community-based care coordination mechanisms, drive policy reform at the local and state level (i.e. expansion of dental therapists and scope of practice for other mid-level providers), leveraging technologies and systems integration to support better population health management, and strategies for partnering providers and ultimately the region. Finally, a coordinated approach to reducing downstream intensive healthcare utilization (i.e. ED utilization, jail) through community engagement builds a strong case for sustainability.

How GCACH has addressed any gaps/areas for improvement identified through Phase II Certification relating to alignment of ACH project to existing project within the region.

GCACH has worked to identify broader strategies beyond the MDT. GCACH staff and the Project Advisory Committee, with the help of consultants from HMA and our Mike Bonetto, our Regional Coordinator, held a half-day strategy session in September 2017 to identify opportunities for alignment across the projects, shared target populations and connections to broader efforts within the region. In addition, the GCACH LOI process identified partnering provider resources and needs / gaps.

Another way that GCACH is leveraging the MTD to advance regional health priorities is supporting existing and emerging Local Health Improvement Networks (LHINs), in its sub regions. LHINs are important partners to GCACH because they can address specific community health priorities and have

relationships with the local healthcare delivery system. Similarly, by providing sub regions with specific data surrounding gaps in health and social wellbeing, this prompted more confidence in our approach and built trust with our partners.

Governance

Describe the ACH's governance structure. In the narrative response, address the following:

- Describe how the ACH's governance provides oversight for the following five required domains:
 - **Financial**, including decisions about the allocation methodology, the roles and responsibilities of each partnering providers, and budget development
 - **Clinical**, including appropriate expertise and strategies for monitoring clinical outcomes and care delivery redesign and incorporating clinical leadership, including large, small, urban, and rural providers
 - **Community**, including an emphasis on health equity and a process to engage the community and consumers
 - **Data**, including the processes and resources to support data-driven decision-making and formative evaluation
 - **Program management and strategy development**, including organizational capacity and administrative support for regional coordination and communication

- If applicable, provide a summary of any significant changes or developments related to the governance structure (e.g., composition, committee structures, decision-making approach) and decision-making processes since Phase II Certification, including a rationale for changes.
- Discuss how the ACH addressed areas of improvement identified in its Phase II Certification related to its governance structure and decision-making processes.
- Describe the process for ensuring oversight of partnering provider participation and performance, including how the ACH will address low-performing partnering providers or partnering providers who cease to participate with the ACH.
- Submit a visual/chart of the governance structure (*submit as Governance – Attachment A*).

ACH Response

GCACH's governance structure

Greater Columbia ACH (GCACH) is a 501(c)3 organization governed by a Board of Directors representing 17 sectors. The Board has established seven committees to support oversight of the organization: Executive Committee, Nominating Committee, Finance Committee, Budget & Funds Flow Committee, Bylaws Committee, Communications Committee, and Technical Advisory Committee. (See Figure 43 below.)

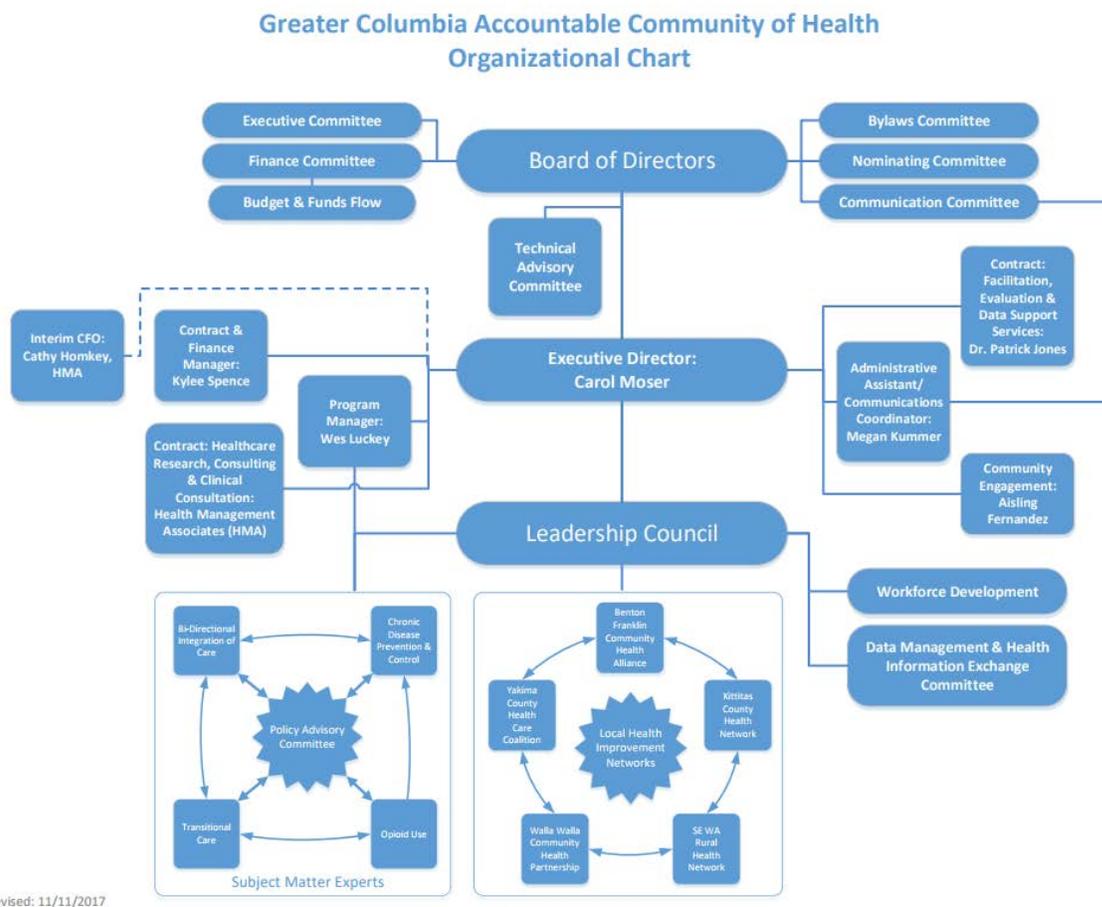


Figure 43: Greater Columbia ACH Organizational Chart 11-14-17

To deepen engagement with each sector represented on the Board, GCACH has formed a Leadership Council (LC) to serve as an advisory body to the Board providing GCACH with subject matter expertise and diverse stakeholder perspectives to inform GCACH’s work. The LC has an open-membership structure and a current roster of over 450 members across the nine counties in the GCACH region. Since May 2017, over 100 LC members have actively participated in one of eight Project Teams to inform the development Demonstration project proposals. The LC has established three committees to advise the LC in providing recommendations to the Board: Project Advisory Committee, Data Management and HIE Committee, Workforce Committee. Leadership Council members also serve on the Board’s Budget and Funds Flow Committee and the Communications Committee. (See Figure 44 below.)

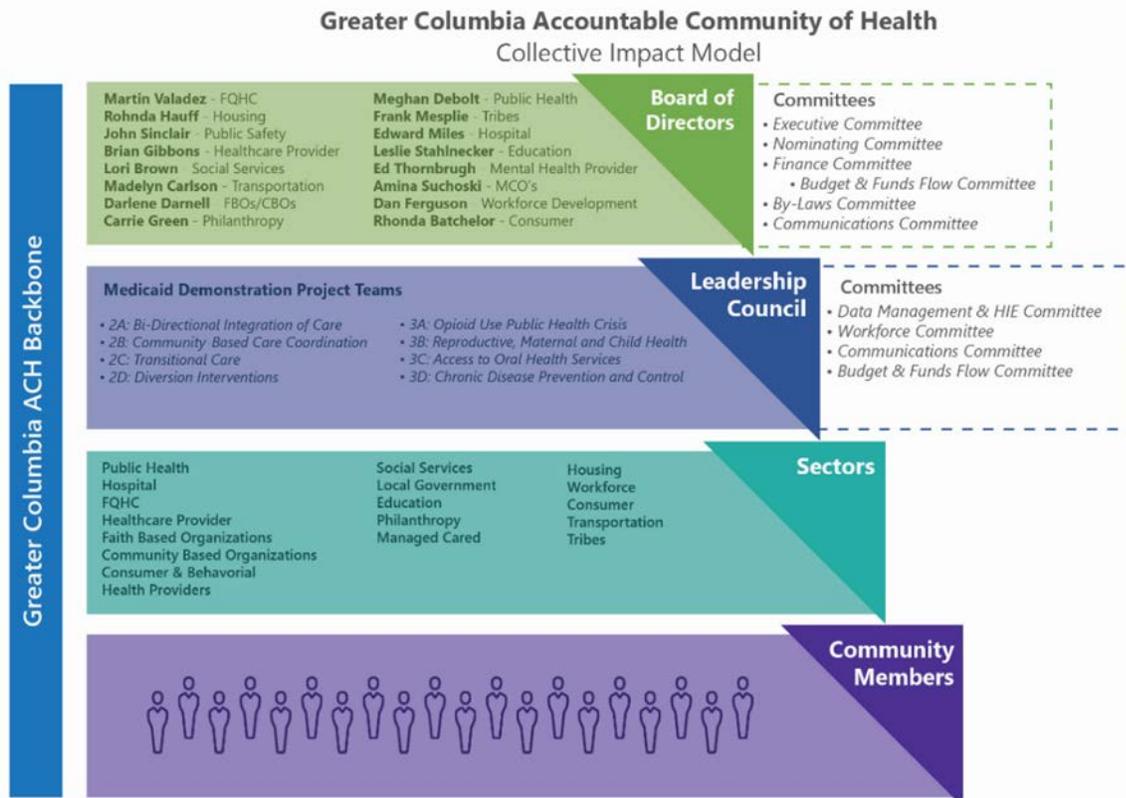


Figure 44: Collective Impact Model of Governance

The governance structure and sector representation of Greater Columbia was determined by its members over a course of many months, beginning in 2014, after studying other ACH models and engaging the ACH stakeholders in a ten-county retreat that determined the priority issues of the region and a preferred governance structure. Our goal was to include a broad and meaningful representation of potential partners, including, but not limited to large and small, urban and rural, clinical providers, public health, hospitals, community and faith-based organizations, the Tribe, local government, consumers, social services, and the risk-bearing Medicaid managed care organizations in our region.

The GCACH Board and Leadership Council meet monthly in person and including web-based conferencing options for individuals attending remotely (See Figure 45). The LC meetings occur directly prior to and at the same location as the monthly GCACH Board meeting, allowing the Leadership Council to inform Board deliberations and decisions, and to attend and provide public comment at

Board Meetings as desired. GCACH's Board and LC Committees and Project Teams meet more frequently, holding over 100 meetings since the start of 2017. This level of activity was required to meet the request of the Board to review all eight of the project areas in the project plan, and a great majority of these meetings were web-based meetings to facilitate desktop sharing.



Figure 45: June 22, 2017 Leadership Council Meeting

GCACH oversight of five required domains

GCACH's governance ensures oversight of the five required domains through a range of Board and LC committees and Project Teams, as described below. (See also Figure 46 for an overview of or Board and LC committee responsibilities.)

Financial: GCACH has two committees that provide financial oversight of the organization: Finance Committee and Budget and Funds Flow Committee. Both committees are staffed by GCACH's Finance Director and include members with organizational financial management expertise and experience (including the Chief Operating Officer of a local health system, an FQHC executive director, a rural fire chief, and others).

- The Finance Committee is responsible for development of the organization's overall annual budget and review of monthly financial reports for Board approval. The GCACH Finance Committee oversees the Budget and Funds Flow Committee's work to provide a streamlined financial report and recommendations to the Board.
- The Budget and Funds Flow Committee focuses on development of the Demonstration's funds flow allocation methodology, development of project incentive budgets, and will provide training to partnering providers regarding roles and responsibilities, project budgets and the overall funds flow process.

Clinical: GCACH has engaged several groups to ensure clinical oversight of the demonstration projects. These include:

- **Project Teams:** GCACH's Project Teams have led efforts to evaluate regional health needs and develop proposed project plans in each of the eight Demonstration project areas. There are currently over 40 licensed providers and clinicians serving on PTs, and six of the Project Teams have been led by provider champions, including physicians, psychologists, dentists, hygienists,

nurses and more from both rural and urban areas. (See Attachment B) The Project Teams and clinical champions will continue to play an integral role in oversight of care delivery redesign, as well as monitoring clinical outcomes in forthcoming Demonstration years.

- *Technical Advisory Committee:* GCACH's Technical Advisory Committee (TAC) serves as an independent advisory body to the Board and to provide clinical and subject matter expertise inform the project plan application. Members of the TAC include: Dr. John Kitzhaber (former Governor of Oregon), Dr. Hugh Straley (President of the of the Bree Collaborative, and Chair of the HILN Clinical Engagement Subcommittee), Mike Bonetto (Principal, Tenfold Health Consulting), Bob Burden (retired executive, Kaiser Permanente), and Dr. Lee Ostler (former Chair of the American Academy for the Oral Systemic Link).
- *Workforce Development Committee:* GCACH has established a workforce committee oversee GCACH workforce strategies. The Chairman of this Committee is Board Member, Dan Ferguson. Dan is the Executive Director of the WA State Allied Health Center of Excellence, Yakima Valley College. This committee includes members with clinical and subject matter expertise to oversee clinical workforce issues. Committee members include physicians, paramedics, Washington Department of Health, workforce development professionals, and others.

Community: GCACH's governance structure provides oversight of our strategies to engage consumers and the community, ensuring a focus on health equity, through several mechanisms:

- GCACH's Board includes a seat for a consumer representative. Since Phase II Certification, we have successfully filled this seat and Ronni Bachelor is serving as our consumer representative. Ronni is a Family Peer Support Specialist with Lutheran Community Services, and she brings lived experience and supports others through challenges such as homelessness, addiction, mood disorders, disease states, and food insecurity.
- GCACH's Leadership Council serves as an advisory body to the Board, providing GCACH with diverse stakeholder and community perspectives. As described above, the LC has an open-membership structure and a current roster of over 450 members across the nine counties in the GCACH region. The LC is an integral part of the GCACH governance model and our ability to oversee efforts to mobilize broader cross-sector, community and consumer engagement.
- GCACH is forming a Consumer Council (CC) in the first part of 2018. The CC will be comprised of 6-8 current and former Medicaid consumers and/or their family members, as well as Medicare, VA, privately insured and uninsured individuals. The CC structure will provide support for and empower community and consumer voices to guide GCACH's work. The formation of CCs will be included in the contracts with each of the Local Health Improvement Networks (county-level network structures in the GCACH region) to ensure that we are receiving feedback from Medicaid beneficiaries in all parts of our region.
- GCACH has dedicated a full-time Director of Community Engagement staff position to lead and oversee our work around community and consumer engagement. This position is filled by Aisling Fernandez, a competent Spanish-speaker.
- GCACH Board and Leadership Council have emphasized health equity as fundamental aspect of our theory of action guiding project plan development, project selection, and future planning efforts.

Data: GCACH has established a Data Management & HIE Committee to provide oversight and strategic guidance on GCACH efforts to develop a coherent strategy for organizing, governing, analyzing, and deploying health information. GCACH's Program Manager (Wes Lucky) brings senior-level data analytic skills and will staff this committee. Current members include MIS analysts and managers from various health systems, data experts, clinical and care coordination experts, and PAC representatives.

GCACH is also exploring potential contracts with data and monitoring system design contractors, including Providence Center for Outcome Research and Evaluation and King County ACH. This data contractor will support identification and synthesis of key provider data, data analysis and monitoring, and a mechanism for provider feedback and continuous improvement. The LC attracts broader sector representation, Tribal members, consumers, Community Based Organizations, state agency representatives and Board members. The LC has two standing committees: Workforce Development, and Data and Health Information Exchange. Including attendees by phone, the LC at times has included more than 100 participants. Nearly 450 individuals and organizations across nine counties are included in the monthly routing of the LC agenda and documents.

The LC meetings occur directly prior to and usually at the same location as the monthly GCACH Board meeting, allowing the Leadership Council to inform Board deliberations and decisions, and to attend and provide public comment at Board Meetings as desired. Other committees providing oversight to the Board governance structure include an Executive Committee, Finance Committee, Budget and Funds Flow Committee, a Communications Committee, a Nominating Committee, and a Bylaws Committee.

Program management and strategy development: The GCACH Board and LC provide strategic direction to the organization. Program management, strategy development and data and analytics are led by the Executive Director and Program Manager with strong support from consultants (including Health Management Associates, and Dr. Patrick Jones, an economist from Eastern Washington University). HMA is providing strategic advice regarding project selection, as well as providing administrative support in Finance and Communication. Dr. Jones is providing facilitation services to the LC, strategic guidance and analytical insights. GCACH is also staffed by a Communications Coordinator and a Community Engagement Specialist.

The Project Advisory Committee (PAC) has worked intensively over the last several months find areas of alignment and identify common target populations across the various Demonstration project areas (see Figure 3 below). The PAC will continue to serve in this strategic advisory role throughout the demonstration planning and implementation.

A brief outline of LC and Board committees and their responsibilities are as shown in Figure 46:

Greater Columbia Accountable Community of Health Roles of Organizational Entities

Entity	Functions
PAC / Project Teams	<ul style="list-style-type: none"> • Provide support, expertise and monitoring over DSRIP Project Areas • Select evidence-based project approaches • Create alignment across all project areas • Identify target populations
Budget & Funds Flow Committee	<ul style="list-style-type: none"> • Formulate, test, submit then monitor "funds flow" allocation process / methodology for recommendation to the Finance Committee • Formulate, submit, execute, monitor and evaluate project incentive budgets • Provide training and be a resource to partner organizations regarding project budgets and overall funds flow
Bylaws Committee	<ul style="list-style-type: none"> • Review Bylaws and Charters annually to assure they reflect the intent of the Bylaws • Develop strategies for necessary revisions, submit recommendations to the Board • Support Board and/or membership with interpretation of Bylaws • Recommend to the Board the adoption of Board policies (as needed)
Communications Committee	<ul style="list-style-type: none"> • Develop key messages that align with the programmatic priorities • Advance population health through community engagement • Disseminate information to stakeholders, partners, and the public • Craft a distinct brand identity that positions the organization as a thought-leader
Data Management & Health Information Exchange Committee	<ul style="list-style-type: none"> • Identify data gaps, data integration needs to support Participating Provider organizations and reporting requirements • Facilitate information sharing and coordination among GCACH member organizations on data related matters • Serve as a forum for member organizations to strategize around the organizing, governing, analyzing, and deploying health information; • Collaborate on ways to optimize data analytics, modeling, visualization, and transformation
Executive Committee	<ul style="list-style-type: none"> • Establish the agenda for regular board meetings • Provide support and guidance of the Executive Director. • May serve as the hiring committee for the executive director position. • May appoint members of the Nominating Committee.
Finance Committee	<ul style="list-style-type: none"> • Reviews, scrutinizes and approves monthly financial reports for Board submission and approval • Oversees progress is made regarding Budget and Funds Flow committee projects and tasks • Reviews, scrutinizes and approves financial policies and procedures for submission to the Board for adoption
Nominating Committee	<ul style="list-style-type: none"> • Reviews and vets sector representatives for the Board's consideration • Recommends Board members for officer positions • Evaluates the skills and characteristics needed in Board candidates, and officer positions, and forward nominations to the Board for approval.
Technical Advisory Committee	<ul style="list-style-type: none"> • Provide independent input and guidance for the Board's consideration of selecting project areas and scoring potential participating providers for project implementation.
Workforce Development Committee	<ul style="list-style-type: none"> • Develops and recommends a target state for GCACH workforce system needs • Assesses the gap between the current and desired target workforce state • Assesses the impact of DSRIP and the specific DSRIP projects being implemented • Develops a workforce transition roadmap and overseeing the implementation of that roadmap • Develops a workforce training strategy and overseeing the implementation of that training strategy

Figure 46: Roles and Responsibilities of GCACH Board and Leadership Council Committees

Significant changes or developments relating to governance structure since Phase II Certification

Although chartered, the Workforce, Data & HIE, Budget and Funds Flow, and Communications Committees had not met until recently. Each committee has assisted in developing the project plan and provided guidance on specific strategies, particularly in Domain 1.

The GCACH Board recently filled its open seat for a representative to the consumer sector. She is a peer counselor, navigator and community health worker who has worked with LGBT clients and people who have behavioral health and substance abuse issues. In short time, she has provided enlightening facts and insights about high risk individuals in this sector.

The Board also recently developed a Sector Representation Policy (see Attachment C) that defines the expectations of GCACH Directors who represent their sectors. Board Sector representatives will act as a conduit for feedback between and on behalf of their Sectors, distributing pertinent information regarding GCACH activities and events. Board members are also expected reach out to their affiliates and stakeholders when it serves the greater purposes of the organization.

How ACH has addressed areas of improvement identified in its Phase II Certification

No additional focuses areas identified for the project plan.

Process for ensuring partnering provider oversight

Our emerging relationship with our program’s Participating Providers will lead toward the bi-directional sharing of data, performance monitoring and feedback, and continuous improvement over the course of the Transformation timeframe. Each participating provider will sign an MOU that defines the accountabilities for each party. Furthermore, each provider will sign a contract that includes specified deliverables. The contract will state specific terms and contingency plans should any issues arise in delivering their statement of work as stated within the contract. The MOU and contract will serve as the basis for addressing low performing partners or those who cease to participate. Data Sharing Agreements (DSAs), an important part of the contracting cycle, will facilitate the flow of Pay-For-Reporting (P4R) data, Pay-for-Performance (P4P) data, and other additional measures. GCACH will monitor and analyze this data, provide performance feedback to providers, and develop performance reports for community partners, stakeholders, and the HCA.

GCACH is currently considering the method by which to capture this data. Several Customer Relationship Management (CRM) applications have been reviewed (e.g. SpectraMedix, Persistent Systems, Salesforce), which can survey providers and upload data. GCACH is also evaluating services provided by Providence Center for Outcome Research and Evaluation and the King County ACH. A key principle that will guide GCACH’s decision on a data system approach will be a priority on monitoring systems that have minimal burden to reporting providers.

Under the chosen arrangement, “rapid fire” surveys will capture measurement data monthly, and attribute it at the provider, sub-region and ACH level. This will tie to the distribution of incentive payments. It will also afford the opportunity to feedback provider performance and profile providers against their peers, and allow for continuous improvement as shown in Figure 47. Learning from the best practices of our Partnering Providers, this too will be shared across the GCACH network. The Project Teams in their expanding roles may act as the continuous quality improvement (CQI) committees or members of the teams may come together in a central council that performs CQI functions. The goal is not to penalize lagging performance but to do widespread education and adoption of best practices. This will optimize the GCACH’s work and outcomes.

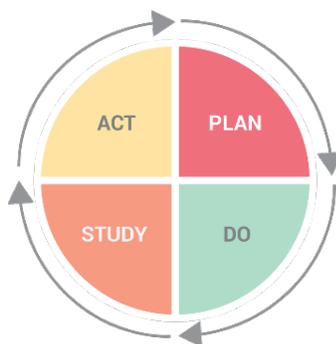


Figure 47

Community and Stakeholder Engagement and Input

Describe the ACH’s community and stakeholder engagement and input. In the narrative response, ACH Project Plan Template (October 16, 2017)

address the following:

- Describe and provide evidence of how the ACH solicited robust public input into project selection and planning (e.g., attachments of meeting minutes or meeting summaries where input was solicited) (*submit as Community and Stakeholder Engagement and Input – Attachment A*). In the narrative, address:
 - Through what means and how frequently were these opportunities for input made available? (e.g., ACH website posting, ACH listserv, surveys, newspaper, etc.)
 - How did the ACH ensure a broad reach and ample response time in its solicitation?
 - How did the ACH ensure transparency to show how public input was considered?
 - How did the ACH address concerns and questions from community stakeholders?
- Provide examples of at least three key elements of the Project Plan that were shaped by community input.
- Describe the processes the ACH will use to continue engaging the public throughout the Demonstration period.
- Describe the processes the ACH used, and will continue to use, to engage local county government(s) throughout the Demonstration period.
- Discuss how the ACH addressed areas of improvement, as identified in its Phase II Certification, related to meaningful community engagement, partnering provider engagement, or transparency and communications.

ACH Response

Process to engage robust public input

GCACH has gathered community member and stakeholder feedback on projects through its Leadership Council (LC) meetings and Project Teams (PT) one-on-one meetings with clinicians and social service providers, and attendance at community forums and meetings focusing on social determinants. To ensure that we were getting feedback from a broad representation of our stakeholders, we also conducted an online regional survey. Because of our large geographic region, it is more efficient to engage people where they are, as opposed to expecting them to come to us, so GCACH staff attended meetings across the region to get input into the project plans and to learn about the various challenges already experienced by Medicaid providers. (Please see Attachment A for a list of presentations and meetings with the public.)

GCACH actively encourages and enables community participation in open and transparent Board and LC meetings. Board and LC meeting minutes and materials are posted publicly on our website, and links are included in our monthly newsletter. LC materials are emailed to our list of 400 community members and partners. Our website includes a calendar of meetings, all past and current Board and LC meeting minutes, materials, and other resources. Key processes to engage public input are summarized below:



Figure 48: Leadership Council Project Teams and Standing Committees

- **Leadership Council:** The LC was established to help deepen sector engagement in the GCACH, and facilitate broad community and stakeholder input into GCACH efforts. The LC now includes

a roster of over 450 individuals and we regularly have an average of 75 LC members attending our monthly LC meeting (by phone or in person), and an average of 24 people attending the Board meetings. These meetings occur directly prior to and at the same location as our monthly GCACH Board meeting, allowing the Leadership Council to inform Board deliberations and decisions, and to attend and provide public comment at Board Meetings as desired (see Figure 49). At the June LC meeting, Project Teams presented their project ideas and over 100 participants completed and returned feedback forms. The feedback received has been compiled and shared with the Project Teams, LC and the Board. In addition to the feedback received in our June LC meeting, we also allow feedback and public input at all LC and Board meetings. During Board Meetings specifically, public comments are taken at the end of all agenda items and included in our minutes. LC meetings are less formal, but often include dynamic and open discussions with our public guests and community partners. The comments from the LC meetings are also captured in the minutes.



Figure 49: August 17th Leadership Council Meeting at United Way in Kennewick

- **Project Teams:** GCACH supported approximately 100 meetings by PTs and the LC in 2017 to develop the project plan. We have over 100 LC members serving on Project Teams, Domain 1 Workgroups, and Board subcommittees to inform the development of Transformation Project proposals and system support strategies. The Project Teams and the LC will provide recommendations to the Board on key regional health needs and proposed projects to move forward in the ACH Transformation Project plan application. Each of the Project Teams have three to four providers engaged in their project development work.
- **Medicaid beneficiaries:** To ensure that we have Medicaid beneficiary input, GCACH staff will go to events, centers and residential areas and meet beneficiaries where they are. We will also work to engage beneficiaries and get their input through focus groups and on the Consumer Council. We plan to include family members of hard-to-reach consumers on the Consumer Council (CC) and in focus groups, as one way of addressing barriers beneficiaries may face in engagement. The formation of CCs will be included in the contracts with each of the Local Health Improvement Networks to ensure that we are receiving feedback from Medicaid beneficiaries in all parts of our region.
- **Tribal engagement:** GCACH has undertaken several key actions to deepen our engagement with the Yakama Nation and obtain input into project selection and planning. Tonya Kreis, a Behavioral Health Therapist with the Yakama Nation, attended the ACH Chelan convening in

June as a designee. The convening emphasized practical action steps toward Certification II and project planning, which gave Tonya a deeper understanding of the project areas. From this training, she has been successful in obtaining more support from the Councilmembers to advance Tribal projects, and is working with them to develop a project plan. At our August meeting, Councilman Mesplie and Arlen Washines, “Shx’m’y’ah”, Deputy Director of Human Services Administration, asked for GCACH support in putting together a project plan that would honor their existing programs, culture, and health concerns. At the Tribal training in October (see Figure 50), further discussions regarding dental health aide therapists (DHAT), and better integration of the behavioral health activities and the medical clinic were discussed. Jay Sampson, CEO of the Indian Health Services, Yakama Unit participated in the training, and encouraged the Executive Director to pursue the DHAT program through the Tribe.



Figure 50: Tribal Training, October 18, 2017 at Yakama Correctional Facility (Arlen Washines & Jay Sampson presenting)

- Meetings with partners and stakeholders:** GCACH staff have had one-on-one meetings with the Yakama Nation, Benton-Franklin Health District, Virginia Mason Memorial Board of Directors, SE WA Rural Health Coalition, Regional Health senior leadership, Blue Mountain Action Council-Supportive Services for Veteran Families case managers, Benton-Franklin Community Action Council case managers, Benton and Franklin Counties Housing Continuum of Care Task Force, Lutheran Community Services Northwest, all five of the Local Health Improvement Coalitions, Tri-Cities Diabetes Coalition, Yakima Valley Farm Workers Clinic, Molina Healthcare, Coordinated Care, Tri-Cities Community Health, Chaplaincy Healthcare, County Commissioners, Washington Association of Community and Migrant Health Centers, ACEs/Resilience Collaborative, Department of Social and Human Service (DSHS) Community Service Offices (CSOs) in Kennewick and Toppenish, Benton Franklin Medical Society, and the Benton-Franklin Community Health Alliance Board of Directors.

See Attachment A for a full list of meetings and community outreach.

Stakeholder input and the project portfolio

The stakeholder and partner meetings that GCACH attended provided valuable insight about how the system needs to be improved for their Medicaid clients. There was strong agreement for the need for bi-directional integration of physical and behavioral health, chronic disease management, oral health access, emergency department diversions, opioid crisis, and care coordination. The shape of our project portfolio was significantly influenced by the themes we heard throughout the community engagement process, especially about the barriers in the existing system. For example:

- The system of care needs to be easier to navigate and access.
- Providers and consumers need a centralized database of community resources that is easily accessible and up-to-date.
- Providers need a way to share information about their patients and coordinate their care.
- Individuals need a support system to address their health issues. These issues often extend to the whole family.
- Social Determinants (e.g., poverty, lack of education, and cultural differences) create significant barriers to care.
- Our rural areas are an important part of our region, and need to be included in ways that help address their specific challenges.
- There are many factors impacting emergency department utilization, especially for Medicaid beneficiaries.

Three Key Elements of the Project Plan shaped by community input

Integration. The Bi-Directional Integration Project Team chose to adopt all four approaches in the Toolkit so that there would be “no wrong door” to enter a system of care, making it easier to navigate, access, share data and information, and coordinate care. Central to integration is electronically linking systems of care and the ability to share information.

Coordination. Care coordination is fundamental to our project portfolio as GCACH has chosen to target the high-risk, high utilizers of the health system who require clinical and social services that need to be coordinated. Stakeholders and providers requested that they have latitude to implement care coordination approaches that match the needs and characteristics of their patient populations and the providers’ capabilities.

Use of Community Health Workers. Disparities of care exist across the GCACH region with root causes tied to poverty, education, and cultural barriers. The use of community health workers can reduce barriers to clinical care, improve access to community services, and improve health literacy. Navigators also provide strong social supports that are culturally appropriate and add unique perspectives to patient care.

Continuing Public Engagement throughout Transformation

GCACH plans to engage the public through our website which will be designed to support education, easy to use calendars and events that push upcoming meetings and events, links to documents, community dashboards and other web-based resources. GCACH staff will also have a presence at community events such as health fairs, and connect to Consumer Councils through the Local Health Improvement Coalitions. A long-term goal is the development of a robust community resource guide that is web-based and available to all community members.

Engaging Local County Governments

Local elected officials will continue to be engaged throughout the Transformation project in several ways. Seventeen agencies with government ties (fire departments, public hospitals, public health, schools) have submitted letters of interest for various projects. County Commissioners will be involved in making decisions around fully integrated managed care, and models of integrated care for the region. GCACH currently has one open seat on the Board for local government representation, and are waiting to confirm the availability of a Pasco Councilwoman.

Tribal Engagement and Collaboration

Describe the ACH’s current Tribal and Indian Health Care Provider (IHCP) engagement and collaboration efforts. In the narrative response, address the following:

- How are Tribal and IHCP priorities being identified, either through the ACH or through Tribal/IHCP partners?
- Have those priorities informed project selection and planning?
 - If applicable, provide examples of at least three key elements of the Project Plan that were informed by Tribal input.
 - If Tribes/IHCPs are not involved in ACH project selection and design, describe how the ACH is considering the needs of American Indians/Alaska Natives in the ACH region
- If possible, provide as attachments statements of support for the ACH from Indian Health Service, Tribally operated, or urban Indian health program (ITUs) in the ACH region. (*Submit as Tribal Engagement and Collaboration – Attachment A.*)
- Discuss how the ACH addressed areas of improvement identified in its Phase II Certification related to Tribal engagement and collaboration.

ACH Response

How Tribal and IHCP priorities are being identified

Greater Columbia ACH (GCACH) represents a broad geographic area that encompasses Washington’s largest federally recognized Tribe: The Yakama Nation. The Yakama Nation covers more than 1.1 million acres and serves as an essential community provider for more than 11,700 American Indian/Alaska Native individuals in the GCACH region. In May 2017, the GCACH Board of Directors adopted the Model ACH Tribal Collaboration and Communication Policy, and this policy was signed by Tribal Council member, Frank Mesplie, “Twii t’ash”, on August 4, 2017 during an in-person meeting with GCACH leadership (this signed policy was submitted with our Phase II Certification materials).

Our primary strategy for ensuring that Tribal and Indian Health Care Providers (IHCP) priorities are being identified is our strong partnership and connection to the Yakama Nation. Yakama Nation Councilman Frank Mesplie currently serves on our Board of Directors and Yakama Nation representatives regularly attend GCACH monthly Board and Leadership Council meetings (*See Figure 51 below*). This participation in GCACH project planning efforts has brought important Tribal perspectives to discussion of regional health priorities and project development.

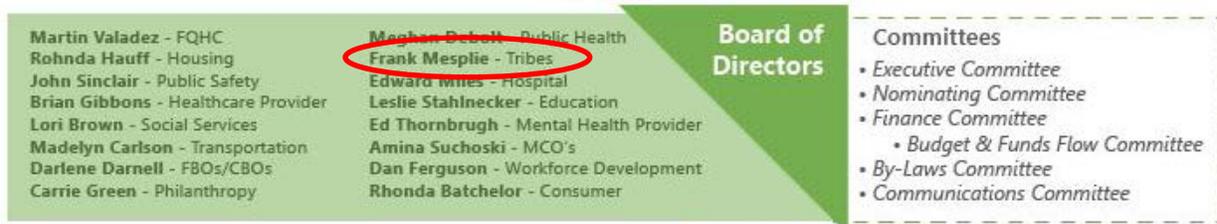


Figure 51: GCACH Board of Directors, Tribal Members

Frank Mesplie is a member of the Yakama Tribal Council, providing GCACH with a direct connection and open communication with the Tribal Council, a central policy and decision-making body for the Yakama Nation. Councilman Mesplie has provided an invaluable connection for GCACH’s work with the Yakama Nation to identify Tribal priorities.

In addition to participation by Yakama Nation representatives on the GCACH Board, Leadership Council and Project Teams, GCACH has facilitated regular communication and board trainings with the Yakama Nation to identify and better understand Tribal health priorities. On October 18th, GCACH facilitated an annual board training on Tribal issues, providing board members the opportunity to learn more about Tribal history, governance, and health concerns (see *Figure 52 below*). Yakama Nation leaders, including Councilman Mesplie, and representatives Arlen Washines, Tonya Kreis, and Jay Sampson led the training. Councilman Mesplie shared stories about the importance of their sacred ceremonies, loss of identity, the trauma of boarding schools, and the difficulty of finding deer for their ceremonial food. GCACH board members gained a better understanding of the trauma that has impacted and disrupted Yakama’s culture, and the resulting impacts on increased rates of alcohol and drug addictions, suicide, and obesity among Tribal members.



Figure 52: GCACH Board Tribal Training, October 2017

GCACH staff have met in-person with Yakama Nation representatives to discuss what collaboration would look like to the Yakamas. Yakama Nation representatives articulated that they would like support from GCACH in developing Tribal project selection and planning documents. Importantly, they noted the need to strike a balance between collaborating and ensuring that there is support and space for traditional Native American approaches to addressing health concerns. While GCACH and the Yakama Nation have many health issues in common, especially in behavioral health, substance abuse, chronic disease, and obesity, our approaches to addressing these concerns may differ. For example, the Yakamas have prioritized and designed programs to address priorities such as on suicide rates, anger management, and addictions issues, with culturally appropriate best practices.

How have Tribal priorities informed project selection and planning

Tribal participation on the GCACH Board, Leadership Council and Project Teams have actively informed GCACH project selection and planning efforts. In addition, board trainings and in-person meetings between GCACH staff and Tribal leaders have informed GCACH project selection and planning.

Tribal representatives have specifically communicated the need for HIT infrastructure support. The Tribal behavioral health clinic, for example, lacks IT infrastructure and reliable internet and phone service to respond to crisis calls in a timely fashion. GCACH has therefore committed \$30,000 from Phase I certification funds to support Tribal HIT Infrastructure and consultation.

The Yakama Nation has communicated its desire to develop a Tribal Medicaid Transformation Project Plan and requested GCACH support in this effort. GCACH is honored to support this work and we have indicated our availability to assist the Tribe when they are ready. GCACH has set aside over \$385,000 for consultation and infrastructure from Design funding that we can use to support this work.

There are several project areas the Yakamas are interested in pursuing that align with GCACH projects, including: access to oral health, bi-directional integration, primary care access, and the opioid crisis. Emergency department utilization is also a key area of common interest since Tribal members often seek care in the emergency department since the Tribal medical clinic is only open 8am-5pm during weekdays.

At our October 18th Tribal board training, we were able to speak with Jay Sampson, CEO of the Yakama Service Unit, Indian Health Center about pursuing Dental Health Aide Therapists (DHAT) on the reservation. We have followed up with initial contacts provided and are actively pursuing opportunities to address Tribal oral health priorities with Christina Peters, Native Dental Therapy Initiative Project Director, Northwest Portland Area Indian Health Board, and Maxine Janis, the Yakama Tribe's Educational Committee Chair. GCACH's newest Board member representing consumers, Ronnie Batchelor, is also engaging in discussion with Councilman Mesplie regarding potential collaboration around suicide prevention. GCACH has also been contacted by Katherine Saluskin about possible tele-health opportunities.

Funds Allocation

Funds Flow Oversight

Describe the ACH's process for funds flow oversight. In the narrative response, address the following:

- Describe how the ACH will manage and oversee the funds flow process for DSRIP funds (Project Incentive funds, Managed Care Integration Incentive funds, and VBP Incentive funds), including how decisions will be made about the distribution of funds earned by the ACH.
- Discuss the roles and responsibilities of, and relationships between, the ACH governance body and partnering providers in managing the funds flow process.
- Describe the ACH process for ensuring stewardship and transparency of DSRIP funds (Project Design funds, Project Incentive funds, Managed Care Integration Incentive funds, and VBP Incentive funds) over the course of the Demonstration.
- If applicable, provide a summary of any significant changes since Phase II Certification in state or federal funding or in-kind support provided to the ACH and how the funding aligns with the Demonstration activities.
- If applicable, provide a summary of any significant changes to the ACH's tracking mechanism to account for various funding streams since Phase II Certification.

ACH Response

Funds Flow Oversight

GCACH recognizes the imperative to design and implement a financially rational portfolio of projects that will collectively achieve measurable improved health outcomes and contribute to cost-savings necessary to support the sustainability of health system transformation. GCACH has convened community-led, cross-sector and region-wide stakeholders to provide strategic direction and work in partnership to design and implement transformation projects and provide oversight of DSRIP funds, including payment distribution direction to the financial executor. Carol Moser, Executive Director, reports to the Board of Directors and is responsible for program administration, including submission of reports to the HCA. GCACH hired CFO leadership in June of 2017 to oversee and direct the budget and funds flow development, and in October GCACH retained Health Management Associates to provide interim financial support during the recruitment of staff for direction and management of finance department functions.

The 16-member GCACH Board of Directors serves as the primary decision-making body to select project areas and approve the funds flow allocation and distribution. Board members represent physical and behavioral health providers, local government, Yakama Tribe, community based organizations and MCO's. Each sector represented may have a maximum of one member serving on the Board, and each member has one vote. GCACH Board members may represent organizations with significant financial interests in advancing certain projects, participation of entities in the project, or allocation of funds. The GCACH conflict of interest policy adopted 4/21/16 (Attachment A) defines conflicts of interests and outlines expectations for Board members to take appropriate action on matters in which they are conflicted. All GCACH Board members have signed the GCACH conflict of interest policy. In addition, all Board meetings begin with an attestation of conflicts of interest, and a written reference defining conflict of interest is at the top of each Board meeting agenda (see Attachment B).

Under the GCACH governance structure, the Finance Committee which is composed of three board members, the President, Treasurer, and Secretary and supported by the CFO position, has been chartered (Attachment B) and is responsible for developing and overseeing processes to support the financial success of GCACH and for the establishment of financial controls to ensure compliance with DSRIP program requirements. The responsibilities of the Finance Committee include, but are not limited to:

- Making recommendations to the Board with respect to allocation and distribution of DSRIP funds;
- Developing a communication plan to engage and educate network partners on the funds flow model;
- Monitoring the ACH's budget(s), audit(s) and investment(s) and their performance relative to their unique standards;
- Developing and overseeing the implementation of the ACH's financial oversight structure;
- Establishing/reviewing significant accounting and financial reporting practices including internal financial statements reporting the receipt and distribution of project funds, cash position, and cash flow;
- Establishing/evaluating the effectiveness of the internal control system with respect to financial reporting and controls over receiving and distributing project funds;
- Developing approaches for assisting financially impacted ACH participants

- Making recommendations with respect to value-based purchasing and the management of risk contracts;
- Ensuring annual independent audit of the financial management practices of GCACH for compliance with DSRIP requirements;
- Collaborating with other committees as appropriate;
- Ensuring compliance with applicable state and federal laws, regulations, and agreements;
- Ensuring that GCACH accounting and financial statements are independently audited annually.

The Finance Committee created a Budget and Funds Flow (B&FF) Committee (see Attachment C). The committee consists of GCACH governance members as well as partnering provider financial representatives with expertise to assess the impact of selected projects and recommend a funds flow approach and distribution plan to the Finance Committee, project teams, and Leadership Council for review and recommendation to the Board for approval. The B&FF committee is cross-sector representing a broad perspective of health and health care coverage, including organizations such as hospitals, business, behavioral and public health, faith-based and community based organizations, social services, and managed care organization. The Committee serves as an advisory arm of the Finance Committee to develop provisions for monitoring and modifying the funds flow methodology over the course of the demonstration. The responsibilities of the Budget and Funds Flow Committee include, but are not limited to:

- Developing the funds flow distribution schedule;
- Providing input to Project Impact Assessment and Matrix;
- Reviewing the provider-level projections of DSRIP impacts and costs submitted by network providers;
- Establishing procedures for monitoring and reporting of project incentive costs;
- Recommending process to collect, analyze and report financial results;
- Monitoring, evaluating, and recommending modifications to distribution plan;
- Contributing to the plan for communication to, and training of, network participating providers for review and input.

Figure 53 shows the tiered governance structure and the relationship of the B&FF and Finance committees to the Board of Directors.

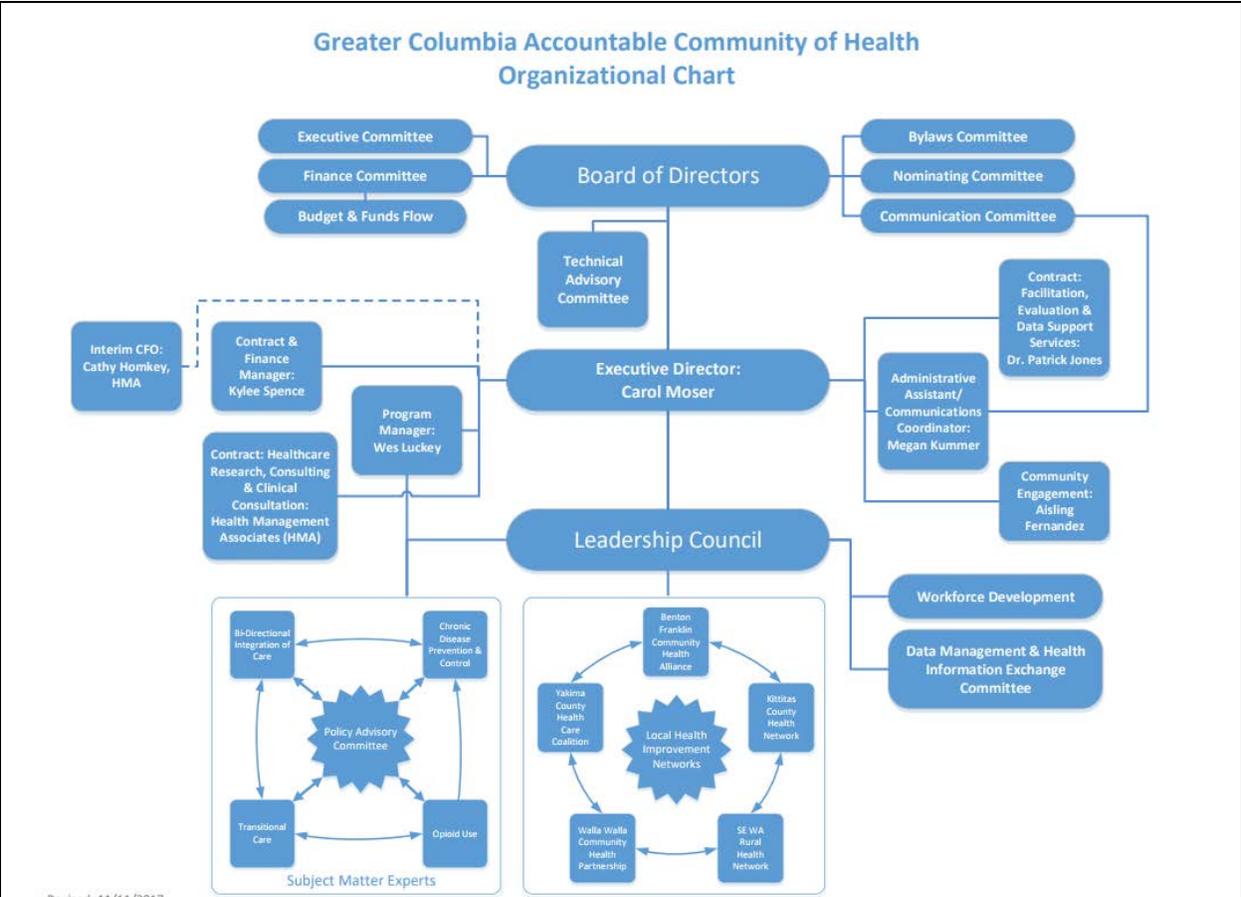


Figure 53: Greater Columbia ACH organizational structure as of 11/11/17

Process for ensuring stewardship and transparency of DSRIP funds over the course of the Demonstration:

Policies and procedures are under development and will address general accounting procedures; monthly financial statement presentations, budget preparation and modification; and budget-to-actual reporting. Currently, procedures are in place to prepare and submit for approval by the Finance Committee the monthly financial statements including the Statement of Financial Position (Balance Sheet), Statement of Activity by Class for Phase I and Phase II Design Funding and State Innovation Model Funding, and the budget-to-actual variances one week before the monthly Board meeting. These reports are reviewed by the Finance Committee, and then taken to the full Board of Directors for approval. Under existing procedure, the Executive Director and Finance Manager will have limited authority to approve modifications to allocations between budget use categories. However, deviations exceeding defined dollar thresholds or involving substantive changes to allocation methodology will require Finance Committee and Board approval.

Projections for GCACH project management and administration and Domain 1 investments will be finalized prior to fiscal year end 2017. Budget development will contemplate input from partner organizations regarding Domain 1 investment, leave-behinds, and the sustainability plan for the ACH.

Budgets will be supported by vendor quotes and will be reviewed and approved by the Finance Committee, and reported to the Board.

GCACH leadership understands that transparency with community stakeholders will be one of the keys to GCACH success. During the project design phase, outreach efforts were prioritized to engage partners and key stakeholders in the selection and valuation of projects. Leadership traveled to various locations within ACH's catchment area to train partner organizations on the new Delivery System Reform and Incentive Payment (DSRIP) calculation tool and how best to utilize this information during the project selection and development phase. A training on the DSRIP calculator was also given to the Leadership Council at the September 21st meeting, and a Budget and Funds Flow presentation was given to both Leadership Council and Board members on October 26th. The power point presentations are made available on the GCACH website, and detailed minutes provide a narrative of the presentations. This transparent process was designed to identify scenarios that include:

- Number of projects selected;
- Variation in meeting overall Pay for Reporting (P4R) and Pay for Performance (P4P);
- Impact of not meeting P4P metrics specific to project selection
- Changes to State-level maximum potential DSRIP funding or funding protocol.

During the duration of the demonstration, GCACH will continue efforts to ensure the funds flow methodology, including payment distribution direction to the financial executor is transparent to all ACH partners and key stakeholders. GCACH established a Budget and Funds Flow Committee (B&FF) comprised of Leadership Council, Board Members, MCOs, and outside agencies, such as the Tri-Cities Regional Chamber of Commerce to ensure broad representation of health interests. Using the board-approved funds flow guiding principles the B&FF Committee makes recommendations to the Finance Committee for ultimate approval by the community-led, cross-sector and region-wide governance structure that provides oversight of DSRIP funds in a public forum. To solicit community and partner feedback, we post meeting times and locations on our website, as well as provide either phone or webinar dial-in options for remote attendees. Board actions are communicated on the website and in community forums. GCACH will develop and implement a communication and training program for providers on funds flow, the contracting and administrative requirements related to the plan and related schedules for reporting and distribution of funds.

Summary of significant changes since Phase II Certification

While there has been no significant change in funding, the Health Care Authority State Innovation Model (SIM) funds have been leveraged, in lieu of Phase I Design Funds, for the administration and program oversight of aligned demonstration activities. To date \$409,402 of the SIM funds have been used since January 9th, 2017for:

- GCACH leadership, health & delivery system transformation and project management staff
- Consultants for project plan development and program management
- Tribal training and Board education of Tribal issues
- Costs associated with data, finance, communication, and community engagement activities
- Operating expenses, including space at Community Action Connections

Summary of significant changes to the ACH's tracking mechanism to account for various funding streams since Phase II Certification

GCACH has contracted with a Financial Consultant to develop separate reporting mechanisms to track SIM, Phase I and II funding streams. These new financial reports were presented at the October 26th meeting, and provided greater clarity for the Board to track activities by class. The report also included a projected spend down and cash flow of SIM funding.

Project Design Funds

Describe, in narrative form, how Project Design funds have been used thus far and the projected use for remaining funds through the rest of the Demonstration.

ACH Response

\$13,815 of Phase I Project Design funds have been expended as follows:

- \$9,900 for consulting services to facilitate project plan development discussions.
- \$3,915 for education and training of the Board, Yakama Tribe and staff.

Beginning in 2018, the remaining Phase I and Phase II Design Funds will be used for:

- **ACH Project Plan Development (5%):** GCACH staff will continue to work with consultants in developing, monitoring, evaluating and facilitating the advancement of the project plans;
- **Community Engagement (21%):** funds will support Local Health Improvement Coalitions, Tribal consultations, meetings and for marketing and outreach efforts;
- **Investments in ACH Administration and Project Management (22%):** funds will allow GCACH to hire project managers for Care Coordination, Systems Integration, Contracting, and other contracted support positions, and for needed environmental scans and assessments in areas such as workforce, housing, and other social support systems;
- **Information Technology and Population Health Management Systems (39%):** funds will be invested for assessments, increased capacity and interoperability for our providing partners involved in care coordination and on the Yakama Reservation, and to improve the IT capabilities and capacity for GCACH staff;
- **Building Community Capacity (8%):** Funds will be invested in workforce, workforce training, education, and recruitment;
- **Other (5%):** Upfront program investments will be funded and Business & Occupations Tax paid. To date, we have not had a clear ruling from the Department of Revenue as to whether ACHs are obligated to pay this tax.

The Board of Directors approved the Memorandum of Understanding (MOU) with five Local Health Improvement Networks (LHINs) on September 21, 2017; Benton-Franklin Community Health Alliance (BFCHA), (Benton and Franklin Counties), Yakima County Health Care Coalition (Yakima County), Healthy Communities Coalition (Walla Walla, Columbia, and Umatilla, Oregon Counties), Kittitas

County Health Network (Kittitas County) and the SE Washington Local Health Improvement Collaborative (Whitman, Asotin, Garfield, and Columbia Counties). To date, the Health Communities Coalition and the BFCHA have approved the MOU. Once the MOUs are approved and signed, GCACH will execute a contract with each LHIN for \$30,000, which will include specific services to be provided by GCACH and the LHIN during the year. A total of \$800,00 has been allocated to engage the LHINs during the demonstration. The MOUs and subsequent contracts are meant “to mutually advance our health improvement goals, leverage existing efforts, align strategy, bolster channels of communication, and to bring local perspectives into regional decisions.”

GCACH staff has been working through Yakama Councilman Frank Mesplie and Tonya Kreis, Behavioral Health Specialist, to support a plan for improving Tribal information and technology infrastructure. Electronic communications between the behavioral health services in Toppenish and the Indian Health Services clinic are challenging, as there are not reliable internet connections across the reservation. Mr. Mesplie has asked Arlen Washines Yakama Deputy Director of Human Services Administration, to form a committee to develop a process for developing a project plan. In a meeting on August 4th, 2017, GCACH was encouraged to support, not lead, a process that best serves the Yakama Tribe. GCACH has identified approximately \$235,000 for IT investment, and \$150,000 for Tribal consultation.

Dental access is also problematic for the Yakamas, so GCACH has been discussing with Councilman Mesplie and Jay Sampson, CEO, Yakama Unit, Indian Health Services, the possibility of bringing in a Dental Health Therapist (DHAT) and a DHAT training program. Initial outreach has been made to Maxine Janis, the Yakama Educational Committee Chair. The GCACH Executive Director had an informal meeting with Jay Sampson on October 18th, 2017, to discuss the possibility of providing mid-level oral health care like the Swinomish Indian Tribal Community do in Mukilteo, and was encouraged to work through the Yakama Tribe for this type of service.

Funds Flow Distribution

Describe the ACH’s anticipated funds flow distribution. In the narrative response, address the following:

- Describe how Project Incentive funds are anticipated to be used throughout the Demonstration. Provide a narrative description of how funds are anticipated to be distributed across use categories and by organization type. (*Refer to the Funds Distribution tabs of the ACH Project Plan Supplemental Data Workbook for use categories and organization types to inform the narrative response*).

ACH Response

The Finance Committee/Board adopted guiding principles to inform the funds flow allocation decision-making. These principles provide for: accountability, transparency, collaboration, value-driven decisions and flexibility.

Based on recommendations of the GCACH Budget and Funds Flow Committee and Finance Committee, the Board adopted four primary use categories:

ACH Administration and Project Management Funds will support the administrative costs to efficiently operate GCACH, including deployment of project plans, convening stakeholders, reporting

and other activities that advance DSRIP objectives; costs include salaries and benefits, independent contractors, program management tools, meetings, travel and other expenses.

Project Engagement, Participation and Implementation: Payments for engagement in GCACH planning activities, achievement of participation requirements identified by GCACH, and support for implementation of projects that have greatest reach into identified target population. Funds may be used to underwrite partner resource commitments: subject matter experts, regional and team leadership, project champions, participation in governance and infrastructure components to manage value based contracts.

Provider Performance and Quality Incentive Payments: Payments will be distributed to partnering organizations in accordance with contract deliverables. Incentive funds will be used to reward progress towards meeting project milestones and achievement against a set of performance targets and transformation goals.

Health System and Community Capacity (Domain 1): Funds will be used to build expertise, leverage resources, align strategies, assist partners with transition to value-based payment, and promote sustainability. Costs to support and advance new or existing statewide and regional infrastructures may include personnel, contracted services, technology platforms, and analytics.

Additionally, the Board adopted two ACH-defined use categories:

- An *Integration Fund* that recognizes that systems collaboration and integration is foundational to budget and funds flow. The fund will be designed to support improved population health, well-being, and equity.
- A *Contingency Fund* will reserve for unanticipated events or costs, provide safeguards of resources for projects and administration, and consideration of cash flow needs.

The following assumptions were made in determining allocation of project funds by use category:

- 27% reduction in available funds across all 5 years
- Selection of four projects
- Project Plan Score of 100%
- Average Pay-for-Reporting Achievement Value of 90% across all four years
- Average Pay-for-Performance Achievement Value of 70% across all three years.

The following funds flow allocations were approved prior to the October 27, 2017 HCA notice outlining changes to its funding protocols considering reductions to overall DSRIP funds. After modeling the impact of these changes, some modification to the approved allocations may be required. If so, changes will be vetted via the decision-making process described above.

ALLOCATION OF PROJECT FUNDS BY USE CATEGORY

Use Category	5-Year Total
Project Management and Administration	5%
Provider Engagement, Participation and Implementation	32%

Provider Performance and Quality Incentive Payments	28%
Financial Stability Through VBP (Domain 1)	3%
Population Health Management (Domain 1)	10%
Workforce (Domain 1)	4%
Integration	13%
Contingency	5%

With reservation and the understanding that agreements with partner organizations have not been formalized and there is uncertainty about total available funds, the Board of Directors approved the recommended concept for distribution to partner organizations. As the network is formalized, GCACH will strive to align the distribution of funds with project goals and coordination of transformation efforts. The distribution model will incentivize performance and drive accountability amongst partner organizations.

The allocation methodology contemplates:

- GCACH project management capacity to support DSRIP program strategies, resources to work with the State of Washington to build health system and community capacity, and administration of the inflows and outflows of waiver dollars;
- The value of the Yakama Tribe’s contribution and partnership in the transformation of the health care delivery system;
- Collaboration with Community Based Organizations providing services to Medicaid clients;
- Varying levels of engagement, capacity, and willingness to support project implementation by both providers traditionally and not traditionally reimbursed by Medicaid.

ALLOCATION OF PROJECT FUNDS BY ORAGANIZATION TYPE

	DY1 – 2017
ACH	16%
Medicaid Providers	50%
Non-Medicaid Providers	33%
Tribes/ITU	1%
Other	0%
	100.0%

- Using the **Funds Distribution** tabs of the **ACH Project Plan Supplemental Data Workbook**:
 - **Funds Distribution – 1**: Provide the projected percent funding of the Project Incentive funds by use category over the course of the demonstration (DY 1 through DY 5 combined). “Project Management and Administration,” “Provider Engagement,

Participation and Implementation,” “Provider Performance and Quality Incentive Payments,” and “Health Systems and Community Capacity Building” are use categories that are fixed in the workbook. ACHs may enter additional use categories. For each use category (fixed and additional), ACHs must provide a definition and the projected percentage of Project Incentive funds over the course of the demonstration.

- **Funds Distribution – 2:** Provide the projected percent funding of the Project Incentive funds by/for organization type for DY 1. “ACH Organization/Sub-contractors” and four “Partnering Provider Organizations” types are fixed in the workbook. ACHs must define “Other” organizations if the organization type is used. For each organization type, ACHs must provide a projected percentage of Project Incentive funds for DY 1.
- Attest to whether all counties in the corresponding Regional Service Areas (RSAs) have submitted a binding letter of intent (LOI) to integrate physical and behavioral health managed care.

YES	NO
X	

- Attest to whether the ACH region has implemented fully integrated managed care.

YES	NO
	X

- If the ACH attests to having implemented fully integrated managed care, provide date of implementation.

DATE (month, year)	

- If the ACH attests to not having implemented fully integrated managed care, provide date of projected implementation.

DATE (month, year)	January 2019

- If applicable (*regions that have submitted LOI and implementation is expected*), please describe how the ACH is working within the community to identify how Integrated Managed Care Incentive funds will be used or invested. Identify the process for determining how Integration Managed Care Incentives will be allocated and invested, including details for how behavioral health providers and county government(s) are participating in the discussion. Additionally, using the guidance provided below, describe anticipated use of funds.
(The Managed Care Integration Incentives are intended to assist providers and the region with the process of transitioning to integrated managed care. This could include using funds to assist with the uptake of new billing systems or technical assistance for behavioral health providers who are not accustomed to conducting traditional medical billing or working with

managed care business processes. County governments are one example of a potential partnering provider that could receive earned integration incentives, but integration incentives are dispersed by the financial executor, according to an allocation approach defined by the ACHs. Include use categories defined by the ACH for planned funds distribution).

ACH Response

The Greater Columbia Behavioral Health Organization (GCBHO) submitted their binding letter of intent on October 16, 2017 making the GCACH eligible for an additional \$10.78 million of Integrated Managed Care Incentive Funds.

On October 5, 2017, the Greater Columbia Behavioral Health Organization (GCBHO) voted to become a Mid-Adopter Behavioral Health-Administrative Service Organization with a transitional year in 2019 (see Attachment D). The GCACH Executive Director has been reaching out to the North Sound Behavioral Health Organization, members of the Bi-Directional Integration Project Team, and the Executive Director of the GCBHO to determine a process and form an Interlocal Leadership Committee. During the planning phase, GCACH will conduct a comprehensive assessment of the regional behavioral health system including County Mental Health/Behavioral Health agencies, housing, support services and facilities. The assessment will help identify investments needed in the areas of IT Infrastructure, training and technical assistance. During 2018, under the GCACH governance model, GCACH leadership and community partners will collaborate to determine the use and allocation of the \$10.78 million of Integrated Managed Care Incentive Funds.

GCACH has not yet defined allocation of Value Based Payment Incentive funds.

Required Health Systems and Community Capacity (Domain 1) Focus Areas for all ACHs

The Medicaid Transformation Project Demonstration requires all ACHs to focus on three areas that address the core health system capacities that will be developed or enhanced to transform the delivery system: financial sustainability through value-based payment (VBP), workforce, and systems for population health management.

The focus areas in Domain 1 require system-wide planning and capacity development to support payment and service-delivery transformation activities. ACHs, in collaboration with HCA and statewide partners and organizations will need to work to use existing infrastructure, and develop sustainable solutions. While regional project implementation will require some level of targeted efforts, ACHs should focus on collective approaches to develop and reinforce statewide strategies and capacity. As a foundation for all efforts within Domains 2 and 3, this collective effort will enhance efficiency, lead to coordinated solutions, and promote sustainability. To the maximum extent possible, ACHs should seek to collaborate with state government and statewide entities, and support partnerships between ACHs, providers, and payers on common topics for all Domain 1 strategies to promote efficiencies and reduce costs.

Domain 1 Strategies

- Describe how capacity-building in these three Domain 1 focus areas will support all selected projects.

- Describe the investments or infrastructure the ACH has identified as necessary to carry out its projects in domain 2 and 3.

Value-based Payment Strategies

ACHs should use the statewide and regional results from the 2017 MCO and Provider VBP Surveys, and other engagement with partnering providers, to respond to the questions within this section.

Describe the ACH's approach to implementing and supporting VBP strategies in all projects. In the narrative response, address the following:

- Describe how the ACH supported and/or promoted the distribution of the 2017 Provider VBP Survey.
- Describe the current state of VBP among the ACH's providers.
 - Has the ACH obtained additional information beyond what the survey included? If so, were these findings consistent or inconsistent with the survey results?
- How do providers expect their participation in VBP to change in the next 12 months?
- For your partnering providers, what are the current barriers and enablers to VBP adoption that are driving change?
- Describe the regional strategies that will support attainment of, and readiness to, achieve statewide VBP targets, including plans for the ACH to partner with MCOs and provider associations.
- What will be the ACH's role in supporting providers in the transition to VBP arrangements? What are the preliminary considerations and strategies regarding alignment of VBP strategies in all projects?

Workforce Strategies

Workforce strategies provide a foundation for creating sustainable community-based and statewide delivery system transformation. ACHs should consider opportunities to invest their resources to ensure sustainable workforce capacity assessment and development by leveraging collaborative activities with Washington's statewide health workforce resources.

Describe the ACH's preliminary considerations and approach to adapting workforce strategies across all selected projects. In the narrative response, address the following:

- Describe how the ACH will identify the workforce necessary to support payment and service delivery transformation activities, and assess current workforce capabilities, capacity and gaps.
- Describe how the ACH is considering and prioritizing the advancement of statewide and regional innovations and approaches in workforce capacity development. How will the ACH use existing workforce initiatives and resources, including strategies to support team-based care, cultural competency, and health literacy (i.e., Workforce Training & Education Coordinating Board's Health Workforce Council, Department of Health's Office of Rural Health, Health Sentinel Network, Practice Transformation Support Hub, etc.)?

Population Health Management Systems

The term population health management systems refer to health information technology (HIT) and health information exchange (HIE) technologies that are used at the point-of-care, and to support service delivery. Examples of HIT tools include, but are not limited to, electronic health records (EHRs), OneHealthPort (OHP) Clinical Data Repository (CDR), registries, analytics, decision support and reporting tools that support clinical decision-making and care management.

The overarching goal of population health management systems is to expand interoperable HIT and HIE infrastructure and tools so that relevant data (including clinical and claims data) can be captured, analyzed, and shared to support VBP models and care delivery redesign.

Describe the ACH’s preliminary considerations and approach for expanding, using, supporting and maintaining population health management systems across all selected projects. In the narrative response, address the following:

- Describe how the ACH will work with partnering providers to identify population health management systems that are necessary to support payment and service delivery transformation activities, and to assess current population health management systems capabilities, capacity and gaps.
- Describe how the ACH will work with partnering providers, managed care organizations and other ACH stakeholders to expand, use, support, and maintain population health management systems across all projects.

ACH Response

Domain 1 Strategies:

The underlying foundational strategies of the Medicaid Demonstration are designed to enhance health system capacity. Greater Columbia ACH views these investments as catalysts for reform,



Figure 54: Domain 1: GCACH Foundational Investments

not ongoing operating budget expansions.

For all Accountable Communities of Health, investments in workforce, health information technology, and rewarding providers to undertake new VBP arrangements are drivers for health care transformation. As illustrated in Figure 54, these investments underpin Domains 2 and 3. These investments are necessary in order for integration and collaboration to happen among providers and systems, and to allow old systems to end while new systems emerge. Systems change is difficult, and the Healthier Washington Initiative is using many strategies to transform our healthcare delivery system. Figures 55 and 56 below illustrate two different theories of systems change, but they both illustrate the need to support the emergence or transition to a new state.

GCACH has identified access to primary care as a major gap in health delivery system, necessitating the need to augment our workforce. Adding additional primary care physicians would be ideal, but not attainable in a five-year period, so GCACH will train and grow a workforce of community health workers, and cross-train existing health care professionals to meet project needs. GCACH is planning to make a large investment in health information technology, and improve systems interoperability to support population health management for the providers. GCACH is also investing in education, with a vision to create a regional resource directory that helps the users of the health system easily find social services and supports. Education for providers will help them develop VBP readiness plans, and understand and analyze VBP models.

BERKANA TWO LOOPS

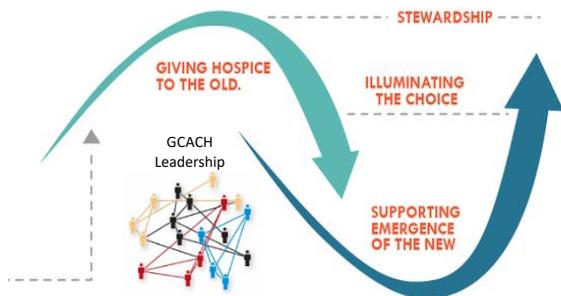
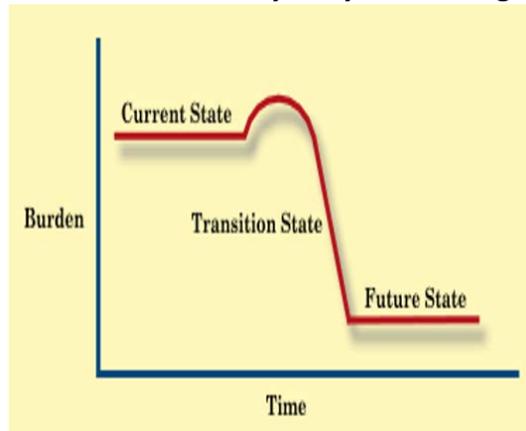


Figure 55: Berkana Institute: How to support systems change

J. Kitzhaber's Theory of System Change



ACH Figure 56: Investment in Current State required to get to Future State, 4/19/17 GCACH Retreat

leadership is needed to coordinate systems change among aligned stakeholders, and to build new networks through collective impact. Networks, in and of themselves, are the catalyst for change. By combining the collective vision of our multi-sector membership with evidence-based research and some investment funding, we will move ideas into action.

GCACH Domain 1 Investments

The Greater Columbia ACH has established a Budget and Funds Flow Committee that recommended eight use categories in the Demonstration budget which are illustrated in the Table 2 below. This model was built on three assumptions:

- A Project Plan Application Score of 90%
- Average Pay for Reporting Achievement Value of 90%
- Average Pay for Performance Achievement Value of 70%

Table 2: Allocation of GCACH Project Funds by Use Category

GREATER COLUMBIA ACCOUNTABLE COMMUNITY OF HEALTH DSRIP PROJECT FUNDS ALLOCATION													
PROJECT PLAN SCORE		90%											
AVERAGE P4R ACHIEVEMENT VALUE		90%											
AVERAGE P4P ACHIEVEMENT VALUE		70%											
		DY1-2017	DY2-2018	DY3-2019	DY4-2020	DY5-2021	5-year total						
Project Management and Administration		5%	0.69	5%	0.86	5%	0.80	5%	0.70	5%	3.61		
Project Costs	Project Engagement, Participation and Implementation	50%	6.86	40%	6.91	35%	5.59	25%	3.48	15%	1.70	34%	24.53
	Provider Performance and Quality Incentive Payments	4%	0.55	18%	3.11	28%	4.47	40%	5.57	50%	5.67	27%	19.36
		54%	7.41	58%	10.01	63%	10.06	65%	9.05	65%	7.37	61%	43.89
Domain 1	Financial Stability Through VBP	1%	0.14	2%	0.35	2%	0.32	4%	0.56	5%	0.57	3%	1.93
	Population Health Management	20%	2.74	14%	2.42	5%	0.80	5%	0.70	3%	0.34	10%	6.99
	Workforce / Training	5%	0.69	5%	0.86	5%	0.80	7%	0.97	9%	1.02	6%	4.34
		26%	3.57	21%	3.63	12%	1.92	16%	2.23	17%	1.93	18%	13.26
ACH-defined	Integration	8%	1.10	10%	1.73	15%	2.40	10%	1.39	10%	1.13	11%	7.74
	Contingency/Reserve (not to exceed \$XXX)	7%	0.96	6%	1.04	5%	0.80	4%	0.56	3%	0.34	5%	3.69
		15%	2.06	16%	2.76	20%	3.19	14%	1.95	13%	1.47	16%	11.44
		100%	13.72	100%	17.27	100%	15.97	100%	13.92	100%	11.33	100%	72.20

dollars in millions

Domain 1 investments comprise approximately 18% or \$13.3 million of the total budget. Domain 1 investments are spread across the five year program and ramp up or down depending where and when investments need to occur. For example, assessments for workforce, health information technology, and capacity and gaps of bi-directional integration will need to occur before many of the implementation plans can be developed. Investments in population health management infrastructure, such as a business intelligence (BI) tools to aggregate data and provide a comprehensive clinical picture of each patient, will be needed across the care coordination network early on to build system capacity and support for providers. Training and education to support implementation of the software platforms will coincide with this activity. Investments in workforce will also need to happen prior to project implementation in order to train new community health workers and have them integrated into care teams. Investment in value-based payment education for providers is increased in 2019-2020 to support the State’s goals of VBP by 2021. Funding will also be allocated to engage experts and speakers that support the project areas, and provide education for end-of-life care, or pain management alternatives.

IMPLEMENTING AND SUPPORTING VBP STRATEGIES

ACH support of the 2017 Provider VBP Survey

GCACH actively supported the distribution of the 2017 Provider VBP survey by sending out a request to all of our provider organizations to respond, and then sending out personal emails to provider systems that had not responded. Additionally, our partner, SignalHealth sent out a request to providers in their region.

The Current State of VBP among ACH Providers

Provider VBP survey: early findings

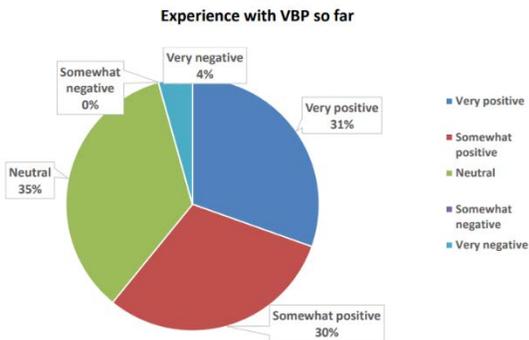


Figure 57: Current State of VBP Providers, Statewide

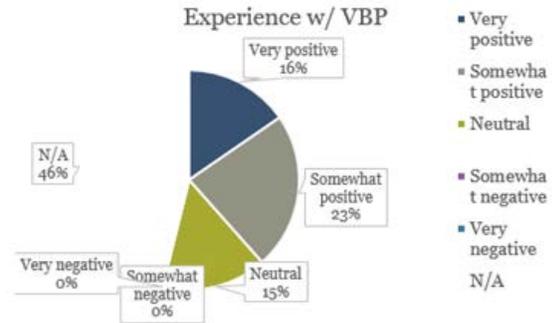


Figure 58: Current state of VBP, GCACH Providers

As depicted in Figure 58, thirty-nine percent (39%) of the GCACH providers who responded to the VBP survey had a very positive or somewhat positive experience with value-based payment arrangements. The largest majority, 46% answered that it was not applicable. Fifteen percent (15%) were neutral, and there were no negative experiences recorded. Statewide (see Figure 57), 61% of the providers had a very positive or somewhat positive experience with VBP, with 4% very negative and 35% neutral. This may indicate that more outreach and education to GCACH provider organizations will yield positive results.

Providers participation in VBP in the next 12 months

It is difficult to predict from the regional survey how providers will participate in VBP during the next twelve months, as the sample size was very small (see Figure 59). However, from results, it would appear that out of the 12 responses in the GCACH region:

- 33% will increase by up to 10%
- 25% will increase by 10-24%
- 25% will increase by 25-50%
- 8% will stay the same
- 8% will increase by more than 50%

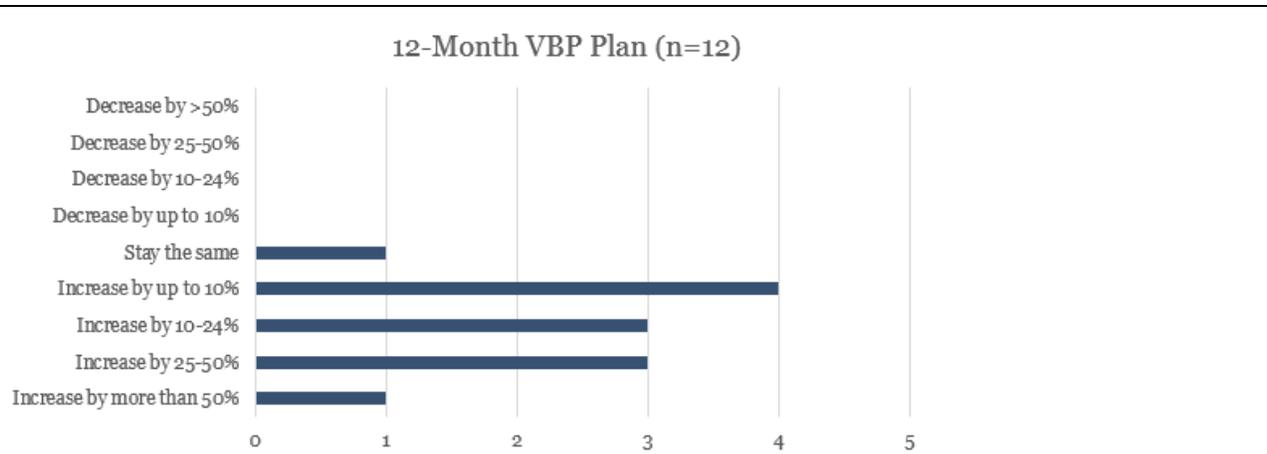


Figure 59: Provider Participation in VBP in next 12 months

Current Barriers and Enablers

Of the 12 GCACH respondents regarding BARRIERS:

- 75% cited Lack of access to comprehensive data on patient populations
- 67% cited 1) Lack of interoperable data systems
2) Lack of availability of timely patient/population cost data to assist with financial management

- 50% listed Misaligned incentives and/or contract requirements
- 42% cited Misaligned quality measurements and definitions
- 25% cited Lack of consumer engagement
- 17% cited:
 - Inability to adequately understand and analyze payment models
 - Insufficient patient volume by payer to take on clinical risk
 - Differing clinical protocols and/or guidelines associated with training for providers
 - Regulation or policies
 - Lack of trusted partnerships and collaboration with providers outside your organization
- 8% cited:
 - Implementation of State-based initiatives
 - Lack of trusted partnerships and collaboration with payers
 - Lack of or difficulty developing medical home culture with engaged providers

Of the 6 respondents regarding ENABLERS:

- 67% cited:
 - Trusted partnerships and collaboration with payers
 - Aligned quality measurements and definitions
 - Ability to adequately understand and analyze payment models
- 50% cited:
 - State-based initiatives

- Aligned incentives and/or contract requirements
- Sufficient patient volume by payer to take on clinical risk
- Access to comprehensive data on patient populations
- 33% cited:
 - Trusted partnerships and collaboration with providers outside your organization
 - Regulatory changes
 - Common clinical protocols and/or guidelines associated with training for providers
 - Development of medical home culture with engaged providers
- 17% cited:
 - Consumer Engagement
 - Availability of timely patient/population cost data to assist with financial management
 - Interoperable data systems

Current barriers and enablers to VBP adoption that are driving change

The enablers and the barriers to engage in VBP contracts were very informative. Lack of access to comprehensive data on patient populations was the most common barrier cited. Lack of interoperable data systems and lack of available timely patient/population cost data were also commonly cited. Opportunities will come from developing trusted partnerships and collaboration with payers, and making sure that quality measurements are aligned and defined so the providers are equipped with a clear understanding of the risks and advantages of certain payment models.

Provider VBP survey: early findings

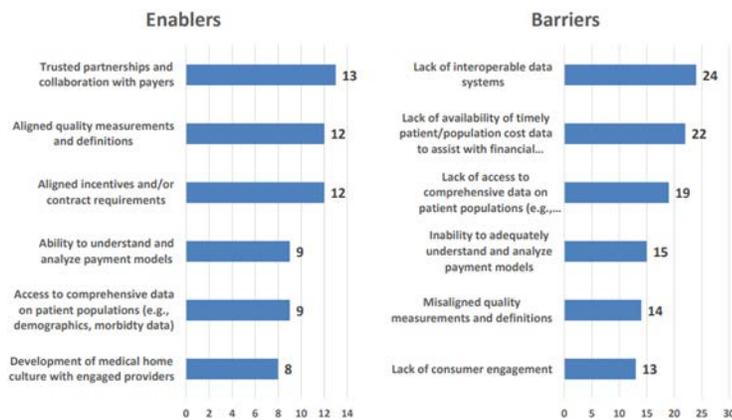


Figure 60: Statewide Results, VBP Barriers/Enablers

As shown in Figure 60, the Statewide results includes the top three barriers as the GCACH results, but slightly differ in their order.

GCACH recognizes that one of the keys to sustainability beyond the five-year Demonstration is to invest in systems that allow providers to have access to comprehensive data on patient populations, to be able to collaborate and share information, and have real-time feedback on patient health so our investment emphasis on population health management systems is aligned with

these findings. Trusted partnerships with payers, aligned quality measurements, and the ability to understand payment models are areas that will enable further VBP arrangements.

Value-based Payment Strategies:

Regional strategies that will support attainment of statewide VBP targets

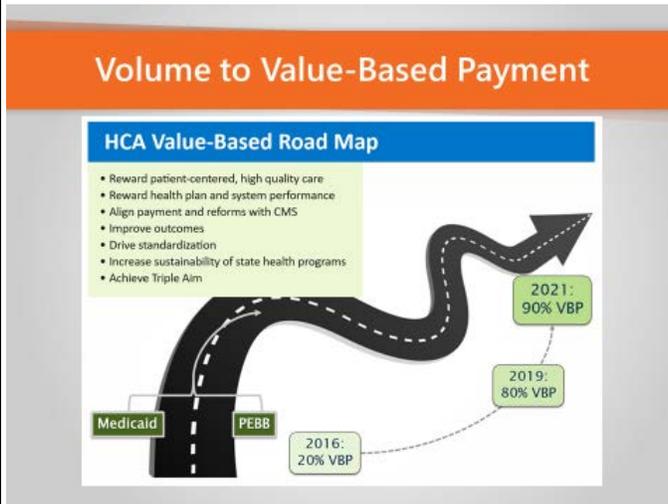


Figure 61: VBP Road Map in GCACH Community Presentations

GCACH has laid the groundwork to support VBP targets by including the Medicaid Demonstration goals in dozens of presentations. We use the Volume to Value-Based Payment visual in our power point presentations (see Figure 61), and have included “Responsibilities of Partnering Provider” language to support the Medicaid Demonstration goals in our Letter of Interest that went out to over 400 organizations in our service area. GCACH has given VBP presentations to the NW Rural Health Network Board of Directors, the GCACH Leadership Council and the GCACH Board. We will also be supporting our Rural Health Network as they explore options to participate in the Caravan Health ACO which also ties to VBP contracting

arrangements. GCACH can help offset some of these upfront costs, basically serving as seed money to help the health systems get signed up for the Medicaid VBP arrangement, especially those organizations that are not integrated with other systems.

Additionally, GCACH was instrumental in getting our Behavioral Health Organization to become a mid-adopter for fully integrated managed care which will provide financial incentives for investments necessary to transition to new payment model. Finally, GCACH will invest resources in population health management infrastructure so that it is ready to support our providers for technical assistance and training to ensure that any provider organizations, interested or willing to know more about VBP has the necessary tools to make informed decisions, and a clear understanding of the requirements to be successful.

ACH’s role in supporting providers in the transition to VBP arrangements

Greater Columbia ACH has chosen a cohesive project portfolio that targets resources that will positively impact our high-needs patients. The process has been data-driven, but informed by clinicians, subject matter experts, and community stakeholders who all share a common desire to improve population health. As shown in Figure 62, GCACH is concentrating on four project areas that have the highest likelihood of meeting performance measures, and targeting a population with evidence-based strategies and preventative services that will improve their health. As a result, providers will receive a portion of these savings through incentive payments. Underpinning the project portfolio will be investments in health IT infrastructure, workforce, education, training, and community engagement that will support our providers and transition them into developing models of care that rewards value over volume. GCACH has assembled a network of stakeholders that are breaking down the barriers to VBP arrangements by investing in systems that will be interoperable, provide timely and comprehensive data on patient populations, and aligned them quality metrics.

MTD Toolkit: P4P Reporting Metrics

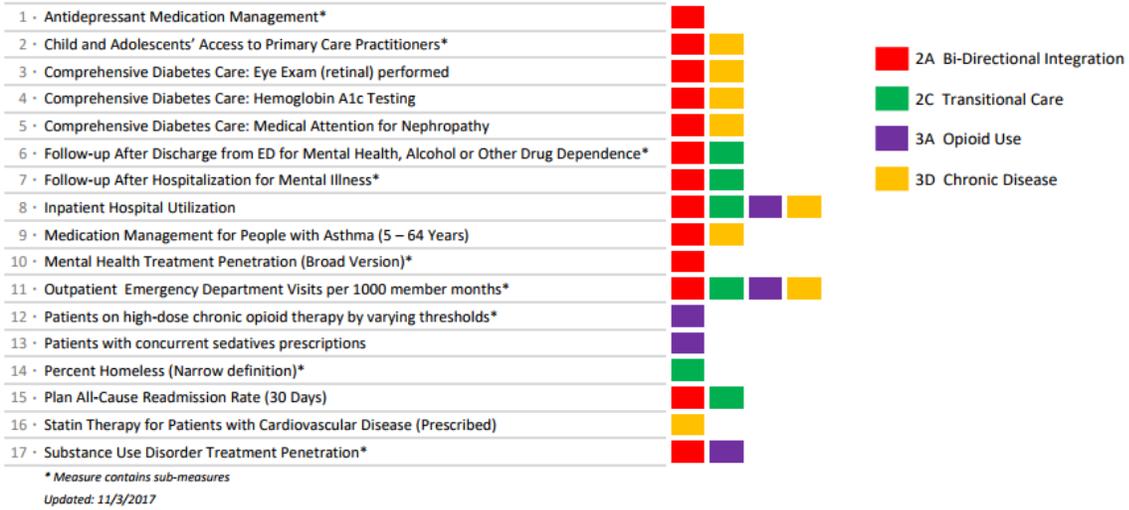


Figure 62: Pay for Performance Metrics across GCACH Project Areas

Workforce Strategies:

Adapting workforce strategies across all selected projects

Without a comprehensive, trained workforce none of the organizations participating in Greater Columbia ACH projects can hope to succeed at meeting our region’s goals for population health improvement. As shown in Figure 63, every county in the GCACH region already experiences shortages of health care professionals in almost every health-related occupation, a common challenge for rural communities. The additional work that will be required over the next four years will exacerbate this existing need. There are many factors contributing to these shortages including insufficient numbers of trained personnel and difficulty in recruiting and retaining trained personnel in rural communities. Not only will GCACH’s strategies need to address all the factors contributing to workforce shortages, but also incorporate the dynamic forces affecting rural health systems in general.

While existing workforce shortages and the new demands presented by the four selected GCACH projects create challenges in our largely rural region, the smaller organizations and communities that will be participating also provide a strong foundation for workforce development strategies that will support all projects in Domains 2 and 3. By necessity, rural organizations and communities have long experience maximizing limited resources and figuring out how to weave different personnel and programs together to achieve the best outcomes for the populations they serve. No one in a rural community or organization wears just one hat. We can take advantage of this history to define workforce development strategies that build on local strengths and add sufficient capacity to support all the projects a community has elected to take on.

Fortunately, there are many resources, reports, and studies to draw upon when devising our strategies to address workforce shortages, services delivery transformation activities, and workforce capabilities, capacity and gaps in rural areas. There are also existing initiatives that can help address short term gaps while creating programs that will help rural health systems meet long term needs. Leveraging these studies and including the community leaders, employers, providers, payers, stakeholders and consumers will be necessary in each sub-region to develop an effective implementation plan.

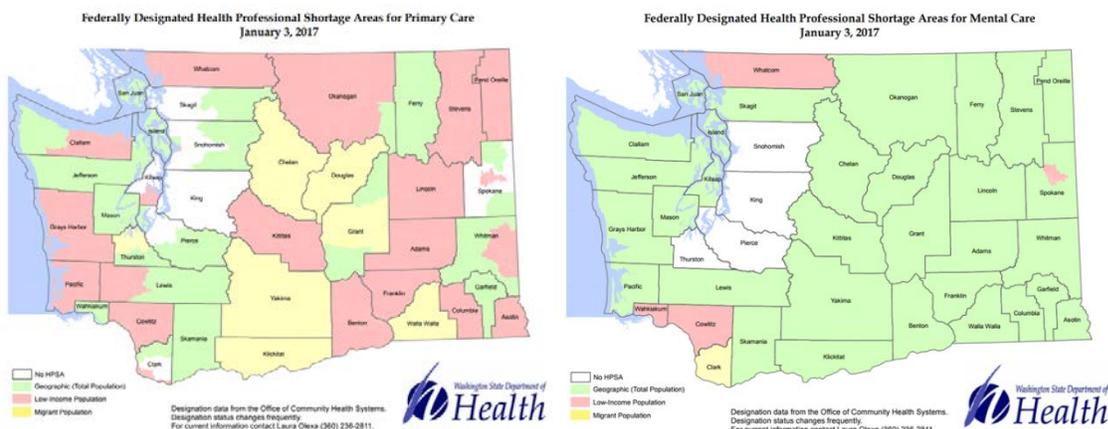


Figure 63: Professional Shortage Areas in GCACH in Primary Care and Mental Health

**HEALTH CARE AUTHORITY DENTAL SERVICES
ANNUAL PERCENT OF ELIGIBLE CLIENTS RECEIVING DENTAL SERVICES
ALL AGES - FISCAL YEAR 2016**

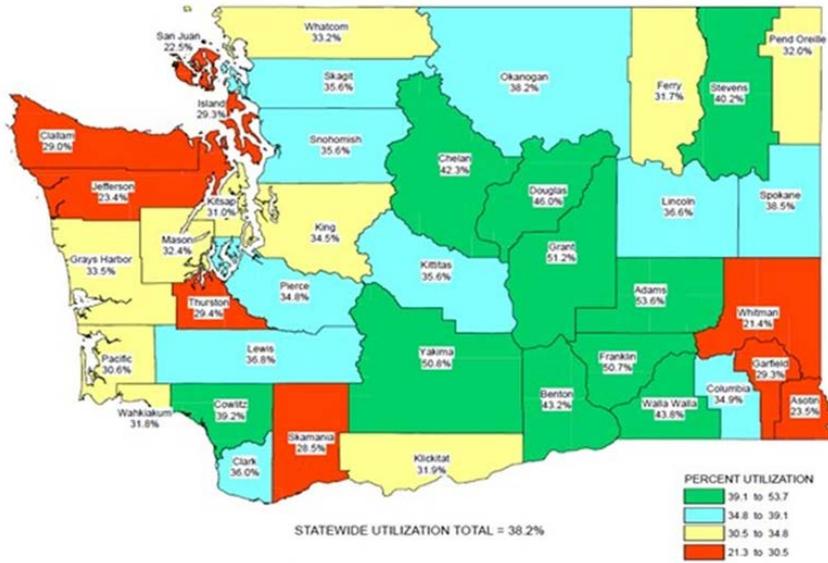


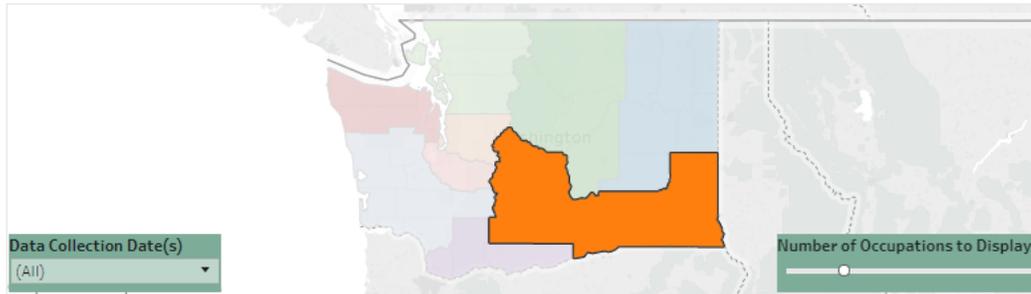
Figure 64: Dental Shortages in SE WA

Identifying Necessary Workforce

The Washington State Health Workforce Sentinel Network has conducted surveys to identify healthcare occupations with exceptionally long vacancies. These findings are aggregated by ACH, and closely align with an independent study done by Eastern WA University in the Spring of 2017 for GCACH. The two figures below (Figures 64 and 65) compare the State and Regional survey results.

Washington State Health Workforce Sentinel Network

Exceptionally Long Vacancies by Geographic Region



Occupations with Exceptionally Long Vacancies

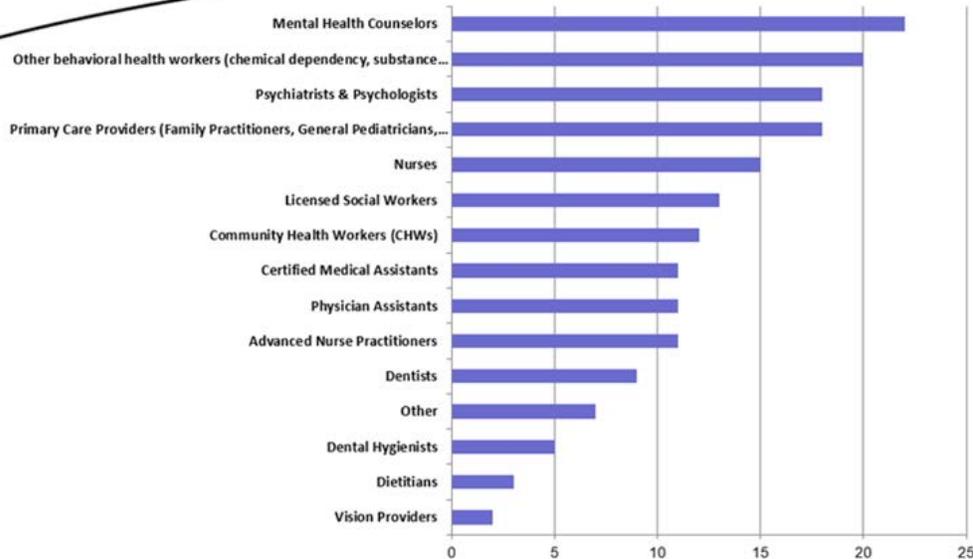
Click on an occupation (CtrlCmd + Click on multiple occupations) to view reasons

Data Collection Date(s)	Geographic Region	Occupation	Number of Vacancies
Apr. 1, 2017 - May 15, 2017	Greater Columbia (hover on map to see region)	Mental Health Counselor	10
		Social Worker, Clinical	8
		Nurse, Registered	7
		Marriage And Family Cou..	6
		Physician/Surgeon	6
		Nurse Practitioner	5
		Psychologist - Clinical, Co..	5
		Medical Assistant	3
		Psychiatrist - Child	2
Nov. 1, 2016 - Dec. 15, 2016	Greater Columbia (hover on map to see region)	Nurse, Registered	15
		Nurse, Licensed Practical	12
		Mental Health Counselor	10
		Nurse Practitioner	10
		Substance Abuse And Beh..	10
		Medical Assistant	8
		Nursing Assistant	8
		Social Worker, Clinical	7
		Physician/Surgeon	6

Figure 65: WA State Health Workforce Sentinel Network: Results from data submitted April 1-May 15, 2017 and November-December 2016

Workforce question results: current area of “greatest need”

■ start something big



 EASTERN WASHINGTON UNIVERSITY
start something big

Figure 66: GCACH Regional Workforce Survey, April 2015

Another source providing key workforce data for the GCACH is the Washington State Employment Security Department/LMPA, Occupational Employment Statistics. This information is published at the County level and tracks the top twenty-five occupations that are advertised online by Standard Occupational Classification (SOC), title, and is regularly updated. Table 3 below extracts SOCs for the nine counties in the GCACH service area. Registered nurses top the list in all but one county, Kittitas. It should be noted, however, that some occupations with high turnover, nursing, for example, may contribute to the job posting data.

Table 3: Top 25 Occupations advertised online by the Employment Security Dept.

Source: Employment Security Department/LMPA, Occupational Employment Statistics; The Conference Board, Help Wanted OnLine job announcements

Rank	SOC	Title	All job postings ¹	New job postings ²	Average annual wages ³	Median annual wages ³
Asotin County, September 2017						
1	29-1141	Registered Nurses	20	2	\$74,468	\$71,863
2	Nov-11	Medical and Health Services Managers	5	1	\$99,261	\$91,741
3	31-1014	Nursing Assistants	5	3	\$25,859	\$22,607
Benton County, September 2017						
1	29-1141	Registered Nurses	231	56	\$68,439	\$70,997
5	29-1069	Physicians and Surgeons, All Other	55	8	\$259,059	\$286,061
Columbia County, September 2017						
1	29-1141	Registered Nurses	12	5	\$74,468	\$71,863
5	29-1123	Physical Therapists	3	3	\$93,627	\$90,947
Franklin County, September 2017						
2	29-1141	Registered Nurses	71	22	\$68,439	\$70,997
7	21-1093	Social and Human Service Assistants	21	7	\$32,788	\$35,221
9	31-9092	Medical Assistants	19	7	\$32,889	\$33,302
Garfield County, September 2017						
1	29-1141	Registered Nurses	25	3	\$74,468	\$71,863
Kittitas County, September 2017						
4	29-1123	Physical Therapists	12	1	\$90,681	\$90,947
6	29-1141	Registered Nurses	11	8	\$73,601	\$71,863
10	31-1014	Nursing Assistants	9	3	\$26,062	\$22,762
12	21-1093	Social and Human Service Assistants	9	8	\$34,621	\$34,997
Walla Walla County, September 2017						
1	29-1141	Registered Nurses	121	16	\$74,468	\$71,863
3	31-9092	Medical Assistants	33	4	\$33,668	\$35,178
4	29-1123	Physical Therapists	28	8	\$93,627	\$90,947
6	Nov-11	Medical and Health Services Managers	20	5	\$99,261	\$91,741
7	31-1014	Nursing Assistants	19	2	\$25,859	\$22,607
8	21-1093	Social and Human Service Assistants	18	6	\$35,811	\$35,396
Whitman County, September 2017						
1	29-1141	Registered Nurses	40	8	\$74,468	\$71,863
6	21-1093	Social and Human Service Assistants	16	10	\$35,811	\$35,396
Yakima County, September 2017						
1	29-1141	Registered Nurses	281	84	\$73,601	\$71,863
5	21-1093	Social and Human Service Assistants	61	30	\$34,621	\$34,997
15	31-1014	Nursing Assistants	29	19	\$26,062	\$22,762
18	29-1123	Physical Therapists	27	5	\$90,681	\$90,947
19	29-2061	Licensed Practical and Licensed Vocatio	27	13	\$44,129	\$44,566
22	31-9092	Medical Assistants	26	12	\$33,154	\$35,178

While the data leads us to assume workforce shortages in Mental Health Counselors, Nurses, Behavioral Health professionals, Social Workers, and Community Health Workers, it will be extremely important to work with the providers to determine what will actually be needed to be able to respond to the Demonstration opportunities. The regional survey gives us some ideas, but the actual capabilities of the workforce in each subregion will be assessed. For example, there are many different types of community health workers already in the workforce, but with different titles; patient navigators, client advocates, community paramedics, school coordinators, outreach coordinators. How these positions are used also varies between organizations. Some prefer to use nurses for care coordination as their programs have a more clinical focus. Other organizations place more emphasis on social determinants of health and find that social workers are a better fit for their programs.

Advancement of Statewide and Regional Innovations and Approaches in Workforce Capacity Development

There has been a body of evidence-based practices that GCACH can draw upon to address our rural healthcare shortages. These reports have findings that align with our cultural diversity, rates of poverty, educational attainment, employment rates, and regional assets:

- **Rural Healthcare:** A strategic plan for Washington State 2nd Edition • Winter 2012
- **The New Blue H:** A report on the findings of the 2014 Rural Health Workgroup, a partner project between the Washington State Department of Health and the Washington State Hospital Association
- **Robert Wood Johnson Foundation, What Works for Health:** Strategies to Improve Rural Health, February 2016
- **U.S. Department of Health and Human Services Health Resources and Services Administration** the Office of Rural Health Policy May 2012
- **In the Nation's Compelling Interest:** Ensuring Diversity in the Health-Care Workforce, Institute of Medicine (US) Committee on Institutional and Policy-Level Strategies for Increasing the Diversity of the U.S. Healthcare Workforce; Smedley BD, Stith Butler A, Bristow LR, editors

Our foundational strategies of integration and care coordination are imbedded across each project plan, and are supported by literature. For example, building care coordination networks in each of the subregions, and integrating information systems that link care providers in each region are strategies found in the Rural Healthcare strategic plan. Likewise, we will look for opportunities to “grow our own” workforce by using Community Health Workers, Peer Counselors, and Promotores to help patients navigate their care, as suggested by the Institute of Medicine. GCACH is pursuing the use of Dental Health Therapists in collaboration with the Yakama Nation, and has reached out to Christina Peters, the Native Dental Therapy Initiative Project Director for the Portland Area Indian Health Board and the Arcora Foundation for assistance.

For health care personnel workforce needs we will look to recommendations in the New Blue H, including strategies that can help encourage nurses and primary care physicians and mid-level providers to practice in rural communities. We can leverage existing resources including the J-1 Visa Waiver Program, the national Health Service Corps Loan Repayment and Scholarship Programs, and the Washington State Health Professional Loan Repayment program. We will also collaborate with the other ACHs and state agencies to address licensure issues that may limit the work providers can do in rural communities. Short-term we can help communities take advantage of the state’s Volunteer and Retired Provider Malpractice Insurance program to encourage engagement by retired health professionals across our region.

Finally, GCACH will work with each of the Local Health Improvement Networks to determine their preferred approach to care coordination. The need to incorporate Community Health Workers to expand capacity and coordination has been a common need across all project areas. Whether regions choose the Pathways HUB as their chosen approach, or team based care, GCACH will invest in the training and technology needed to advance culturally appropriate workers who can improve the system of care in every part of our region.

Developing Workforce Strategies

Greater Columbia ACH is fortunate to have a workforce development expert, Dan Ferguson, on its Board of Directors who has agreed to chair the GCACH Workforce Committee. Dan is the Director of the Washington State Allied Health Center of Excellence, and serves on many workforce committees across the state, including the Washington Health Workforce Sentinel Network, The Health Workforce Council, and is associated with the University of Washington Center for Health Workforce Studies, Pacific Northwest University of Health Sciences, Heritage University, and the Washington State Board for Community and Technical Colleges.

It will be the responsibility of the Committee to assess, develop, implement, and oversee a comprehensive workforce strategy to ensure that the GCACH provider system retains, hires, and trains the staff necessary to support the successful implementation of the DSRIP projects being implemented. The Committee membership includes professionals from community colleges, the Richland School District, the Chief Medical Officer of Yakima Neighborhood Health Center, Lutheran Community Services, Yakima Valley Farm Workers Clinic, the Executive Director of the Northwest Rural Health Network, Community Health Workers, Washington State Department of Health, the Practice Transformation Hub, the Employment Security Department, B-F Workforce Development Council, and will collaborate with GCACH Project Teams, and the Local Health Improvement Networks in each subregion.

While this committee has not yet developed a detailed plan for developing the workforce strategies, the workforce assessments in each of the project areas will need to be completed by the end of Quarter Two (2) of 2018 as part of the capacity assessments required in the project toolkit. The work will proceed in six general stages:

- Conduct a comprehensive assessment of existing workforce needs and cross-walk those needs to the four project areas
 - As the assessment phase moves forward, it will be important to match the four project areas, Bi-Directional Integration, Transitional Care, Opioid Public Health Crisis, and Chronic Disease with the actual capabilities of the workforce in each sub region. Providers will need to be consulted during the implementation planning to share expectations within each project area, and to ensure that they can effectively address our target population.

Month of Planned Activity	2018											
	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Assess current regional capacity OF INTEGRATED CARE MODEL Adoption												
Assess current regional capacity to effectively deliver CARE TRANSITION services												
Assess current regional capacity to effectively impact the OPIOID CRISIS and include strategies to leverage current capacity and address identified gaps												
Assess current regional capacity to effectively impact CHRONIC DISEASE												

Figure 67: Timeline of Workforce Assessments

- Identify options and alternatives for addressing workforce needs
 - o Drawing on the resources and recommendations identified above, we will create a menu of options and alternative strategies that communities and organizations can use to meet their workforce needs. Opportunities for internships, apprenticeships, clinical rotations, standardized trainings, and community based education will be explored and documented. What provider training and educational needs for existing staff would be helpful? Trusted pathways for patients will be explored. Where do they seek services? Who will they entrust their care to? How can technology be leveraged?
- Map the options and alternatives to each community through the Local Health Improvement Networks
 - o Not all strategies for workforce development will work for each community. After identifying the current workforce needs and additional needs presented by the four GCACH projects, the Workforce Committee will work with the LHINs from the menu of alternative strategies to identify those that will best meet local needs and circumstances.
- Identify resources necessary for each community to implement the strategies it has identified
 - o These resources might include bringing in outside trainers to conduct educational sessions for existing providers or enrolling residents into key training programs at regional or state universities. Other strategies might address the development or adoption of apprenticeship programs, or the promotion of on-line degree programs such as those available through Western Governors University.
- Create a workforce workplan for each Local Health Improvement Network and a master workplan for the entire GCACH region
 - o Implementation of any workforce workplan will need to be done at both a regional and a local level. At the regional level, there is a need to track all activities and assure overall ACH goals are being met. Some workforce development interventions will best be delivered from a regional level. At the same time, actual application of any interventions will be occurring at a local level and some shared local plan will assure that workforce development efforts are optimized. For example, two organizations may elect to each send a staff member to distant “train the trainer” training, and then have each of those individuals serve as trainers for other organizations in the community.
- Create a process for ongoing monitoring and course correction
 - Over the four-year project period, GCACH will need to monitor workforce development across the region. This is necessary not only to assure goals are met, but also to determine if some strategies are not working and decide on alternative approaches that may be more effective.

Population Health Management Systems:

GCACH understands that a critical lever for transformation of the healthcare delivery system is a population health management system that can capture and exchange relevant clinical, behavioral, and social determinant data.

Data has been essential to the Demonstration project and been used by GCACH leadership, staff and Project Teams to explore populations to inform its theory of action; identify health care needs, gaps, and disparities; select projects and estimate potential project impact; identify priority populations for projects; identify potential partnering providers and organizations; understand community needs; engage stakeholders; design and plan projects; and assess workforce capacity and gaps.

The GCACH has had a Data Committee for several years, which met sporadically. The committee was reconstituted in 2017 and rebranded as the Data Management and Health Information Exchange (DMHIE) Committee, whose goals are to support data-driven decision-making through the review and interpretation of available information, to identify data gaps and needs, and to make recommendations regarding issues of strategic importance to the organization.

The DMHIE committee is also tasked with identifying health information technology (HIT) and health information exchange (HIE) system and integration needs for the overall GCACH Transformation project. GCACH's DMHIE committee includes representation from MCOs, FQHCs, large hospital providers, the Demonstration's Practice Transformation Coaching organization (Qualis), a regional care coordination agency, social service providers and more. These partners bring cross-sector content expertise to the DMHIE committee, giving it the capacity to assess community needs, review available information and vendors, and to make recommendations across a variety of subject areas.

As they have an HCA claims data feed, GCACH has contacted both Providence CORE and King County Public Health (KCPH) to determine future data and analytic support and reporting around both P4P and P4R performance monitoring and more. GCACH and KCPH have already collaborated on an online Tableau reporting tool (https://public.tableau.com/profile/apde.datarequest#!/vizhome/GC_PerformanceGapAnalysis/Readme), that allows community partner and stakeholders to identify performance targets and the numbers-needed-to treat (numerator counts) to meet those targets. This highly useful tool has been successfully presented to the Project Teams, Leadership Council, Board and community partners. GCACH has also been participating in group discussions with all ACH leaders about HIT/HIE needs and has participated in a review process of at least one possible CRM platform.

Working with providers to identify and support population health management system needs

A key issue relating to the success of the Transformation Projects relates to the ability of different health information technology systems across different potential Participating Providers to communicate, exchange data, and use the information that has been exchanged. This is mission critical to our success. It is also an area of great concern to our community partners, as shown in Figure 68. Lack of interoperable data systems, and the ability to access timely, comprehensive data on patient populations is a barrier to engage in value-based purchasing, but also a challenge to meet GCACH's goal of systems integration.

**HCA Provider Survey on Value-Based Payment (VBP) - CY 2016
GCACH Sample Results**

What are the greatest barriers for engaging in value-based purchasing?

Provider Organization	Lack of interoperable data systems	Lack of access to comprehensive data on patient populations (e.g., demographics, morbidity data)	Lack of availability of timely patient/population cost data to assist with financial management
Provider 1	X	X	X
Provider 2	X	X	
Provider 3		X	X
Provider 4	X	X	X
Provider 5			
Provider 6	X	X	X
Provider 7	X	X	
Provider 8	X	X	X
Percent Responding Positively	75%	88%	63%

Figure 68: Sample Results, GCACH responses to VBP Statewide Survey

Based on extensive meetings and community conversations, we believe this level of concern over interoperability is shared by most of our network of stakeholders and partners.

The DMHIE Committee and GCACH are beginning to work with partnering providers and other community partners to determine integrative systems capacity and needs to support project goals. A data assessment project for the DMHIE committee will inventory the broad HIT/HIE system capabilities of our potential Participating Providers. This inventory will be used to assess the systems and processes in place that will facilitate future integration across the ACH. This survey will include, but not be limited to, an assessment of the following:

- EMR/EHR(s) in operation within the provider practice or system
- Electronic population health management tools linked into the EHR/EMR, e.g. quality/outcome measure dashboards, patient registries, risk stratification technology, etc.
- Levels of implementation of HL7 CDA / C-CDA (XML)
- Referral management systems in current use
- Use of CollectiveMedical Technologies' EDIE/PreManage systems
- Work the organization is doing to collect Social Determinants of Health (SDoH) data at the patient level, its integration into the EMR/EHR, and its use in Population Health Management (PHM) initiatives within the organization
- HIE systems the organization is linked to

This information will serve as the baseline HIT capacity analysis for the GCACH delivery system.

The GCACH will simultaneously be working with its Project Teams 2016 to determine their HIT/HIE requirements needed to drive implementation across the four GCACH Demonstration project areas: 2A Bi-Directional Integration, 2C Transitional Care, 3A Opioid Use and 3D Chronic Disease Management.

One of the goals throughout all this work will be to build upon the existing work of our potential Participating Providers, rather than try to create a very expensive system from scratch that might not be implemented in time to meet Demonstration timelines. An ACO already exists within the GCACH that

includes Dayton General Hospital, Pullman Regional Hospital, Astria Health, Tri-State Memorial Hospital and others. Leveraging the systems, skills, and capabilities of such efforts would be cost-effective and would facilitate provider support.

We plan on bringing into our work an internal or an independent external IT consultant with data integration, population health and, ideally, DSRIP experience who will help facilitate all this work and create a cost-efficient process that is optimal to the GCACH's needs. This data integrator would facilitate the collection of the HIT capability survey data (above), help establish the requirements needed to successfully complete the integration piece of the demonstration project and possibly do project management across the implementation phase in 2018.

Health Information Exchange

The implementation of a successful Health Information Exchange (HIE) across the GCACH would be an ideal mechanism to facilitate interoperability across providers and health system, leading to improvements that enhance population health. Sharing patient information in a secure, efficient manner has the potential to substantially reduce costs, and waste. Ideally, all nine ACHs, state's HIT staff and the MCOs would come together and form a statewide solution. This would optimize cross-ACH information transfer and achieve economies of scale. Given the complexity, cost and timeline of such a venture, and given where the state is at in this process, making this happen within the timeframe of the Demonstration remains uncertain.

Greater Columbia has begun to identify possible existing options that might fulfill its HIE needs. We have contacted Reliance eHealth Collaborative (formerly known as Jefferson Health Information Exchange), which began in 2011 and currently serves 13 counties in Oregon and Northern California. Given its location in neighboring Oregon, and its experience in serving Coordinated Care Organizations (CCOs) there, it would be ideally suited to extend its reach northward. Another option, Lightbeam Health Solutions, which provides analytics services to the ACO described above, also as an HIE component: Lightbeam HIE. It could provide an opportunity to our work and its associated analytics capabilities might also work within our system. We are looking to begin discussions with Reliance eHealth and Lightbeam before the end of 2017 to understand their system capabilities, limitations and pricing.

Social Determinants of Health (SDoH)

We strongly believe that social factors outside the health care system greatly influence an individual's health, well-being and outcomes. Research indicates SDoHs affect both utilization (e.g. inpatient admissions/readmissions, ED visits) and outcomes (e.g. heart attack, mortality). As such, they have significance to our work. Optimal models for improving care for high utilizing patients, a chief area of focus for the GCACH, often include the integration and delivery of social services in addition to better coordinated medical care. While the GCACH is making significant investments in social service organizations through incentive funding, there are challenges to this integration.

First, there is not an adequate, comprehensive, user friendly, publicly-facing web resource that makes it easy for consumers, CHWs, non-profits, Medicaid providers and others to access and possibly self-manage their use of community-based resources. GCACH has amassed two large directories of programs and services (the Community Asset Inventory and GCACH Provider Directory). There are also other resources such as WIN 211, 4people.org, the Community Action Connections social services directory (Benton, Franklin) and others. However, we still see opportunities in this area. We have identified a truly robust and modern online resource directory that helps low-income families in San Francisco access the resources they need to achieve social and economic mobility (www.1degree.org). We are

investigating to see if this could be sponsored by GCACH for use in this region or co-sponsored with other ACHs as a statewide resource, perhaps in combination with another agency, such as WIN 211.

Another challenge lies in the absence of a standardized SDoH data collection tool. One possible tool is Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) (http://www.nachc.org/wp-content/uploads/2015/10/PRAPARE_Paper_Version_Revised_3_2016_Clean.pdf), which is a screening tool combined with a patient engagement tool, and a compendium of implementation and response resources. While PRAPARE is designed to be integrated into the EHR to facilitate assessment and intervention, many health care organizations are not yet able to support sophisticated capabilities to collect relevant data from the patient population and across the health care system, identify methods to integrate the data and measure performance, and then develop relationships with community organizations that are also addressing social needs in their communities (Deloitte). The GCACH hopes to leverage prospective Participating Provider contracts in a way that either facilitates the uptake and integration of SDoH data into their EHR in some proven standardized fashion or facilitates the use of a social resource care management model.

This relates to the next challenge of reporting client level SDoH data (e.g. issues with transportation, housing and employment) in a uniform manner across cross-sector social service organizations and communities and then aggregating this data in a CRM database platform for use by case managers linked to our potential Participating Providers and Local Health Improvement Networks (LHINs). A couple of social resource care management HIT models have already been reviewed for this purpose, including Clara by Vistalogic (https://www.vistalogic.net/Clara_ThreePerspectives.pdf) and Penelope by Athena Software (<https://www.athenasoftware.net/>). The standard Pathways Community HUB is also a contender in this arena but has limitations due to cost and the inability to create non-standardized pathways. These models, and others, could stand as CRM platforms for social service Participating Providers, integrating community/region-wide resource directories, and could be used to uniformly case manage the social service needs of clients.

We seek to support provider organizations in their efforts to carry-out PHM efforts across their populations. This might mean support to enhance CDA/C-CDA capabilities, develop and incorporate templates for SDoH data, purchase population health management tools from their software vendor or other. Much of this will depend on the current capacity of our provider partners and what is most cost-efficient.

Research conducted by the GCACH has demonstrated that to succeed with PHM, organizations must manage the risk, outcomes, utilization and even well-being of specific patient populations, particularly high-utilizing, high cost patient populations. GCACH Project Teams have focused their work on identifying target populations that are likely to be high utilizing (e.g. patient with severe persistent mental illness who have co-morbidities). Targeting interventions toward high risk individuals can often produce greater savings and lead to the most significant improvements in health outcomes.

However, there are significant challenges in this area, including at least the following:

- **Patient Attribution:** Attributing the patient to some sort of medical home is vital for accountability, report and incentive funds flow and has already been an area of discussion with HCA, the MCOs and the ACHs.
- **Patient Risk Stratification:** The relative health risk of each patient is identified from analysis of claims and pharmacy data, EHRs, and other transactional system data on a person's health

history. It will also rely on the social service needs for patients at risk under the SDoH framework. As well, understanding which patients in each population respond positively to care management interventions (known as “impactability”) may aid in patient selection and could be gleaned Patient Activation Measure assessment. The GCACH would like to facilitate provider organizations receiving the PRISM risk stratification tool, which is now being provided by DSHS. The GCACH could also sponsor or co-sponsor a community-wide PHM risk stratification tool, such as Arcadia Healthcare Solutions, which is now being provided by one MCO to several FQHCs across the state, including Yakima Valley Farmworkers Clinic. We believe a successful PHM plan will need to have strategies and HIT technologies to ensure proactive management of high cost patients. Most organizations do not have the capacity to attack every single problem all at once. Building upon their initial analysis of high-cost patients, and guided by GCACH incentive payments and our identified target populations, we hope to engage our Local Health Improvement Networks in starting with small pilot cases that produce the most measurable clinical improvements with the least amount of effort and which test and improve the effectiveness of their PHM capabilities.

SECTION II: PROJECT-LEVEL

Section II (including selection of the relevant project from the menu) will need to be duplicated for each project selected (at least a minimum of four).

Transformation Project Description

Select the project from the menu below and complete the Section II questions for that project.

Menu of Transformation Projects	
Domain 2: Care Delivery Redesign	
<input type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversions Interventions
Domain 3: Prevention and Health Promotion	
<input type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input type="checkbox"/>	3D: Chronic Disease Prevention and Control

Project Selection & Expected Outcomes

The scope of the project may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH will be required to finalize selections of target population and evidence-based approaches, and secure commitments from partnering providers.

Describe the rationale for project selection, and the expected outcomes. In the narrative response, address the following:

- Provide justification for selecting this project, how it addresses regional priorities, and how it will support sustainable health system transformation for the target population.

- Discuss how the ACH will ensure the selected project is coordinated with, and does not duplicate, existing efforts in the region.
- Describe the anticipated scope of the project:
 - Describe the project’s anticipated target population. How many individuals does the ACH anticipate reaching through the project?
 - What types of partnering providers are involved in this project thus far, and why are they critical to the success of the project?
 - How did the ACH consider the level of impact when selecting the project’s anticipated target population? (e.g., geography, subgroups, etc.)
 - How will the ACH ensure that health equity (e.g., demographic, geographic) is addressed in the project design?
- To support broad-reaching, system-wide transformation, projects must improve the efficiency and quality of care for the ACH region’s Medicaid population. Describe how the ACH will ensure the selected project will have lasting impacts and benefit the region’s overall Medicaid population, regardless of chosen target population(s) or selected approaches/strategies

ACH Response

Implementation Approach and Timing

Using the **Implementation Approach tabs of the ACH Project Plan Supplemental Data Workbook**, provide a short description of how the ACH will accomplish each set of project milestones in Stage 1, Stage 2, and Stage 3.

- The ACH Project Plan Supplemental Data Workbook includes an Implementation Approach tab for each project. Fill in the appropriate tabs based on the ACH’s selected projects.
- In the implementation approach descriptions:
 - Describe the ACHs general approach to accomplishing requirements.
 - Include resources to be deployed to support partnering providers, anticipated barriers/challenges and ACH tactics for addressing them.
 - Specify which evidence-based approach option(s) will be used for the project.
 - If applicable, indicate in italics whether a project milestone can be completed earlier than the required deadline in the Completion Deadline column.

Partnering Providers

Partnering providers may include clinical providers, community-based organizations, county governments, and/or Tribal governments and providers, among others. The list of partnering providers may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH must provide a final list and secure commitments from partnering providers.

Using the **Partnering Providers tabs of the ACH Project Plan Supplemental Data Workbook**, list partnering providers that have expressed interest in supporting the development and implementation of the project.

Based on the ACH's selected projects, fill in the appropriate **Partnering Providers tab of the ACH Project Plan Supplemental Data Workbook** (applicable workbook tabs must be submitted by December 15, 2017). Suggested sub-section word count does not pertain to partnering provider list. Include:

- Organization name
- Organization type
- Organization phone number
- Organization e-mail address
- Brief description of organization
- Employer Identification Number (EIN)
- Upload to Financial Executor portal

Describe engagement with partnering providers. In the narrative response, address the following:

- Demonstrate how the ACH has included partnering providers that collectively serve a significant portion of the Medicaid population.
- Describe process for ensuring partnering providers commit to serving the Medicaid population.
- Describe the process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented.
Describe how the ACH is leveraging MCOs' expertise in project implementation, and ensuring there is no duplication.

ACH Response

Regional Assets, Anticipated Challenges and Proposed Solutions

Describe regional assets that will be brought to the project, as well as anticipated challenges with the project and proposed solutions. In the narrative response, address the following:

- Describe the assets the ACH and regional partnering providers will bring to the project.
- Describe the challenges or barriers to improving outcomes and lowering costs for the target populations through this project.
- Describe the ACH strategy for mitigating the identified risks and overcoming barriers.

ACH Response

Monitoring and Continuous Improvement

Describe the ACH's process for project monitoring and continuous improvement, and how this process will feed into a potential Project Plan modification request. In the narrative response, address the following:

- Describe the ACH's plan for monitoring project implementation progress. How will the ACH address delays in implementation?
- Describe the ACH's plan for monitoring continuous improvement. How will the ACH support

partnering providers to achieve continuous improvement? How will the ACH monitor day-to-day performance and understand, in real-time, whether the ACH is on the path to reaching their expected outcomes?

- Describe how the ACH will identify and address project initiatives or strategies that are not working or are not achieving desired outcomes.

ACH Response

Project Metrics and Reporting Requirements

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO

Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO

Project Sustainability

Describe the ACH’s strategy for long-term project sustainability, and its impact on Washington’s health system transformation beyond the Demonstration period.

ACH Response



SUPPLEMENTARY MATERIALS CHECKLIST

SECTION I: ACH-LEVEL	
Regional Health Needs Inventory	
<i>None</i>	
ACH Theory of Action and Alignment Strategy	
<input type="checkbox"/>	Attachment(s): Logic model(s), driver diagrams, tables, and/or theory of action illustrations that visually communicate the region-wide strategy and the relationships, linkages and interdependencies between priorities, key partners, populations, regional activities (including workforce and population health management systems), projects, and outcomes.
Governance	
<input type="checkbox"/>	Attachment(s): Visual/chart of the governance structure
Community and Stakeholder Engagement and Input	
<input type="checkbox"/>	Attachment(s): Evidence of how the ACH solicited robust public input into project selection and planning
Tribal Engagement and Collaboration	
<input type="checkbox"/>	Optional Attachment(s): Statements of support for the ACH from ITUs in the ACH region
Funds Allocation	
<input type="checkbox"/>	Supplemental Data Workbook: Funds Distribution Tabs
Required Health Systems and Community Capacity (Domain I) Focus Areas for all ACHs	
<i>None</i>	
SECTION II: PROJECT-LEVEL	
Project Selection & Expected Outcomes	
<i>None</i>	
Implementation Approach and Timing	
<input type="checkbox"/>	Supplemental Data Workbook: Implementation Approach Tabs
Partnering Providers	
<input type="checkbox"/>	Supplemental Data Workbook: Partnering Providers Tabs
Regional Assets, Anticipated Challenges and Proposed Solutions	
<i>None</i>	
Monitoring and Continuous Improvement	
<i>None</i>	
Project Metrics and Reporting Requirements	
<i>None</i>	
Relationships with Other Initiatives	
<i>None</i>	
Project Sustainability	
<i>None</i>	

Table of Contents

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Project Selection & Expected Outcomes

The scope of the project may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH will be required to finalize selections of target population and evidence-based approaches, and secure commitments from partnering providers.

ACH Response

Project Description and Outcomes

This project will support providers in the GCACH region to adopt a continuum of complementary evidence-based care integration models. These models will optimize delivery system resources, tailor services based on patient complexity levels, and increase access to behavioral health services in the region. Regional health needs assessments and capacity inventories have underscored significant population behavioral health needs and a lack of mental health providers. Key components of this project include:

- Analysis of current system integration resources and gaps
- Development of data sharing systems to support integrated care
- Hiring, training and supporting providers to adopt integration models targeting regional needs
- Toolkit evidence-based integration models (Bree Collaborative, Collaborative Care Model) serving patients with varied levels of care needs

At this point, the GCACH has elected to utilize all of the models available in the Healthier Washington Toolkit to allow for the differing practice needs of partnering providers. During the 2018 planning year GCACH will complete thorough landscape analysis of partnering providers to learn more about where they fall on the SAMHSA levels of integration and we will work them to develop and adapt the model that works best for them given the size of their practice, patient population needs, workforce, location, existing relationships and experience with providing integrated care. Despite some variations in the models, they all share the four main principles of integrated care which have been shown to improve outcomes and lower costs:¹

- *Team-Based and Person-Centered:* Primary care and behavioral health providers collaborate effectively using shared care plans;
- *Evidence-based:* Uses therapeutic interventions proven to work in the primary care setting, psychopharmacologic treatments are according to guidelines and standards
- *Population-Based and Data-Driven:* A defined group of patients or clients is tracked in a registry so that no one “falls through the cracks”;
- *Measurement-Based Treatment to Target:* Treatment goals clearly defined and tracked for every patient. Treatments are actively changed until clinical goals are achieved.

The use of these models will allow for a team-based and person-centered approach that will deploy evidence-based models that are standardized and measured to ensure effectiveness and improved outcomes.

This project seeks to improve outcomes identified in the Bi-Directional Integration project P4P and P4R metrics, and align efforts with other projects in our portfolio around shared metrics, including for example:

- Increased follow up after discharge from ED for mental health, alcohol or other drug dependence (shared with the Transitional Care project)
- Increased follow up after hospitalization for mental illness (shared with the Transitional Care project)
- Reduced inpatient hospital utilization (shared with the Transitional Care, Opioid, and Chronic Disease projects)
- Reduced outpatient emergency department visits (shared metric across all projects)
- Reduced plan all-cause readmission rates (shared with the Transitional Care project)

Additional outcomes will be defined during the planning year as we further develop our Monitoring and Continuous Improvement Process for the project.

Justification for selecting project and how it addresses regional priorities

Approximately 46% of adults in the United States experience a mental illness or substance use disorder at some point in their lifetimes, 25% in one year alone.² Behavioral health disorders result in a median reduction of 10.1 years of life, largely due to untreated and ineffectively

managed chronic health conditions often exacerbated by behavioral health conditions.³ National data indicate that between 2006 and 2014, the rate of ED visits related to behavioral health increased by 44.1% and the ED visit rate among mental health/substance abuse visits that resulted in an admission to the same hospital increased 31.8%.⁴ ED visits involving behavioral health are generally considered potentially avoidable if appropriately diagnosed, treated and managed effectively in an appropriate outpatient setting. Health care costs for Individuals diagnosed with one or more chronic medical conditions such as diabetes, heart disease or asthma and with one or more behavioral health issues are estimated to be two to three times higher.⁵

ED utilization rates in the GCACH region are significantly higher than the statewide rate- 67% in the GCACH compared with the statewide rate of 51%- this is also true for ED visits considered potentially avoidable- 19% in the GCACH region compared with the statewide rate of 15%.⁶ While state data indicate lower rates of diagnosed depression in the GCACH region when compared with statewide rates (8% vs 10% respectively), mental health status in the region is on par with the statewide rates (11%);⁷ research indicates that these rates may likely be an underrepresentation because behavioral health disorders are often left undiagnosed.⁸ Moreover, regional data indicate that access to care for behavioral health disorders is a significant problem; only 46% of those who need care for mental health are able to receive it and only 26% of those with a substance use disorder who seek treatment are able to receive it.⁹ When individuals do receive a mental illness or substance use disorder diagnosis, treatment and ongoing management in the region are below the statewide averages- antidepressant management for the GCACH region is 50% compared with 53% statewide, mental health penetration rate for the GCACH region is 41% compared with the statewide rate of 43% and the substance use disorder penetration rate for the GCACH is 23% compared with the statewide rate of 27%.¹⁰

To effectively improve the health of the GCACH region, we must employ a strategy that improves access to care and the use of screenings to effectively diagnose behavioral health disorders, access to care that provides ongoing and effective care in the community rather than in the emergency room or hospital. The bi-directional care project presents the GCACH region the opportunity to address untreated behavioral health issues by increasing access to care in the community-based setting wherever people are seeking care either in a primary care setting or in a behavioral health care setting.

The GCACH analyzed providers serving Medicaid clients within its service area for primary care and behavioral health to ensure there was adequate coverage especially for vulnerable populations living in rural areas, adults and children. This was done using HCA reports that counted beneficiaries and claims for all professional services billed by Medicaid service providers in 2016. From this analysis, we developed a list of professional service providers by volume of clients served, providers currently under contract with the Greater Columbia

Behavioral Health Organization (GCBHO) serving clients with mental and substance abuse needs, and providers serving rural areas.

When Letters of Interest (LOIs) were distributed to our network of partners and stakeholders, a concerted effort was made to ensure that every organization on the list not only received an LOI but responded to it as well. For the most part, we have been successful at achieving engagement. The returned LOIs indicate the total volume of Medicaid client served by those providers wanting to participate in Project 2A:

- Yakima Valley Farmworkers Clinic: 137,822 (Benton, Franklin, Walla Walla, Yakima)
- Comprehensive Healthcare 16,700 (Kittitas, Yakima, Yakama Nation, Benton, Franklin, Walla Walla)
- Lourdes Health: 5,233 (Behavioral Health) Benton, Franklin
- Consistent Care Services: 1500 (Benton, Franklin, Kittitas, Walla Walla, Yakima, Yakama Nation)
- Providence Health Services: 93,928 (all counties)
- Prosser Memorial Hospital: 21,000 (Benton, Yakima)
- Community Health of Central WA: 16,000 (Kittitas, Yakima)
- Columbia County Public Hospital District #1: 5,800 (Columbia, Garfield)
- Whitman County Health Network: 48,000 (Whitman, Asotin)
- Quality Behavioral Health: 924 (Garfield, Asotin)

and many more. Critical to success of this project is the involvement of these regional high-volume service providers, providers in rural areas, those serving the Yakama Nation, and those currently under contract with the GCBHO. These organizations all exist along different points of the continuum that leads to integrated care. Not only are they well-known and respected behavioral health providers in our region, they are also part of the project team that has developed the evidence-based approaches we intend to use going forward for Project 2A. The goal will be to build upon existing successful integration efforts and scale up where needed.

How Project will support sustainable health system transformation for the target population

Providing clinically integrated care is cornerstone to delivery system transformation for the region's Medicaid population. While numerous efforts in the region have aimed to support integrated care, these efforts have remained limited in scope and scale because of scarce resources. This project will support partnering providers to make the investments needed to integrate services and provide a whole-person approach to care for the region's Medicaid population overall. In addition to investments needed to change the delivery of care, the project will support a value-based payment model that can be utilized by all private and public payers. This will transform how care is provided and sustained for all client populations, including, but not limited to the project's target population and all Medicaid recipients.

How GCACH will ensure project coordinates with and doesn't duplicate existing efforts

The GCACH will ensure that this project is coordinated with and does not duplicate efforts in a number of ways. The GCACH Bi-Directional Integration Project Team has provided intensive support to develop this project. Their subject matter expertise and local area knowledge of existing programs has helped to ensure proposed project plans build on rather than duplicate existing services. As listed below (*Involvement of Partnering Providers*) Project Team members include many of the largest Medicaid providers in the region- from both the primary care and behavioral health community, many of whom have experience with providing some level of integration in their clinics. Project Team members have emphasized that much of the integration to date has been limited to specific populations and has not been taken to scale and/or still operates in financial and technological siloes, preventing true clinical integration. In addition, there is representation on the Project Team from the Greater Columbia Behavioral Health Organization (BHO) to ensure coordination in efforts as the region moves towards full financial integration through fully integrated managed care (FIMC) that builds from the clinical integration care that will be realized through this project.

During the planning phase (Q1 and Q2 of 2018), GCACH will conduct an inventory of existing programs and resources, as well as a needs-gaps assessment. This work will provide a detailed landscape of provider adoption of integrated care models and current needs which will be used to inform implementation plans. In addition, GCACH will form a Bi-Directional Project Implementation Team and Strategic Planning Committee (SPC) in Q1 2018 to continue to engage a broad spectrum of partnering providers in project planning and implementation. The Bi-Directional Project Implementation Team will include members of the Bi-Directional Integration Project Team (participating in the development of the project application), as well as additional partnering providers identified through our Letter of Interest process in September 2017. The SPC will include representatives from each Demonstration project area selected (2A, 2C, 3A, 3D) to provide strategic alignment, coordination, and avoid duplication across the Demonstration projects. Although not formalized, GCACH staff has envisioned that our current Project Advisory Committee will form the core of a Strategic Planning Committee (SPC).

A key step to safeguard against duplication is a concerted and focused effort now to align with the work of the Washington State Practice Transformation Hub operated by Qualis Health. The practice coach for the region is part of the Project Team and the GCACH has begun coordinating with Qualis to engage providers in the region and encourage their participation in practice assessments about their level of integration. Coordinating with Qualis on these practice assessments is a critical component to ensure that GCACH has an accurate picture of

to what extent and where integration is occurring in the region and how and where efforts need to be deployed in 2018.

Project Scope

Target Population

The Healthier Washington Toolkit suggests an overall target population that includes the entire Medicaid population in the GCACH region, approximately 260,000 individuals who will be served through an overall integrated system of care that supports whole person care and access to universal screening, diagnosis and treatment of behavioral health disorders. However, to effectively achieve the outcomes the project is expected to achieve, the Bi-Directional Integration Project Team and Project Advisory Committee have looked more closely at initial target populations, starting with a high-risk population of Medicaid enrollees with co-occurring behavioral health and one or more chronic conditions. With this focus, we estimate a target population of 37,000 Medicaid beneficiaries in the GCACH region have a mental health or substance abuse disorder and one or more chronic diseases.

The estimated 37,000 individuals identified as the target population for this project was extracted from a September 2017 HCA report that analyzed Medicaid beneficiaries with either a mental health or substance abuse disorder and one or more chronic health conditions. The estimate includes individuals from all age groups, including around 4,250 children (0-11 years) and 5,350 adolescents (12-19 years). The GCACH has identified these groups as potentially benefiting from enhanced integrated care and plans to include these cohorts into its project work. It has already met with the Practice Facilitator for the Pediatric-Transforming Clinical Practice Initiative (TCPi) through the state's Department of Health. GCACH will be working in partnership with TCPi to support pediatric primary care and behavioral health providers and to perform outreach and support expanded bi-directional, and possibly tri-directional (which would include oral health), integrated care for children and youth.

During Q1 2018, the Bi-Directional Integration Project Implementation Team will work with GCACH's data vendor to conduct more detailed analysis of Medicaid beneficiaries in the region and further refine the target population, focusing on populations experiencing significant health disparities. Figures in Table 2, for example, show that disabled beneficiaries and Medicaid expansion adults have higher rates of co-occurring chronic disease and behavioral health conditions (mental health or substance use disorder) than traditional Medicaid.

Table 2: Co-occurring conditions by Medicaid eligibility group in Greater Columbia region¹¹

Coverage group	SUD	MH condition	Chronic Disease	SUD or MH and CD
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Disabled	24%	57%	27%	54%
New adults	18%	29%	26%	27%
Traditional Medicaid	5%	16%	29%	10%

The Bi-Directional Integration Project Team and the Project Advisory Committee have also identified a number of priority subpopulations to focus on in order to achieve the outcomes including the following:

- Medicaid clients with Serious and Persistent Mental Illness and co-morbid chronic health conditions
- Medicaid clients with 2 hospital re-admits within a 30-day period
- Medicaid clients with an ED visit
- Primary care patients with anxiety, PTSD, other personality disorders
- Medicaid patients with co-morbid diagnosis of Mental Health and diabetes
- Medicaid clients who are chronically mentally ill & experiencing homeless
- Medicaid clients or uninsured without a primary care provider

During the planning phase, the Bi-Directional Integration Project Implementation Team will work with GCACH’s data vendor to conduct more detailed analysis of Medicaid beneficiaries in the region and further refine the target population. It will be critical that GCACH and its partnering providers have access to data to identify Medicaid enrollees who meet these criteria.

Involvement of Partnering Providers

As indicated by the supplemental workbook, GCACH has a wide array of interested partnering providers, many of whom have participated in the initial project design, including behavioral health providers, primary care providers, FQHCs, hospital systems, MCOs, public health departments, education agencies, social service agencies and others. The Bi-Directional Integration Project Team that developed the project concept included representatives from:

- Amerigroup Washington, Inc.
- Benton-Franklin Health District
- Central Washington Comprehensive Mental Health
- Community Health of Central Washington (CHCW)

- Community Health Plan of Washington
- Coordinated Care Health Plan
- Educational School District 105
- Greater Columbia Behavioral Health
- Lourdes Health Network
- Molina Healthcare
- Nursing Pathways HRSA WFD Grant
- Prosser Economic Development Association
- Qualis Health
- The Washington Council for Behavioral Health
- Tri-City Community of Health (TCCH)
- United Way/ Optum
- UnitedHealthcare
- Virginia Mason Memorial (formerly YVMH)
- Walla Walla Department of Community Health
- Washington State University
- Washington State University College of Nursing
- Yakima Neighborhood Health Services
- Yakima Valley Farm Workers Clinic

In addition to the project team, the project concept was presented and received input and feedback from the full Leadership Council, as well as the GCACH Board of Directors. In addition, GCACH has engaged in extensive outreach to partnering providers, holding over 80 in-person meeting and presentations since January 2017 to discuss the projects and engage provider input.

Level of Impact

As indicated earlier, the Bi-Directional Project Team has evaluated regional data to identify preliminary target populations for the project. The data indicate both geographic and demographic subpopulations where there are disparities in outcomes will require a higher level of focus to achieve outcomes for the region. For example, regional data suggest that two counties within the GCACH Asotin and Columbia have higher rates of individuals diagnosed with depression (13 and 12 percent respectively) compared with the overall GCACH region (8 percent).¹² Another example where these disparities are reflected is in the higher percentage of Native Americans with a behavioral health diagnosis when compared with the overall Medicaid population in the overall population. Targeting our efforts to address these disparities will allow the region to achieve outcome that are broad in scale but also evident where they are most needed. During the planning phase, the Bi-Directional Care Project

Implementation Team will work with GCACH's data vendor to conduct more detailed analysis of Medicaid beneficiaries in the region identify high-risk communities and geographic regions experiencing the greatest disparities.

How GCACH will ensure that health equity is addressed in the project design

Behavioral health and substance use disorders are disproportionately linked to individuals with low income, individuals who identify as an ethnic minority group, individuals who are gender-based minorities (e.g. women, LGBTQ, etc.), individuals who have experienced trauma and individuals who have been or are engaged with the criminal justice system. This project will address equity by increasing access to behavioral health care in all settings where social and ethnic minorities receive care. These settings include primary care, specialty mental health care, substance use treatment centers, and jails/legal system. Given that ethnic, class, and gender minorities are at greater risk for health risks, it helps to address these concerns via an upstream and downstream approach (across all health care and community settings). Similar to the approach outlined above to address regional variations, we will identify gaps to ensure that GCACH has a robust network of partnering providers able to meet the needs of groups who are disproportionately impacted by behavioral health disorders and that each entity is working towards the same end (i.e. reducing disparities) and coordinating care approaches to optimize success.

Project's lasting impacts and benefit to the region's overall Medicaid population

There will be a number of lasting impacts as a result of this project, notably an integrated system of care that addresses whole-person needs through increased interoperability between providers and systems that are currently financially and clinically siloed. While a focus on the target populations noted above to drive the region towards meeting its project metrics, the project overall will increase efficiencies, improve communications, and reduce redundancies, as well as identifying a regional approach to data collection and registries to improve population health.

Success within this project area, as well as the three other project areas, will involve practice transformation on the part our prospective partnering providers. To be transformational, our providers will be guided toward realigning their systems and processes in a way that creates sustainability. This means adopting practices that support provider-led population health management (PHM). This will include information systems and health information technology that includes PHM tools, including risk stratification of patients, patient registries, provider attribution, incorporating evidenced base practice in workflows and more. We may compensate our large provider organizations to upgrade their EHR systems through their vendor to incorporate these tools or we might purchase a stand-alone PHM tool that incorporates both EHR and MCO claims in a complete package, with the tool then being rolled out to providers. Transformation will also mean establishing clinical-community linkages

with outside social service providers. This could include either creating, or building upon existing efforts, a robust consumer-facing online platform or site that provides easy access to information about social service agencies. Wrapped around this might be a case management tool that integrates work done to address patients' social service needs. Transformation will also mean creating new roles and responsibilities, including patient navigators, case managers, care coordinators, peer counselors, community health workers and more. We expect to help support the training of many of these individuals. We also expect to partner with the five MCOs to gain their support, align with their provider payment arrangement and gain long-term commitments over aspects of this work. Once these changes are in place, and as the movement toward value-based pay proceeds with Medicaid, Medicare and ultimately commercial insurance, the groundwork we will have laid will provide a robust structure that will propel sustainability post-DSRIP.

Implementation Approach and Timing

See Supplemental Workbook

Partnering Providers

See Supplemental Workbook

All of the providers listed in the Partnering Provider tab of the ACH Project Plan Supplemental Data Workbook have expressed interest in being a Partnering Provider to the GCACH. This was confirmed through each organization's response to and submission of the GCACH Letter of Interest (LOI) application, where each of the organizations identified in the list expressed interest in participating in Project 2A.

ACH Response

Partnering Providers

How GCACH has included partnering providers that collectively serve a significant portion of the Medicaid population

As noted earlier, the GCACH has taken a number of steps to ensure that partnering providers who serve a significant portion of the Medicaid population are engaged. In September 2017, GCACH undertook a Letter of Interest process to identify partnering providers interested in the various Demonstration project areas. In response to this inquiry, GCACH received LOIs from approximately 39 providers with specific interest in supporting the Bi-Directional Integration of Care Project. As indicated by the supplemental workbook, GCACH has a wide array of interested partnering providers, many of whom have participated in the initial project design, including behavioral health providers, primary care providers, FQHCs, hospital systems, MCOs, public health departments, education agencies, social service agencies and others.

GCACH has evaluated claims data to identify high volume Medicaid providers in the region. Fourteen of the top 29 Medicaid providers serving the Medicaid population in the region

have either participated in the Bi-Directional Care Project Team or responded to the Letter of Interest process that the GCACH undertook in September 2017.

Process for ensuring partnering providers commit to serving the Medicaid population.

The initial LOI process that GCACH undertook in September 2017 offered a preliminary look at partnering providers interested in the project, as well as provider commitments to collaborate with GCACH and other providers to achieve the Demonstration goals. During the first quarter of the 2018, GCACH will be engaging in a more formal process to enlist partnering providers through a formal contracting process. Contracts will require partnering providers to maintain a commitment to serving the Medicaid population throughout the project. This will be evidenced through continuous monitoring and data-sharing.

Process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented

As noted earlier, 23 organizations from across the region have participated in the Bi-Directional Integration Project Team to develop this proposal and approximately 39 providers responded to the LOI process that GCACH undertook in September 2017. The providers represent all counties across the region and multiple sectors including behavioral health, primary care, hospital systems, fire departments, social service agencies and other partners.

GCACH will continue engaging providers in project teams, Leadership Council meetings, presentations conducted at provider organizations and more. GCACH will also be an active participant in the planning group developing a plan, process, and timeline for transitioning to fully integrated managed care. GCACH has established two staff positions to assist with this engagement: the Clinical Director and the Community Engagement Manager.

Additionally, retroactive engagement funding will be paid to organizations based upon their employee's level of participation to project work. Project Team facilitators and members of the Leadership Council and Board who have demonstrated a strong commitment and engagement of participation will receive funding which will be given to the participating provider organizations they belong to. The stipend is to reward their prior participation and oversight in building up the approaches for each of the project areas, achieving PCMH status, attendance at Leadership Council/Board meetings, submission of an LOI, being the Project Team Leader, Medicaid attribution, and possibly other criteria as determined by the Budget and Funds Flow Committee (B&FFC) The B&FFC will then submit this methodology to the Finance Committee, and hopefully approved by the Board of Directors by the end of January, 2018. Future engagement funding is expected to be distributed based on a similar methodology as developed by the BP&FFC, and become a part of the Memorandums and contractual arrangements between the provider organizations and GCACH.

How GCACH is leveraging MCO's expertise in project implementation, and ensuring there is no duplication

All five MCOs operating in the region as well as the Greater Columbia Behavioral Health Organization are active participants in the GCACH Project Teams, and the Leadership Council, and four MCOs are

members of the Bi-Directional Integration Project Team. All have actively been engaged with the development of this project application.

MCO representatives have contributed to the review of the Regional Health Needs Inventory and identification of regional health “gaps” and associated priorities. They have provided input into the project planning process and development of the individual Project Team reports. They will continue to be key partners throughout implementation process. GCACH is partnering with the five MCOs to understand and support their regional VBP strategies, their movement toward fully integrated managed care, and to work with them on integrating care at the clinical level. MCOs are critical to the success of this project, as we need to ensure payment mechanisms are aligned with and support our project interventions. We anticipate that the MCOs will play an active role in the Medicaid Transformation project planning and implementation. This will ensure there is good coordination between payers, their expertise is leveraged, and duplication will be avoided.

These payers will continue to be involved in the planning phase of the project in 2018 and beyond. The GCACH anticipates that continuous involvement of payers will be critical to the project’s long-term sustainability in the region. In addition to their role on the Project Team and Project Implementation Team (to be formed in Q1 2018), the MCOs are represented on the GCACH Board. MCO representation will also be included in the Strategic Planning Committee.

Regional Assets, Anticipated Challenges and Proposed Solutions

ACH Response

Assets the ACH and regional partners providers will bring to the project

By far the greatest asset for the Bi-Directional Care project in the GCACH region is the number of organizations that have experience providing some level of integrated care. More specifically, there are a number of organizations already providing some level of integrated care to distinct populations. Given the disparities in prevalence among specific populations noted earlier, having a provider community that is familiar with best practices around cultural competency in delivery care will be essential for the region to achieve improved outcomes and address issues of equity. While this is a notable asset, part of the landscape analysis will be to better ascertain what capacity these providers have to provide these options and what else is needed. Other regional assets include support for efforts to divert individuals with behavioral health disorders from the criminal justice system and hospitals. Examples of this include the use of the local one tenth of one percent sales tax in many of the counties within the GCACH to support a transitions center, mental health courts and pre-trial diversion programs. There is also a significant focus on providing wraparound services for individuals with severe and persistent mental illness.

Challenges to improving outcomes and lowering costs for target population and strategy to mitigate risks and overcome barriers, and GCACH Strategy for mitigating the identified risks and overcoming barriers

<i>Challenges to improving outcomes and lowering costs</i>	<i>Strategy to mitigate risks and overcome barriers</i>
<p>Data & HIT barriers to information sharing, monitoring, and supporting transitions to value-based payment models.</p>	<p>This issue crosses all the projects the GCACH will be undertaking and will be a foundational investment that will need to be made by the ACH with other ACHs and the state as partners. The Bi-Directional Project can support this by enlisting key partnering providers to participate in solutions being developed.</p>
<p>Legal barriers to information sharing. There are many real and some perceived barriers related to sharing information among providers, specifically related to 42CFR and HIPAA compliance. For this project, this is a notable concern given not only potential legal concerns, but also the stigma associated with behavioral health disorders.</p>	<p>The GCACH support trainings and require mandatory participation for partnering providers to address many of these issues, ranging from what is an isn't shareable information, to providing trauma-informed care, motivational interviewing and more. The GCACH will also need to work with the state to develop templates legal documents for partnering providers that allow for information sharing that complies with state law and gives partnering providers the assurance that they can, in fact share information. Other solutions for partnering providers engaged in this work could include developing a "release of information" for GCACH patients that will allow partnering providers in the GCACH to share information about shared patients more seamlessly.</p>
<p>Communication barriers between disciplines. Primary Care and Behavioral Health (including mental health and substance use) providers speak different</p>	<p>The GCACH will facilitate learning collaboratives for providers to be able to learn from one another and begin to understand and appreciate what they can</p>

<p>languages in how they approach and how they deliver services to their patients. These language differences contribute to an ongoing siloed and uncoordinated approach, but also to a lack of appreciation for what other providers can and do offer to shared patients.</p>	<p>offer the patient. In addition to team-based learning collaboratives across siloes, it was suggested by the Bi-Directional Integration Project Team that there be opportunities for providers to “shadow” or follow one another to facilitate shared learning across disciplines. Another suggestion to support provider learning was to work with provider organizations to obtain Continuing Medical Education (CME) credits for providers who participate in the trainings sponsored by GCACH.</p>
<p>Barriers to housing and other community-based supports for individuals with behavioral health disorders.</p>	<p>The GCACH will work on a strategy to increase low barrier housing and community-based placement options for individuals with behavioral health disorders. This is a potential investment area for our region’s earned dollars. Treating individuals in the community is less expensive than in hospitals or within the criminal justice system. If the GCACH efforts are successful, outcomes will be improved and costs will be saved, not only in the health care delivery system, but also in the criminal justice system. It will be important to work with key partners in that system and others to make wiser investments that allow for individuals to receive care in the community such as housing. Another strategy to address this challenge is the leverage another component of the Healthier Washington Demonstration focused on the foundation community supports such as supportive housing and supportive employment. GCACH and the Bi-Directional Integration Project Team will work to align with these efforts. Finally, another</p>

	<p>important local resource that could potentially help to address these challenges are local sales taxes that many cities in the GCACH region that have helped to fund efforts related to public safety and mental health and chemical dependency. GCACH could work with local governments to align and leverage these important resources.</p>
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GCACH is establishing a Strategic Planning Committee (SPC) to oversee project implementation, ensure cross-sector collaboration and coordination across the Project Portfolio including Domain 1 needs, plan for long-term sustainability and identify supports or resources necessary for project success. The SPC will include subject matter experts, clinicians and representatives from the Board of Directors, as well as the finance committee.

GCACH has also develop a staffing plan to support partnering providers during the implementation phase. A project director and two project manager positions will be filled in 2018 to oversee project implementation and provide technical assistance and support. These positions will be expected to maintain close relationships with partnering providers and spend a significant amount of time “out in the field.” GCACH will also recruit a physician to serve as a Clinical Director. This position will provide clinical leadership and guidance to our implementation efforts, including serving as a “champion for change” through physician to physician conversations. Lastly, GCACH will develop technical assistance and systems for shared learning for partnering providers, which will include the provision of technical assistance through consultants, as well as training and learning collaboratives for peer-to-peer learning and sharing of best practices. GCACH will work closely with partnering providers as well as the SPC throughout the planning phase to identify technical assistance needs.

Monitoring and Continuous Improvement

<p>ACH Response</p>
<p><i>Plan for monitoring project implementation progress</i></p> <p>GCACH’s plan for monitoring project implementation progress is still under development, and will evolve as the projects develop around the common metrics during the implementation planning phase. However, on October 23, the ACHs and key state staff gathered at the Homewood Suites in Tukwila for a full-day work/learn session to talk about what a conceptual framework to manage a Demonstration Project might look like. The ACHs also</p>

developed a set of design principles as a framework to keep our expectations within reasonable boundaries for the data providers. (A data provider was defined as a stakeholder that collect or maintains raw data sets or processed data products that may be shared to support data processes or requirements.)

One of the design principles was to choose monitoring systems that had minimal burden to the data provider, as the provider will be the one in the center of patient care, and the one, in many cases, providing the monitoring data. However, “least burdensome” also makes good business sense. Given that lens, Greater Columbia has been in an investigative mode in talking to vendors about their products, and learning more about the capacities and capabilities that will be needed to monitor performance. The HCA has also started thinking about the performance monitoring system at the state level, so the HCA information technology staff has been asked to develop a simple tool that could be used to get PM off the ground until other monitoring systems can be put in place.

GCACH has started on a conceptual framework for a project management system, and will work with the Project Teams, Providers, and Provider organizations to design a project management system that makes it easy to understand the relationships between the data sets, and provides early warning signals when the data is trending in the wrong direction. GCACH will look for visualization software, like Light Beam or Tableau that can provide insightful analytics to the providers, and enable them to make corrective actions which will lead to higher performance scores. The Demonstration projects will require Plan Do Study Act (PDSA) management, so GCACH will consider how various monitoring systems make it easy to collect, interpret and react to data.

Some of the ideas surfaced at the working session to monitor project implementation progress included dashboards, excel spreadsheets, Gantt charts, tables, Tableau, and survey tools, like Survey Monkey. Tools for monitoring can be very detailed, such as customer relationship management (CRM) software, or constructed using Excel or adapting other types of project management dashboard templates. GCACH will try to strike the right balance between complexity and minimal administrative burden.

GCACH staff has started populating a database about potential participating providers’ capacities, and asked a series of questions in our Letter of Interest (LOI) to potential providers including:

- Provider capacity
- Number of clients served by type

- Primary demographics
- Registry functions
- Key technological gaps
- Willingness to screen clients for social service need

Ultimately, this project data ecology will be shaped by the GCACH's project portfolio and selection of programs to implement. The design of each project will have a significant impact on monitoring and evaluation, so these systems will have to be complementary to the many different ways that data is captured and reported, and be sensitive to the amount of input required. The SPW will develop the initial framework that can then be used as the standard reporting format across the region, and modified according to project area. This understanding will then guide the development of project activities, schedules, budgeting. The SPW will report out progress to the GCACH Leadership Council and Board at the monthly meetings.

Addressing delays in implementation

GCACH will work with the Strategic Planning Committee to identify the functions and processes necessary to manage and monitor project implementation, and be proactive in anticipating barriers or delays in implementation. In this manner, the projects will be developed through the experiences of a cross-sector team and subject matter experts, and with guidance from consultants with DSRIP experience in order to anticipate implementation barriers and delays. GCACH has also budgeted for contingencies, such as project delays, and will deploy a robust communications campaign to keep everyone informed of progress. That being said, when delays occur, GCACH will look for processes that can be performed in parallel, add capacity, or make more resources available to get the project back on track.

GCACH's Data Management and Health Information Exchange Committee will oversee a rigorous project monitoring and continuous improvement process for the project. The DMHIE Committee will work with Bi-Directional Integration Project Implementation Team and the Project Manager to determine and track key measures, including project milestones, pay-for-reporting and pay-for-performance metrics. GCACH will develop regular reports to participating providers to support rapid PDSA cycles to track and improve provider performance, and communicate progress or slipping schedules. GCACH will identify delays in project implementation using a continuous quality improvement approach, and work with our partners to identify potential schedule delays, and work-arounds. GCACH will also work with our MCO partners for input on the reporting metrics, particularly for purposes of VBP models. GCACH's DMHIE Committee will recommend and seek Board approval of the QIP.

We will continue to monitor the appropriateness of our approach as we implement the project. Technical and training support in the form of tele-health, in-person trainings, webinars and other collateral expertise will be provided during implementation to all participating providers throughout the course of planning and implementation as needed. Our project is designed specifically with partnerships strengthening and cross services collaboration. Our Bi-Directional Integration Project Implementation Team will meet regularly and will share lessons learned, trends among patients and recommendations for improvement to the program.

Plan for monitoring continuous improvement and real-time performance

GCACH will contract with a vendor partner to develop, implement and manage a real-time performance system. GCACH is currently exploring partnership with Providence CORE and/or King County ACH to utilize their expertise and capacity to develop a monitoring system, including timely data to support project implementation and continuous improvement. GCACH will work with partnering providers during the planning phase to establish process measures and milestones, along with data reporting systems to track project performance metrics in as close to real time as possible. We have also investigated different Client Relationship Management tools such as SpetraMedix and Caravan Health that offer these types of monitoring systems.

For the Bi-Directional Integration project, we will include the project's P4P and P4R metrics, and align efforts with other projects in our portfolio around shared metrics, including for example:

- Increased follow up after discharge from ED for mental health, alcohol or other drug dependence (shared with the Transitional Care project)
- Increased follow up after hospitalization for mental illness (shared with the Transitional Care project)
- Reduced inpatient hospital utilization (shared with the Transitional Care, Opioid, and Chronic Disease projects)
- Reduced outpatient emergency department visits (shared metric across all projects)
- Reduced plan all-cause readmission rates (shared with the Transitional Care project)

Additional outcomes will be defined during the planning year as we further develop our Monitoring and Continuous Improvement Process for the project.

Plan for addressing strategies that are not working

GCACH staff and consultants will be working closely with the Strategic Planning Committee (SPC) throughout the demonstration to monitor progress and achievement. Along with the development of data tracking and reporting systems, GCACH will work with the care

coordination teams to support overall implementation, the spread of best practices and sharing lessons learned. This learning system will enable GCACH partnering providers, across projects, to learn from and support each other over the course of the Demonstration. In addition, GCACH is contracting with consultants with expertise in each of the project areas in order to have the capacity to provide rapid technical assistance to partnering providers when implementation challenges arise.

Project Metrics and Reporting Requirements

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
X	

Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
X	

Project Sustainability

ACH Response

GCACH strategy for long-term project sustainability

Through the course of the project, GCACH and its partners will be able to demonstrate to payers the value of a clinically integrated system of care as evident through earlier and additional access to care for behavioral health issues, better managed chronic diseases. This will result in lower rates of ER usage and hospitalizations and decreased costs overall. When fully integrated managed care (FIMC) is implemented payers will hold providers accountable for whole-person health needs; providers in the GCACH will be poised to succeed because they will have learned how to do the work through the Demonstration and will have made the investments and transformations needed to provide this type of care in an ongoing and sustainable fashion. In addition, the project will advance value-based payment models needed to sustain the delivery system transformation made by the project over the long term.

Project's impact on Washington's health system transformation beyond the Demonstration period

Providing clinically integrated care has been shown to improve health outcomes and save dollars. There have been numerous efforts to provide integrated care in Washington and in the GCACH region. However, many of these efforts remain limited in scope and scale because of the scarce resources available to support the practice transformation necessary to achieve full clinical integration. The value of this project is that it makes resources available to partnering providers to transform their clinical practices to provide clinically integrated care and learn what works best to improve outcomes and lower costs. The investments made during the demonstration to transform their practices will last far beyond the project itself.

¹ Melek S. Milliman. Bending the Medicaid healthcare cost curve through financially sustainable medical-behavioral integration. July 2012. Available: www.milliman.com/uploadedFiles/insight/healthpublished/pdfs/bending-medicaid-cost-curve.pdf.

² Kessler RC, Wang PS. The descriptive epidemiology of commonly occurring mental disorders in the United States. *Annu Rev Public Health*. 2008;29:115-29.

³ Walker ER, McGee RE, Druss BG. Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis. *JAMA Psychiatry*. 2015 Apr;72(4):334-41.

⁴ Moore BJ (IBM Watson Health), Stocks C (AHRQ), Owens PL (AHRQ). Trends in Emergency Department Visits, 2006–2014. HCUP Statistical Brief #227. September 2017. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-VisitTrends.pdf.

⁵ Melek S. Milliman. Bending the Medicaid healthcare cost curve through financially sustainable medical-behavioral integration. July 2012. Available: www.milliman.com/uploadedFiles/insight/healthpublished/pdfs/bending-medicaid-cost-curve.pdf.

⁶ HCA RHNI “starter set” files

⁷ HCA RHNI “starter set” files

⁸ (1) Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, Eshleman S, Wittchen H-U, Kendler KS: Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. *Arch Gen Psychiatry* 1994; 51:8–19 (2)

⁹ HCA RHNI “starter set” files

¹⁰ HCA RHNI “starter set” files

¹¹ HCA table: Behavioral health and co-occurring conditions for GCACH (June 2016) see: <https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/file/240950936790>

¹² HCA RHNI “starter set” files

Table of Contents

SECTION II: PROJECT-LEVEL

Section II (including selection of the relevant project from the menu) will need to be duplicated for each project selected (at least a minimum of four).

Transformation Project Description

Select the project from the menu below and complete the Section II questions for that project.

Menu of Transformation Projects	
Domain 2: Care Delivery Redesign	
<input type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input checked="" type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversions Interventions
Domain 3: Prevention and Health Promotion	
<input type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input type="checkbox"/>	3D: Chronic Disease Prevention and Control

Project Selection & Expected Outcomes

The scope of the project may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH will be required to finalize selections of target population and evidence-based approaches, and secure commitments from partnering providers.

ACH Response

Project Description and Justification

This project will improve support for at-risk enrollees during transitions from acute to less intensive care settings. The project will build upon and expand several existing programs within the region that have demonstrated success to support care transitions. In addition, the project will implement proven tools to support management of acute changes in condition without transport to the hospital. The project encompasses care transitions from hospital to home, home health agency, skilled nursing facility or other setting, as well as transitions from these settings to less intensive care levels. Key components of this project include:

- Adoption of Interventions to Reduce Acute Care Transfers (INTERACT) evidence-based model referenced in Toolkit
- Expansion of collaborative community paramedicine efforts (referenced in Toolkit as an evidence-based strategy to reduce inappropriate ED utilization)
- Leverage and expand existing family and patient-centered interagency interdisciplinary collaborative care models

- Expand use of field-based nurse care coordinators, CHWs, and community paramedics

This project seeks to improve outcomes identified in the Transitional Care project P4P and P4R metrics, and align efforts with other projects in our portfolio around shared metrics, including for example:

- Increased follow up after discharge from ED for mental health, alcohol or other drug dependence (shared with the Bi-Directional Integration project)
- Increased follow up after hospitalization for mental illness (shared with the Bi-Directional Integration project)
- Reduced inpatient hospital utilization (shared with the Bi-Directional Integration, Opioid, and Chronic Disease projects)
- Reduced outpatient emergency department visits (shared metric across all projects)
- Reduced percent homeless
- Reduced plan all-cause readmission rates (shared with the Bi-Directional Integration project)

Additional outcomes will be defined during the planning year as we further develop our Monitoring and Continuous Improvement Process for the project.

Justification for selecting project and how it addresses regional priorities

Poor transitions of care have been shown to lead to adverse events resulting in increased avoidable emergency department utilization and hospital readmissions.^{1,2} The emergency department utilization rate in the GCACH region (67%) is significantly higher than the statewide rate of 51%. Similarly, data indicate that GCACH's rate of potentially avoidable ED visits (19%) is also higher than the statewide rate (15%).³ While the hospital readmission rates for the region for both all-cause and psychiatric inpatient are better than the statewide rates (13% vs. 16% for the 30-day all cause rate, and 11% vs. 13% for psychiatric readmissions)⁴, root cause analysis suggest that almost a quarter of these readmissions could be prevented with the appropriate supports to ensure a successful transition.⁵

In order for GCACH to effectively reduce unnecessary ED visits and continue recent progress on reducing hospital readmissions, the GCACH is including the Transitional Care Project in its project portfolio. The Transitional Care Project will improve support for at-risk enrollees at care transitions. To do this, GCACH has opted to move forward implementing the Transitional Care Model (TCM) and INTERACT 4.0 model, both of which are evidence-based models recognized by the Healthier Washington Toolkit and have shown success in reducing preventable readmissions and ED visits, improving patient outcomes and lowering costs.

There is a significant body of research demonstrating the value of improving transitions of care for at-risk populations. The INTERACT (Interventions to Reduce Acute Care Transfers) has been widely studied as a practice to maximize the care received in a variety of post-acute care

settings, reduce transports to EDs and improved communications when transport to acute care settings is needed. One study found a reduction of up to 24% in ED transports over a 6-month period as a result of the INTERACT program.⁶ A more recent study looked at the impact of supporting effective transitions for individuals transferring from Skilled Nursing Facilities (SNF) to home after an inpatient hospitalization and found the impact of a home visit to be significant in reducing readmissions to the hospital, suggesting another avenue for employing this strategy.⁷

How project will support sustainable health system transformation for the target population

Care transitions for high-needs, high-risk populations are a critical aspect of health system transformation. This project focuses on developing a strong cross-sector network and adoption of evidence-based models to support successful transitions to get people the care they need, to improve outcomes, and to reduce health system costs generated through avoidable hospital admissions and emergency department visits. This project allows investments in the essential delivery system infrastructure to support provider collaboration and communication to provide high-quality, patient-centered care to the target population. In tandem with these investments, the project will advance opportunities to measure the return-on-investment of evidence-based transitional care models. With accountability for demonstrating impacts on reducing ED visits and hospital admissions, among other P4P metrics, the project will demonstrate the measurable return-on-investment of the projects strategies and will support development of longer-term value based payment models that will sustain the health system transformation made for the target population.

How GCACH will ensure project coordinates with and doesn't duplicate existing efforts

The Transitional Care Project Team includes representatives from a diverse range of providers currently involved in care transitions in the region (See below, *Involvement of Partnering Providers*). Their subject matter expertise and local area knowledge of existing programs has helped to ensure proposed project plans build on rather than duplicate existing services. For example, there have been a number of efforts in the region to improve transitions of care through Health Homes, the work the Washington State Hospital Association and Washington State Medical Association have done to increase the use of Advanced Care Plans and Honoring Choices PNW, and the Readmissions Pilot Program (RAPP). The organizations that have been involved in the development of this project application and will be involved in project implementation are some of the key players that have been involved in these efforts. This will ensure that the new efforts supported through this project are coordinated and aligned, rather than duplicated.

During the planning phase (Q1 and Q2 of 2018), GCACH will conduct an inventory of existing programs and resources, as well as a needs-gaps assessment. This work will provide a detailed landscape of existing programs which will be used to inform implementation plans. In addition, GCACH will form a Transitional Care Project Implementation Team and Strategic Planning Workgroup in Q1 2018 to continue to engage a broad spectrum of partnering providers in project planning and implementation. The Transitional Care Project Implementation Team will include members of the Transitional Care Project Team (participating in the development of the project application), as well as additional partnering providers identified through our Letter of Interest process in September 2017. The Strategic Planning Workgroup will include representatives from each Demonstration project area selected (2A, 2C, 3A, 3D) to provide strategic alignment, coordination, and avoid duplication across the Demonstration projects. Although not formalized, GCACH staff has envisioned that our current Project Advisory Committee will form the core of a Strategic Planning Workgroup (SPW).

Anticipated Project Scope

Anticipated Target Population

The scope of this project will include a target population of Medicaid enrollees who are discharging from hospital to home, a home health agency, a skilled nursing facility or other domiciliary and those transitioning from those settings to a less intensive level of care. We hope to decrease re-admissions by 80 readmits per year per urban metro area for the three major urban areas in the GCACH: Tri-Cities, Walla Walla and Yakima. During the planning phase, the Transitional Care Project Implementation Team will work with GCACH's data vendor to conduct more detailed analysis of Medicaid beneficiaries in the region and further refine the target population.

During Q1 2018, the Transitional Care Project Implementation Team will work with GCACH's data vendor to conduct more detailed analysis of Medicaid beneficiaries in the region and further refine the target population, focusing on populations experiencing significant health disparities. Figures in Table 2, for example, show that disabled beneficiaries and Medicaid expansion adults have higher rates of co-occurring chronic disease and behavioral health conditions (mental health or substance use disorder) than traditional Medicaid.

Table 2: Co-occurring conditions by Medicaid eligibility group in Greater Columbia region⁸

Coverage group	SUD	MH condition	Chronic Disease	SUD or MH and CD
Disabled	24%	57%	27%	54%
New adults	18%	29%	26%	27%
Traditional Medicaid	5%	16%	29%	10%

Involvement of Partnering Providers

As indicated by the supplemental workbook, GCACH has a wide array of interested partnering providers, many of whom have participated in the initial project design, including many of the hospitals in the region, skilled nursing facilities, long-term care facilities, assisted living facilities, first responders that have community paramedicine programs, home health agencies, care coordination agencies, and other groups. The Project Team that developed the project concept included representatives from:

- Amerigroup Washington, Inc.
- Benton-Franklin Council of Governments
- Community Health of Central Washington (CHCW)
- Community Health Plan of Washington
- Community Members (no known affiliation)
- Consistent Care
- Coordinated Care Health Plan
- Critical Access Hospital Network
- Kittitas Valley Healthcare
- Kittitas Valley Healthcare Home Health & Hospice
- Molina Healthcare
- Pasco Fire Department
- People for People
- PMH Medical Center
- Prestige Care
- Prestige Post-Acute and Rehab Center (Kittitas)
- Qualis Health
- SE Washington Aging & Long Term Care Council
- Senior Life Resources
- Signal Health
- Tri-City Community of Health (TCCH)

- UnitedHealthcare
- Virginia Mason Memorial (formerly YVMH)
- Walla Walla County
- Yakima Valley Community Foundation
- Yakima Valley Farm Workers Clinic

In addition to the project team, the project concept was presented and received input and feedback from the full Leadership Council, as well as the GCACH Board of Directors. In addition, GCACH has engaged in extensive outreach to partnering providers, holding over 80 in-person meetings and presentations since January 2017 to discuss the projects and engage provider input.

Level of Impact

To effectively achieve the outcomes the project is expected to achieve, the Transitional Care Project Team will use county level data about ED utilization and hospital readmissions to evaluate where there are regional differences and where a heightened focus will be needed to address care transitions. Beyond these regional differences in ED utilization and readmissions, the GCACH must have access to additional data to identify Medicaid enrollees who are at greatest risk for a poor transition of care criteria in order to prioritize and organize regional efforts.

Those at highest risk for readmission are those impacted by social determinants of health such as a lack of housing or transportation, having a low-income, and being non-English speaking. Because these individuals are at a greater risk for a poor transition of care, they will appropriately receive greater service and support.

How GCACH will ensure that health equity is addressed in the project design

Research has indicated that racial and ethnic minorities experience poorer quality of care and are more likely to experience a preventable hospital readmission.^{9,10} In order to achieve systemwide impacts to improve the transitions of care, our project design and implementation will focus on strategies to address these disparities. In addition to the providers already engaged in this work who have significant experience in working with racial and ethnic minorities in the region, GCACH will ensure that additional providers and workforce are engaged who are considered trusted partners among racial and ethnic minority communities. Moreover, GCACH will develop education culturally and linguistically relevant materials. Bilingual and bicultural facilitators will be used where appropriate.

Project’s lasting impacts and benefit to the region’s overall Medicaid population

By expanding the availability of models to support successful transitions of care in the region, and creating standardized processes for communication and linkages across the community to provide transitional care, this project will help to create a system that supports successful transitions of care.

Our previous experience with the Readmission Avoidance Pilot (RAP) project was extremely successful due to the clinical-community linkages made between the skilled nursing facilities, hospitals, and palliative care/hospice organizations who had never before come together as a group to address transitional care. This group has organized, and with the help of Qualis, developed a charter and has been meeting monthly to find efficiencies, share information, and explore new discharge planning tools. Health Homes only touch a small percentage of eligible patients in the GCACH region, so training hospital staff and skilled nursing facilities to offer other models of transitional care will ensure that more patients receive quality discharge plans and follow-up. As GCACH scales up Transitional Care in the region, it will build on the success of the RAP to implement transitional care that complements the assets and resources of the community. New partners, such as community paramedics, nursing students, and community health workers will facilitate stronger partnerships between the clinical health care delivery system and community-based services that will hopefully endure beyond the five-year Demonstration period.

Implementation Approach and Timing

See Supplemental Workbook

Partnering Providers

See Supplemental Workbook

All of the providers listed in the Partnering Provider tab of the ACH Project Plan supplemental Data Workbook have expressed interest in being a Partnering Provider to the GCACH. This was confirmed through each organization's response to and submission of the GCACH Letter of Interest (LOI) application, where each of the organizations identified in the list expressed interest in participating in Project 2C.

ACH Response

Partnering Providers

How GCACH has included partnering providers that collectively serve a significant portion of the Medicaid population

GCACH has taken many steps to ensure that partnering providers who serve a significant portion of the Medicaid population are engaged. In September 2017, GCACH undertook a Letter of Interest process to identify partnering providers interested in the various Demonstration project areas. In response to this inquiry, GCACH received LOIs from approximately 34 providers with specific interest in supporting the Transitional Care Project. As indicated by the supplemental workbook, GCACH has a wide array of interested partnering providers, many of whom have participated in the initial project design, including many of the hospitals in the region, skilled nursing facilities, long-term care facilities, assisted living facilities, first responders that have community paramedicine programs, home health agencies, care coordination agencies, and other groups.

GCACH has evaluated claims data to identify high volume Medicaid providers in the region. Of the 29 highest volume providers serving Medicaid clients in the GCACH, 13 have either participated in the Transitional Care Project Team or responded to the Letter of Interest process that the GCACH undertook in September 2017.

Process for ensuring partnering providers commit to serving the Medicaid population.

The initial LOI process that GCACH undertook in September 2017 offered a preliminary look at partnering providers interested in the project, as well as provider commitments to collaborate with GCACH and other providers to achieve Demonstration goals. During the first quarter of the 2018, GCACH will be engaging in a more formal process to enlist partnering providers through a formal contracting process. Contracts will require partnering providers to maintain a commitment to serving the Medicaid population throughout the project. This will be evidenced through continuous monitoring and data-sharing.

Process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented

As noted earlier, 26 organizations from across the region have participated in the Transitional Care Project Team, and 35 providers responded to the initial to the LOI process the GCACH undertook in September 2017. As detailed in the supplemental workbook partners represent a broad range of providers including many of the hospitals in the region, skilled nursing facilities, long-term care facilities, assisted living facilities, select first responders that have community paramedicine programs, home health agencies, care coordination agencies, and other groups.

How GCACH is leveraging MCO's expertise in project implementation, and ensuring there is no duplication

All five MCOs operating in the region are participating in the Transitional Care Project Team and have actively been engaged with the development of this project application. The MCOs will continue to be involved in the planning phase of the project in 2018 and beyond. The

GCACH understands that continuous involvement of payers will be critical to the project's long-term sustainability in the region. In addition to their role on the Project Team and Project Implementation Team (to be formed in 2018 Q1), the MCOs are represented on the GCACH Board.

Regional Assets, Anticipated Challenges and Proposed Solutions

ACH Response

Assets GCACH and regional partners providers will bring to the project

The most important asset the GCACH brings to this project is the significant experience in the community doing this work. Many of the GCACH partners have implemented programs to address poor transitions of care and have demonstrated success and garnered community and partner support. This track record of success and these established and trusted relationships within the community are the foundation needed to support care in place and increase the safety in care at transitions.

Partnering providers in the GCACH region are leading successful transitional care programs, such as the Readmission Pilot Program (RAP) operated by the Consistent Care Program. This Program is built on the Transitional Care Model (one of the evidence based tools offered in the toolkit) and in addition employs a wider focus on addressing other factors such as housing, transportation that impact the patient. In a study funded by the State Innovation Model grant program, those enrolled in the Consistent Care Program showed a 34% decrease in ED visits and an average cost savings of \$1659 per patient per year. This was our Proof of Concept through our Regional Health Improvement Project, demonstrating that we fulfilled the goals of our planning process.

Additionally, advance directives have been shown to reduce readmission to hospital from skilled nursing facilities and from home. Honoring Choices PNW is a joint effort by WSMA and WSHA to facilitate advance care planning at a population level across the state and we will benefit from that work which has already begun in our region.

Challenges to improving outcomes and lowering costs for target population and strategy to mitigate risks and overcome barriers

<i>Challenges to improving outcomes and lowering costs</i>	<i>Strategy to mitigate risks and overcome barriers</i>
<p>To address the potential skepticism community partners, it is important that the GCACH partner with local agencies and trusted and familiar partners to do this work.</p>	<p>This work has already begun through the trusted partners that have been involved in the work so far and the development of the project application. The GCACH will continue to build on this work in its approach to communications and outreach about the project in the future by working through these trusted partners.</p>
<p>Workforce capacity to support the project.</p>	<p>The GCACH will use data to monitor the growth of this project with its partners to identify where capacity will be an issue. This work has begun through the GCACH through its LOI process to identify partnering providers and comparing it with the needs of the target population and identifying high volume Medicaid providers who may not be engaged. The GCACH will work with the Transitional Care Project Implementation Team to engage and reach out to additional partners where needed. In addition, there will be a need for additional training and education to further develop the workforce needed long-term. The Transitional Care Project Team includes partners from local community colleges, four-year colleges and others to simultaneously support the development of training programs to develop this workforce.</p>
<p>Data & HIT barriers to information sharing and coordination. The various IT platforms in use by partnering providers may make it difficult for providers to coordinate and communicate with one another.</p>	<p>This issue crosses all the projects the GCACH will be undertaking and will be a foundational investment that will need to be made by the ACH with other ACHs and the state as partners. The Transitional Care Project can support this by enlisting key partnering providers to participate in solutions being developed.</p>

<p>Legal barriers to information sharing. There are many real and some perceived legal barriers related to sharing information among providers.</p>	<p>GCACH will support trainings and require mandatory participation for partnering providers to address many of these issues, ranging from what is an isn't shareable information, to providing trauma-informed care, motivational interviewing and more. The GCACH will also need to work with the state to develop template legal documents for partnering providers that allow for information sharing that complies with state law and gives partnering providers the assurance that they can, in fact share information.</p>
<p>Communication Barriers Between Disciplines. Successful transitions of care between settings requires providers to work across disciplines to maintain the focus on the needs of patients and families. The disciplines involved in this work range from first responders to hospitals, behavioral health agencies and others speak different languages in how they approach and how they deliver services to their patients. These language differences contribute to an ongoing siloed and uncoordinated approach, but also to a lack of appreciation for what other providers can and do offer to shared patients.</p>	<p>The GCACH will facilitate learning collaboratives for providers to be able to learn from one another and begin to understand and appreciate what they can offer the patient.</p>

In addition to the strategies outlined above, GCACH's Program Manager is currently exploring population health management tools, and plans to hire a contractor to work with participating providers to enhance their systems' interoperability. GCACH has allocated significant funding resources to support information sharing for our participating providers. The Executive Director will be meeting with the hospital leadership to determine what barriers may exist to take on a transitional care model, and if appropriate, offer financial incentives to get programs started. GCACH will also invest in education and training for the clinical staff, as lack of education at the hospital level was an initial barrier for the RAP program. This work will result in a detailed written implementation plan that includes required elements, including but not limited to timelines, refined strategies, identify needed system supports, strategies for long-term sustainability, alignment with existing state and local efforts, and clarity of roles and responsibilities.

GCACH is establishing a Strategic Planning Committee (SPC) to oversee project implementation, ensure cross-sector collaboration and coordination across the Project

Portfolio including Domain 1 needs, plan for long-term sustainability and identify supports or resources necessary for project success. The SPC will include subject matter experts, clinicians and representatives from the Board of Directors, as well as the finance committee.

GCACH has also develop a staffing plan to support partnering providers during the implementation phase. A project director and two project manager positions will be filled in 2018 to oversee project implementation and provide technical assistance and support. These positions will be expected to maintain close relationships with partnering providers and spend a significant amount of time “out in the field.” GCACH will also recruit a physician to serve as a Clinical Director. This position will provide clinical leadership and guidance to our implementation efforts, including serving as a “champion for change” through physician to physician conversations. Lastly, GCACH will develop technical assistance and systems for shared learning for partnering providers, which will include the provision of technical assistance through consultants, as well as training and learning collaboratives for peer-to-peer learning and sharing of best practices. GCACH will work closely with partnering providers as well as the SPC throughout the planning phase to identify technical assistance needs.

Finally, retroactive engagement funding will be paid to organizations based upon their employee’s level of participation to project work. Project Team facilitators and members of the Leadership Council and Board who have demonstrated a strong commitment and engagement of participation will receive funding which will be given to the participating provider organizations they belong to. The stipend is to reward their prior participation and oversight in building up the approaches for each of the project areas, achieving PCMH status, attendance at Leadership Council/Board meetings, submission of an LOI, being the Project Team Leader, Medicaid attribution, and possibly other criteria as determined by the Budget and Funds Flow Committee (B&FFC). Although not yet approved by the Board, engagement funds to participating providers will be distributed throughout the term of the Demonstration to ensure providers are being rewarded financially for their involvement, beyond the incentive payment structure.

Monitoring and Continuous Improvement

ACH Response

Monitoring and Continuous Improvement

Plan for monitoring project implementation progress

GCACH’s plan for monitoring project implementation progress is still under development, and will evolve as the projects develop around the common metrics during the implementation planning phase. However, on October 23, the ACHs and key state staff gathered at the Homewood Suites in Tukwila for a full-day work/learn session to talk about what a conceptual framework to manage a Demonstration Project might look like. The ACHs also developed a set of design principles as a framework to keep our expectations within

reasonable boundaries for the data providers. (A data provider was defined as a stakeholder that collect or maintains raw data sets or processed data products that may be shared to support data processes or requirements.)

One of the design principles was to choose monitoring systems that had minimal burden to the data provider, as the provider will be the one in the center of patient care, and the one, in many cases, providing the monitoring data. However, “least burdensome” also makes good business sense. Given that lens, Greater Columbia has been in an investigative mode in talking to vendors about their products, and learning more about the capacities and capabilities that will be needed to monitor performance. The HCA has also started thinking about the performance monitoring system at the state level, so the HCA information technology staff has been asked to develop a simple tool that could be used to get PM off the ground until other monitoring systems can be put in place.

GCACH has started on a conceptual framework for a project management system, and will work with the Project Teams, Providers, and Provider organizations to design a project management system that makes it easy to understand the relationships between the data sets, and provides early warning signals when the data is trending in the wrong direction. GCACH will look for visualization software, like Light Beam or Tableau that can provide insightful analytics to the providers, and enable them to make corrective actions which will lead to higher performance scores. The Demonstration projects will require Plan Do Study Act (PDSA) management, so GCACH will consider how various monitoring systems make it easy to collect, interpret and react to data.

Some of the ideas surfaced at the working session to monitor project implementation progress included dashboards, excel spreadsheets, Gantt charts, tables, Tableau, and survey tools, like Survey Monkey. Tools for monitoring can be very detailed, such as customer relationship management (CRM) software, or constructed using Excel or adapting other types of project management dashboard templates. GCACH will try to strike the right balance between complexity and minimal administrative burden.

GCACH staff has started populating a database about potential participating providers’ capacities, and asked a series of questions in our Letter of Interest (LOI) to potential providers including:

- provider capacity
- number of clients served by type
- primary demographics
- registry functions
- key technological gaps

- willingness to screen clients for social service need

Ultimately, this project data ecology will be shaped by the GCACH's project portfolio and selection of programs to implement. The design of each project will have a significant impact on monitoring and evaluation, so these systems will have to be complementary to the many different ways that data is captured and reported, and be sensitive to the amount of input required. The SPW will develop the initial framework that can then be used as the standard reporting format across the region, and modified according to project area. This understanding will then guide the development of project activities, schedules, budgeting. The SPW will report out progress to the GCACH Leadership Council and Board at the monthly meetings.

Addressing delays in implementation

GCACH will work with the Strategic Planning Committee to identify the functions and processes necessary to manage and monitor project implementation, and be proactive in anticipating barriers or delays in implementation. In this manner, the projects will be developed through the experiences of a cross-sector team and subject matter experts, and with guidance from consultants with DSRIP experience in order to anticipate implementation barriers and delays. GCACH has also budgeted for contingencies, such as project delays, and will deploy a robust communications campaign to keep everyone informed of progress. That being said, when delays occur, GCACH will look for processes that can be performed in parallel, add capacity, or make more resources available to get the project back on track.

GCACH's Data Management and Health Information Exchange Committee will oversee a rigorous project monitoring and continuous improvement process for the project. The DMHIE Committee will work with Transitional Care Project Implementation Team and the Project Manager to determine and track key measures, including project milestones, pay-for-reporting and pay-for-performance metrics. GCACH will develop regular reports to participating providers to support rapid PDSA cycles to track and improve provider performance, and communicate progress or slipping schedules. GCACH will identify delays in project implementation using a continuous quality improvement approach, and work with our partners to identify potential schedule delays, and work-arounds. GCACH will also work with our MCO partners for input on the reporting metrics, particularly for purposes of VBP models. GCACH's DMHIE Committee will recommend and seek Board approval of the QIP.

We will continue to monitor the appropriateness of our approach as we implement the project. Technical and training support in the form of tele-health, in-person trainings, webinars and other collateral expertise will be provided during implementation to all participating providers throughout the course of planning and implementation as needed. Our project is designed specifically with partnerships strengthening and cross services

collaboration. Our Transitional Care Project Implementation Team will meet regularly and will share lessons learned, trends among patients and recommendations for improvement to the program.

Plan for monitoring continuous improvement and real-time performance

GCACH will contract with a vendor partner to develop, implement and manage a real-time performance system. GCACH is currently exploring partnership with Providence CORE and/or King County ACH to utilize their expertise and capacity to develop a monitoring system, including timely data to support project implementation and continuous improvement. GCACH will work with partnering providers during the planning phase to establish process measures and milestones, along with data reporting systems to track project performance metrics in as close to real time as possible. We have also investigated different Client Relationship Management tools such as SpetraMedix and Caravan Health that offer these types of monitoring systems.

For the Transitional Care project, we will include the project's P4P and P4R metrics, and align efforts with other projects in our portfolio around shared metrics, including for example:

- Increased follow up after discharge from ED for mental health, alcohol or other drug dependence (shared with the Bi-Directional Integration project)
- Increased follow up after hospitalization for mental illness (shared with the Bi-Directional Integration project)
- Reduced inpatient hospital utilization (shared with the Bi-Directional Integration, Opioid, and Chronic Disease projects)
- Reduced outpatient emergency department visits (shared metric across all projects)
- Reduced percent homeless
- Reduced plan all-cause readmission rates (shared with the Bi-Directional Integration project)

Additional outcomes will be defined during the planning year as we further develop our Monitoring and Continuous Improvement Process for the project.

Plan for addressing strategies that are not working

GCACH staff and consultants will be working closely with the Strategic Planning Workgroup throughout the demonstration to monitor progress and achievement. Along with the development of data tracking and reporting systems, GCACH will work with the care coordination teams to support overall implementation, the spread of best practices and sharing lessons learned. This learning system will enable GCACH partnering providers, across projects, to learn from and support each other over the course of the Demonstration. In

addition, GCACH is contracting with consultants with expertise in each of the project areas in order to have the capacity to provide rapid technical assistance to partnering providers when implementation challenges arise.

Project Metrics and Reporting Requirements

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
X	

Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
X	

Project Sustainability

ACH Response

GCACH strategy for long-term project sustainability

There are considerable costs associated with poor transitions of care- reducing these costs will result in a significant return on investment. Through the course of this project, the GCACH will demonstrate the value of this ROI to the payors in the region. By the end of the Demonstration, the expectation is that the payors (MCOs) involved will be willing to fund the ongoing costs of maintaining the work as part of their contracts because of this ROI. At the

same time, the providers engaged with the project will have had the opportunity to earn the dollars needed to invest in the systems changes needed to provide this care for anyone beyond the Demonstration period.

Project's impact on Washington's health system transformation beyond the Demonstration period

This project will invest resources into organizations involved in supporting effective transitions of care, to better standardize and systematize their work in the GCACH. There have been many efforts to focus on reducing hospital readmissions and hospitalizations that have touched on the impact of poor transitions of care. The project allows for a more focused approach to create a system that ensures support for successful transitions of care, regardless of who a patient is and where they are transferring to and from. These investments in system change will last far beyond the Medicaid Demonstration.

¹ Forster AJ, et al: Adverse drug events occurring following hospital discharge. *Journal of General Internal Medicine*, April 2005;20(4):317-23

² Medicare Payment Advisory Commission, Report to the Congress: Reforming the Delivery System, Washington, D.C.: MedPAC, June 2008.

³ HCA RHNI "starter set" files

⁴ HCA RHNI "starter set" files

⁵ Alpert, G, Engstrom, G, Naharci, I, Newman, D, Ouslander, JG, Rojido, C, Shutes, J, Tappen, R & Wolf, DG. Lessons Learned From Root Cause Analyses of Transfers of Skilled Nursing Facility (SNF) Patients to Acute Hospitals: Transfers Rated as Preventable Versus Nonpreventable by SNF Staff. *Journal of Post-Acute and Long Term Care Medicine*. 2016 (17): 596-601.

⁶ Bonner, A., Herndon, L, Ouslander, JG, Shutes, J. The INTERACT Quality Improvement Program: An Overview for Medical Directors and Primary Care Clinicians in Long-Term Care. *Journal of the American Medical Directors Association*. March 2014; 15(3): 162–170.

⁷ Callahan, C., Carnahan, J., Slaven, J., Torke, A., Tu, W. Transitions From Skilled Nursing Facility to Home: The Relationship of Early Outpatient Care to Hospital Readmission. *Journal of Post-Acute and Long-term Care Medicine*. October 2017 18: 853-859.

⁸ HCA table: Behavioral health and co-occurring conditions for GCACH (June 2016) see: <https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/file/240950936790>

⁹ The Hospital Quality Alliance. The hospital quality alliance: About us. 2010 Retrieved from <http://www.hospitalqualityalliance.org/hospitalqualityalliance/aboutus/aboutus.html>.

¹⁰ Unequal treatment: Confronting racial and ethnic disparities in health care. Washington, DC: National Academies Press; 2002. [PMC free article] [PubMed]

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SECTION II: PROJECT-LEVEL

Section II (including selection of the relevant project from the menu) will need to be duplicated for each project selected (at least a minimum of four).

Transformation Project Description

Select the project from the menu below and complete the Section II questions for that project.

Menu of Transformation Projects	
Domain 2: Care Delivery Redesign	
<input type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversions Interventions
Domain 3: Prevention and Health Promotion	
<input checked="" type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input type="checkbox"/>	3D: Chronic Disease Prevention and Control

Project Selection & Expected Outcomes

The scope of the project may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH will be required to finalize selections of target population and evidence-based approaches, and secure commitments from partnering providers.

ACH Response
<p>The Addressing Opioid Use Public Health Crisis Project (Opioid Crisis Project) proposes to develop community-based Opioid Resource Networks to advance strategies in four core areas: dependence prevention, treatment, overdose prevention, and recovery. Each Opioid Resource Networks will serve as a resource for local communities throughout the region by providing trauma-informed case management for individuals with opioid dependence serving each community throughout the GCACH as a locus for cross-sector partnerships between health care providers, medication assisted therapy (MAT) providers, law enforcement, justice systems, drug prevention specialists, and other key community partners to advance system-level prevention, access to treatment, overdose prevention, and recovery.</p> <p>This project seeks to improve outcomes identified in the Opioid Crisis Project P4P and P4R metrics, and align efforts with other projects in our portfolio around shared metrics, including for example:</p> <ul style="list-style-type: none">• Reduced inpatient hospital utilization (shared metric with the Bi-Directional Integration, Transitional Care, and Chronic Disease projects)• Reduced outpatient emergency department visits (shared metric across all projects)

- Increase substance use disorder treatment penetration (shared metric with the Bi-Directional Integration project)
- Increase access to Medication Assisted Therapy

Additional outcomes will be defined during the planning year as we further develop our Monitoring and Continuous Improvement Process for the project.

Justification for selecting project and how it addresses regional priorities

The Opioid Crisis Project aligns with GCACH regional priorities focusing on behavioral health, including mental health and substance use disorders. Prior to the Demonstration, GCACH engaged an 18-month regional, community-based process to evaluate local, state, and national data sources examining key health indicators in our region. This work resulted in the identification of the region's most pressing health priorities in five key areas, including Behavioral Health, Care Coordination, Diabetes/Obesity, Healthy Youth & Equitable Communities, and Oral Health. Specifically, based on a review of regional health data, GCACH has identified significant health needs in relation to opioid use:

- Approximately 20 percent of GCACH opioid users have used opioids for more than 30 days, which is higher than state averages across all age groups.¹
- Opioid deaths across the GCACH region have continued to increase over the last decade, consistent with state and national trends. In Asotin and Benton counties, for example, opioid-related deaths increased by 30.5 percent and 75.5 percent between 2002 and 2013, respectively.²
- Between 2002 and 2013, publicly funded treatment admissions involving opioids, state wide, increased by 196.5 percent. Three counties in the GCACH region (Asotin, Kittitas, Walla Walla) publicly funded treatment admissions involving opioids increased over 250 percent.³
- There are limited Naloxone distribution sites in the GCACH region, with most sites located in Western Washington.⁴
- The increase in access to prescription opioids due to inappropriate prescribing and subsequent tightening of prescribing rules has resulted in increased use of heroin.

Exacerbating these data are a general lack of preventive health care utilization among opioid-dependent individuals, and a lower than average rate of insurance enrollment, resulting in overutilization of hospital systems and emergency care, related or unrelated to accidental overdose.⁵ This project seeks to increase insurance enrollment among opioid injectors, and via comprehensive case management services with MAT partner providers, significantly reduce hospital and emergency department overutilization. Further, by increasing cross-functional team and agency participation to

reach as many opioid-dependent individuals as possible, we hope to see a strengthening of the health care infrastructure across the GCACH in response to the opioid crisis.

How Project will support sustainable health system transformation for the target population

Currently many individuals in our target population are underserved or avoid health care services until they have a critical injury requiring immediate attention. This project prioritizes building trust with patients in order to encourage them and support them in receiving preventive care no matter their engagement with opioids, and to refer them into lower-cost health care and possibly MAT to manage their dependency on opioids. We will support sustainable health system transformation for the Medicaid target population through the creation of Opioid Resource Networks that provide both client-centered, trauma-informed case management to empower individuals with opioid dependence to access treatment, as well as linking cross-sector partners (such as hospitals, law enforcement, social services, managed care, primary care, and behavioral health providers) to advance system-level changes focusing on prevention, increased access to treatment, overdose prevention, and long-term recovery support. With this approach, the project will work to identify value-based payment approaches that reinvest savings achieved from a shift in crisis-oriented and reactive services to a comprehensive and proactive approach to the opioid epidemic that supports individuals, cross-sector collaboration and health of our communities.

How GCACH will ensure project coordinates with and doesn't duplicate existing efforts

The GCACH Board and Leadership Council established an Opioid Project Team to provide subject matter expertise and strategic input into development and implementation of the proposed project. This Project Team brings front-line and local experience with the opioid crisis in the region, and provides importance guidance to GCACH to ensure that the project coordinates with and does not duplicate existing efforts in the region. The Opioid Project Team includes representatives from a diverse range of providers currently involved in addressing opioid use in the region (See below, *Involvement of Partnering Providers*).

The project relies on a currently unestablished network of service provision, cross-functional team communication, and case management. However, we will assess local resources to ensure we are not duplicating an existing program. We also want to stress that there will be ongoing partner meetings across this network to address emerging trends or needs among clientele and providers, and we will continue to monitor, through the meetings of this group, whether new resources have come onto the marketplace in our region.

One local resource is the ED diversion work that has been underway in Greater Columbia. Providers in the Tri-Cities area have piloted a promising care coordination model targeting frequent emergency department users exhibiting signs of opioid use disorder. The model involves collaboration between a community-based care coordination agency and all hospitals in the Tri-Cities area. The care coordination agency supports a multi-disciplinary team to develop holistic care plans integrating health and social supports to address the needs of the target population. Care plans are linked with an internet-based ED HIT platform (Washington's Emergency Department Information Exchange

platform, as described further below), allowing ED providers to support the holistic care plan and notifying care coordinators when clients appear in the emergency room. This work has resulted in reduced ED visits among the target population as well as reduced opioid prescribing among ED providers. The proposed Opioid Project can expand upon and draw on best practices and lessons learned from providers leading this pilot effort already underway in our region.⁶

Key partners in the region have also received SAMSHA funding to increase naloxone distribution, and GCACH can work with the partners to leverage and scale these efforts. The Washington State Project to Prevent Prescription Drug/Opioid Overdose is a statewide network of organizations mobilizing communities, providing overdose response training, and distributing naloxone through syringe exchange programs in four high need areas, including the GCACH. Activities engage professional and lay first responders, pharmacies, local and regional stakeholders, and health care providers to reduce overdose risk and deaths among people who use heroin and prescription opioids.

During the planning phase (Q1 and Q2 of 2018), GCACH will conduct an inventory of existing programs and resources, as well as a needs-gaps assessment. This work will provide a detailed landscape of existing programs which will be used to inform implementation plans. Assessment will seek to understand the current capability of a resource, the limitations of the resource (e.g., whether it serves Medicaid patients, what age range of patients it serves), and the possibilities for extending the capability of the resource. The flexibility of this approach means that we are prepared to leverage existing provider resources, provide technical assistance to enhance existing provider resources if necessary, or seek to establish new partnerships to extend existing provider resources so that all critical pieces of the network are capable of supporting the project. In addition, GCACH will form an Opioid Project Implementation Team and Strategic Planning Committee in Q1 2018 to continue to engage a broad spectrum of partnering providers in project planning and implementation. The Opioid Project Implementation Team will include members of the Opioid Project Team (participating in the development of the project application), as well as additional partnering providers identified through our Letter of Interest process in September 2017 (see providers listed in the supplemental workbook). The Strategic Planning Committee will include representatives from each Demonstration project area selected (2A, 2C, 3A, 3D) to provide strategic alignment, coordination, and avoid duplication across the Demonstration projects. Although not formalized, GCACH staff has envisioned that our current Project Advisory Committee will form the core of a Strategic Planning Committee (SPC).

By design, this project expands current work taking place across the region to develop a two-pronged approach to improving outcomes for opioid users who face challenges due to their opioid use. Specifically, this project prioritizes a case management system focused on the needs of eligible individuals and fosters multi-sector collaboration among a range of community agencies (described further below under *Regional Assets*). This project will build on this work and expand to the target Medicaid populations. In addition, the project has intentionally created a local Opioid Resource Network model to ensure that Networks leverage existing community resources and tailor strategies to meet local needs, as the resources vary widely across the region. GCACH will work with each Opioid Resource Network to ensure that the Networks coordinate with and do not duplicate existing local services. We also want to stress that there will be ongoing partner meetings across this network to address emerging trends or needs among clientele and providers, and we will continue to monitor, through the meetings of this group, whether new resources have come onto the marketplace in our region.

Anticipated Project Scope

GCACH will explore establishing an Opioid Resource Network in each of GCACH nine counties, or in each of the sub-regions to provide in-depth understanding of local community resources and opportunities to advance prevention, treatment, overdose prevention, and recovery efforts.

Each Opioid Resource Network will serve as a central resource for local communities by providing trauma-informed support for individuals with opioid dependence, as well as a locus for cross-sector partnerships between health care providers, law enforcement, justice systems, jails, pharmacies, and other key community partners to advance system-level prevention, treatment access, overdose prevention, and recovery support.

GCACH will work with Opioid Resource Networks to advance goals and strategies outlined in both the OCH's "6 Building Blocks" for physician reform of opioid prescribing and the 2016 Washington State Interagency Opioid Working Plan.⁷ Below is an overview of project strategies focusing on prevention, treatment, overdose prevention, and recovery:

Prevention: Community Opioid Resource Networks will work with local health care providers and existing community prevention efforts aligning with the state Opioid Working Plan, Goal 1 (Strategies 1 & 2) to:

- 1) Promote adoption of the Washington Agency Medical Directors' Group (AMDG) Guidelines on Prescribing Opioids for Pain and the Washington Emergency Department Opioid Prescribing Guidelines and work with the OCH's 6 Building Blocks trainer program to provide CMEs for physicians and other opioid prescribers in the region to ensure appropriate prescribing practices and identification of patients at risk for Opioid Use Disorder (OUD).
- 2) Increase use of the Prescription Drug Monitoring Program (PDMP).
- 3) Distribute counseling guidelines to pharmacists and providers and encourage patient education regarding the risks of opioid use, safe home storage, disposal, and overdose prevention and response.
- 4) Identify area partners to increase the availability of drug take back events and sites.

Treatment: Opioid Resource Networks will increase access to treatment for eligible individuals through three primary strategies that align with Opioid Working Plan Goal 2 (Strategies 1 & 2) including:

- 1) Build capacity of health care providers to recognize signs of possible opioid misuse, screen for opioid use disorder, and link patients to appropriate treatment resources.
- 2) Provide trauma-informed case management that builds trust with individuals using opioids to connect them to community resources and treatment when they are ready, and to address broader social determinants impacting individuals' ability to improve

their health. The focus is on a harm reduction approach that supports patients regardless of their readiness to obtain treatment, and provides a bridge to recovery where barriers to effective treatment are addressed. The Opioid Resource Network care management team will co-locate onsite at physician groups in order to support their work with patients, especially if that work includes prescribing Suboxone or other eligible, MAT for case managed individuals. Opioid Resource Networks will staff their services to fill in current gaps in local areas around the GCACH region, and may include physicians, nurses, social workers, and/or Community Health Workers and Peer Support Specialists to conduct comprehensive assessments to identify support tailored to individual needs. Community Health Workers will conduct outreach, connect individuals to services, and work within an established set of best practices for enrolling, assessing, and managing client cases, all while working with physician and MAT partners in the system.

3) Build relationships and increase the number of providers offering MAT by providing case management support to help providers manage this complex, high-needs patient population. Many providers are concerned about providing care to this patient population, and case management support is a critical tool to increase access to these services. Training in prescribing MAT, cultural competencies for working with OUD and opioid-dependent patients, and the legalities of prescribing MAT will all be provided by the Opioid Resource Networks and their partners in order to foster support from area health care workers for the program.

4) Serve as a central community resource for multiple sectors and providers (e.g. law enforcement, jails, emergency rooms, hospitals) to refer to individuals with opioid use concerns. This model will emphasize building trust with and support for opioid populations to connect them to the right resources when they are ready, and will give community partners an important resource for referring individuals who may be otherwise be in frequent contact with the emergency room, law enforcement, or other public systems.

Overdose prevention: Opioid Resource Networks will support and expand these current efforts to intervene and prevent opioid overdose deaths through strategies that align with the state Opioid Working Plan, Goal 3, (Strategies 1 & 2), including:

1) Educating individuals on how to recognize and appropriately response to an overdose, including support for efforts to train law enforcement agencies and other front-line responders on overdose response and assisting emergency departments to provide overdose education and take-home naloxone.

2) Increasing availability of naloxone by increasing access through pharmacies, provider co-prescribing, law enforcement education, and other community access points. This work will

expand on current regional efforts funded by SAMHSA to support a much wider distribution of naloxone.

Recovery: The Opioid Resource Networks' case management model will provide a client-centered approach to connect individuals to the full range of support from increasing wellness to accessing treatment to long-term recovery services. The Opioid Resource Networks will provide support to strengthen recovery supports for individuals in the treatment systems, and in addition assess system-level capacity needed to support long-term recovery.

Target Population

The target populations for this project include the following Medicaid beneficiaries:

- Medicaid beneficiaries who are receiving over 120 MED (Morphine Equivalents) of any opioid with any concurrent sedative prescriptions
- Medicaid beneficiaries who have co-occurring mental health, substance abuse disorder and more than one chronic condition

Based upon the number of Medicaid beneficiaries with co-occurring a mental health condition, a substance abuse disorder and more than one chronic condition (i.e. 6,740 per HCA for the GCACH), we will be targeting the top 5% or approximately 350 beneficiaries over the course of the Demonstration. Special attention will be given to ensure inclusion of individual participants at enrollment/assessment about social determinants of health, race/ethnicity and gender-related health disparities, and potential risk for accidental overdose.

During the planning phase, the Opioid Project Implementation Team will work with GCACH's data vendor to conduct more detailed analysis of Medicaid beneficiaries in the region and further refine the target population. Blue Mountain Heart to Heart (operating a Collaborative Care model program with co-located syringe exchange and clinic services for opioid users and a Harm Reduction program of naloxone distribution) and the Consistent Care Services (which provides City of Pasco police with OD kits and training to use as first responder to reduce OD deaths) have jointly estimated the target group of Medicaid beneficiaries who are receiving over 120 MED to be around 400 individuals referred annually to the program. Referrals will ultimately be used to capture the true size of this population.

GCACH has intentionally selected a narrow target population for our Project Portfolio. During the period where target populations were identified for each of the Demonstration project areas, the GCACH conducted a literature search on the subject of high-cost, high-utilizing patients. Reviewing the research of several different organizations—including the Health Care Transformation Task Force (which HCA is part of), AHRQ, Commonwealth, National Institute for Healthcare Management and others—indicates the healthcare utilization and costs are highly concentrated in a relatively small subset of any large patient population. For example, the top 5% of chronic disease patients spend around 30% of total care costs, and the top 5% of an overall population accounts for nearly half of all healthcare costs. These patients represent a broad spectrum of demographic and clinical

characteristics and socioeconomic conditions. For the GCACH, a rough estimate puts the total spending for the top 5% of the GCACH Medicaid population at around \$500 million.

Some of these are non-persistent, high spenders who have expensive acute care spending in the current year but which decreases in subsequent years. Little can be done to reduce this spending. However we are planning on doing broad community education around appropriate use of the ED, which might affect this group. Non-persistent high spenders typically accumulate between and four ED visits during the year of high utilization.

Others are nearing the end-of-life, including those with advanced illness such as COPD, heart failure, cancer, chronic liver disease and more. Part of our work will be to convene a working group in 2018 that will focus on community outreach and engagement to educate providers around the following:

- Opportunities to provide home and community-based services that can cut down on unnecessary hospitalizations;
- Care management involving informed choice and;
- Other support that can optimize the use of hospice and other palliative care services to redirect end-of-life care from hospital to home and community.

Not only is this in the best interest of the patient, recognizing that most patients would prefer not to die in the hospital, but the potential for savings from such strategies is high.

The third group, patients with persistent high-spending patterns, will be a large area of focus and care coordination. This group typically has multiple chronic conditions, many face psychological and social barriers to care, and many are good candidates for care management and social support services. The prevalence of behavioral health and/or disabilities can dramatically increase spending in this group. Per capita costs are double or triple for Medicaid patients with a co-morbid mental health diagnosis or with evidence of substance abuse. Concentration of spending in Medicaid is particularly significant, where 60% of patients in the Top 10% Spender Tier in any given year remain in that tier the following year.

Several methods will be used to identify high-cost patients, including claims analysis (e.g. >6 ED visits, >2 inpatient stays in a year, >5 prescriptions, absence of PCP visits, etc.), patient surveys (e.g. PHQ-2 and PHQ-9, PAM score), presence of chronic need for social services (e.g. homelessness), and more. Additional research indicates that certain high-cost patients may not be “impactable” (i.e. not amenable to change), which may guide decision making around patient selection.

For the GCACH, the top 5% of the population would comprise around 12,500 patients. Although there might be \$millions in project incentive funds available, dispersing these dollars evenly over this fraction of our Medicaid population points out the need to be very strategic in how we focus our work. Identifying and managing care for this group of patients is an important step towards improving health outcomes and reducing total costs for the entire population.

Involvement of Partnering Providers

As indicated by the supplemental workbook, GCACH has a wide array of interested partnering providers, many of whom have participated in the initial Opioid Crisis Project design, including behavioral health providers, federally qualified health centers, county public health departments, managed care plans, community-based organizations, housing agencies, local coalitions, managed care plans, educational institutions, and other groups. The Project Team that developed the project concept included representatives from:

- Amerigroup Washington, Inc.
- Benton-Franklins Health District
- Blue Mountain Heart to Heart
- Central Washington Comprehensive Mental Health
- Community Health Plan of Washington
- Community members (no known affiliation)
- Comprehensive Healthcare
- Consistent Care
- Coordinated Care Health Plan
- Greater Columbia Behavioral Health
- Ideal Counseling
- Ideal Option & Balance
- Kittitas County Public Health Department
- Molina Healthcare
- Pacific Northwest University
- Substance Abuse Coalition
- Transform Yakima Together
- UnitedHealthcare
- Virginia Mason Memorial (formerly YVMH)
- Walla Walla Department of Community Health
- Yakima Neighborhood Health Services

In addition to the project team, the project concept was presented and received input and feedback from the full Leadership Council, as well as the GCACH Board of Directors. In addition, GCACH has engaged in extensive outreach to partnering providers, holding over 80 in-person meeting and presentations since January 2017 to discuss the projects and engage provider input.

This cross-sector engagement and collaboration is critical to reform the health care delivery system to focus on prevention while at the same time supporting individuals with opioid dependence to access the care they need. By design, local Opioid Resource Networks will continue to support cross-sector collaboration and partnerships between health care providers, law enforcement, justice systems,

social services, and other key community partners to advance system-level prevention, access to treatment, overdose prevention, and recovery support across the region.

Level of Impact

GCACH selected the target population based on regional health needs data, with a focus on populations experiencing the greatest disparities and those most at risk for opioid addiction and overdose. In 2018, GCACH will finalize selection of target populations based on evaluation of racial, cultural and rural and urban geographic disparities.

A special emphasis to establish Networks in Counties experiencing higher rates of opioid deaths will be prioritized.

County	Number of Deaths	Rate per 100,000 population
Asotin	12	10.8
Benton	84	9.3
Columbia	2	suppressed
Franklin	17	4.4
Garfield	0	0
Kittitas	17	9.1
Walla Walla	25	8.5
Whitman	113	8.1
Yakima	65	5.5

How GCACH will ensure that health equity is addressed in the project design

GCACH has embedded a health equity approach throughout the design of the proposed Opioid project. Health equity is an underlying principle that applies to all aspects of project planning. Core principles of the project’s approach to health equity include:

- System-level, policy changes are essential to address social determinants of health which are core drivers of health inequities.
- Prioritizing strategies that address health disparities with the aim of improving health equity for all populations.
- Engaging and empowering individuals, establishing trust, and building on assets and strengths of marginalized populations.

- Comprehensive approaches that address multiple social factors impacting individuals with opioid dependence, rather than a single issue.

Project’s lasting impacts and benefit to the region’s overall Medicaid population

This project will result in system-level changes that will benefit all Medicaid populations, focusing on improved provider opioid prescribing practices based on the Washington AMDG guidelines, a trauma-informed and patient-centered approach to increase access to treatment and recovery support for individuals with opioid use disorder, and development of regional capacity to support cross-sector, community-based collaboration to advance the state’s Opioid Working Plan goals.

Implementation Approach and Timing

See Supplemental Workbook

Partnering Providers

See Supplemental Workbook

All of the providers listed in the Partnering Provider tab of the ACH Project Plan Supplemental Data Workbook have expressed interest in being a Partnering Provider to the GCACH. This was confirmed through each organization's response to and submission of the GCACH Letter of Interest (LOI) application, where each of the organizations identified in the list expressed interest in participating in Project 3A. There are, however, additional organizations who have expressed interest but had not yet supplied an LOI as of the GCACH deadline. Therefore, this partnering provider list is the minimum participation we expect to see.

ACH Response

Partnering Providers

How GCACH has included partnering providers that collectively serve a significant portion of the Medicaid population

GCACH has taken a number of steps to ensure that the Opioid Crisis Project is engaging partnering providers serving a significant portion of the Medicaid population. In September 2017, GCACH undertook a Letter of Interest process to identify partnering providers interested in the various Demonstration project areas. In response to this inquiry, GCACH received LOIs from approximately 32 providers with specific interest in supporting the Opioid Crisis Project. Providers represented each county within the region as well as broad range of sectors, including hospitals, behavioral health providers, federally qualified health centers, public health, fire departments and first responders, and social service agencies. Eleven of the top 29 Medicaid providers, by volume, serving the Medicaid population in the region have either participated in the Opioid Use Project Team or responded to the Letter of Interest process that the GCACH undertook in September 2017. Additional outreach to our communities through our Local Health Improvement Networks may yield other potential partnering provider organizations.

Process for ensuring partnering providers commit to serving the Medicaid population.

The initial LOI process that GCACH undertook in September 2017 offered a preliminary look at partnering providers interested in the project, as well as provider commitments to collaborate with GCACH and other providers to achieve Demonstration goals. During the first quarter of the 2018, GCACH will be engaging in a more formal process to enlist partnering providers through a formal contracting process. Contracts will require partnering providers to maintain a commitment to serving the Medicaid population throughout the project. This will be evidenced through continuous monitoring and data-sharing.

Process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented

As noted earlier, 21 organizations from across the region have participated in the Opioid Project Team, and 32 providers responded to the initial LOI process the GCACH undertook in September 2017. As detailed in the supplemental workbook partners represent a broad range of providers including health care, behavioral health, social services, pharmacies, public health, law enforcement, emergency medical system first responders, housing, and others. The project will leverage existing provider services across the social service and health care infrastructure, and incentivize new services to fill in the gaps.

In hosting conversations with service providers in our region, our project team leaders identified many of the barriers to cross-team collaboration that have previously limited partnering around opioid crisis response and management of cases of individuals struggling with opioid dependency. These include:

- Concerns that providers don't know enough about MAT and how to prescribe it or monitor its use in patient care
- Bad experiences working with opioid-dependent patients who were aggressive to them and their staff
- Fears that prescribing MAT in their own practice will result in too many patients seeking MAT
- Attitudes ranging from dismissive to fearful that opioid dependent patients will ever change; opinions voiced included that these patients will lie about their health or other circumstances either in order to get more opioids or to receive a service

We see from these conversations that service providers do not have a baseline level of trust with this population and will require support from a professional service to establish a working relationship with opioid-dependent people. Our project is designed to stabilize this relationship between providers and patients and thus to improve cross-team collaboration. Local health providers already have opioid-dependent patients but often refrain from offering a full range of treatment options for them because of physician fears of increasing dependence or doing harm to the patient, and many opioid-dependent individuals avoid going to the doctor until an acute problem like cellulitis or overdose

occurs. By co-locating a Community Health Worker at the site of the clinical practice we can help mediate the doctor-patient relationship, advocate for the patient in the moment, and help the patient adhere to treatment. This is exactly the model established with the Ryan White Care Act that supports patients with HIV/AIDS and has a twenty-five year history of successful outcomes for those patients. This project takes partnership with providers in other sectors very importantly and we understand that it is the partnership building—and its ability to support at-risk patients comprehensively across their many needs—that is key to the success of the project.

How GCACH is leveraging MCO's expertise in project implementation, and ensuring there is no duplication

MCOs have been active participants in the GCACH Project Teams, the Leadership Council, and Board of Directors. MCO representatives have contributed to the review of the Regional Health Needs Inventory and identification of regional health “gaps” and associated priorities. All five MCOs operating in the region are participating in the Opioid Project Team and have actively been engaged with the development of this project application. The MCOs will continue to be involved in the planning phase of the project in 2018 and beyond. The GCACH understands that continuous involvement of payers will be critical to the project’s long-term sustainability in the region. In addition to their past work on the Project Team, we expect MCOs to participate on all of the Project Implementation Teams (to be formed in 2018 Q1), as well as on the Strategic Planning Committee (SPC) of the Board.

GCACH’s Opioid Project Team includes providers with experience contracting with MCOs to provide care coordination services to members with OUD accessing care through emergency departments. This work with MCOs will provide valuable implementation experience to develop sustainable partnerships and funding models to meet the needs of Medicaid members with opioid use disorder or at risk.

Regional Assets, Anticipated Challenges and Proposed Solutions

ACH Response

Assets the ACH and regional partners providers will bring to the project

Strong partner engagement and support: Our planning for this project resulted in many energized partners who relayed their strong interest in improving the health and lowering the over utilization of crisis-oriented services by our target population. Our project design reflects this strong interest. This input from partners has led us to create a highly scalable project model to accommodate significant differences across our ACH region.

Successful ED care coordination pilots in the region: Providers in the Tri-Cities area have piloted a promising care coordination model targeting frequent emergency department users exhibiting signs of opioid use disorder. The model involves collaboration between a community-based care coordination agency and all hospitals in the Tri-Cities area. The care coordination agency supports a

multi-disciplinary team to develop holistic care plans integrating health and social supports to address the needs of the target population. Care plans are linked with an internet-based ED HIT platform (Washington’s Emergency Department Information Exchange platform, as described further below), allowing ED providers to support the holistic care plan and notifying care coordinators when clients appear in the emergency room. This work has resulted in reduced ED visits among the target population as well as reduced opioid prescribing among ED providers. The proposed Opioid Project can expand upon and draw on best practices and lessons learned from providers leading this pilot effort already underway in our region.⁸

Washington Emergency Department Information Exchange (EDIE): Washington’s EDIE HIT platform provides an internet-based HIT infrastructure that allows hospitals to analyze patient utilization patterns and support care coordination efforts. This infrastructure can be used to identify target populations with OUD or at risk and seeking prescribed opioids in emergency departments. In addition, this project can draw on this system to develop comprehensive care plans for target populations that allow emergency room providers to work with community-based care coordinators to support a holistic care plan.

SAMHSA grants supporting naloxone education: Key partners in the region have received SAMSHA funding to increase naloxone distribution, and GCACH can work with the partners to leverage and scale these efforts. The Washington State Project to Prevent Prescription Drug/Opioid Overdose is a statewide network of organizations mobilizing communities, providing overdose response training, and distributing naloxone through syringe exchange programs in four high need areas, including the GCACH. Activities engage professional and lay first responders, pharmacies, local and regional stakeholders, and health care providers to reduce overdose risk and deaths among people who use heroin and prescription opioids.

Challenges to improving outcomes and lowering costs for target population, and strategy to mitigate risks and overcome barriers

<i>Challenges to improving outcomes and lowering costs</i>	<i>Strategy to mitigate risks and overcome barriers</i>
<i>Provider concern about intensity of support needed for populations with opioid use disorder:</i> Providers have expressed reluctance to offer MAT to populations with opioid use disorder, given the complex needs of this population and case management support needed.	<i>Expanding providers offering MAT by supporting with case management:</i> To address provider concerns about the intensity of needs among populations with opioid use disorder, this project builds relationships with providers by offer case management support to meet the complex needs of this population.
<i>Target population readiness for treatment:</i> Treatment for individuals with opioid use disorder will not be effective until individuals	<i>Building trust with populations with OUD to support readiness to access treatment:</i> This project supports a case management model that

<p>are ready. A model supporting access to treatment must involve strategies to build relationships and trust with the target population to support access to care when they are ready.</p>	<p>builds trust with individuals using opioids to connect them to community resources and treatment when they are ready, and to address broader social determinants impacting individuals' ability to improve their health. The focus is on a harm reduction approach that supports patients regardless of their readiness to obtain treatment, and provides a bridge to recovery where barriers to effective treatment are addressed. The project will draw on Community Health Workers and Peer Support Specialists to build trust with the target populations.</p>
<p><i>Emergency provider access to patient medical records and treatment history:</i> Pain is the most common reason people seek care in emergency departments. ED providers, however, lack information about patient's full medical history, and often prescribe opioids to address pain-related complaints. If patients are unable to obtain prescribed opioids from one ED, they often seek prescribed opioids from other local EDs or providers.</p>	<p><i>Developing an internet-based care plan that is accessible by community-wide ED providers:</i> This project will expand on pilot efforts in our region leverage the EDIE system to provide ED providers with a holistic care plan for target populations with OUD.</p>
<p><i>Rural access to care, particularly providers offering MAT:</i> Rural areas face geographical challenges in access to providers.</p>	<p><i>Development of local Opioid Resource Networks to harness local resources and identify strategies to address geographic barriers to care.</i> With Opioid Resource Networks assigned to each county within the region, the project focuses on maximizing local resources and identification of strategies to address key gaps in capacity, such as the use of telehealth.</p>
<p><i>Social and political stigma associated with addictions:</i> There is general social and political stigma associated addiction and questioning the distribution of naloxone as a strategy to address the needs of individuals with OUD.</p>	<p><i>Cross-sector and community education regarding the importance of harm reduction approach to care</i> to ensure individuals have the supports needed to access effective treatment and to prevent overdose deaths through tools such as naloxone. This education is critical to</p>

	addressing social and political stigma in relation to addiction.
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Monitoring and Continuous Improvement

ACH Response
<p><i>Plan for monitoring project implementation progress</i></p> <p>GCACH’s plan for monitoring project implementation progress is still under development, and will evolve as the projects develop around the common metrics during the implementation planning phase. However, on October 23, the ACHs and key state staff gathered at the Homewood Suites in Tukwila for a full-day work/learn session to talk about what a conceptual framework to manage a Demonstration Project might look like. The ACHs also developed a set of design principles as a framework to keep our expectations within reasonable boundaries for the data providers. (A data provider was defined as a stakeholder that collect or maintains raw data sets or processed data products that may be shared to support data processes or requirements.)</p> <p>One of the design principles was to choose monitoring systems that had minimal burden to the data provider, as the provider will be the one in the center of patient care, and the one, in many cases, providing the monitoring data. However, “least burdensome” also makes good business sense. Given that lens, Greater Columbia has been in an investigative mode in talking to vendors about their products, and learning more about the capacities and capabilities that will be needed to monitor performance. The HCA has also started thinking about the performance monitoring system at the state level, so the HCA information technology staff has been asked to develop a simple tool that could be used to get PM off the ground until other monitoring systems can be put in place.</p> <p>GCACH has started on a conceptual framework for a project management system, and will work with the Project Teams, Providers, and Provider organizations to design a project management system that makes it easy to understand the relationships between the data sets, and provides early warning signals when the data is trending in the wrong direction. GCACH will look for visualization software, like Light Beam or Tableau that can provide insightful analytics to the providers, and enable them to make corrective actions which will lead to higher performance scores. The Demonstration projects will require Plan Do Study Act (PDSA) management, so GCACH will consider how various monitoring systems make it easy to collect, interpret and react to data.</p> <p>Some of the ideas surfaced at the working session to monitor project implementation progress included dashboards, excel spreadsheets, Gantt charts, tables, Tableau, and survey tools, like Survey Monkey. Tools for monitoring can be very detailed, such as customer relationship management (CRM) software, or constructed using Excel or adapting other types of project management dashboard</p>

templates. GCACH will try to strike the right balance between complexity and minimal administrative burden.

GCACH staff has started populating a database about potential participating providers' capacities, and asked a series of questions in our Letter of Interest (LOI) to potential providers including:

- provider capacity
- number of clients served by type
- primary demographics
- registry functions
- key technological gaps
- willingness to screen clients for social service need

Ultimately, this project data ecology will be shaped by the GCACH's project portfolio and selection of programs to implement. The design of each project will have a significant impact on monitoring and evaluation, so these systems will have to be complementary to the many different ways that data is captured and reported, and be sensitive to the amount of input required. The SPW will develop the initial framework that can then be used as the standard reporting format across the region, and modified according to project area. This understanding will then guide the development of project activities, schedules, budgeting. The SPW will report out progress to the GCACH Leadership Council and Board at the monthly meetings.

Addressing delays in implementation

GCACH will work with the Strategic Planning Committee to identify the functions and processes necessary to manage and monitor project implementation, and be proactive in anticipating barriers or delays in implementation. In this manner, the projects will be developed through the experiences of a cross-sector team and subject matter experts, and with guidance from consultants with DSRIP experience in order to anticipate implementation barriers and delays. GCACH has also budgeted for contingencies, such as project delays, and will deploy a robust communications campaign to keep everyone informed of progress. That being said, when delays occur, GCACH will look for processes that can be performed in parallel, add capacity, or make more resources available to get the project back on track.

GCACH's Data Management and Health Information Exchange Committee will oversee a rigorous project monitoring and continuous improvement process for the project. The DMHIE Committee will work with Transitional Care Project Implementation Team and the Project Manager to determine and track key measures, including project milestones, pay-for-reporting and pay-for-performance metrics. GCACH will develop regular reports to participating providers to support rapid PDSA cycles to track and improve provider

performance, and communicate progress or slipping schedules. GCACH will identify delays in project implementation using a continuous quality improvement approach, and work with our partners to identify potential schedule delays, and work-arounds. GCACH will also work with our MCO partners for input on the reporting metrics, particularly for purposes of VBP models. GCACH's DMHIE Committee and will recommend and seek Board approval of the QIP.

We will continue to monitor the appropriateness of our approach as we implement the project. Technical and training support in the form of tele-health, in-person trainings, webinars and other collateral expertise will be provided during implementation to all participating providers throughout the course of planning and implementation as needed. Our project is designed specifically with partnerships strengthening and cross services collaboration. Our Transitional Care Project Implementation Team will meet regularly and will share lessons learned, trends among patients and recommendations for improvement to the program.

Plan for monitoring continuous improvement and real-time performance

GCACH will contract with a vendor partner to develop, implement and manage a real-time performance system. GCACH is currently exploring partnership with Providence CORE and/or King County ACH to utilize their expertise and capacity to develop a monitoring system, including timely data to support project implementation and continuous improvement. GCACH will work with partnering providers during the planning phase to establish process measures and milestones, along with data reporting systems to track project performance metrics in as close to real time as possible. We have also investigated different Client Relationship Management tools such as SpetraMedix and Caravan Health that offer these types of monitoring systems.

For the Opioid Crisis Project, we will include the project's P4P and P4R metrics, and align efforts with other projects in our portfolio around shared metrics, including for example:

- Reduced inpatient hospital utilization (shared metric with the Bi-Directional Integration, Transitional Care, and Chronic Disease projects)
- Reduced outpatient emergency department visits (shared metric across all projects)
- Increase substance use disorder treatment penetration (shared metric with the Bi-Directional Integration project)
- Increase access to Medication Assisted Therapy

Additional outcomes will be defined during the planning year as we further develop our Monitoring and Continuous Improvement Process for the project.

Plan for addressing strategies that are not working

GCACH staff and consultants will be working closely with the Strategic Planning Committee throughout the demonstration to monitor progress and achievement. Along with the development of data tracking and reporting systems, GCACH will work with the care coordination teams to support overall implementation, the spread of best practices and sharing lessons learned. This learning system will enable GCACH partnering providers, across projects, to learn from and support each other over the course of the Demonstration. In addition, GCACH is contracting with consultants with expertise in each of the project areas in order to have the capacity to provide rapid technical assistance to partnering providers when implementation challenges arise.

Project Metrics and Reporting Requirements

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
X	

Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
X	

Project Sustainability

ACH Response

GCACH strategy for long-term project sustainability

GCACH is developing essential infrastructure needed to support delivery system transformation combined with value-based payment models that will support the long-term sustainability of this project. This project offers the opportunity to re-direct spending on high-cost, crisis oriented services across the health, social service, law enforcement, justice system, and other sectors to support a

patient-centered, holistic system of care that emphasizes prevention and empowers individuals to access treatment and sustain long-term recovery. Through the Strategic Planning Committee (SPC), GCACH will work closely with MCOs and health systems to demonstrate the return on investment for this project area. GCACH will also play a leadership role in aligning other funds in the region (Federal, state and county) to address the opioids crisis in order to maximize impact and efficiently leverage resources. GCACH will support the development of integration of successful projects into a value-based payment model for long-term sustainability.

Project's impact on Washington's health system transformation beyond the Demonstration period

There are considerable human and economic costs associated with the opioid crisis in the GCACH region and across Washington. The project will have a lasting impact on Washington's health system beyond the Demonstration by establishing infrastructure to support lasting cross-sector partnerships that reduce opioid prescribing, divert individuals out of jails and emergency departments, and create a holistic system of care that supports individuals to access treatment and long-term recovery support.

¹ (n.d.). Retrieved November 15, 2017, from <http://stopoverdose.org/section/data-and-research/>

² HCA RHNI “starter set” files

³ (n.d.). Retrieved November 15, 2017, from <http://stopoverdose.org/section/data-and-research/>

⁴ (n.d.). Retrieved November 15, 2017, from <http://stopoverdose.org/section/data-and-research/>

⁵ Kingston, S., & Banta-Green, C. (2016, February). Results from the 2015 Washington State Drug Injector Health Survey. Retrieved November 15, 2017, from <http://adai.uw.edu/pubs/infobriefs/2015druginjectorhealthsurvey.pdf>

⁶ Neven, D., Paulozzi, L., Howell, D., Mcpherson, S., Murphy, S. M., Grohs, B., Roll, J. (2016). A Randomized Controlled Trial of a Citywide Emergency Department Care Coordination Program to Reduce Prescription Opioid Related Emergency Department Visits. *The Journal of Emergency Medicine*, 51(5), 498-507.

doi:10.1016/j.jemermed.2016.06.057

⁷ Washington State Interagency Opioid Working Plan. (2016, January). Retrieved November 15, 2017, from http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_Jan2016.pdf

⁸ Neven, D., Paulozzi, L., Howell, D., Mcpherson, S., Murphy, S. M., Grohs, B., Roll, J. (2016). A Randomized Controlled Trial of a Citywide Emergency Department Care Coordination Program to Reduce Prescription Opioid Related Emergency Department Visits. *The Journal of Emergency Medicine*, 51(5), 498-507.

doi:10.1016/j.jemermed.2016.06.057

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SECTION II: PROJECT-LEVEL

Section II (including selection of the relevant project from the menu) will need to be duplicated for each project selected (at least a minimum of four).

Transformation Project Description

Select the project from the menu below and complete the Section II questions for that project.

Menu of Transformation Projects	
Domain 2: Care Delivery Redesign	
<input type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversions Interventions
Domain 3: Prevention and Health Promotion	
<input type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input checked="" type="checkbox"/>	3D: Chronic Disease Prevention and Control

Project Selection & Expected Outcomes

ACH Response
<p><u>Project Description and Expected Outcomes</u></p> <p>GCACH will target prevention and management of chronic disease through multi-county collaboration and partnerships, with an emphasis on obesity and diabetes. The project focuses on expanding adoption of evidence-based diabetes and obesity chronic disease prevention and treatment models across the region, including promotion of the 5210 media campaign, Diabetes Prevention Program, Chronic Disease Self-Management Program, Million Hearts Campaign, Mind, Exercise, Nutrition, Do it! (MEND), and models addressing childhood obesity. This effort would build upon the experience and success of Yakima County in implementing the Diabetes Prevention Program and Chronic Disease Self-Management Program. GCACH will also utilize the Community paramedicine model in counties with interested and available partnering providers. Lastly, this project will promote implementation of the Chronic Care Model in primary care practices.</p> <p>According to the Centers for Disease Control and Prevention, root causes of chronic diseases include underlying socioeconomic, cultural, political and environmental determinants (genetics, poverty, crime/lack of safety-perceived or actual, built environment, pollution, cultural perception/acceptance of obesity/diabetes). The common modifiable risk factors include but are not limited to: poor nutrition (foods high in fat, sugar, and sugary beverages), physical inactivity, tobacco use, and chronic stress. Intermediate risk factors of these are raised blood pressure, raised blood glucose, abnormal</p>

blood lipids, and overweight/obesity, just to name a few. All of the above factors can contribute to onset of chronic diseases including diabetes, heart disease, cancer, stroke, chronic respiratory disease, and more.

In order to address upstream causes of chronic disease, project efforts will emphasize prevention, patient education and engagement and utilize community health workers and other community-based resources. This project, in collaboration with the Bi-Directional Integration of Care project, will also develop specific change strategies to implement across all aspects of the Chronic Care Model: self-management support; delivery system design; decision support; clinical information systems; community-based resources and policy; and health care organization. Specific components of the project include:

- Implementing evidence-based models through existing local community resources and health care providers, including community coalitions, schools, public health, and health care providers.
- Developing regional project management and resources to support local implementation.
- Providing outreach and education to clinical providers, community health workers, and outreach coordinators through trained facilitators in each county.
- Conducting place-based dissemination of evidence based programs (e.g., housing sites, schools, early learning centers).
- Building upon existing Community Paramedicine program infrastructure in the region (in Benton, Franklin, Yakima, Kittitas, and Walla Walla counties), and develop cost-effective strategies to implement models in rural areas with smaller population size, such as sharing services across counties or development of remote learning options.
- Hot spotting and GIS mapping to identify areas of greatest need, and gaps in services and resources.

GCACH anticipates these efforts will result in the following outcomes over the Demonstration:

- Increased awareness of Chronic Disease Prevention and Control (Chronic Disease Self-Management Program and Diabetes Prevention Program).
- Increased referrals to Diabetes Prevention Program and Chronic Disease Self-Management Programs (CDSMP) in the GCACH region
- Reduction in avoidable ED utilization for people with multiple chronic diseases and/or co-occurring chronic disease and behavioral health disorders.
- Increased utilization of primary care among Medicaid beneficiaries with multiple chronic diseases.
- Improvements in measures of Comprehensive Diabetes Care
- Improved self-management of diabetes among Medicaid beneficiaries
- Improved medication management for Medicaid beneficiaries with asthma
- Increased availability of community-based supports for Medicaid beneficiaries with multiple chronic diseases and/or co-occurring chronic disease and behavioral health disorders.

In collaboration with the Bi-Directional Integration of Care project focused on efforts to improve regional performance on the seven performance metrics shared between the two projects:

- Outpatient Emergency Department Visits per 1000 Member Months
- Inpatient Hospital Utilization
- Child and Adolescents' Access to Primary Care Practitioners
- Comprehensive Diabetes Care: Eye Exam (retinal) performed
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Depression Screening and Follow-up for Adolescents and Adults
- Medication Management for People with Asthma (5 – 64 Years)

Justification for selecting project and how it addresses regional priorities

Chronic disease is the leading cause of death in the United States and accounts for more than 75% of health care costs.¹ Eighty-six percent of the nation's \$2.7 trillion annual health care expenditures are for people with chronic physical and mental health conditions.² Chronic diseases disproportionately affect vulnerable populations, exacerbating disparities of health by race and ethnicity and socio-economic status. Improved prevention and management of chronic disease is a foundational component of transforming health care delivery.

Prior to the Demonstration, the GCACH engaged an 18-month regional, community-based process to evaluate local, state, and national data sources examining key health indicators in our region. From this, diabetes and obesity were identified as a common theme across many of the counties in the region.

Obesity is the second highest leading preventable cause of disease and death and addressing it is considered a winnable battle by the CDC. According to the CDC, 86 million adults in the U.S. (more than 1 of 3) have prediabetes; 9 out of 10 people with prediabetes don't know they have it.³ Our focus is on upstream health (prevention) that will also address chronic disease management.

Regional health needs assessments have underscored high rates of obesity and diabetes in the region and significant health disparities across population groups. Addressing chronic disease has been identified as a regional health priority by both the GCACH Leadership Council and the Board of Directors. Diabetes is a significant health problem in the Greater Columbia region. In 2015, the age adjusted rate of hospitalization with diabetes mellitus as the primary diagnosis was 129.3 per 100,000 in the GCACH region, which is significantly higher than the state rate.⁴

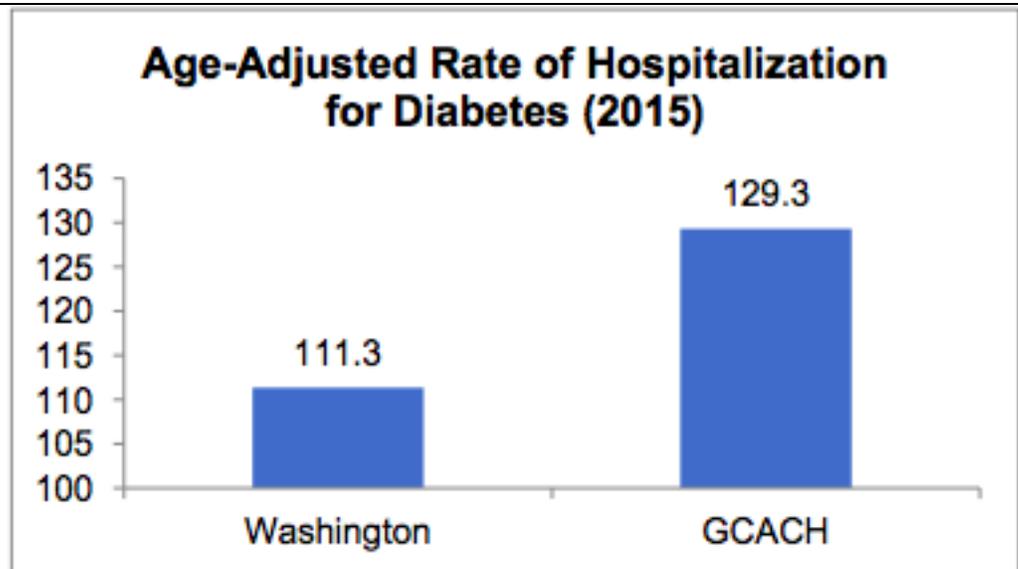


Figure 1: Hospitalization Rates for Diabetes in the GCACH Region Compared with Statewide

In 2015, the age-adjusted rate of mortality resulting from diabetes mellitus in the GCACH region was 26.73 per 100,000 (23.07-30.86), which was higher than the age adjusted mortality rate of 22.48 per 100,000 (21.43-23.57) in Washington.⁵

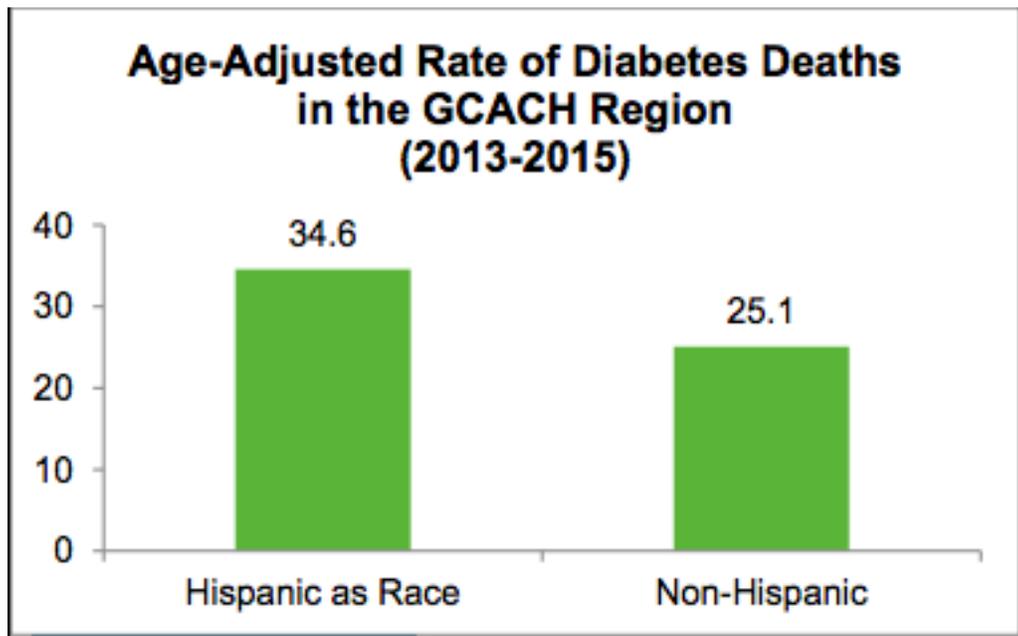


Figure 2 Death Rates for Hispanics v. Non-Hispanics due Diabetes in the GCACH Region

According to Medicaid claims data, an average of 7% of adults 19 years of age and older in the GCACH Region were diagnosed with diabetes (95% CI: 6,8) this was highest among the American Indian/Alaska Native population (6%, 95% CI: 5,7).⁶ Additionally, the figure above shows the rate of diabetes deaths in the GCACH region was higher among the Hispanic population (34.6 per 100,000) when compared to that of the Non-Hispanic population (25.1 per 100,000).⁷

How Project will support sustainable health system transformation for the target population

Improving prevention and management of chronic disease is critical to improving health outcomes for the target populations as well as developing a more sustainable health system. Chronic disease is a significant contributor to the unsustainable rise in health care costs, currently accounting for over 75% of costs. Eighty-six percent of the nation's health care expenditures are for people with chronic and mental health conditions.⁸ Over time, the project's strategies will have a widespread influence on the region's health system. In addition to investments needed to change the delivery of care, the project will support a value-based payment model that can be utilized by all private and public payers, for both clinical and community-based providers. This will transform how care is provided and sustained for all client populations, including, but not limited to the project's target population and all Medicaid recipients.

How GCACH will ensure project coordinates with and doesn't duplicate existing efforts

The Chronic Disease Project Team includes representatives from regional health systems and County Public Health Departments who currently provide chronic disease programs, as well as MCO representation (See below, *Involvement of Partnering Providers*). Their subject matter expertise and local area knowledge of existing programs has helped to ensure proposed project plans build on rather than duplicate existing services.

During the planning phase (Q1 and Q2 of 2018), GCACH will conduct an inventory of existing programs and resources, as well as a needs-gaps assessment. This work will provide a detailed landscape of existing programs which will be used to inform implementation plans. In addition, GCACH will form a Chronic Disease Project Implementation Team and Strategic Planning Committee in Q1 2018 to continue to engage a broad spectrum of partnering providers in project planning and implementation. The Chronic Disease Project Implementation Team will include members of the Chronic Disease Project Team (participating in the development of the project application), as well as additional partnering providers identified through our Letter of Interest process in September 2017. The Strategic Planning Committee will include representatives from each Demonstration project area selected (2A, 2C, 3A, 3D) to provide strategic alignment, coordination, and avoid duplication across the Demonstration projects. Although not formalized, GCACH staff has envisioned that our current Project Advisory Committee will form the core of a Strategic Planning Committee (SPC).

The GCACH has created extensive inventories of the health and social well-being services and programs being provided within its service area. For example, the GCACH Community Asset Inventory (CAI), created in 2017, contains nearly 170 different programs that relate to the project areas listed in the Project Toolkit. The GCACH also conducted an extensive Regional Health Improvement Plan initiative in 2016 that examined community assets and supports. Although these were not exhaustive reviews, they have provided the GCACH with a deep understanding of the resources that are available throughout its service area. In the first half of 2018, the CAI will be refreshed and updated with new programs and services being offered throughout the region.

The CAI currently indicates the following chronic disease management programs:

- Virginia Mason Memorial in Yakima county offers diabetes wellness, diabetes prevention, and chronic disease management programs;
- Yakima Neighborhood Health Services offers a diabetes management and control program;
- The Benton-Franklin Health District in Benton and Franklin counties offer Diabetes Self Management/Programa de Manejo Personal de la Diabetes, a model of the Stanford evidence-based programs;
- Providence St. Mary's in Walla Walla offers Obesity/Chronic disease and they are pursuing that every 4th grader in service area receives a 'fitbit'

All of these are evidenced-based approaches with proven outcomes that could be scaled-up to populations not currently being served. With the planned CAI refresh in first-half 2018, an assessment or gap analysis will be included to understand what populations and what services are being reached, and where are there gaps for future improvement and additional program implementation. The ACH will be adding new programs, such as 5210 and MEND, where it make sense and the need is evident. All this will be overseen by the multi-stakeholder Project Team tied to Project 3A, which includes representatives from across the nine-county ACH. GCACH is working to build upon our region's collective work to improve chronic disease prevention and control and to avoid duplicative efforts and capacity for Project 3D. The goal is to build upon existing assets in the region that are proven to work and to strengthen existing infrastructure and care systems to the greatest extent possible.

Project Scope

Target Population

Approximately 37,375 Medicaid beneficiaries in the Greater Columbia region have at least one chronic condition, and 21,257 have two or more chronic conditions.⁹ Treating patients with several chronic conditions can cost as much as seven times what it costs to treat someone with just one chronic illness.¹⁰ There is a high prevalence of co-morbidity of mental health disorders and chronic disease. Having a mental health disorder significantly increases the risk for developing a chronic condition and vice versa.

The broad target population for this project are Medicaid beneficiaries, children and adults, in all counties, with a focus on high-risk and populations experiencing health disparities. This project will align with the other projects in the GCACH portfolio by focusing on Medicaid beneficiaries with co-occurring chronic disease and behavioral health disorder.

We anticipate reaching approximately 1,900 high-needs Medicaid beneficiaries through the course of this project, 5% of the identified population (5% of 36,890 Beneficiaries with one or more chronic disease and co-occurring behavioral health disorder).

GCACH has intentionally selected a narrow target population for our Project Portfolio. During the period where target populations were identified for each of the Demonstration project areas, the

GCACH conducted a literature search on the subject of high-cost, high-utilizing patients. Reviewing the research of several different organizations—including the Health Care Transformation Task Force (which HCA is part of), AHRQ, Commonwealth, National Institute for Healthcare Management and others—indicates the healthcare utilization and costs are highly concentrated in a relatively small subset of any large patient population. For example, the top 5% of chronic disease patients spend around 30% of total care costs, and the top 5% of an overall population accounts for nearly half of all healthcare costs. These patients represent a broad spectrum of demographic and clinical characteristics and socioeconomic conditions. For the GCACH, a rough estimate puts the total spending for the top 5% of the GCACH Medicaid population at around \$500 million.

Some of these are non-persistent, high spenders who have expensive acute care spending in the current year but which decreases in subsequent years. Little can be done to reduce this spending. However we are planning on doing broad community education around appropriate use of the ED, which might affect this group. Non-persistent high spenders typically accumulate between and four ED visits during the year of high utilization.

Others are nearing the end-of-life, including those with advanced illness such as COPD, heart failure, cancer, chronic liver disease and more. Part of our work will be to convene a working group in 2018 that will focus on community outreach and engagement to educate providers around the following:

- Opportunities to provide home and community-based services that can cut down on unnecessary hospitalizations;
- Care management involving informed choice and;
- Other support that can optimize the use of hospice and other palliative care services to redirect end-of-life care from hospital to home and community.

Not only is this in the best interest of the patient, recognizing that most patients would prefer not to die in the hospital, but the potential for savings from such strategies is high.

The third group, patients with persistent high-spending patterns, will be a large area of focus and care coordination. This group typically has multiple chronic conditions, many face psychological and social barriers to care, and many are good candidates for care management and social support services. The prevalence of behavioral health and/or disabilities can dramatically increase spending in this group. Per capita costs are double or triple for Medicaid patients with a co-morbid mental health diagnosis or with evidence of substance abuse. Concentration of spending in Medicaid is particularly significant, where 60% of patients in the Top 10% Spender Tier in any given year remain in that tier the following year.

Several methods will be used to identify high-cost patients, including claims analysis (e.g. >6 ED visits, >2 inpatient stays in a year, >5 prescriptions, absence of PCP visits, etc.), patient surveys (e.g. PHQ-2 and PHQ-9, PAM score), presence of chronic need for social services (e.g. homelessness), and more. Additional research indicates that certain high-cost patients may not be “impactable” (i.e. not amenable to change), which may guide decision making around patient selection.

For the GCACH, the top 5% of the population would comprise around 12,500 patients. Although there might be \$millions in project incentive funds available, dispersing these dollars evenly over this fraction of our Medicaid population points out the need to be very strategic in how we focus our work. Identifying and managing care for this group of patients is an important step towards improving health outcomes and reducing total costs for the entire population.

Proposed Target Population	Estimated Number
Medicaid Beneficiaries with one or more chronic disease	58,632
Beneficiaries with one or more chronic disease and co-occurring behavioral health disorder	36,890

The primary initial target population for Project 3D will be Beneficiaries with one or more chronic disease and a co-occurring behavioral health disorder, which makes up approximately 37,000 individuals. As described in the response just above, we hope to initially focus on high-utilizing, high-cost patients, then expand project successes to additional populations that would fall into this project area.

During the planning phase, the Chronic Disease Prevention and Control project will work with GCACH’s data vendor to conduct more detailed analysis of Medicaid beneficiaries in the region and further refine the target population, likely including the following sub-populations:

- Medicaid Beneficiaries with ≥3 Chronic Conditions and Absence of PCP visits
- Medicaid Beneficiaries with ≥2 (non-OB) admissions in last year with priority if one in last 6 months
- Medicaid Beneficiaries with ≥6 ED visits in the last year
- Medicaid Beneficiaries with ≥5 prescription medications

Involvement of Partnering Providers

As indicated by the supplemental workbook, GCACH has a wide array of interested partnering providers, many of whom have participated in the initial project design, including the region’s Public Health Districts, public safety, hospital systems, FQHCs and other clinical providers, as well as education districts and social service providers. The project team that developed the project concept included representatives from:

- Amerigroup Washington, Inc.
- Asotin County Health District
- Benton-Franklin Health District
- Columbia County Health District
- Columbia County Public Health Department

- Community Health Plan of Washington
- Coordinated Care Health Plan
- Grace Clinic
- Kadlec
- Kittitas County Public Health Department
- Molina Healthcare
- People for People
- SE Washington Aging & Long Term Care Council
- Second Harvest
- UnitedHealthcare
- Virginia Mason Memorial
- Walla Department of Community Health
- Walla Walla Health District
- Washington State University Extension
- WSU Master Gardeners
- Yakima Valley Community Foundation
- Yakima Valley Farm Workers Clinic

In addition to the project team, the project concept was presented and received input and feedback from the full Leadership Council, as well as the GCACH Board of Directors. In addition, GCACH has engaged in extensive outreach to partnering providers, holding over 80 in-person meeting and presentations since January 2017 to discuss the projects and engage provider input.

Level of Impact

Because of high rates of disparities of chronic disease, this project will identify and focus efforts in high-risk communities, including Hispanic and Native American communities, particularly in Yakima County and through work in partnership with the Yakama Nation. As highlighted above, for example, the American Indian/Alaska Native population experience the highest rates of diabetes in the region. Regional data also highlight disparities experienced by Hispanic populations. For example, the rate of diabetes deaths in the GCACH region was higher among the Hispanic population (34.6 per 100,000) when compared to that of the Non-Hispanic population (25.1 per 100,000) (2013-2015).¹¹

During the planning phase, the Chronic Disease Project Implementation Team will work with GCACH’s data vendor to conduct more detailed analysis of Medicaid beneficiaries in the region identify high-risk communities and geographic regions experiencing the greatest disparities.

Success within this project area, as well as the three other project areas, will involve practice transformation on the part of our prospective partnering providers. To be transformational, our providers will be guided toward realigning their systems and processes in a way that creates sustainability. This means adopting practices that support provider-led population health management (PHM). This will include information systems and health information technology that includes PHM tools, including risk stratification of patients, patient registries, provider attribution, incorporating evidenced based practice in workflows and more. We may compensate our large provider organizations to upgrade their EHR systems through their vendor to incorporate these tools or we might purchase a stand-alone PHM tool that incorporates both EHR and MCO claims in a complete package, with the tool then being rolled out to providers. Transformation will also mean establishing clinical-community linkages with outside social service providers. This could include either creating, or building upon existing efforts, a robust consumer-facing online platform or site that provides easy access to information about social service agencies. Wrapped around this might be a case management tool that integrates work done to address patients' social service needs. Transformation will also mean creating new roles and responsibilities, including patient navigators, case managers, care coordinators, peer counselors, community health workers and more. We expect to help support the training of many of these individuals. We also expect to partner with the five MCOs to gain their support, align with their provider payment arrangement and gain long-term commitments over aspects of this work. Once these changes are in place, and as the movement toward value-based pay proceeds with Medicaid, Medicare and ultimately commercial insurance, the groundwork we will have laid will provide a robust structure that will propel sustainability post-DSRIP.

How GCACH will ensure health equity is addressed in project design

Communities of color face significantly higher rates of chronic disease. This is of particular concern for the Greater Columbia region because of our significant Hispanic/ Latino and American Indian/ Alaska Native populations. Hispanics are 66 percent more likely to be diagnosed with diabetes than whites, while American Indian/Alaska Native adults are 2.4 times as likely as white adults to be diagnosed with diabetes.^{12,13} Because of high rates of disparities of chronic disease, this project will identify and focus efforts in high-risk communities, including Hispanic and Native American communities, particularly in Yakima County and through work in partnership with the Yakama Nation. Education materials will be culturally and linguistically relevant for these communities. Bilingual and bicultural facilitators will be used where appropriate. This project will also utilize Community Health Workers (CHWs) who come from the communities being served. Emphasis will be placed on effectively targeting these communities in the project planning phase and throughout implementation.

Implementation Approach and Timing

See Supplemental Workbook

Partnering Providers

See Supplemental Workbook

All of the providers listed in the Partnering Provider tab of the ACH Project Plan Supplemental Data Workbook have expressed interest in being a Partnering Provider to the GCACH. This was confirmed through each organization's response to and submission of the GCACH Letter of Interest (LOI) application, where each of the organizations identified in the list expressed interest in participating in Project 3D Chronic Disease and Prevention.

ACH Response

How GCACH has included partnering providers that collectively serve a significant portion of the Medicaid population

GCACH has taken a number of steps to ensure that partnering providers who serve a significant portion of the Medicaid population are engaged. In September 2017, GCACH undertook a Letter of Interest process to identify partnering providers interested in the various Demonstration project areas. In response to this inquiry, GCACH received LOIs from approximately 35 providers with specific interest in supporting the Chronic Disease Prevention and Control Project. As indicated by the supplemental workbook, GCACH has a wide array of interested partnering providers, many of whom have participated in the initial project design, including the region's Public Health Districts, public safety, hospital systems, FQHCs and other clinical providers, as well as education districts and social service providers.

GCACH has evaluated HCA claims summary data to identify high volume Medicaid providers in the region. Eleven of the top 29 Medicaid providers, by volume, serving the Medicaid population in the region have either participated in the Chronic Disease Project Team or responded to the Letter of Interest process that the GCACH undertook in September 2017.

Process for ensuring partnering providers commit to serving the Medicaid population.

The initial LOI process that GCACH undertook in September 2017 offered a preliminary look at partnering providers interested in the project, as well as provider commitments to collaborate with GCACH and other providers to achieve the Demonstration goals. During the first quarter of the 2018, GCACH will be engaging in a more formal process to enlist partnering providers through a formal contracting process. Contracts will require partnering providers to maintain a commitment to serving the Medicaid population throughout the project. This will be evidenced through continuous monitoring and data-sharing.

Process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented

As noted earlier, over 22 organizations from across the region have participated in the Chronic Disease project team representing all counties and multiple sectors including primary care, hospital systems, emergency medical services, social service agencies and a total of 35 providers responded to the initial to the LOI process the GCACH undertook in September 2017.

How GCACH is leveraging MCO's expertise in project implementation, and ensuring there is no duplication

All five MCOs operating in the region as well as the Greater Columbia Behavioral Health Organization are members of the Chronic Disease Project Team and have actively been engaged

with the development of this project application. These payers will continue to be involved in the planning phase of the project in 2018 and beyond. The GCACH understands that continuous involvement of payers will be critical to the project's long-term sustainability in the region. In addition to their role on the Project Team and Project Implementation Team (to be formed in 2018 Q1), MCOs are represented on the GCACH Board.

Regional Assets, Anticipated Challenges and Proposed Solutions

ACH Response

Assets GCACH and regional partners providers will bring to the project

The Greater Columbia region has a number of existing resources on which project efforts will be built. Diabetes Prevention Program, Chronic Disease Self-Management Program and obesity prevention and education programs have strong evidence and have been proven and successful in Yakima county. The PMH Medical Center has a successful Community Paramedicine project and their experience in improving care for people with diabetes in the Lower Yakima Valley and Tri-cities area will inform project planning.

The Tri-Cities Diabetes Coalition is an active group of diabetes professionals, registered dietitians, and community leaders from public health, hospitals, community based organizations, and health plans who sponsor an annual diabetes health fair that includes speakers, and screenings for diabetes. This year, the Coalition also participated in the Vista Hermosa Community Health Fair "Raices Saludables," in Prescott, and offered services including: glucose testing, blood pressure check-ups, fluoride applications, and vaccines. Healthcare representatives were available for questions and information about diabetes prevention, cancer awareness and child developmental programs. Camp Trios, a summer day camp program for children ages 6 to 14 diagnosed with Type 1 diabetes, is sponsored by Trios Health. The goal of this 3-day camp is to teach participants about their diagnoses and provide them with tools for managing it in a way that doesn't limit their daily life. Diabetes Self-Management Education programs are offered in both English and Spanish at Astria Sunnyside Hospital and Virginia Mason Memorial in Yakima. Pullman Regional Hospital offers a Wellness for Life, Diabetes Prevention Program, the Kadlec's Diabetes Learning Center offers classes, support groups, and nutrition counseling in Richland, as does Providence St. Joseph's in Walla Walla. Civic organizations in the GCACH also fund scholarships for diabetes camps and education.

There is also a strong interest in providing fresh food to underserved areas in the GCACH region. WSU has extension offices in Kittitas, Yakima, Benton, Franklin, and Whitman Counties. The Master Gardeners program of Benton and Franklin County has started over 100 community gardens in low income areas in Benton and Franklin Counties, and there are community garden programs in most of the GCACH counties.

Challenges to improving outcomes and lowering costs for target population and strategy to mitigate risks and overcome barriers

<i>Challenges to improving outcomes and lowering costs</i>	<i>Strategy to mitigate risks and overcome barriers</i>
Scale to smaller counties: given population size having adequate participants in the evidenced based programs may be a challenge.	We intend to address this issue by collaborating between counties and share resources (facilitators) through remote learning.
Shortage of community health workers in smaller communities and/or rural areas.	We intend to address this issue by identifying and using existing local workforce to help to support the project, such as community paramedics. We will also seek opportunities to increase and train a CHW workforce in rural areas. This may include “Train the Trainer” to facilitate trainings for lay educators that will teach the classes.
Time to build trust and relationships needed in the smaller communities.	One way to address/resolve these are to partner with other entities, including University programs, apprenticeships, and residency programs in health care to bring services to the smaller communities through health fairs and/or a large community-wide event. Another avenue would be to invest in an Outreach Coordinator who is committed to building relationships and trust within the communities.
Data collection pre/post intervention and outcome analytics	GCACH is investing in HIT infrastructure to support monitoring and continuous improvement of projects.

Monitoring and Continuous Improvement

ACH Response
<p><i>Plan for monitoring project implementation progress</i></p> <p>GCACH’s plan for monitoring project implementation progress is still under development, and will evolve as the projects develop around the common metrics during the implementation planning phase. However, on October 23, the ACHs and key state staff gathered at the Homewood Suites in Tukwila for a full-day work/learn session to talk about what a conceptual framework to manage a Demonstration Project might look like. The ACHs also developed a set of design principles as a framework to keep our expectations within reasonable boundaries for the data providers. (A data provider was defined as a stakeholder that collect or maintains raw data sets or processed data products that may be shared to support data processes or requirements.)</p> <p>One of the design principles was to choose monitoring systems that had minimal burden to the data provider, as the provider will be the one in the center of patient care, and the one, in many cases, providing the monitoring data. However, “least burdensome” also makes good business sense. Given that lens, Greater Columbia has been in an investigative mode in talking to vendors about their products, and learning more about the capacities and capabilities that will be needed to monitor</p>

performance. The HCA has also started thinking about the performance monitoring system at the state level, so the HCA information technology staff has been asked to develop a simple tool that could be used to get PM off the ground until other monitoring systems can be put in place.

GCACH has started on a conceptual framework for a project management system, and will work with the Project Teams, Providers, and Provider organizations to design a project management system that makes it easy to understand the relationships between the data sets, and provides early warning signals when the data is trending in the wrong direction. GCACH will look for visualization software, like Light Beam or Tableau that can provide insightful analytics to the providers, and enable them to make corrective actions which will lead to higher performance scores. The Demonstration projects will require Plan Do Study Act (PDSA) management, so GCACH will consider how various monitoring systems make it easy to collect, interpret and react to data.

Some of the ideas surfaced at the working session to monitor project implementation progress included dashboards, excel spreadsheets, Gantt charts, tables, Tableau, and survey tools, like Survey Monkey. Tools for monitoring can be very detailed, such as customer relationship management (CRM) software, or constructed using Excel or adapting other types of project management dashboard templates. GCACH will try to strike the right balance between complexity and minimal administrative burden.

GCACH staff has started populating a database about potential participating providers' capacities, and asked a series of questions in our Letter of Interest (LOI) to potential providers including:

- provider capacity
- number of clients served by type
- primary demographics
- registry functions
- key technological gaps
- willingness to screen clients for social service need

Ultimately, this project data ecology will be shaped by the GCACH's project portfolio and selection of programs to implement. The design of each project will have a significant impact on monitoring and evaluation, so these systems will have to be complementary to the many different ways that data is captured and reported, and be sensitive to the amount of input required. The SPW will develop the initial framework that can then be used as the standard reporting format across the region, and modified according to project area. This understanding will then guide the development of project activities, schedules, budgeting. The SPW will report out progress to the GCACH Leadership Council and Board at the monthly meetings.

Addressing delays in implementation

GCACH will work with the Strategic Planning Committee to identify the functions and processes necessary to manage and monitor project implementation, and be proactive in anticipating barriers or delays in implementation. In this manner, the projects will be developed through the experiences of a

cross-sector team and subject matter experts, and with guidance from consultants with DSRIP experience in order to anticipate implementation barriers and delays. GCACH has also budgeted for contingencies, such as project delays, and will deploy a robust communications campaign to keep everyone informed of progress. That being said, when delays occur, GCACH will look for processes that can be performed in parallel, add capacity, or make more resources available to get the project back on track.

GCACH's Data Management and Health Information Exchange Committee will oversee a rigorous project monitoring and continuous improvement process for the project. The DMHIE Committee will work with Transitional Care Project Implementation Team and the Project Manager to determine and track key measures, including project milestones, pay-for-reporting and pay-for-performance metrics. GCACH will develop regular reports to participating providers to support rapid PDSA cycles to track and improve provider performance, and communicate progress or slipping schedules. GCACH will identify delays in project implementation using a continuous quality improvement approach, and work with our partners to identify potential schedule delays, and work-arounds. GCACH will also work with our MCO partners for input on the reporting metrics, particularly for purposes of VBP models. GCACH's DMHIE Committee will recommend and seek Board approval of the QIP.

We will continue to monitor the appropriateness of our approach as we implement the project. Technical and training support in the form of tele-health, in-person trainings, webinars and other collateral expertise will be provided during implementation to all participating providers throughout the course of planning and implementation as needed.

Our project is designed specifically with partnerships strengthening and cross services collaboration. Our Transitional Care Project Implementation Team will meet regularly and will share lessons learned, trends among patients and recommendations for improvement to the program.

Plan for monitoring continuous improvement and real-time performance

GCACH will contract with a vendor partner to develop, implement and manage a real-time performance system. GCACH is currently exploring partnership with Providence CORE and/or King County ACH to utilize their expertise and capacity to develop a monitoring system, including timely data to support project implementation and continuous improvement. GCACH will work with partnering providers during the planning phase to establish process measures and milestones, along with data reporting systems to track project performance metrics in as close to real time as possible. We have also investigated different Client Relationship Management tools such as SpetraMedix and Caravan Health that offer these types of monitoring systems.

For the Chronic Disease project, we will include the project's P4P and P4R metrics, and align efforts with other projects in our portfolio around shared metrics, including for example:

- Child and adolescents' access to primary care practitioners (shared with Bi-Directional Integration project)
- Comprehensive diabetes care: eye exam (retinal) performed (shared with Bi-Directional Integration project)

- Comprehensive diabetes care: hemoglobin A1c testing (shared with Bi-Directional Integration project)
- Comprehensive diabetes care: medical attention for nephropathy (shared with Bi-Directional Integration project)
- Depression screening and follow-up for adolescents and adults (shared with Bi-Directional Integration project)
- Inpatient hospital utilization (shared across all projects)
- Medicaid management for people with asthma (5-64 years) (shared with Bi-Directional Integration project)
- Outpatient emergency department visits per 1000 member months (shared across all projects)
- Statin therapy for patients with cardiovascular disease

Additional outcomes will be defined during the planning year as we further develop our Monitoring and Continuous Improvement Process for the project.

Plan for addressing strategies that are not working

GCACH staff and consultants will be working closely with the Strategic Planning Committee throughout the demonstration to monitor progress and achievement. Along with the development of data tracking and reporting systems, GCACH will work with the care coordination teams to support overall implementation, the spread of best practices and sharing lessons learned. This learning system will enable GCACH partnering providers, across projects, to learn from and support each other over the course of the Demonstration. In addition, GCACH is contracting with consultants with expertise in each of the project areas in order to have the capacity to provide rapid technical assistance to partnering providers when implementation challenges arise.

Project Metrics and Reporting Requirements

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
X	

Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not*

duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.

- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
X	

Project Sustainability

ACH Response

Project Sustainability Post-Demonstration

Chronic disease is the most significant cost in the health care system. Through the course of the project, GCACH and its partners will be able to demonstrate to payers the value of investments in prevention and better managed chronic diseases. This will result in lower rates of ER usage and hospitalizations and decreased costs overall. Providers in the GCACH will be poised to succeed because they will have learned how to do the work through the Demonstration and will have made the investments and transformations needed to provide this type of care in an ongoing and sustainable fashion. In addition, the project will advance value-based payment models needed to sustain the delivery system transformation made by the project over the long term. We are hopeful through increased public awareness regarding the effects and interventions to prevent chronic disease, this will have a lasting effect on community lifestyles and behaviors. The community and provider linkages that are formed will also carry for forward after the Demonstration period.

Lasting Impact on Washington Health System Transformation

Better prevention and management of chronic diseases are one of the most significant steps toward health system transformation that we can make. Reducing the prevalence of chronic disease and better managing the people who live with these conditions will free up dollars for other needed investments, improve outcomes and make significant strides toward reducing health disparities. The investments made during the demonstration to transform provider practices will last far beyond the project itself. The relationships and networks of care that are formed and shaped as a result of this work will likely have a lasting impact in creating and improving programs within the community. As well, by addressing childhood obesity, this will have a lasting affect over the course of the person's life, whether or not they remain on Medicaid. The goal is to create lasting behavioral changes and modified lifestyle habits. Ultimately, this will result in change at the cultural level.

¹ Chronic Disease Prevention and Health Promotion. (2017, June 28). Retrieved November 15, 2017, from <https://www.cdc.gov/chronicdisease/overview/index.htm>

² Chronic Disease Prevention and Health Promotion. (2017, June 28). Retrieved November 15, 2017, from <https://www.cdc.gov/chronicdisease/overview/index.htm>

³ Chronic Disease Prevention and Health Promotion. (2017, June 28). Retrieved November 15, 2017, from <https://www.cdc.gov/chronicdisease/overview/index.htm>

⁴ WA Hospital Discharge Data, CHARs, DOH Center for Health Statistics, August 2016

⁵ HCA RHNI “starter set” files

⁶ HCA RHNI “starter set” files

⁷ WA Hospital Discharge Data, CHARS, DOH Center for Health Statistics, August 2016

⁸ Gerteis J, Izrael D, Deitz D, LeRoy L, Ricciardi R, Miller T, Basu J. Multiple Chronic Conditions Chartbook.[PDF – 10.62 MB] AHRQ Publications No, Q14-0038. Rockville, MD: Agency for Healthcare Research and Quality; 2014. Accessed November 15, 2017.

⁹ HCA RHNI “starter set” files

¹⁰ Sambamoorthi, U., Tan, X., & Deb, A. (2015). Multiple chronic conditions and healthcare costs among adults. *Expert Review of Pharmacoeconomics & Outcomes Research*, 15(5), 823-832. doi:10.1586/14737167.2015.1091730

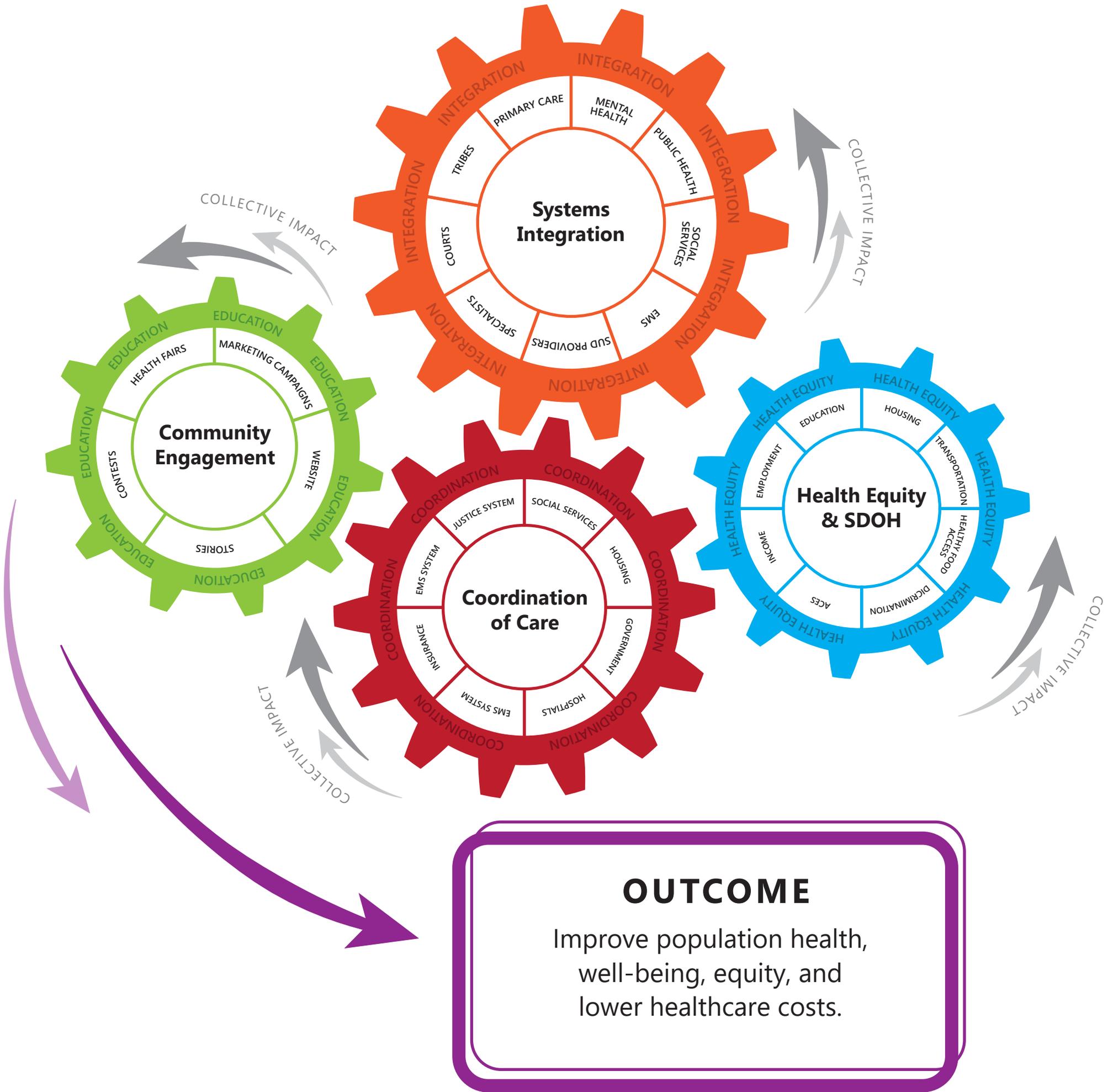
¹¹ WA Hospital Discharge Data, CHARS, DOH Center for Health Statistics, August 2016

¹² The United States Can Reduce Socioeconomic Disparities By Focusing On Chronic Diseases," Health Affairs Blog, August 17, 2017. DOI: 10.1377/hblog20170817.061561

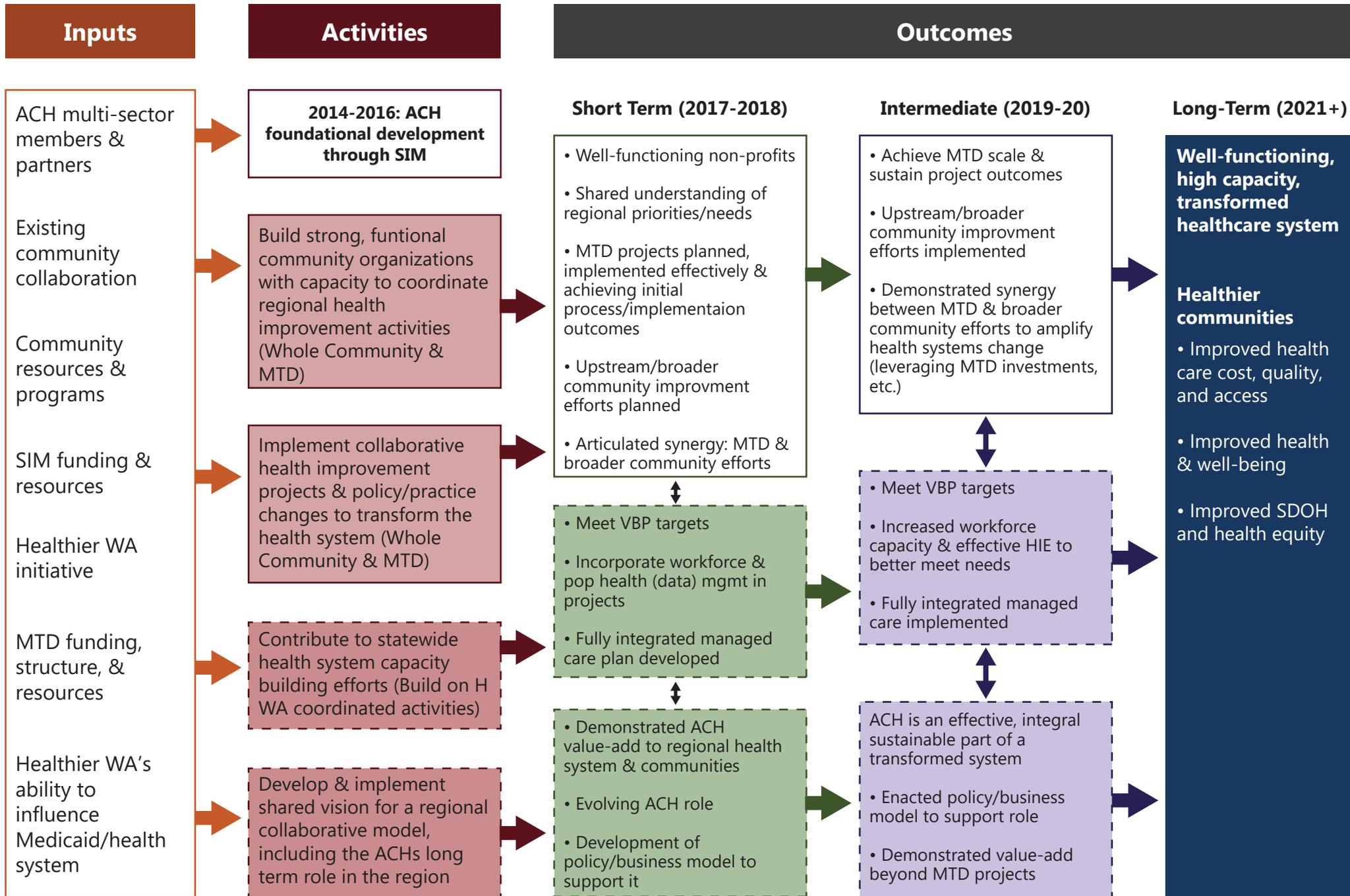
¹³ Office of Minority Health. (n.d.). Retrieved November 15, 2017, from <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=33>

Greater Columbia ACH Theory of Action

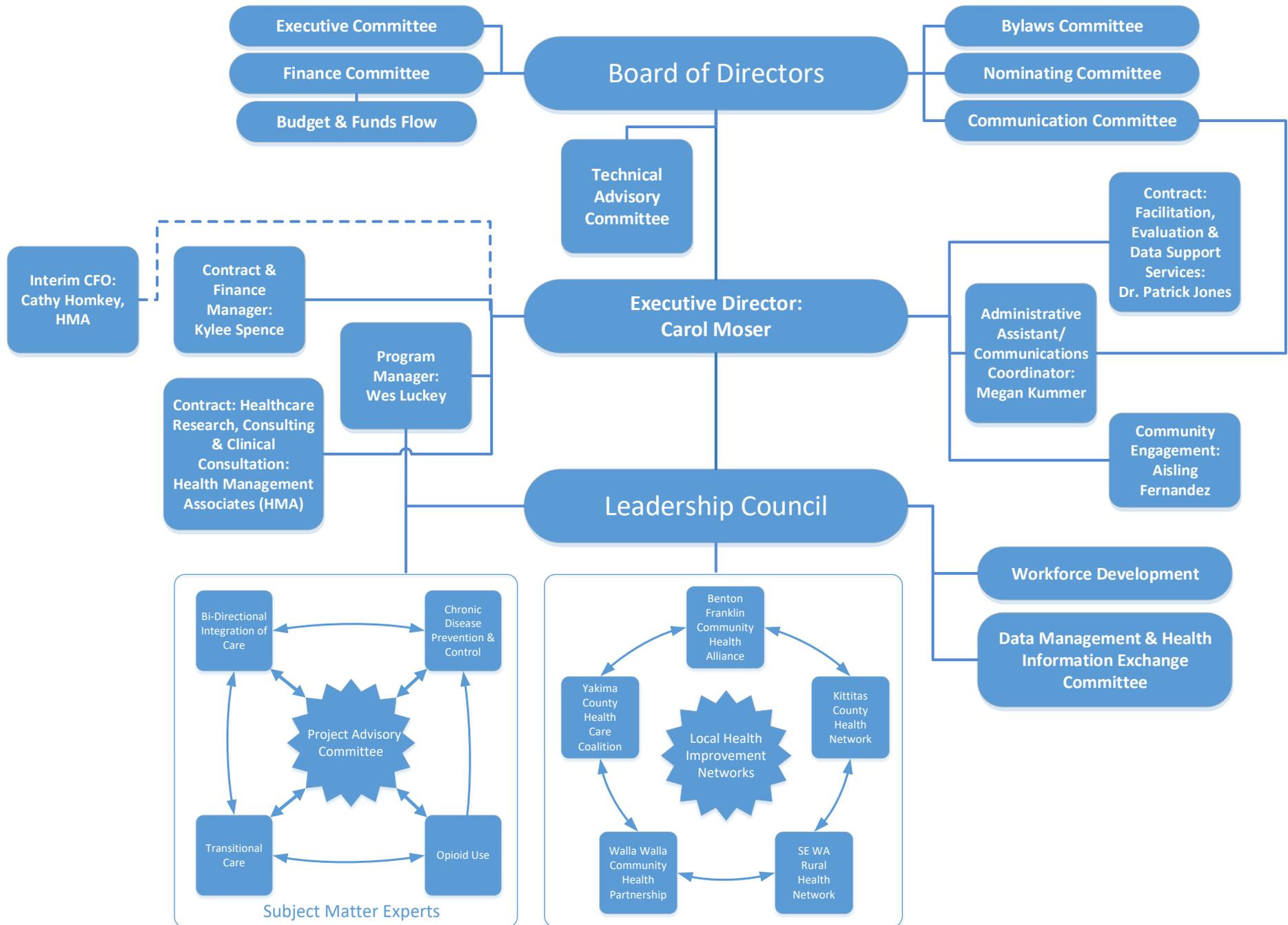
Adapted from RWJF Culture of Health Framework



Greater Columbia ACH Logic Model



Greater Columbia Accountable Community of Health Organizational Chart



Attachment A – Clinical Capacity Attachments

Clinical and Workforce Subject Matter Experts - Bios

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Clinical Experts

[Amy Person, MD, Health Officer, Benton-Franklin Health District](#)

Amy Person has been a board-certified pediatrician for over 25 years, working with teen mothers and Medicaid families. She also holds a Master's in Health Care Informatics and is certified in GIS, focusing on location analytics to measure community health. In her current roles as Health Officer for Benton-Franklin Health District and Chairperson of the Benton-Franklin Community Health Alliance, she is working to build community-clinical linkages and to address social determinants of health at the population level.

GCACH Project Team:

Bi-Directional Integration of Physical & Behavioral Health
Chronic Disease Prevention & Control

[Becky Grohs, RN, BSN, CCM, Consistent Care Services, SPC](#)

Becky Grohs has over 20 years' of experience in delivering Case Management services for Managed Care Organizations, hospitals and community agencies. She currently is the Director of a Social Purpose Corporation that focuses on over-utilizers of the EDs across 9 counties in Washington State. Her interest and expertise lies in managing patients that suffer from homelessness, substance abuse and mental illness.

GCACH Project Team: Addressing the Opioid Use Public Health Crisis

[Brian E. Sandoval, Psy.D.](#)

Dr. Brian Sandoval is a clinical psychologist with 9 years of primary care experience in several capacities including clinical work, program development, policy, and research. He is the Director of the Primary Care Behavioral Health program at the Yakima Valley Farm Workers Clinic. Dr. Sandoval currently participates in several state committees in Oregon and Washington focused on development of clinical practice standards, quality metrics, and payment reform strategies for the integration of behavioral and physical health. He is a member of the Bree Collaborative and also a co-chair of the behavioral health workgroup at the Greater Columbia ACH. Dr. Sandoval is committed to working with the underserved and continues to provide direct patient care services.

GACH Project Team: Bi-Directional Integration of Physical & Behavioral Health

[Carla Prock, RN](#)

Carla Prock is a Registered Nurse with a BSN degree from the WSU College of Nursing. Carla has been a public health nurse working in community health with a focus on Maternal Child Health for 17 years. She has been certified in Child Passenger Safety and as an International Board

Certified Lactation Consultant. Carla is the Senior Manager of Healthy People & Communities at Benton-Franklin Health District.

GCACH Project Team: Reproductive, Maternal & Child Health

[Darin Neven, MD, President, Consistent Care Services, PLLC](#)

Darin Neven is a residency trained and board certified emergency physician practicing at Sacred Heart Medical Center since 2005.

He operates emergency department care coordination programs in Spokane, Yakima, Benton, Franklin, and Snohomish counties. This work often includes working with addicted patients and helping them obtain treatment.

In 2016 he performed a clinical trial in Spokane that started opioid addicted patients on Suboxone in the Emergency Department. He continues to explore new ways to treat addiction in the Emergency Department.

GCACH Project Team: Diversion Interventions

[Dell Anderson, M.Ed Counseling Psychology, BS Family & Human Development, Director of Behavioral Health Services, Tri-Cities Community Health](#)

Dell Anderson is the Director of Behavioral Health Services at Tri-Cities Community Health. He has held diverse positions as a case manager, mental health therapist, clinical supervisor, and director of outpatient mental health services. Tri-Cities Community Health is a federally qualified health center that is fully integrated with dental, physical, and behavioral health services. Dell's recognitions and certifications include Benton/Franklin Counties Family System of Care, Provider of the Year, 2013, WA State Child Mental Health Specialist, 2008, and WA State Licensed Mental Health Counselor, 2010.

GACH Project Team: Bi-Directional Integration of Physical & Behavioral Health

[Diane Liebe, MD, Developmental and Behavioral Pediatrics](#)

Diane Liebe earned her medical degree from the State University of New York, Health Science Center at Syracuse in Syracuse, New York. She completed her residency at Children's Hospital in Pittsburgh, Pennsylvania. She is currently the Clinic Medical Director at Children's Village in Yakima, Washington, and specialized in developmental and behavioral pediatrics.

GCACH Project Team: Community-Based Care Coordination

[Donald Ashley, MD, FAAP](#)

Donald K. Ashley, MD FAAP (NPM) MPH. Regional Medical Consultant for Children's Administration. President, Walla Walla Valley Medical Society. Advocate for decreasing cumulative adversity, and for improving environmental infrastructure, in order to empower healthier communities.

GCACH Project Team: Chronic Disease Prevention & Control

[Don Solberg, MD](#)

Dr. Don Solberg joined Kittitas Valley Healthcare in September, 2009 as the Chief Medical Officer (CMO) for the organization. He is a board-certified in family medicine and has practiced in Ellensburg for over 37 years. In his role as CMO, he serves as a liaison between medical staff and KVCH Administration and oversees the management of medical education, medical staff services, quality assurance, and regulatory compliance. He retired his clinical practice duties in July, 2016, but continues his CMO duties for KVH on a 0.6 FTE basis

Dr. Solberg earned his bachelor's degree from Willamette University. He graduated from the University of Washington School of Medicine and completed his family practice residency at North Colorado Medical Center.

Dr. Solberg is a member and past President of Washington Academy of Family Physicians. He has been active in issues of Care Transformation for many years.

GCACH Project Team: Transitional Care

[Gail Park Fast, RN, MN, NCSN,](#)

Gail currently serves as the School Nurse Corps Nurse Administrator at ESD 105 in Yakima. In this role she manages a state grant to provide funding support for school nursing services in several small, rural school districts with demonstrated need and consultation and technical assistance related to school based health services for staff in all 25 school districts within the ESD. She also is an ACEs awareness trainer for schools, colleges and community groups.

GCACH Project Team:

Bi-Directional Integration of Physical & Behavioral Health
Reproductive, Maternal & Child Health

[Heidi Desmarais, RDH, BA, MSDH](#)

Heidi Desmarais has been a clinical dental hygienist since 1995, serving in general and specialty practice capacities, such as periodontics and public health dental hygiene. Her dental hygiene education was awarded from Shoreline Community College, her bachelor's degree from University of Washington, and she is currently attending Eastern Washington University's Master of Science in Dental Hygiene program. As co-chair of the Oral Health committee, Heidi has helped to develop and present to the Washington State Healthcare Authority a dental hygiene-based access model inclusive of telehealth technology, as successfully utilized by states such as California and Oregon. Heidi is a member of the American Dental Hygienists Association, Washington State Dental Hygienists Association, American Dental Education Association, Association of State and Territorial Dental Directors, the Washington State Oral

Health Coalition, the Benton-Franklin Oral Health Coalition, and the Greater Columbia Accountable Community of Health.

GCACH Project Team: Access to Oral Health Services

[Hugh Straley, MD, TAC \(Technical Advisory Committee\) Member](#)

Dr. Hugh Straley has four decades of experience as a clinician and healthcare executive. In 2015, Dr. Straley was appointed by Washington Governor Jay Inslee to serve as Chair of the Dr. Robert Bree Collaborative, a group that makes evidence-based recommendations on healthcare topics. After a long career at Group Health (now Kaiser Foundation Health Plan of Washington) in Seattle, Dr. Straley served as Chief Medical Officer for Soundpath Health, a regional organization of local physicians founded for the purpose of providing quality medical care to Medicare beneficiaries, from 2009 to 2011. Prior to retiring as President of Group Health Cooperative and Medical Director for Group Health Physicians in 2008, Dr. Straley held several positions within the Group Health organization, including Associate Medical Director for Quality and Research, Assistant Chief of Staff for Specialty Services, Director of Hospice, and Chief of Oncology. He currently serves on the Healthier Washington Health Innovation Leadership Network Clinical Engagement Accelerator Committee; the Washington Health Alliance Quality Improvement Committee, where he is a past Chair; and YouthCare, where he is a past President. He a former member of the Group Health board of trustees. He has held seats on the board of directors for the Puget Sound Health Alliance, the Washington State Medical Association and the Foundation for Medical Excellence. He also served as a Surveyor for the National Committee for Quality Assurance from 1995 to 2002. In 2004, Dr. Straley received the Robert H. Williams Leadership Award from the Seattle Society of Internal Medicine for outstanding leadership in the community. After receiving a Bachelor's degree from Yale University, Dr. Straley earned his MD from the University of Washington in Seattle. He completed both his residency and fellowship in hematology/oncology at the University of Washington, and is board certified in both internal medicine and medical oncology. He also holds a Certificate in Medical Management from the University of Washington School of Public Health. Dr. Straley joined the Qualis Health Board in 2009.

[Jeffrey Allgaier, M.D. FACEP](#)

Dr. Jeffrey Allgaier is the President and Chief Executive Officer of Ideal Option, a highly specialized evidence based counseling agency for patients with addiction and dependence on substances of all kinds. Ideal Option is certified by the Washington State Division of Behavioral Health and Recovery, and is run by physicians who are double Board Certified in both Addiction Medicine and Emergency Medicine. Dr. Allgaier received his Doctor of Medicine Degree at Wake Forest University School of Medicine, and did his Emergency Medicine Residency at Maricopa Medical Center in Phoenix, AZ.

GCACH Project Team: Addressing the Opioid Use Public Health Crisis

[Jim Jackson, LICSW](#)

Jim Jackson is a licensed clinical social worker with 25 years' experience in clinical and administrative positions serving persons with behavioral health disorders. Formerly of the Pierce County Regional Support Network, Jim has experience in correctional mental health, crisis service operations, mental health residential services, and integrated care in a primary care setting. Jim is currently working for the Washington State Division of Behavioral Health and Recovery as the Department of Social and Health Services (DSHS) liaison to Accountable Communities of Health and DSHS Connector for the Healthier Washington initiative.

GACH Project Team: Bi-Directional Integration of Physical & Behavioral Health

[Jocelyn Pedrosa, MD](#)

Jocelyn Pedrosa, MD is the Chief Medical Officer of YNHS, having started her professional career with this Community Health Center in 1996 after completing her residency in Pediatrics from the University of Illinois at Chicago, and her Doctor of Medicine from the University of the Philippines, College of Medicine in Manila in 1991.

Dr. Pedrosa oversees a clinical staff of inter-disciplinary providers and support staff in the areas of primary care, behavioral health, pharmacy, nutrition services, outreach and housing to support patient centered care for all the center's patients, and particularly special needs agricultural workers, homeless, and residents of public housing in Yakima County. YNHS has eight primary care sites, in metropolitan and rural settings in the Yakima Valley, including one mobile medical unit to serve rural communities without public transportation. Neighborhood Health Services is Joint Commission Accredited, and was the first Community Health Center in Washington State to achieve NCQA Level 3 Patient Centered Medical Home Recognition in 2011.

GCACH Project Team: Addressing the Opioid Use Public Health Crisis

[Governor John Kitzhaber, TAC \(Technical Advisory Committee\) Member](#)

Governor Kitzhaber was born in Colfax, Washington, and graduated from Dartmouth College with a B.A. degree, earning his M.D. from Oregon Health & Science University. Dr. Kitzhaber began his career as an emergency physician before he was elected to the Oregon House of Representatives in 1978. After his first tenure as governor, Kitzhaber became the director of the Center for Evidence Based Policy at the Oregon Health & Science University, served as the executive chair and president at both the Foundation for Medical Excellence and the Estes Park Institute, and founded the health care advocacy group the Archimedes Movement.

[Karla Green, RN, BSN](#)

Karla Greene is a board certified emergency nurse and board certified pediatric emergency nurse with over 20 years' experience. She has worked as a staff RN and has taught first year nursing students as well. Karla currently works coordinating Prosser Hospitals' innovative Community Paramedic Program. Karla has been involved in the ED Transitions workgroup and has a passion for bringing healthcare to those in rural Washington state.

GCACH Project Team: Diversion Interventions

[Kathy Story, BS, RDH](#)

Kathy Story has 35 years' experience in the oral health field as a private practice clinician, educator, and as a public health clinician, coordinator and advocate. She has worked on mobile units, created and coordinated off-site screening programs and data survey projects. She has co-authored a community educational and preventive program used in dentally high-risk communities.

GCACH Project Team: Access to Oral Health Services

[Keith Watson, DO, President, Pacific Northwest University of Health Sciences](#)

With over 30 years of experience in medical education and policy, Dr. Watson serves as president of a health sciences university focused on educating primary care physicians who will return to practice in the rural and underserved areas of the Pacific Northwest. Through his participation on the Council on Graduate Medical Education, Dr. Watson advised national policy makers on legislative bills that affect medical students and practicing physicians.

[Kevin Martin, M.D., Medical Director for Community-Based Care Services., Kittitas Valley Healthcare](#)

In Kevin Martin's 19 years practicing family medicine in the state of Washington, he has been involved in medical directorship, leadership, and a wide range of quality improvement initiatives starting with the first Washington State Diabetes Breakthrough Collaborative in 1999. A relative new-comer to Central Washington, his current role focuses on population health, support for individuals aging in place, and championing innovation and quality improvement in home health, hospice, and long-term care across the county. A large part of this work involves working with many stakeholders in the community who share the goals of improving care and communication across transitions, improving care by reducing unnecessary emergency department and hospital utilization, and supporting individuals with appropriate care in the least restrictive setting possible.

GCACH Project Team:

Community-Based Care Coordination
Transitional Care

[Lee Ostler , DDS, TAC \(Technical Advisory Committee\) Member](#)

Dr. Ostler is a graduate of the University of Washington School of Dentistry. Following three years as a clinic director with the Public Health Service he established his private practice 27 years ago here in Richland Washington. He has received advanced training at the Las Vegas Institute for Advanced Dental Studies and has been a clinical instructor there teaching dentists from around the world the advanced techniques required for modern dentistry. He has also been a clinical instructor at the Baylor University and University of Kentucky Lexington post-graduate aesthetic dentistry continuums. Despite his extensive background Dr. Ostler is committed to understanding the needs and desires of each patient. He takes the time to get to know each and every patient one on one, helping you make an informed choice regarding your dental needs. While creating personalized smiles he prides himself in providing the best dentistry has to offer.

When he's not practicing dentistry, his calendar is full of traveling and speaking engagements around the country. He is passionate about educating other health care professionals regarding the connection between the mouth and body.

[Liz Whitaker, BSN, MN, RN](#)

Liz is the Community Health Supervisor at Kittitas County Public Health, where she oversees communicable disease, vaccination, and harm reduction programs. She has particular interest in maternal and child health issues, and experience in perinatal nursing and home visiting as well as her current public health duties.

GCACH Project Team: Addressing the Opioid Use Public Health Crisis

[Malvina A. Goodwin, RD, CDN, Supervisor – Healthy People & Communities](#)

Malvina “Annie” Goodwin graduated from WSU with a degree in Nutrition and is a Registered Dietitian Nutritionist at Benton-Franklin Health District. Annie has worked in the WIC program for 39 years, 34 of those years at the Health District. In 2008 she received the Washington State Academy of Nutrition and Dietetics Community Nutrition Award for Excellence.

Annie currently supervises the WIC program at the district as well as Oral Health, Injury prevention and clerical services. She has experience working with nutrition issues for children with special needs, and has co-authored a chapter on Congenital Health Disease for a Department of Health publication.

GCACH Project Team: Access to Oral Health Services

[Mandee Olsen, RN, Director of Quality and Risk Management](#)

Mandee Olsen is the current Director of Quality and Risk Management for Kittitas Valley Healthcare in Ellensburg, WA. She is a member of the Rural Patient Safety Sub-Committee through the Washington State Hospital Association, and a member of the National Association for Healthcare Quality.

GCACH Project Team: Transitional Care

[Mark Koday DDS, Chief Dental Officer – Yakima Valley Farm Workers Clinic](#)

Dr. Mark Koday has served as the Chief Dental Officer for the Yakima Valley Farm Workers Clinic in Toppenish, WA since 1986. His distinguished career includes employment in the U.S. Public Health Service Commissioned Corps, Director of the Northwest Dental residency program, and Founder and Manager of Dental Quality Consulting of Washington LLC. Dr. Koday graduated from the Indiana University School of Dentistry where he received his Doctor of Dental surgery in 1978, and went on to receive his AEGC Residency Certificate of Completion at the Naval Dental School in Bethesda, Maryland. He is the current Chair of the Yakima Valley Inter-professional Practice & Education Collaborative Advisory Committee, and serves on a number of other technical and professional dental boards and associations.

GCACH Project Team: Access to Oral Health Services

[Michael Maples, MD, CEO – Community Health of Central Washington](#)

Dr. Maples is the CEO of Community Health of Central Washington. CHCW provides medical, behavioral and oral health services to 30,000 residents of central Washington State. Dr. Maples has worked to improve primary care in Yakima and the region for over thirty years – beginning as family doctor (1983), developing and directing the Central Washington Family Medicine Residency program (1993), expanding service as a community health center (beginning in 2003), and joining the PNWU Board of Trustees (2005). His wife, Dr. Marjorie Henderson, practices physical medicine and rehabilitation. They have two sons, both of whom currently reside on the other coast.

GCACH Project Team: Access to Oral Health Services

[Miguel Messina, MS, LMHC](#)

Miguel Messina, MS, LMHC, recently joined Comprehensive Healthcare as a Vice President of Substance Abuse and Co-occurring disorders. He brings 18 years of professional experience in the treatment of chemical dependency and behavioral health. His experience includes the clinical, educational and leadership areas. Mr. Messina has experience providing services in different modalities, which include crisis stabilization/detox, short-term residential, long-term residential, therapeutic communities, outpatient and intensive outpatient as well as different population, adults, women and adolescents. He demonstrates a passion in working with culturally diverse populations, including those whose primary language is Spanish.

Mr. Messina promotes a holistic approach to treatment particularly, in the understanding of how attachment, traumatic events, and stress conduce to the development of addictions and other behavioral health problems. He considers of great importance, addressing the entire person in treatment, promoting health and well-being, strengthening relationships and assisting individuals in becoming productive in their communities, as an effective recipe in the

recovery process. At the present time Mr. Messina is a full-time, third year student at University of the Rockies in their Psy. D. program with a concentration in Organizational Leadership. His practice and academic interest lies in the understanding how leadership plays a role in mitigating the factor in the prevention and management of organizational trauma. An additional practice and academic interest relate to the integration of healthcare systems particularly in the areas of chemical dependency and behavioral health disorders.

GCACH Project Team: Addressing the Opioid Use Public Health Crisis

[Rick Helms, MSW, Operations Manager, Practice Transformation Support Hub, Qualis Health](#)

Rick Helms is a clinical social worker by training, and joined Qualis Health with a diverse background in healthcare administration, including 10 years of experience managing academic, nonprofit and managed care operations. His most recent position was with the University of Nebraska Medical Center where he led operations for integrating academic practitioners into community settings. His prior positions include managing provider relations for a managed care organization. Rick lives and works in Seattle.

GACH Project Team: Bi-Directional Integration of Physical & Behavioral Health

[Shawnie Haas, RN, MBA, President and CEO, SignalHealth](#)

Shawnie Haas is the President and Chief Executive Officer for SignalHealth. SignalHealth is a clinically integrated network in Central Washington, representing more than 500 combined providers. SignalHealth operates in pursuit of the Quadruple Aim through commercial, Medicare and Medicaid arrangements.

GCACH Project Team:

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[Susan Campbell, MN, RN, CNE, Faculty, RN-BSN Program, Columbia Basin College, Health Science Center](#)

Susan has enjoyed a full career with experiences in hospital based nursing, community health, and education. She values life-long learning and looks forward to learning from all of her students. She currently works with students in the first semester of the nursing program and in their last semester. She provides leadership for the students in the Tri Cities as the Assistant Director.

GCACH Project Team: Community-Based Care Coordination

[Stein Karspeck, Medical Program Officer, Richland Fire and Emergency Services,](#)

Stein Karspeck has over 25 years of EMS experience. Stein served in the armed forces as a combat field medical specialist early in his career then began working in the private industry as a Paramedic. Currently Stein is the Medical Program Officer for Richland Fire and Emergency Services, and is working to build high quality and sustainable emergent and non-emergent medical care models for municipal Fire Department based EMS systems.

GCACH Project Team: Diversion Interventions

[Thatcher Felt DO FAAP, Yakima Valley Farm Workers Clinic](#)

Thatcher Felt is a pediatrician of eleven years at a rural community health center in Grandview Washington. He serves as a Trustee for the Washington Chapter of the American Academy of Pediatrics (WCAAP). His role in the Greater Columbia ACH is to function as the physician champion for WCAAP’s Pediatric Transforming Clinical Practice Initiative (P-TCPI).

Workforce and Additional Subject Matter Experts

[Alicia Bissonnette, MPA](#)

Alicia Bissonnette is a project coordinator for Molina Healthcare. She is a current graduate student at Seattle U, obtaining her Masters degree in Public Administration with a focus on governmental policy. Alicia’s experience in healthcare has generally been from the care-taking or policy perspective, from working as a unit floor secretary as a young adult, and working on healthcare policy in her early twenties. Previous to working at Molina, she worked as an organizer and an advocate. Alicia is the go-to person at Molina for scheduling and people-finding purposes.

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Chronic Disease Prevention & Control

[Angelina Thomas, MHA](#)

Angelina Thomas has worked with community non-profits for almost a decade and is currently serving as an operations manager in Behavioral Health Services for the Yakima Valley Farm Workers Clinic in Yakima, WA. She made the transition to health administration while in her residency as a clinical mental health counselor graduate student as she was inspired to help

improve our care delivery system. She currently serves as one of the Project Team Facilitators on the Bi-Direction Integration of Physical and Behavioral Health Project Team.

GCACH Project Team: Bi-Directional Integration of Physical & Behavioral Health

[Bertha Lopez, MBA, Senior Director Community Health/Children’s Village Interim Director](#)

Bertha is responsible for the leadership and operations of the Community Health Department, Diabetes Education, Pediatric Therapy Services, Maternal Health Services, Environmental Sustainability, Health Equity, Community Benefit and Needs Assessment for Virginia Mason Memorial Hospital. She has extensive public health and research experience focused on health disparities, community engagement, health promotion, and population health. Bertha received her MBA from the University of Washington, Foster School of Business, and has received education from the UW School of Public Health. Her passion is addressing health disparities and currently serves on the UW Latino Center for Health Research Board, and Healthier Washington’s Communities and Equity Accelerator Committee.

GCACH Project Team:

Addressing the Opioid Use in Public Health
Chronic Disease Prevention & Control

[Caitlin Safford](#)

Caitlin Safford began her career as a grassroots community organizer, helping school districts statewide implement improved health education policies. From there, she joined the state Department of Health, working on policy for their adolescent health and family planning programs before moving to the agency’s Office of the Secretary to work on policy and communications for Health Systems Transformation and Innovation. Her knowledge of the Innovation work and public health led to her moving into the Medicaid managed care health plan-side of the system. She started at Amerigroup as their Director of External Affairs and Community Development, which included serving as Amerigroup’s primary representative in all 9 ACHs across the state and to HCA for all of their Transformation activities. In March 2017, she added legislative and political affairs to her responsibilities and became the Director of Government Relations for the Washington health plan.

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[Dan Ferguson, MS, Director, WA State Allied Health Center of Excellence](#)

Dan Ferguson has over thirty years of experience in higher education, non-profit management, health care and human services. In Dan's current role as the Director of the Washington State Allied Health Center of Excellence, he is working to assist the community college system in understanding and adapting to the health care workforce changes due to the affordable care act.

[Elissa Southward, Ph.D.](#)

Elissa Southward earned her Ph.D. and Masters degrees at the University of Bristol, United Kingdom, in Exercise and Health Sciences. She currently serves as the Community Health Supervisor at Virginia Mason Memorial Hospital in Yakima, WA. Prior to her employment at Virginia Mason Memorial, Ms. Southward was the Manager for Health Communities for the Rails-to-Trails Conservancy in Oakland, CA, and Washington DC. Professional Memberships.

GCACH Project Team:

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[Grant Baynes](#)

Grant joined Senior Life Resources NW Inc. in March 2015. He retired as the City of Richland Fire Chief after over 35 years in the fire service, in various positions and ranks.

His education includes an MPA, BA, M. Institute of Fire Engineers, Diploma of Teaching, and Executive Fire Officer.

Grant has served on the Washington Fire Chiefs Board of Directors, Kadlec Foundation Board of Trustees, and the Washington State Fire Defense Committee. Today, he is active as the Treasurer on the Columbia Basin Dive Rescue Board of Directors, the Board of Directors for Chaplain Services Network, the Benton Franklin Care Transition Coalition Steering Committee, and the Tri-Cities Patient Safety Coalition.

His focus is on the coordination of community-based programs that preserve and enhance the quality of life of seniors and other vulnerable adults, through collaboration and innovation.

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Jay Henry, MHA, Partner at Tenfold Health

Jay Henry came into his career in healthcare on a stretcher. A patient experience in the 1980's left an indelible impression on him that deep and broad change was needed across this most personal of industries. He has enjoyed serving as CEO of small and large hospitals and health delivery systems of up to \$1B in annual revenues. His executive experience includes organizations like St. Charles Health System, Mid-Columbia Medical Center, and Memorial Hospital. His leadership in these organizations has been focused on making bold leaps forward through aligned teams, creative thinking, and operational excellence. A few select highlights include:

- Top 5% in the nation for Clinical Excellence
- 99th percentile physician satisfaction
- Dartmouth Atlas recognition as a top performing region of the nation
- 98th percentile nationally for Case Mix Adjusted ALOS

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Kat Ferguson-Mahan Latet

At CHPW, as the Manager of Health System Innovation, Kat Ferguson Mahan Latet works to ensure the plan is on the leading edge of health systems innovation and transformation. Ms. Latet leads value based payment and care strategies with a cross departmental team design. Through this work, Ms. Latet is working to establish the plan's value statement as we shift into a world where more risk is placed on providers. Additionally, Ms. Latet works with CHPW teams to align efforts, so contracts are synergistic and encourage collaboration across all provider types. Ms. Latet acts as a liaison for many of the Washington's transformation efforts for CHPW, including the Accountable Communities of Health and the Medicaid Demonstration. Ms. Latet manages the engagement and staffing strategy for CHPW's participation in ACHs and Demonstration efforts. Prior to her role at CHPW, Ms. Latet was a Senior Health Policy Analyst with Washington's Health Care Authority. She led design, development and implementation of health system transformation policy and programs, including the State Health Care Innovation Plan, subsequent State Innovation Models Test Grant, FQHC Alternative Payment Methodologies and the Medicaid Transformation Waiver. Before moving to Washington, Ms.

Latet worked in Oregon as the policy lead for the Oregon Primary Care Association working specifically in design and development of the Coordinated Care Organizations at a statewide and local level. She also managed its 501c4 organization sister, Community Health Advocates of Oregon. Before moving to Portland, Ms. Latet worked in Chicago in education policy and political campaigns. She also served in the Peace Corps in Romania.

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[Kayla Down](#)

Kayla Down began her career in health services and policy with an undergraduate education focused on medical anthropology and global health. While pursuing her degrees, Kayla focused on HIV/AIDS prevention and treatment awareness campaigns in sub-Saharan Africa, drawing parallels between continents on issues related to access, policy, education and community organization. Kayla joined the Health Care Authority's Healthier WA team as a community transformation specialist immediately after graduate school, working exclusively with the Accountable Communities of Health. Much of her time at HCA was spent with ACHs directly, navigating the intersections of Healthier WA work with concurrent regional and statewide health activates. Kayla's time at HCA made for a nice transition to the managed care side of the system, where she is the Manager of Health Policy & External Relations for Coordinated Care.

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[Mary Franzen, MPH](#)

Mary Franzen is a Quality Improvement Consultant at Qualis Health, the Medicare-funded Quality Improvement Organization for Washington and Idaho. She works with practices and facilities throughout the state to improve clinical outcomes and reduce hospital readmissions, with a focus on under-served patient populations.

GCACH Project Team: Transitional Care

[Mike Bonetto ,MPH, PhD, Partner at Tenfold Health](#)

Mike Bonetto has a unique portfolio of over 20 years of health care strategic planning and policy experience. He was previously the Chief of Staff and Senior Health Policy Advisor in the Oregon Governor’s Office – where he helped lead the transformation of the state’s Medicaid program. Prior to that he served as Vice President of Business and Community Development at St Charles Health System in Bend, OR; Senior Vice President at ZoomCare in Portland, OR; Senior Vice President of Planning & Development for Clear Choice Health Plans in Bend, OR; Director of the Oregon Health Policy Commission; Senior Policy Advisor to the Oregon Senate Republican Caucus; and Policy Analyst for the Oregon Insurance Pool Governing Board.

Mike received a Ph.D. in health policy and MPH from Oregon State University, an MS from California State University, Fullerton, and a BA from Occidental College. He lives in Bend, OR with his wife and three children and enjoys everything the Central Oregon region has to offer.

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[Mike Norton- Vice President Comprehensive Healthcare](#)

6 years- leadership at Comprehensive Healthcare. 10 years’ service on Board of Directors. Experience in business, program development and marketing.

GCACH Project Team: Addressing the Opioid Use Public Health Crisis

[Sierra Knutson](#)

Sierra Knutson is the Homeless Program Coordinator with Walla Walla County Department of Community Health. In this role, Sierra helps coordinate with local agencies to make sure individuals facing homelessness have the help they need and are connected with appropriate resources within the community. Sierra is local Walla Walla native who enjoys the outdoors, reading, and her fur babies. She has a Bachelor’s degree of Science in Psychology from Washington State University. Sierra has been a social worker serving individuals struggling with behavioral health issues and homelessness the last 5 years.

GCACH Project Team: Transitional Care

[Sue Jetter, MPA, GPC](#)

Sue Jetter, owner of Sue Jetter Consulting Services, has more than 20 years of experience in the grants profession. Initially working in a variety of non-profit social services agencies, she has worked on developing and/or managing dozens of projects including capital facilities, community infrastructure, recreation, domestic violence prevention and community paramedicine.

Sue holds a B.A in Music Therapy from Colorado State University, and a Master's Degree in Public Administration from California State University at Bakersfield. She is Grant Professional Certified by the Grant Professionals Certification Institute, Inc., and serves on the Board of the Grant Professionals Association. Self-employed for 12 years, the majority of Sue's time is spent working with a partnership of municipalities and agencies in rural eastern Washington.

GACH Project Team: Bi-Directional Integration of Physical & Behavioral Health

[Stan Ledington MPH, DrPH – Executive Director, The Health Center](#)

Dr. Ledington is the executive director of The Health Center. The Health Center operates school based health clinics serving unmet needs of Walla Walla Students with integrated primary and behavioral health care. Dr. Ledington was the Administrative Director of Imaging, Cardiology, Rehab and Wellness at Walla Walla General Hospital for 14 years prior to accepting The Health Center Executive Director position in 2014. He was also director of Health Sciences programs and an associate professor of Health and Physical Education at Walla Walla University from 1992 to 1999.

GCACH Project Team: Reproductive, Maternal & Child Health

[Virginia Janin, M.S., Local Program Coordinator, Southeast Washington Aging & Long Term Care](#)

Virginia Janin has worked for over twenty years Coordinating In-Home Programs and Services for the Aging and Disabled Populations. As Local Program Coordinator with Southeast Washington Aging & Long Term Care, Virginia works with Community Partners to promote Health and Wellness to vulnerable people, oversees Medicaid In-Home Care Programs, and strives for providing the right care, at the right time, in the right setting.

GCACH Project Team: Transitional Care

Clinician Experience Overview

Domain 2: Care Delivery Redesign

2A

Bi-Directional Integration of Physical & Behavioral Health

Gail Park Fast, RN, MN, NCSN
School Nurse Corps Nurse
ESD 105

Dr. Amy Person, MD
Health Officer
Benton-Franklin Health District

Jim Jackson, LCSW
DSHS Liason to ACH's
Washington State
Behavioral Health

Brian Sandoval, PsyD
Director of the
Primary Care Behavioral Health
Yakima Valley Farm Workers Clinic

Rick Helms, MSW
Operations Manager
Qualis Health

Rhonda Hauff, MPH, MSW
COO & Deputy CEO
Yakima Neighborhood
Health Services

2B

Community-Based Care Coordination

Virginia Janin, MS
Program Coordinator
SE Washington Aging
& Long Term Care

Susan Campbell, MN, RN, CNE
Clinical Instructor
Columbia Basin College

Dr. Kevin Martin, MD
Medical Director
Kittitas Valley Healthcare
Community Based Care Services

Dr. Diane Liebe, MD
Medical Director
Children's Villiage (YVFWC)

Shawine Haas, RN, MBA
President & CEO
SignalHealth

2C

Transitional Care

Shawnie Haas, RN, MBA,
President and CEO
SignalHealth

Virginia Janin, MS
Program Coordinator
SE Washington Aging
& Long Term Care

Grant Baynes
Executive Director
Senior Life Resources

Mandee Olsen, RN
Director of Quality
& Risk Management

Dr. Kevin Martin, MD
Medical Director

Dr. Don Solberg, MD
Chief Medical Officer

Kittitas Valley Healthcare

Dr. Elissa Southward, PhD
Community Health Supervisor
Virginia Mason Memorial Hospital

Mandy McCollum, BSN
Consistent Care Services

2D

Diversion Interventions

Stein Karspeck, EMT-P
Medical Program Officer
& Captain Paramedic
Richland Fire &
Emergency Services

Karla Greene, RN, BSN, CEN, CPEN
Community Paramedic
Nurse Case Manager
PMH Medical Center

Shawnie Haas, RN, MBA
President and CEO
SignalHealth

Dr. Elissa Southward, PhD
Community Health Supervisor
Virginia Mason Memorial Hospital

Dr. Darin Neven, MS, MD
President, Founder, CEO
Consistent Care Services

Clinician Experience Overview

Domain 3: Prevention and Health Promotion

3A

Addressing the Opioid Use Public Health Crisis

Becky Grohs RN, BSN, CCM
Program Coordinator
Consistent Care Services

Dr. Jeffrey Allgaeir, MD
President and Chief Executive Officer
Ideal Option Counseling

Dr. Jocelyn Pedrosa, MD
Chief Medical Officer
Yakima Neighborhood Health Services

Liz Whitaker, BSN, MN, RN
Community Health Supervisor
Kittitas County Public Health

3B

Reproductive, Maternal, & Child Health

Gail Park Fast, RN, MN, NCSN
School Nurse Corps Nurse
ESD 105

Dr. Amy Person, MD
Health Officer
Benton-Franklin Health District

Carla Prock, RN
Senior Manager
Benton-Franklin Health District

Dr. Stan Ledington, DrPh
Executive Director
The Health Center
Walla Walla

3C

Access to Oral Health Services

Dr. Michael Maples, MD
CEO
Community Health of Central Washington

Malvina A. Goodwin, RD, CDN
Supervisor
Healthy People & Communities

Susan Campbell, MN, RN, CNE
Clinical Instructor
Columbia Basin College

Dr. Mark Koday, DDS
Chief Dental Officer
Yakima Valley Farm Workers Clinic

Heidi Desmarais, RDH, BA, MSDH
Assistant Professor, Dental Hygiene
Benton-Franklin Health District

Kathy Story, BS, RDH
Community Member

3D

Chronic Disease Prevention & Control

Dr. Don Ashley, MD
Medical Consultant
Health and Recovery Services Administration

Dr. Amy Person, MD
Health Officer
Benton-Franklin Health District

Project Team Facilitator Overview

2A

Bi-Directional Integration of Physical & Behavioral Health

Rhonda Hauff, MPH, MSW
COO & Deputy CEO
Yakima Neighborhood
Health Services

Angelina Thomas, MHA
Yakima Valley Farm Workers Clinic

Brian Sandoval, PsyD
Director, Primary Care
Behavioral Health
Yakima Valley Farm Workers Clinic

3A

Addressing the Opioid Use Public Health Crisis

Becky Grohs RN, BSN, CCM
Program Coordinator
Consistent Care Services

Everett Maroon
Executive Director
Blue Mountain Heart to Heart

2B

Community-Based Care Coordination

Jorge Rivera, MBA
Director, Community Engagement
Molina Healthcare

3B

Reproductive, Maternal, & Child Health

Carla Prock, RN
CSHCN Coordinator
Benton-Franklin Health District

Stan Ledington, DrPh
Executive Director
The Health Center
Walla Walla

2C

Transitional Care

Dr. Kevin Martin, MD
Medical Director
Kittitas Valley Healthcare
Community Based Care Services

Mandy McCollum, BSN
Consistent Care Services

3C

Access to Oral Health Services

Heidi Desmarais, RHD, BA, MSDH
Assistant Professor, Dental Hygiene
Benton-Franklin Health District

Dr. Mark Koday, DDS
Chief Dental Officer
Yakima Valley Farm Workers Clinic

2D

Diversion Interventions

Karla Greene, RN, BSN, CEN, CPEN
Community Paramedic
Nurse Case Manager
PMH Medical Center

Stein Karspeck, EMT-P
Medical Program Officer
& Captain Paramedic
Richland Fire &
Emergency Services

3D

Chronic Disease Prevention & Control

Bertha Lopez, MBA
Health Outreach Manager
Virginia Mason Memorial

Fenice Fregoso, BSW
Community Engagement
Coordinator
Molina Healthcare



Greater Columbia Accountable Community of Health (GCACH)

SUBJECT: Sector Representation Policy

Policy #: 2017-011

Version Date: October 26, 2017

Policy adopted by the GCACH Board of Directors by resolution on:

Purpose:

The purpose of this policy is to define the expectations of Directors who are representing their sectors on the Board of Directors for Greater Columbia Accountable Community of Health.

Definitions:

"Sector" – a category of organizations, governments, businesses and/or individuals who share the same or related mission, product or service within the GCACH regional service area. (For example, Social Services, Hospitals, Providers, Workforce, Transportation, Federally Qualified Health Centers, Philanthropy, Housing, Community Based Organizations, Consumer Representative, Public Health, Managed Care Organizations)

"Stakeholder" - Stakeholders are those entities in the organization's environment that play a role in an organization's health and performance or that are affected by an organizational action. Stakeholder can mean different things to people in the healthcare system. The Agency for Healthcare Research and Quality has defined "stakeholders" as persons or groups that have a vested interest in a clinical decision and the evidence that supports that decision. Stakeholders may be patients, caregivers, clinicians, researchers, advocacy groups, professional societies, businesses, policymakers, or others.

Background:

Per the GCACH Bylaws, Board members are nominated by the Leadership Council based on sector representation, then vetted by the Board of Directors. Sector representation should be based on the needs and health issues of the consumers and stakeholders within the region that need advocacy at the Board level. Representation by various sector organizations is a directive of the Health Care Authority (HCA) who has determined that the ACH decision-making body must include voting partners from seven categories including: primary care, behavioral health, health plans, (MCOs), hospital or health system, local public health jurisdiction, Tribe/IHS facilities, and community based partners. At least 50% of the Board must be non-clinical, non-payer participants. * Broad sector representation provides more opportunity for cross-sector viewpoints and perspectives to be shared, precludes domination of the decision-making process by clinicians, and encourages the ACH to take health equity and social determinants into account when selecting projects for funding.

Sector representatives are chosen for their knowledge, leadership, and individual expertise in their Sectors. Together, these Sectors represent the Board's values and perspectives that enhance the ability of the Board to act as a body, rather than to promote individual or organizational interests.

Policy:

Sector representatives have established networks of co-workers, subject matter experts, and affiliations with professional organizations, and therefore have access to a wide audience of stakeholders within

their fields. ***It is the expectation that Board Sector representatives be a conduit for feedback between and on behalf of their Sectors.***

The sharing of information ensures a more transparent decision making process when all Sectors of the regional service area and their stakeholders are informed of GCACH issues, and when opportunities for gathering community input are widely known. ***It is the expectation that Board members will distribute pertinent information regarding GCACH activities and events, and especially when gathering community input on decisions that will come back to the Board for final rulings. On special occasions, Board members will be expected reach out to their affiliates and stakeholders when it serves the greater purposes of the organization.***

Critical Decisions for the ACHs rest with the governing body regarding member selections for committees, project design, project selection, partner selection, and fund allocation processes to name a few. ***It is the expectation of the Sector representatives to ensure their constituents and stakeholders are informed of critical decisions, especially when it is for their shared benefit.***

Cross-County Representation:

As much as possible, Sector and Board positions will be reflective of the Counties that are in the GCACH service area. Attempts will be made to have every County represented on the Board of Directors. As positions are rotated out, or if Board members have to resign during their tenure, Counties lacking Board participation will be offered Sector positions first. If representation cannot be found through this process, the Board of Directors reserves the right to fill a vacancy in order to fill Board positions.

Board Vacancies:

Board members are responsible for identifying and forwarding Sector candidates to the Board to fill vacant positions.¹ Vacancies occurring on the Board may be voted on and ratified at any regular or special Board meeting by the remaining Directors. Newly elected Directors shall serve the remaining term of the vacant position. (GCACH Bylaws Article IV, Board of Directors - Duties and Principles, Section 11, page 6.) If representation cannot be found through this process, the Board of Directors reserves the right to fill a vacancy in order to fill Board positions.

Sector Representation In Greater Columbia ACH



*Developing Effective ACH Governance; TA Resource, May 2017

GCACH Project Initiative Selection Criteria

Project Name:

Reviewer Name:

Category	Reviewer Score: 1-5	Proposed	Weight	Weighted Score	Comments
1 Support		Does local leadership and community (consumers) have energy around the project proposals?	5%	0.00	
2 Linkages		Does the project demonstrate linkages (i.e. how the project interacts with existing local organizations, particularly those tied to the social determinants)?	10%	0.00	
3 Impact		Does this project fit in and is it synergistic with other project areas within the Demonstration? With the Project Toolkit?	15%	0.00	
4 Sustainability		Does the project have a high likelihood of sustainability post-Demonstration (i.e. 2022 and beyond)?	15%	0.00	
5 ROI		Does the project have a high likelihood of maximizing DSRIP Incentive funds by increasing quality and/or lowering costs?	10%	0.00	
6 Equity		How well does the project address health inequities across the GCACH?	10%	0.00	
7 Alignment with Community Needs		Does the project align with the priorities that arose from the GCACH Regional Survey results, Regional Health Improvement Plan, Community Asset Inventory, and the goals of the Medicaid Demonstration Project? Does the project clearly identify target populations?	10%	0.00	
8 Measurement		Does the infrastructure exist to measure project process and outcomes so as to monitor project performance and provide for improvement?	10%	0.00	
9 Workforce		How will existing workforce be leveraged for project implementation? What strategies be used to address any gaps?	5%	0.00	
10 General Compliance & Implementation		Does the project adopt an evidence-based model and align with other Project Toolkit requirements? Does this project have a well-structured implementation plan? Does the project contemplate adequate partnering providers needed to support successful implementation?	10%	0.00	

100% - of 5.0

Please use the section below to provide any additional comments about this project area. Feel free to suggest anything you find appropriate

Category	Reviewer Score: 1-5	Proposed	Weight	Weighted Score	Comments
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Category	Reviewer Score: 1-5	Proposed	Weight	Weighted Score	Comments
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GCACH Community Engagement

DATE	Event/Organization	Topic	Place	Role
1/5/2017	State of Reform (Statewide)	A Survey of ACH Activity in 2017	Seattle	Carol Moser, Panelist
1/19/2017	GCACH Governing Board & Leadership Council Meetings	GCACH Monthly Meeting	Kennewick	GCACH Staff
2/14/2017	Washington Health Alliance and Qualis Health Forum	Disparities in Care	Seattle	Carol Moser, Panelist
2/16/2017	GCACH Governing Board & Leadership Council Meetings	GCACH Monthly Meeting	Pasco	GCACH Staff
2/21/2017	Tri-Cities Hispanic Chamber of Commerce	Greater Columbia ACH	Pasco	Carol Moser, Guest Speaker
3/11/2017	Medicaid Transformation Public Forum	Greater Columbia ACH Overview/Briefing	Kennewick	Carol Moser, Speaker
3/16/2017	GCACH Governing Board & Leadership Council Meetings	GCACH Monthly Meeting	Pasco	GCACH Staff
3/30/2017	Future of Healthcare in Washington	Accountable Communities of Health and the Future of Health Care	Renton	Carol Moser, Panelist
4/6/2017	Benton-Franklin League of Women Voters	Briefing – Greater Columbia ACH	Richland	Carol Moser, Guest Speaker
4/6/2017	SE WA Aging and Long-Term Care Council of Governments Board Meeting	Briefing on Greater Columbia ACH	Kennewick	Wes Luckey, Speaker and Carol Moser staff support
4/14/2017	Briefing with Tonya Kreis, Yakama Nation	Medicaid Transformation Demonstration Toolkit	Yakima	Carol Moser and Wes Luckey, private briefing with Tonya Kreis
4/19/2017	GCACH Governing Board Retreat	Presentation by Dr. John Kitzhaber	Prosser	Wes Luckey, Presenter
4/20/2017	GCACH Leadership Council Meeting	GCACH Monthly Meeting	Pasco	GCACH Staff
4/24/2017	Benton-Franklin Community Health Alliance Governing Board Meeting	GCACH Demographics and Health Measures	Kennewick	Carol Moser, private briefing with Benton-Franklin hospital CEOs
4/28/2017	SE Washington ACH Project Planning	Greater Columbia Overview of Project Selection Process and Data/Measures for SE Region	Clarkston	Carol Moser and Wes Luckey, Briefing with SE WA Health Network
5/10/2017	Governor's Interagency Council on Health Disparities	Briefing – Greater Columbia ACH and Disparities in Care	Yakima	Carol Moser and Wes Luckey, Guest Speakers
5/18/2017	GCACH Governing Board & Leadership Council Meetings	Director's Report & Agenda Items	Pasco	Carol Moser, Presenter
6/1/2017	Yakama Nation Health, Subset of Employment and Welfare Council	GCACH Strategy Presentation	Yakima	Carol Moser and Wes Luckey, private briefing with HEW Council
6/1/2017	Senior Staff Meeting, Virginia Mason Memorial	GCACH Strategy Presentation	Yakima	Wes Luckey and Carol Moser, private briefing with Sr. Staff of VMM
6/20/2017	Sunnyside Hospital CEO	Project Selection Process and Update on GCACH Activities	Sunnyside	Carol Moser private meeting with Brian Gibbons and hospital consultant
6/22/2017	GCACH Governing Board & Leadership Council Meetings	Director's Report & Agenda Items	Pasco	Carol Moser, Presenter
6/28/2017	ACH Convening	Health Equity Panel Discussion	Chelan	Carol Moser, panelist
7/10/2017	DSHS Workfirst Social Service Supervisor- Kennewick Community Services Division- Lana Stuart-Eskeli	Medicaid Transformation Project Demonstration & Project Selection Process	Kennewick	Carol Moser & Aisling Fernandez, Interviewers
7/19/2017	Benton County Democratic Central Committee	Overview of Medicaid Transformation Project Demonstration	Richland	Carol Moser, presenter
7/20/2017	GCACH Governing Board & Leadership Council Meetings	Director's Report & Agenda Items	Pasco	Carol Moser, Presenter
7/26/2017	Benton-Franklin Health District Board of Directors	Overview of Medicaid Transformation Project Demonstration	Kennewick	Carol & Wes, Presenters
7/26/2017	Benton-Franklin Community Health Alliance	Overview of Medicaid Transformation Project Demonstration	Richland	Carol & Wes, Presenters
8/2/2017	Ellensburg CSO / Goldendale CSO/ White Salmon CSO. Cindy Olgaard (WorkFirst/Social Services Supervisor) & Javier Diaz-Mendoza (Financial Supervisor)	Medicaid Transformation Project Demonstration & Project Selection Process	Conference Call	Aisling Fernandez, doing outreach
8/3/2017	BFCHA Oral Health Coalition	Medicaid Transformation Project - Oral Health Access	Kennewick	Carol, Wes, Stakeholder Input
8/4/2017	Yakima County Health Care Coalition	Common Themes and priority Issues	Yakima	Carol, Wes, William Van Noy, Stakeholder Input
8/4/2017	Yakima County Healthcare Coalition	Demonstration on DSRIP Calculator	Yakima	Carol, Wes, William Van Noy
8/4/2017	Yakama Nation GCACH Meeting with Councilman Frank Mesplie, Arlen Washines, Tonya Kreis	Discussion of Project Selection Process, Tribal Collaboration Policy, Funding for IT/HIE infrastructure, GCACH Board Training	Yakama Nation	Carol, Wes, William
8/7/2017	NW Rural Health Network Updates	Local Health Improvement Network, NWRHN	Conference Call	Carol Moser, Participant
8/9/2017	Tri-Cities Diabetes Coalition	Transformation Demonstration Project Plan Portfolio Discussion	Kennewick	Carol Moser, Wes Luckey, Stakeholder input
8/9/2017	CSOA - Toppenish CSO- Oscar Olney- DSHS	Medicaid Transformation Project Demonstration & Project Selection Process	Conference Call	Aisling, Interviewer

8/9/2017	Medicaid Consumer Focus Group	Feedback on Demonstration Projects	Pasco	Aisling, staff support
8/14/2017	Public meeting Benton and Franklin Counties - FIMC	Public Input on FIMC	Pasco	Carol Moser, Wes Luckey, Testified
8/15/2017	Kadlec Leadership Team	Kadlec Leadership Presentation on GCACH	Richland	Carol Moser, Wes Luckey, Presenters
8/17/2017	GCACH Governing Board & Leadership Council Meetings	GCACH Monthly Meeting	Kennewick	GCACH Staff
8/22/2017	Healthy Communities Coalition	Local Health Improvement Network Meeting	Dayton	Carol Moser, Wes Luckey, Participants
9/6/2017	SE WA ACH Planning Meeting	Local Health Improvement Network Meeting	Clarkston	Carol Moser, Wes Luckey, Participants
9/8/2017	Yakima County Health Care Coalition	Local Health Improvement Network Meeting	Yakima	Carol Moser, Wes Luckey (Called in)
9/13/2017	2017 Inland Northwest State of Reform Health Policy Conference	GCACH Transformation Update	Spokane	Carol Moser, Presenter
9/14/2017	Kittitas Valley Healthcare Network	Local Health Improvement Network Meeting	Ellensburg	Carol Moser, Board Member
9/15/2017	NW Justice Project	Listening Session with NWJP Attorney, J. Coulter	Pasco	Carol Moser, Wes Luckey, Participants
9/19/2017	GCACH Project Advisory Committee (PAC) Retreat	Project Alignment, Data, Target Populations	Prosser	Wes Luckey, Presenter
9/20/2017	Tri-Cities Community Health	GCACH update with R. Hill, CEO, TCCH	Pasco	Carol Moser, Wes Luckey, Participants
9/21/2017	GCACH Governing Board & Leadership Council Meetings	GCACH Monthly Meeting	Pasco	GCACH Staff
9/22/2017	Yakima County Healthcare Coalition	Local Health Improvement Network Meeting - Workforce Development, Dan Ferguson	Yakima	Carol Moser, Wes Luckey, Participants (Called In)
9/26/2017	Blue Mountain Action Council: Supportive Services for Veteran Families Program: Tara Coburn and Betsy Metcalf	Meeting to discuss supportive services for Veteran Families in region	Pasco	Carol Moser, Wes Luckey, Participants
9/27/2017	Benton & Franklin Counties Housing Continuum of Care Task Force	Continuum of Care Task Force of the Tri-Cities	Kennewick	Carol Moser, Participant
9/28/2017	Three Rivers Community Foundation Listening Forum: Building Strategies to Address Intergenerational Poverty facilitated by DSHS	Intergenerational Poverty	Kennewick	Carol Moser, Participant
9/28/2017	Quality of Life Conversation, Champions Meeting: Chaplaincy Healthcare	End of Life Conversation	Richland	Carol Moser, Participant
9/29/2017	GCACH Update, Babs Roberts, Director / DSHS Community Services Division	Opportunities for Collaboration with DSHS	Pasco	Carol Moser, Wes Luckey, Participants
10/2/2017	Sunnyside, Yakima Regional, and Toppenish Hospitals Sr. Leadership Meeting	GCACH Medicaid Demonstration	Sunnyside	Presentation, Carol Moser, Wes Luckey
10/3/2017	NW Rural Hospital Network: Value Based Purchasing Jeff Uyyek (HMA) and Mike Bonetto (RC)	Value Based Purchasing	Spokane	Presentation, Jeff Uyyek, Mike Bonetto
10/4/2017	Benton-Franklin Community Health Alliance	BFCHA Mental Health & Behavioral Health Meeting	Kennewick	Carol Moser, Wes Luckey Presenters
10/9/2017	GCACH Budget and Funds Flow Committee Retreat	GCACH Retreat for Budget & Funds Flow Committee	Pasco	Carol Moser, Wes Luckey, Cathy Hornkey, Presenters
10/11/2017	ACH Peer Learning: ED Diversion Presentation	ACH Development Council Call	Statewide	Carol Moser, Wes Luckey presenters
10/13/2017	Yakima County Healthcare Coalition	Local Health Improvement Network Meeting	Yakima	Carol Moser, Wes Luckey (Called in)
10/16/2017	Yakima Community College, Deans and Directors Meeting	Presentation to Deans and Directors in SE and Central WA	Yakima	Carol Moser
10/17/2017	Community Pathways to Mental Health Strategy Retreat: Providence St. Joseph Health	Retreat with BH/MH Providers in GCACH Region	Richland	Carol Moser, Wes Luckey Participants
10/18/2017	Tribal Training Retreat: Yakama Nation	Yakama Nation History & Government, Yakama Nation Healthcare	Toppenish	Participants/Listeners
10/19/2017	Healthier Washington Symposium: Seatac	HCA Symposium	Seatac	Participants/Listeners
10/23/2017	ACH Convening	Data	Tukwila	Carol Moser, Wes Luckey, Participants
10/24/2017	Virginia Mason Memorial Presentation: Cle Elum	Presentation to the VMM Board of Directors	Cle Elum	Carol Moser, Wes Luckey
10/25/2017	Community Action Connections Listening Session	Listening Session of CAC Staff	Pasco	Facilitators, Listeners
10/26/2017	GCACH Governing Board & Leadership Council Meetings	GCACH Monthly Meeting	Pasco	GCACH Staff
10/30/2017	GCACH Workforce Meeting	Review Workforce Section Project Plan	Pasco	Conference Call
10/31/2017	Benton-Franklin Workforce Development Board Meeting	Board Meeting	Kennewick	Carol Moser
11/1/2017	Data/HIE Meeting	Committee Meeting on DATA	Pasco	Conference Call
11/1/2017	SE Washington Health Network Meeting	Local Health Improvement Network Meeting	Pomeroy	Carol Moser
11/2/2017	Yakima Valley Farmworkers Clinic Presentation	Presentation to Carlos Oliveras, CEO & Sr. Staff	Yakima	Carol Moser, Wes Luckey
11/3/2017	Meeting with Jason Zacarria, Benton-Franklin Health District & Kirk Williamson	GCACH Update BFHD Administrator & BFCHA Program Mgr	Kennewick	Carol Moser
11/7/2017	Dr. Farion Williams, MD - WSU Medical Program	Meeting to discuss WSU Medical Program; Workforce needs GCACH	Pasco	Carol Moser, Wes Luckey
11/8/2017	Yakima Valley Community Foundation- Investing in Children Presentation	Presentation	Toppenish	Carol Moser, Wes Luckey
11/14/2017	Benton County Medical Society Presentation	Presentation	Richland	Carol Moser, Wes Luckey
11/14/2017	Benton-Franklin Community Health Alliance GCACH Update	Local Health Improvement Network Meeting	Richland	Carol Moser, Wes Luckey
11/16/2017	GCACH Governing Board & Leadership Council Meetings	GCACH Monthly Meeting	Pasco	GCACH Staff

To view the monthly GCACH Board & Leadership Council Meeting Minutes (where public comments and discussion are held), please follow this link:

<http://www.greatercolumbiaach.org/minutes.html>



Confederated Tribes and Bands
of the Yakama Nation

Established by the
Treaty of June 9, 1855

November 8, 2017

To Whom It May Concern,

On behalf of the Confederated Tribes of the Yakama Nation, I am writing this letter of support and gratitude to the Greater Columbia Accountable Community of Health (GCACH) for the collaborative efforts extended to the Yakama Nation, to improve outcomes of patient service delivery for American Indian/Alaskan Natives on the Yakama Reservation.

Yakama Nation has been actively participating on the GCACH Board during the planning process of transforming the health system in the state to bring better health, better care and lower costs to Tribal members and Washington residents.

We look forward to the end results after the demonstration projects are completed, as it is our goal to advance the health of our population by decreasing health disparities, improving efficiency of health care delivery, and empowering individuals and communities through collaboration, innovation, and community engagement.

If you would like to discuss this further, please contact me at (509)865-5121 ext. 4335.

Sincerely,

Frank Mesplie,
Tribal Councilman
Chairman of Health Education & Wellness Committee
POB 151
Toppenish, WA 98948
Frank_Mesplie@yakama.com
(509)865-5121 ext. 4335
(509)865-5983 FAX

OVERVIEW

As part of the Project Plan Application for Greater Columbia Accountable Community of Health (GCACH), we are required to procure statements of support from our Tribal Participants.

We would greatly appreciate your statement of support of the collaborative efforts between the Yakama Nation and Greater Columbia ACH.

STATEMENT OF SUPPORT

November 8, 2017

To Whom It May Concern,

On behalf of the Confederated Tribes of the Yakama Nation, I am writing this letter of support and gratitude to the Greater Columbia Accountable Community of Health (GCACH) for the collaborative efforts extended to the Yakama Nation, to improve outcomes of patient service delivery for American Indian/Alaskan Natives on the Yakama Reservation.

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Sincerely, 

Frank Mesplie,
Tribal Councilman
Chairman of Health Education & Wellness Committee
POB 151
Toppenish, WA 98948
Frank_Mesplie@yakama.com
(509)865-5121 ext. 4335
(509)865-5983 FAX

Frank Mesplie, Yakama Nation Tribal Councilman

Printed Name

11/08/2017

Signature

Date



Greater Columbia Accountable Community of Health (GCACH)

SUBJECT: Conflict of Interest Policy

Policy #: 2016-003

Version Date: December 14, 2016

Policy adopted by the GCACH Board of Directors by resolution on April 21, 2016

Purpose:

The purpose of this Conflict of Interest Policy is to protect the interest of the Greater Columbia Accountable Community of Health ("GCACH" or "Organization") when it is contemplating entering into a transaction or arrangement that might benefit the private interest of any officer, director, member (including members of the Leadership Council), employee, and/or agent of the Organization or might result in a possible excess benefit transaction. To ensure the GCACH operates in a manner consistent with its charitable purposes and does not engage in activities that could jeopardize its tax-exempt status, the GCACH Board of Directors ("Board") shall conduct periodic reviews of the GCACH Bylaws and this Conflict of Interest Policy. The periodic reviews shall, at a minimum, include the following subjects:

Whether compensation arrangements and benefits are reasonable, based on competent survey information, and the result of arm's length bargaining; and

Whether partnership, joint ventures, and arrangements with management organizations conform to the Corporation's written policies, are properly recorded, reflect reasonable investment or payments for goods and services, further charitable purposes and do not result in inurement, impermissible private benefit or in an excess benefit transaction.

Definitions:

"Conflict of Interest" means a situation in which an Interested Person has the potential to vote on or influence a matter that would provide direct or indirect financial benefit to that Director or their immediate family or to any agency with which that member is affiliated.

"Director" means an individual appointed as a member of the Board of Directors pursuant to the Bylaws.

"Executive Committee" means the Board of Directors President, Vice-President, Secretary, Treasurer, and Past President.

"Financial Interest" means having directly or indirectly, through business, investment, or family:

1. An ownership or investment interest in any entity with which the Organization has a transaction or arrangement,
2. A compensation arrangement with the Organization or with any entity or individual with which the Organization has a transaction or arrangement, or
3. A potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which the Organization is negotiating a transaction or arrangement.

"Interested Person" means any Director, officer, employee, member (including Leadership Council members), or agent who has a Financial Interest.

Annual Disclosure:

Each Director and principal officer shall annually sign a disclosure statement which affirms such person: (i) has received a copy of the conflicts of interest policy; (ii) has read and understands the conflicts of interest policy; (iii) has agreed to comply with the conflicts of interest policy, and (iv) understands the GCACH is charitable and in order to maintain its federal tax exemption it must be organized and operated for one or more tax-exempt purposes set forth in Section 501 (c)(3) of the Internal Revenue Code. In addition, such disclosure statement shall include each director's affiliations (as trustee, board member, officer, employee, advisory committee member, development committee member, volunteer, etc.) with any actual or potential grantee or borrower of the GCACH or any other organization with which the GCACH may have a financial relationship, and the affiliations of persons with whom a director has a close relationship (a family member or close companion) with any actual or potential grantee or borrower of the GCACH or any other organization with which the GCACH may have a financial relationship. The form of such annual disclosure statement shall be prescribed and adopted by the Board of Directors and reviewed on an annual basis by the Executive Committee.

Self-Dealing Transactions:

Prohibition and Standard for Approval:

Except as provided in the GCACH Bylaws, the Board of Directors shall not approve or permit the GCACH to engage in any self-dealing transaction. A self-dealing transaction is a transaction to which the GCACH is a party and in which one or more of the Directors has a Financial interest.

Notwithstanding the foregoing, the GCACH may engage in a self-dealing transaction only as follows:

1. If the transaction is approved by a court or by the Attorney General, or
2. If the Board determines, before the transaction, that (1) the GCACH is entering into the transaction for its own benefit; (2) the transaction is fair and reasonable to the GCACH at the time; and (3) after reasonable investigation, the Board determines that it could not have obtained a more advantageous arrangement with reasonable effort under the circumstances. Such determinations must be made by the Board in good faith, with knowledge of the material facts concerning the transaction and the interest of the director or directors in the transaction, and by a vote of a majority of the directors then in office, without counting the vote of the interested director or directors.

Notification and Process:

Whenever an Interested Person has a Conflict of Interest in any matter coming before the Board, the affected person shall a) fully disclose the nature of the interest and b) withdraw from discussion, lobbying, and voting on the matter. Any transaction or vote involving a potential conflict of interest shall be approved only when a majority of disinterested Directors determine that it is in the best interest of the corporation to do so. The minutes of meetings at which such votes are taken shall record such disclosure, abstention and rationale for approval.

The Board may also vote to exclude an Interested Person against whom a claim of Conflict of Interest or violation of appearance of fairness is made from Board votes or from executive sessions until the claim against the member is resolved. Additionally, the Board may by majority vote exclude an Interested Person from a portion of any executive session where a matter of potential legal conflict between GCACH and the Interested Person is to be discussed.

No Loans:

No loans shall be contracted on behalf of the GCACH and no evidences of indebtedness shall be issued in its name unless authorized by a resolution of the Board. That authority may be general or confined to specific instances. No loans shall be made by the GCACH to a Director nor shall the GCACH guarantee the obligation of a Director unless either: (a) the particular loan or guarantee is approved by the vote of a majority of the votes represented by members in attendance at the meeting upon which the matter is considered, except the votes of the benefited Director, or (b) the Board determines that the loan or guarantee benefits the GCACH and either approves the specific loan or guarantee or a general plan authorizing loans and guarantees.

Violations of the Conflicts of Interest Policy:

1. If the Board (or committee) has reasonable cause to believe an Interested Person has failed to disclose actual or possible conflicts of interest, it shall inform the Interested Person of the basis for such belief and afford the Interested Person an opportunity to explain the alleged failure to disclose.
2. If, after hearing the Interested Person's response and after making further investigation as warranted by the circumstances, the Board (or committee) determines the Interested Person has failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

Records of Proceedings:

The minutes of the Board and all committees with board delegated powers shall contain:

1. The names of the persons who disclosed or otherwise were found to have a Financial Interest in connection with an actual or possible Conflict of Interest, the nature of the Financial Interest, any action taken to determine whether a Conflict of Interest was present, and the Board's or committee's decision as to whether a Conflict of Interest in fact existed.
2. The names of the persons who were present for discussions and votes relating to the transaction or arrangement, the content of the discussion, including any alternatives to the proposed transaction or arrangement, and a record of any votes taken in connection with the proceedings.

Compensation:

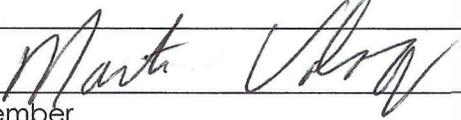
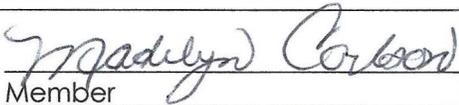
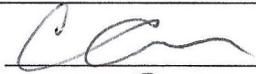
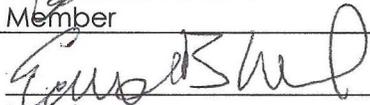
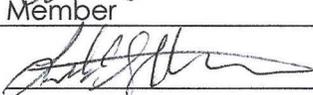
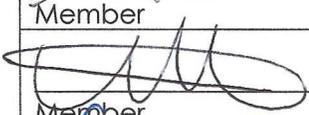
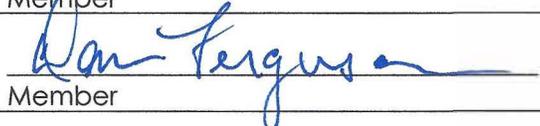
1. A voting member of the Board who receives compensation, directly or indirectly, from the Organization for services is precluded from voting on matters pertaining to that member's compensation.
2. A voting member of any committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from the Organization for services is precluded from voting on matters pertaining to that member's compensation.
3. No voting member of the Board or any committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from the Organization, either individually or collectively, is prohibited from providing information to any committee regarding compensation.

Use of Outside Experts:

When conducting the periodic reviews as provided for in this Conflict of Interest Policy, the Organization may, but is not required to, use outside advisors. If outside experts are used, their use shall not relieve the governing board of its responsibility for ensuring periodic reviews are conducted.

I affirm that I:

1. Have received a copy of the conflicts of interest policy,
2. Have read the policy and understand the policy,
3. Agree to comply with the policy, and
4. Understand the Organization is charitable and in order to maintain its federal tax exemption it must engage primarily in activities which accomplish one or more of its tax-exempt purposes.

 Member	Member
 Member	Member
 Member	Member
 Member	Member
 Member	Member
 Member	Member
 Member	Member
 Member	Member
Member	Member

<i>Brian P. Smith</i> Member	Member
<i>Daniel P. Smith</i> Member	Member
<i>[Signature]</i> Member	Member
<i>Martha Lanna</i> Member	Member
<i>Maddy Carlson</i> Member	Member
<i>Rhonda Haeff</i> Member	Member
<i>Jefferson Smith</i> Member	Member
Member	Member
Member	Member



GCACH Board of Directors Meeting

Thursday, November 16, 2017 | 12:00 PM to 2:30 PM

CBC, L-102 | 2600 N 20th Ave., Pasco, WA 99301

Call in Instructions for Go To Meeting	Wifi Information
<p>Please join the meeting from your computer, tablet or smartphone. https://global.gotomeeting.com/join/776402557</p> <p>You can also dial in using your phone. United States: +1 (312) 757-3121 Access Code: 776-402-557 <i>Same call-in information for the Leadership Council Meeting</i></p>	<p>Name: CBC-Events Sign in: Health11</p>

Meeting Agenda

Welcome & Introductions Martin Board

Attestation of Conflict of Interest

"Conflict of Interest" means a situation in which an Interested Person has the potential to vote on or influence a matter that would provide direct or indirect financial benefit to that Director or their immediate family or to any agency with which that member is affiliated.

Self-Dealing Transactions: Prohibition and Standard for Approval

Except as provided in the GCACH Bylaws, the Board of Directors shall not approve or permit the GCACH to engage in any self-dealing transaction. A self-dealing transaction is a transaction to which the GCACH is a party and in which one or more of the Directors has a Financial interest. GCACH Policy #2016-003 passed 4/21/16

****Public comments will be taken again after all other agenda items****

Consent Calendar

- 10/26/17 Board Meeting Minutes

Director's Report & Updates Carol

- November Project Plan Application Highlights

Action Items

- Financial Reports Carol
 - Statement of Financial Position (Balance Sheet)
 - SIM Funding, Statement of Activity
 - SIM Funding & Projected Spend Down
 - PHASE I & II Design Funding, Statement of Activity

New Business

- Round Robin Committee Updates: Communication, Workforce, and Budget & Funds Flow All
- Bylaws Discussion Martin
- FIMC Interlocal Leadership Council – Contract with Walla Walla County Health? Meghan
- Discussion about Sector Membership for 2018/Lottery? Carol
- Path Forward on Implementation Planning – Provider Incentives Carol/Cathy H
- Discussion about December Meetings Carol/Megan
 - December Board Meeting will be at TCCH from 9:00 am – 11:30 am
 - December Leadership Council Meeting is cancelled Megan

Adjournment

Remaining GCACH Board of Director Meetings for 2017:

Thursday, December 21st- TCCH

Thank you, CBC, for providing the meeting space, and to United Healthcare for providing lunch!



Greater Columbia Accountable Community of Health

Collaboration • Innovation • Engagement

GCACH

Budget and Funds Flow Committee Charter

PURPOSE

The purpose of the Budget and Funds Flow Committee is to: (1) Create policies and procedures for oversight and accountability of the funds flow accounting function, budgeting and reporting as required by GAAP, DSRIP, and all required external compliance. (2) Work with partner organizations to develop a sound, fair and equitable allocation methodology for DSRIP funds. (3) Submit draft allocation methodologies and other Funds Flow related items to the Finance Committee for review and recommendation to the Board of Directors.

RESPONSIBILITIES

The Budget and Funds Flow Committee's responsibilities will include the following:

- Develop funds flow distribution schedule.
- Provide input to Project Impact Assessment and Matrix.
- Review the provider-level projections of DSRIP impacts and costs submitted by network providers.
- Establish procedure for monitoring and reporting of project incentive costs.
- Recommend process to collect, analyze and report financial results.
- Monitor, evaluate, and recommend modifications to distribution plan.
- Contribute to communication and training plan to network participating providers for review and input.

GUIDING PRINCIPLES

The Budget and Funds Flow Committee's guiding principles are:

- Accountability
- Transparency
- Collaboration
- Value-Driven
- Flexibility

COMPOSITION

The Budget and Funds Flow Committee is made up of 10-12 partner organization representatives. The Budget and Funds Flow Committee is comprised of individuals with expertise or working knowledge of budgets, financial statements and Generally Accepted Accounting Principles (GAAP).

The members of the Budget and Funds Flow Committee will be selected to adequately represent a cross-section of healthcare markets within the Accountable Community of Health's (ACH's) catchment area.

The Budget and Funds Flow Committee will submit all proposals and recommendations to the Finance Committee for review and recommendation for approval / adoption to the Board of Directors.

The members of the Budget and Funds Flow Committee will serve for one-year terms. Any mid-term vacancies in the Budget and Funds Flow Committee will be appointed by the Finance Committee, and the individual appointed will serve the remainder of the term.

The members of the Budget and Funds Flow Committee may be removed for cause by a vote of 75% from the Finance Committee. Cause shall include failure to attend three consecutive meetings, unless absence is excused for good cause.

MEETINGS

The Budget and Funds Flow Committee will hold regular monthly meetings at a minimum of one time per month. Initially the committee will likely meet more often to establish a foundation and framework by which to work.

Notice of all regular and special meetings will be sent to members of the Budget and Funds Flow Committee by email at least one week prior to the meeting date.

To constitute a "quorum", at least 75% of all members of the Budget and Funds Flow Committee must be (physically or electronically) present. (*to the extent electronic participation is permitted.)

Each member of the Budget and Funds Flow Committee will act as a fiduciary for the GCACH, rather than a representative of his or her employer. Further, all members of the Budget and Funds Flow Committee must attend at least 75% of all regular and special meetings held during each calendar year, unless the absence is excused for good cause, as determined by the Committee Chair. Failure to meet the attendance requirements will lead to automatic removal of the member, unless otherwise determined by the Finance Committee.

Budget and Funds Flow Committee members will be expected to:

- Read meeting materials in advance and come prepared to contribute substantively in the work of the Committee
- Actively engage in discussions and contribute their respective expertise to decision-making processes
- Provide timely review and feedback on documents when solicited
- Participate in surveys and information gathering as appropriate

DECISION MAKING

The Budget and Funds Flow Committee will use a collaborative, consensus-based decision-making process that requires the approval of at least 75% of the Budget and Funds Flow Committee members (physically or electronically) present for any Budget and Funds Flow Committee decision.

Consensus-based decisions by the Budget and Funds Flow Committee will be submitted to the Finance Committee for review. If the Budget and Funds Flow Committee's decision is approved by the Finance Committee, it will be forwarded to Board of Directors for approval then to GCACH for action. If the Budget and Funds Flow Committee's decision is not approved by the Finance Committee, the Finance Committee will provide Budget and Funds Flow Committee with a summary of the issues on which it agrees and disagrees. The Budget and Funds Flow Committee will work with the Finance Committee to resolve any disagreements. If such disagreements cannot be resolved, the Board of Directors will determine the appropriate course of action.

AMENDMENTS

Amendments to this charter will require the approval of the Finance Committee.

REPORTING

The Budget and Funds Flow Committee will keep regular minutes of its meetings and will provide such minutes to the other committees or sub-committees from time to time or as requested by the Finance Committee and/or Board of Directors. The minutes of the Budget and Funds Flow Committee meetings will be made available upon request.

CONFLICTS OF INTEREST

Budget and Funds Flow Committee members are required to comply with the GCACH's Conflicts of Interest Policy.



Greater Columbia Behavioral Health

509-735-8681 or 1-800-795-9296, Fax 509-783-4165, <http://www.gcbh.org>, 101 N. Edison St.,
Kennewick, WA 99336-1958

October 16, 2017

Mr. Lou McDermott
Interim Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5502

Ms. MaryAnne Lindeblad
State Medicaid Director
Health Care Authority
626 8th Avenue SE
Olympia, WA 98504-5502

Re: LETTER OF INTENT
GCBH - MID-ADOPTION, with Transitional Year
- Election to become BH-ASO for region

Dear Mr. McDermott and Ms. Lindeblad:

We, the undersigned, are Board Members of Greater Columbia Behavioral Health (GCBH). Additionally, we serve as County Commissioners of our respective counties.

By our signatures below, we declare our unanimous intent for GCBH to become Mid-Adopters of Fully Integrated Managed Care in January 2019 and use the year 2019 as a Transitional Year, as proposed by the Health Care Authority, and under the additional conditions that follow. Also, it is the intent of GCBH to become the BH-ASO for our region, during and following full integration. Finally, by our signatures below, we declare that the selection of this "Mid-Adoption with Transitional Year", by GCBH was unanimously agreed by each Board Member for their respective Member County, as voted upon by each Counties individual and respective County Commissions.

GCBH fully declares its unanimous intent to become "Mid Adopters with Transitional Year" with the following conditions and understanding:

1. GCBH requests agreement and assurance from the Governor's Office and from the Health Care Authority to fully support the adoption of a statute establishing a permanent regional "Interlocal Leadership Structure" to be chaired by county authorities. This statute language will be modeled on the "BHO Proviso Language" that was introduced in the 2017 Legislative Session. In addition, the statute establishing the Interlocal Leadership Structure should address clear roles and responsibilities of the System Stakeholders and how decisions will be made to support and implement the new system efficiently to

maximize health outcomes. Consideration should be given to reduce unnecessary duplication of administrative cost in order to preserve money for direct services, provide transparency so that system outcomes in relationship to cost can be evaluated, and provide a mechanism for Counties and the BH-ASO to have meaningful influence on identifying community specific health care priorities and consistency of services for both Medicaid and non-Medicaid individuals to maintain and increase the overall health of the GCBH region as a whole.

2. GCBH requests agreement and assurance from the Health Care Authority to allow and support GCBH's intent, as BH-ASO, to contract with the MCOs selected to serve the GCBH region for certain required and negotiated Medicaid Behavioral Health Services based on the proposed plan for fully integrated managed care developed by the GCBH Interlocal Leadership Structure. This plan should assure that clients are at the center of care delivery and should support integrated delivery of physical and behavioral health care at the provider level. This plan should also minimize duplication in administrative functions and support coordination of care as described in the "BHO Proviso Language". During calendar year 2019, MCOs must contract back to the BHO and/or BH-ASO certain Medicaid behavioral health services to maintain the stability of the current system, to ensure an optimal transition, and to allow for continued design and planning of a full integration model and continuum of care prior to full implementation by January 1, 2020; and, beginning calendar year 2019, a comprehensive plan determining contracting relationship to ensure funding needs to be established.
3. GCBH requests agreement and assurance from the Governor's Office and from the Health Care Authority to seek a legislative budget appropriation providing sufficient dedicated funding to the GCBH Region to operate the BH-ASO. This funding should be sufficient to maintain the current continuum of care in the GCBH administered Crisis Services and other specified ASO monitored programs. This funding agreement will also allow GCBH to submit a spending plan that will allow it to maintain a portion of their existing reserves and unspent funds to cover the estimated start-up costs of transitioning to a BH-ASO.
4. GCBH requests agreement and assurance from the Health Care Authority to allow Counties through the Interlocal Leadership Structure to provide specific input into the GCBH "Addendum" to the 2018 RFP that will be used to procure the MCOs that will be providing Fully Integrated Managed Care in the GCBH region. This should include the ability to recommend specific criteria to ensure that all persons in the GCBH region have equal access to Medicaid health and behavioral health services, including those persons living in

geographically challenged areas. The RFP for MCO's should require the selected MCO's to demonstrate how they are minimizing barriers of entry for those needing services and articulate their plan for addressing community specific health care priorities. Further, MCO's should have a clear plan to address the overlay of their treatment obligations with coordinated crisis care and transition care services.

5. GCBH seeks a stipulation that GCBH may withdraw its agreement to become a mid-adopter, under this Letter of Intent, if the majority of the Counties conclude that these conditions are not being satisfactorily addressed.

We appreciate your assistance with this matter and are looking forward to working with HCA, and all involved parties, in the mid-adoption process and in working with the HCA during the transitional year as outlined above. If you have any additional questions or concerns, please give us a call. Thank you.

Signed and unanimously declared on behalf of GCBH and our respective Counties:



Chris Seubert
Asotin County, Commissioner

Shon Small, GCBH Board Chair
Benton County, Commissioner

Merle Jackson
Columbia County, Commissioner

Robert Koch
Franklin County, Commissioner

Robert Johnson
Garfield County, Commissioner

Obie O'Brien, GCBH Board Vice-Chair
Kittitas County, Commissioner

Jim Duncan
Walla Walla County, Commissioner

Michael Largent
Whitman County, Commissioner

Ron Anderson
Yakima County, Commissioner

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Michael Largent 10-16-17
Whitman County, Commissioner

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Whitman County, Commissioner



Ron Anderson
Yakima County, Commissioner

GCACH MTD Toolkit: P4P Reporting Metrics

1 • Antidepressant Medication Management*	2A
2 • Child and Adolescents' Access to Primary Care Practitioners*	2A, 3D
3 • Comprehensive Diabetes Care: Eye Exam (retinal) performed	2A, 3D
4 • Comprehensive Diabetes Care: Hemoglobin A1c Testing	2A, 3D
5 • Comprehensive Diabetes Care: Medical Attention for Nephropathy	2A, 3D
6 • Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence*	2A, 2C
7 • Follow-up After Hospitalization for Mental Illness*	2A, 2C
8 • Inpatient Hospital Utilization	2A, 2C, 3A, 3D
9 • Medication Management for People with Asthma (5 – 64 Years)	2A, 3D
10 • Mental Health Treatment Penetration (Broad Version)*	2A
11 • Outpatient Emergency Department Visits per 1000 member months*	2A, 2C, 3A, 3D
12 • Patients on high-dose chronic opioid therapy by varying thresholds*	3A
13 • Patients with concurrent sedatives prescriptions	3A
14 • Percent Homeless (Narrow definition)*	2C
15 • Plan All-Cause Readmission Rate (30 Days)	2A, 2C
16 • Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	3D
17 • Substance Use Disorder Treatment Penetration*	2A, 3A

2A Bi-Directional Integration

2C Transitional Care

3A Opioid Use

3D Chronic Disease

* Measure contains sub-measures

Updated: 11/3/2017

GCACH MTD Toolkit: GCACH P4P Reporting Metrics Gap Analysis, Numbers Needed to Treat, and Year 1 Target Population Count

Metric	GTG/IOS	Assessment Start	Number Needed To Treat (NNTT)										P4P Year 1 Target Population Count Estimate	
			Asotin	Benton	Columbia	Franklin	Garfield	Kittitas	Walla Walla	Whitman	Yakima	GCACH		
1 - Antidepressant Medication Management: Acute Phase Tx	GTG	2019	0	13	0	7	0	1	2	2	31	55	83	
1 - Antidepressant Medication Management: Continuation Phase Tx	GTG	2019	1	17	0	10	0	1	3	2	42	75	113	
2 - Child and Adolescents' Access to PCPs: 12-23 months	GTG	2019	1	7	1	3	0	1	2	1	14	30	45	
2 - Child and Adolescents' Access to PCPs: 2-6 years	GTG	2019	7	52	3	27	1	10	11	8	133	259	389	
2 - Child and Adolescents' Access to PCPs: 7-11 years	GTG	2019	4	35	1	13	0	6	4	5	83	151	227	
2 - Child and Adolescents' Access to PCPs: 12-19 years	GTG	2019	4	43	1	21	0	6	8	1	121	188	282	
3 - Comprehensive Diabetes Care: Eye Exam (retinal) performed	GTG	2020	6	49	1	24	1	3	13	9	107	215	323	
4 - Comprehensive Diabetes Care: Hemoglobin A1c Testing	GTG	2019	1	15	0	9	0	1	2	1	14	42	63	
5 - Comprehensive Diabetes Care: Medical Attention for Nephropathy	GTG	2019	0	1	0	3	0	2	2	1	-1	10	15	
6 - Depression Screening and Follow-up for Adolescents and Adults	IOS	2020	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
7 - Follow-up After Discharge from ED for Mental Health, <u>Alcohol or Other Drug Dependence</u> : 7days	GTG	2020	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
7 - Follow-up After Discharge from ED for Mental Health, <u>Alcohol or Other Drug Dependence</u> : 30days	GTG	2020	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
7 - Follow-up After Discharge from ED for <u>Mental Health</u> , Alcohol or Other Drug Dependence: 7days	GTG	2020	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
7 - Follow-up After Discharge from ED for <u>Mental Health</u> , Alcohol or Other Drug Dependence: 30days	GTG	2020	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
8 - Follow-up After Hospitalization for Mental Illness	GTG	2020	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
9 - Inpatient Hospital Utilization (<u>includes psychiatric</u>)	IOS	2020	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	227	340	
10 - Medication Management for People with Asthma (5 – 64 Years)	GTG	2019	1	6	0	4	0	1	2	1	17	33	50	
11 - Mental Health Treatment Penetration (Broad Version)	IOS	2019	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	308	462	
12 - Outpatient Emergency Department Visits per 1000 member months: 0-17 years	IOS	2019	74	426	6	241	5	43	110	36	900	1,867	560	
12 - Outpatient Emergency Department Visits per 1000 member months: 18+ years	IOS	2019	123	558	9	293	7	58	170	50	1,302	2,559	768	
13 - Patients on high-dose chronic opioid therapy by varying thresholds	IOS	2019	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
14 - Patients with concurrent sedatives prescriptions	IOS	2019	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
15 - Percent Homeless (Narrow definition)	IOS	2019	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	58	87	
16 - Plan All-Cause Readmission Rate (30 Days)	GTG	2019	0	2	0	1	0	0	1	0	4	10	15	
17 - Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	IOS	2020	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
18 - Substance Use Disorder Treatment Penetration	IOS	2019	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	70	105	

- 2A Bi-Directional Integration
- 2C Transitional Care
- 3A Opioid Use
- 3D Chronic Disease

Notes:
 TG = Gap to Goal scoring methodology
 IOS = Improvement Over Self scoring methodology

- All numbers are estimates based upon extrapolated county data.
- GTG targets were based on Medicaid 90th-percentile measures from the 2015 NCQA State of Healthcare Quality Report
- OS targets were based on a 2% increase over baseline year
- All numbers represent number of patients except for Outpatient Emergency Department Visits per 1000 member months, which represent number of visits.
- N/A specifies that no preliminary data is available for these measures.
- P4P Year 1 Target Population Count Estimate is calculated as 150% of the GCACH Number Needed to Treat. This number assumes that a large percentage of the target population will fail to achieve improvement through GCACH interventions.
- Outpatient Emergency Department Visits per 1,000 Year 1 Target Population Counts were determined by dividing by five the Number Needed To Treat statistics for this measure (this estimates an average of 5 visits per member for high-utilizers, the target population) and then multiplying this quotient by 1.5.

RWJF County Health Rankings, 2017
Statewide Population

Worse than average Better than average

	Asotin	Benton	Columbia	Franklin	Garfield	Kittitas	Walla Walla	Whitman	Yakima	WA State	Graph	
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%	27%	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	298	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	399.9	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%	

Demographics, Medicaid population 2015 (RHNI) Regional Health Needs Inventory

	GCACH		WA State	
	#	%	#	%
Overall	259,762	13.7%	1,892,696	100.0%

Gender

Male	122,175	47.0%	897,598	47.0%
Female	137,587	53.0%	995,094	53.0%

Race/Ethnicity

American Indian/Alaska Native	8,423	3.2%	53,735	3.0%	●
Asian	2,696	1.0%	86,535	5.0%	
Black	4,621	1.8%	135,494	7.0%	
Native Hawaiian/ Pacific Islander	2,158	0.8%	55,211	3.0%	
White	123,930	47.7%	1,071,745	57.0%	
Multiracial	1,796	0.7%	23,714	1.0%	
Other	91,362	35.2%	278,040	15.0%	●
Unknown	24,596	9.5%	188,222	10.0%	

Ethnicity

Hispanic	130,890	50.4%	401,292	21.0%	●
Not Hispanic	98,132	37.8%	1,139,314	60.0%	
Unknown	30,740	11.8%	352,090	19.0%	

Age (bins tbd)

Adult (19+)	120,932	46.6%	1,029,869	54.0%	●
Child (<19)	138,830	53.4%	862,872	46.0%	●

Language

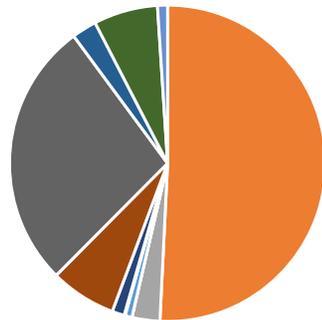
English	162,205	87.6%	1,588,222	83.9%	
Spanish	9,294	5.0%	172,807	9.1%	●
Other	714	0.4%	49,201	2.6%	
Unknown	12,777	6.9%	82,466	4.4%	

GCACH includes Klickitat

GCACH Enrollees in Medical Programs By County, February 2017

Program Name	Asotin	Benton	Columbia	Franklin	Garfield	Kittitas	Walla Walla	Whitman	Yakima	GCACH	%	Statewide Total	GCACH %
AEM Expansion Adults	0	8	0	20	0	0	14	0	35	77	0.0%	340	22.6%
Apple Health For Kids	2,635	29,267	431	22,035	275	3,886	7,910	2,973	61,315	130,727	50.7%	808,833	16.2%
Elderly persons	252	1,450	57	841	19	259	748	250	3,473	7,349	2.9%	74,196	9.9%
Family (TANF) Medical	0	0	0	0	0	0	0	0	0	0	0.0%	14	0.0%
Family Planning	12	396	3	378	0	77	83	52	824	1,825	0.7%	12,418	14.7%
Former Foster Care Adults	6	62	2	18	1	14	27	21	115	266	0.1%	2,159	12.3%
Foster Care	116	712	23	308	14	216	317	123	1,404	3,233	1.3%	30,019	10.8%
Medicaid CN Caretaker Adults	596	4,503	91	2,030	49	692	1,199	555	7,706	17,421	6.8%	135,518	12.9%
Medicaid CN Expansion Adults	2,283	16,330	409	7,753	202	4,048	5,323	3,606	30,670	70,624	27.4%	615,337	11.5%
Other Federal Programs	0	0	0	0	0	0	0	0	0	0	0.0%	27	0.0%
Partial Duals	372	1,400	61	551	26	340	539	238	3,002	6,529	2.5%	60,583	10.8%
Persons with disabilities	800	4,213	170	1,754	47	656	1,442	558	7,270	16,910	6.6%	149,832	11.3%
Pregnant Womens Coverage	35	531	7	532	8	77	137	85	1,228	2,640	1.0%	16,493	16.0%
Total	7,107	58,872	1,254	36,220	641	10,265	17,739	8,461	117,042	257,601	100.0%	1,905,769	13.5%
County %	2.8%	22.9%	0.5%	14.1%	0.2%	4.0%	6.9%	3.3%	45.4%	100.0%			

1. Children's Medical Program includes children financed by Medicaid (Title XIX), State Children's Health insurance Program (CHIP) and state-only financed coverage for children that do not qualify for Medicaid or CHIP.
2. Family (TANF) Medical includes people enrolled in the Medicaid Family Program (TANF households, households eligible for TANF but only receiving medical coverage, and households in transitional medical assistance), Refugee Assistance, and Medicaid Medically Needy (MN) other coverage.
3. "People with disabilities" includes people enrolled in Medicaid Categorically Needy (CN) blind/disabled coverage, CN Health Care for Workers with Disabilities and MN blind/disabled
4. "Elderly People" includes people age 65 and older enrolled in Medicaid CN elderly coverage and MN elderly coverage. And MCS/Disability Lifeline.
5. "Pregnant Women's Coverage" includes women enrolled in Medicaid's pregnant women's program and Title XXI financed coverage for pregnant women.
6. "Partial Duals" includes QMB, QDWI, SLMB, and QI-1 eligibles that receive Medicaid coverage for only their Medicare premium costs and some co-insurance and co-pays according the Medicaid rules.



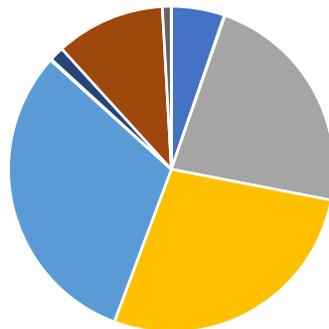
- AEM Expansion Adults
- Elderly persons
- Family Planning
- Foster Care
- Medicaid CN Expansion Adults
- Partial Duals
- Pregnant Womens Coverage
- Apple Health For Kids
- Family (TANF) Medical
- Former Foster Care Adults
- Medicaid CN Caretaker Adults
- Other Federal Programs
- Persons with disabilities

MCO Enrollees By County and MC Program, April 2017

Program	Asotin	Benton	Columbia	Franklin	Garfield	Kittitas	Walla Walla	Whitman	Yakama	Yakima	GCACH	%
Amerigroup Washington Inc	417	4,011	83	1,759	101	431	1,001	613	0	3,373	11,789	5.3%
Community Choice	0	0	0	0	0	0	0	154	0	0	154	0.1%
Community Health Plan Of Washington	849	12,535	28	8,356	0	1,497	2,295	237	0	24,864	50,661	22.7%
Coordinated Care Corporation	394	7,652	106	5,023	12	402	1,883	272	0	46,042	61,786	27.7%
Molina Healthcare Of Washington Inc	3,627	18,301	662	11,657	397	4,705	8,609	5,335	0	15,885	69,178	31.0%
Optumhealth	12	78	2	27	0	8	36	0	0	89	252	0.1%
Se Wa Aging And LTC	169	711	53	363	13	139	344	0	0	1,434	3,226	1.4%
United Health Care Community Plan	575	8,856	108	4,653	39	1,826	1,290	836	0	6,086	24,269	10.9%
Yakama Health Center	0	0	0	0	0	0	0	0	1,949	0	1,949	0.9%
Other	0	0	0	0	0	0	0	0	35	0	35	0.0%
Total	6,043	52,144	1,042	31,838	562	9,008	15,458	7,447	1,984	97,773	223,299	100.0%

Program	Apple Health Adult Coverage (AHAC)	Children's Health Insurance Program (CHIP)	Home Health (HH)	Healthy Options (HO)	Healthy Options Blind and Disabled (HOBD)	Healthy Options Foster Care (HOFC)	Primary Care Case Management (PCCM)	All MC Programs	%
Amerigroup Washington Inc	6,189	215	0	4,816	569	0	0	11,789	5.3%
Community Choice	0	0	154	0	0	0	0	154	0.1%
Community Health Plan Of Washington	14,113	1,193	4	33,021	2,330	0	0	50,661	22.7%
Coordinated Care Corporation	16,713	1,239	0	37,980	3,238	2,616	0	61,786	27.7%
Molina Healthcare Of Washington Inc	18,454	1,850	0	45,582	3,292	0	0	69,178	31.0%
Optumhealth	0	0	252	0	0	0	0	252	0.1%
Se Wa Aging And LTC	0	0	3,226	0	0	0	0	3,226	1.4%
United Health Care Community Plan	10,680	555	68	11,596	1,370	0	0	24,269	10.9%
Yakama Health Center	0	0	0	0	0	0	1,949	1,949	0.9%
Other	0	0	0	0	0	0	35	35	0.0%
Total	66,149	5,052	3,704	132,995	10,799	2,616	1,984	223,299	100.0%

"Other" includes Colville Indian Health Clinic, Inchelium Clinic, Lower Elwha Health Clinic, Lummi Tribal Health Center, Native Health Of Spokane, Puyallup Tribal Health Authority, Roger Saux Health Center - Medical, Seattle Indian Health Board and Tulalip Indian Health Services clients



- Amerigroup Washington Inc
- Community Health Plan Of Washington
- Molina Healthcare Of Washington Inc
- Se Wa Aging And LTC
- Yakama Health Center
- Community Choice
- Coordinated Care Corporation
- Optumhealth
- United Health Care Community Plan
- Other

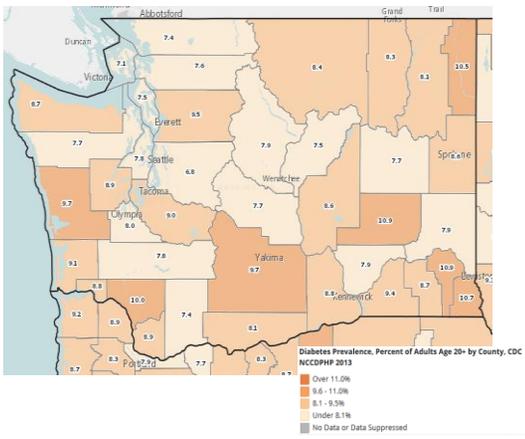
Regional Health Needs Inventory

Worse than average Better than average

Category	Measure	Asotin	Benton	Columbia	Franklin	Garfield	Kittitas	Klickitat	Walla Walla	Whitman	Yakima	GCACH	WA State	Source	
		%	%	%	%	%	%	%	%	%	%	%	%		
Uninsured	Overall: 2014	9%	11%	9%	13%	9%	15%	11%	12%	12%	12%	N/A	8%	OFM	●
Uninsured	Income below 100% of Federal Poverty Level: 2014	19%	15%	19%	14%	19%	23%	19%	16%	20%	19%	N/A	14%	OFM	
Uninsured	Income 100-137% of Federal Poverty Level: 2014	20%	8%	18%	8%	N/A	29%	13%	9%	21%	12%	N/A	13%	OFM	
Poverty	Estimate of people of all ages in poverty: 2015	16%	14%	15%	16%	15%	20%	17%	17%	21%	19%	N/A	12%	Census	●
Graduation Rate	Adjusted 5-year high school graduation rate: 2016	73%	83%	97%	81%	90%	86%	86%	84%	93%	79%	N/A	N/A	OSPI	
Obesity	% who have a BMI>=30 (self-reported weight and height): 2013-2015	38%	27%	31%	34%	24%	26%	32%	35%	25%	33%	31%	27%	BRFSS	●
Smoking	% adults (18yo and older) who reported current smoking: 2013-2015	12%	15%	34%	10%	27%	14%	25%	12%	13%	17%	15%	16%	BRFSS	
Mental Health	% adults who reported poor mental health during the past 30 days: 2013-2015	15%	10%	N/A	9%	N/A	6%	8%	9%	13%	13%	11%	11%	BRFSS	
Diabetes	% adults who were ever told by a doctor they had any type of diabetes: 2013-2015	9%	7%	N/A	9%	N/A	9%	7%	N/A	N/A	N/A	9%	8%	BRFSS	
Asthma	% adults who were ever told by a doctor they had asthma and that they still have asthma: 2013-2015	13%	8%	0%	7%	0%	13%	0%	9%	8%	10%	9%	10%	BRFSS	
Personal Health Care Provider	% having a personal doctor or health care provider: 2013-2015	73%	72%	72%	68%	64%	75%	54%	82%	80%	68%	71%	74%	BRFSS	●
Dental Services	% clients receiving dental services: 2015-2016 Medicaid, ages 5 and under only	31%	52%	39%	57%	31%	48%	42%	60%	33%	65%	58%	53%	HCA	
Dental Services	% clients receiving dental services: 2015-2016 Medicaid, ages 20 and under only	36%	59%	46%	64%	43%	53%	46%	62%	37%	69%	63%	56%	HCA	
Dental Services	% clients receiving dental services: 2015-2016 Medicaid, aged 21 and over only	14%	25%	27%	27%	17%	22%	20%	25%	10%	27%	25%	22%	HCA	
Dental Services	% clients receiving dental services: 2015-2016 Medicaid, all ages	24%	43%	35%	51%	29%	36%	32%	44%	21%	51%	46%	38%	HCA	
Contraception	% eligible population receiving most or moderately effective contraception 2015	30%	32%	32%	30%	29%	40%	35%	33%	38%	32%	32%	31%	First Steps	
Contraception	% eligible population receiving long-acting reversible contraception (LARC) 2015	8%	9%	9%	9%	7%	10%	7%	9%	8%	9%	9%	8%	First Steps	
Contraception	% eligible population receiving postpartum most or moderately effective contraception 2015	N/A	45%	44%	51%	N/A	47%	33%	45%	36%	54%	50%	41%	First Steps	
Contraception	Eligible population receiving postpartum long-acting reversible contraception (LARC) 2015	N/A	18%	6%	21%	N/A	21%	0%	14%	13%	24%	21%	16%	First Steps	
Teen Pregnancy	overall rate 2015	47%	32%	N/A	43%	N/A	10%	N/A	28%	5%	60%	34%	26%	WA DOH	●
Teen Pregnancy	% 15-17 years old rate 2015	N/A	14%	N/A	17%	N/A	N/A	N/A	15%	N/A	25%	16%	12%	WA DOH	
Teen Pregnancy	% 18-19 years old rate 2015	114%	66%	N/A	95%	N/A	15%	N/A	43%	6%	128%	56%	47%	WA DOH	
STD	Chlamydia screening: 2015	N/A	49%	NA	51%	N/A	39%	58%	50%	45%	56%	53%	51%	WHA	
Low Birthweight	Percent low birthweight (<2500g) for all liveborn singleton 2015	13%	5%	9%	5%	N/A	5%	9%	5%	3%	6%	5%	6%	First Steps	

HCA Medicaid Enrollment 2015	Diagnosis: Asthma		Diagnosis: Diabetes		Measure: Diabetes: Blood Sugar (HbA1c) Testing		Measure: Diabetes: Eye Exam		Measure: Diabetes: Kidney Disease Screening		Diagnosis: Depression	
	GCACH	WA State	GCACH	WA State	GCACH	WA State	GCACH	WA State	GCACH	WA State	GCACH	WA State
	%	%	%	%	%	%	%	%	%	%	%	%
Overall	4%	4%	3%	4%	84%	84%	32%	30%	89%	88%	8%	10%
Race												
American Indian/Alaska Native	5%	5%	6%	5%	82%	78%	24%	26%	91%	88%	9%	11%
Black	5%	4%	4%	4%	83%	82%	31%	28%	88%	88%	9%	9%
White	4%	4%	4%	4%	83%	84%	29%	29%	88%	89%	11%	12%
Other	3%	3%	3%	3%	86%	87%	35%	34%	90%	89%	5%	6%
Ethnicity												
Hispanic	3%	3%	3%	3%	86%	86%	35%	33%	89%	89%	5%	6%
Not Hispanic	5%	4%	4%	4%	83%	84%	29%	29%	89%	89%	12%	12%
Age (bins tbd)												
Adult (19+)	4%	4%	7%	6%	85%	84%	32%	30%	89%	99%	14%	15%
Child (<19)	3%	3%	0%	0%	79%	82%	N/A	26%	93%	92%	3%	3%
Language												
English	3%	4%	3%	3%	82%	83%	28%	28%	88%	88%	9%	10%
Spanish	2%	3%	3%	3%	89%	91%	39%	38%	89%	90%	3%	16%
Other	10%	8%	12%	10%	87%	87%	37%	35%	90%	90%	19%	3%

Opiate Abuse: Medicaid only population with full medical eligibility, Medicaid eligible excluding dual Medicare eligibles, third party liability and partial medical eligibility - 2016	% Heavy Opioid Users		% Users of opiates for >30 days		% Receiving Medication Assisted Treatment with Buprenorphine (%)		% Receiving Medication Assisted Treatment with Methadone(%)	
	GCACH	WA State	GCACH	WA State	GCACH	WA State	GCACH	WA State
	%	%	%	%	%	%	%	%
Overall	19%	20%	20%	18%	16%	10%	5%	17%
Gender								
Female	19%	20%	20%	18%	13%	10%	5%	17%
Male	19%	20%	21%	19%	19%	10%	5%	16%
Age								
Ages 0-9	NA	1%	NA	1%	0%	0%	0%	0%
Ages 10-19	16%	17%	1%	1%	NA	2%	0%	SN
Ages 20-29	20%	20%	9%	7%	23%	13%	5%	15%
Ages 30-39	20%	20%	21%	17%	20%	13%	5%	19%
Ages 40-49	20%	20%	33%	27%	12%	8%	5%	16%
Ages 50-59	20%	21%	40%	36%	8%	5%	5%	16%
Ages 60-69	20%	22%	44%	40%	NA	3%	7%	18%
Ethnicity								
Non Hispanic White	20%	20%	27%	22%	18%	10%	5%	17%
Non Hispanic AI/AN	13%	18%	17%	20%	NA	15%	6%	15%
Non Hispanic Black	18%	20%	21%	15%	NA	4%	NA	18%
Hispanic	18%	20%	12%	11%	12%	10%	6%	14%
Other/UNK	21%	21%	18%	12%	12%	7%	NA	13%



Healthier Washington Dashboard

Worse than average Better than average

		Asotin	Benton	Columbia	Franklin	Garfield	Kittitas	Klickitat	Walla Walla	Whitman	Yakima	GCACH	WA State	Graph
		%	%	%	%	%	%	%	%	%	%	%	%	%
Prevalence	Asthma: % members diagnosed with asthma - Medicaid	5%	4%	5%	3%	3%	3%	4%	4%	2%	3%	4%	4%	
	Depression: % members diagnosed with depression - Medicaid	13%	10%	12%	5%	10%	10%	9%	10%	7%	7%	8%	10%	
	Diabetes: % members diagnosed with diabetes - Medicaid	4%	3%	5%	3%	4%	3%	4%	4%	3%	4%	3%	4%	
	Adult tobacco use - 3 yr - Statewide (BRFSS)	12%	15%	34%	10%	27%	14%	25%	12%	13%	17%	15%	16%	
	Adult mental health status - 3 yr - Statewide (BRFSS)	15%	10%	7%	9%	11%	6%	8%	8%	13%	13%	11%	11%	
	Unintended Pregnancy - Statewide (PRAMS)	37%	35%	N/A	35%	N/A	33%	34%	35%	31%	40%	36%	37%	
Clinical Care	Adult Access to Preventive/Ambulatory Health Services - Medicaid	82%	80%	83%	80%	77%	76%	78%	79%	72%	77%	78%	77%	
	Child Access to Primary Care - Medicaid	90%	90%	89%	91%	91%	90%	83%	91%	90%	88%	89%	89%	
	Well-Child Visits age 3-6 - Medicaid	57%	58%	63%	64%	54%	58%	48%	66%	63%	59%	60%	61%	
	Antidepressant Medication Management, Acute - Medicaid	61%	50%	57%	48%	N/A	60%	47%	57%	51%	46%	50%	53%	
	Diabetes: Blood Sugar (HbA1c) Testing - Medicaid	87%	82%	85%	82%	100%	83%	85%	82%	78%	86%	84%	84%	
	Diabetes: Eye Exam - Medicaid	36%	33%	24%	41%	N/A	49%	8%	38%	22%	32%	33%	31%	
	Diabetes: Kidney Disease Screening - Medicaid	88%	87%	90%	85%	93%	79%	81%	81%	81%	87%	86%	86%	
Immunizations	Adolescent HPV immunization rate - Statewide (WAIS)	4%	21%	N/A	30%	N/A	16%	7%	22%	14%	29%	24%	19%	
	Adolescent Tdap & MCV1 immunization rate - Statewide (WAIS)	36%	64%	63%	68%	60%	54%	18%	61%	46%	73%	65%	60%	
	Child Combo 10 HEDIS immunization rate - Statewide (WAIS)	6%	35%	N/A	35%	N/A	18%	N/A	23%	26%	43%	35%	33%	
	Adult Influenza immunization rate - Statewide (BRFSS)	34%	37%	39%	34%	50%	41%	33%	41%	41%	44%	39%	42%	
Hospital Care	Plan All-cause readmissions - Medicaid	13%	10%	N/A	13%	N/A	8%	23%	17%	N/A	12%	12%	15%	
	Emergency Department Utilization per 1000 MM - Medicaid	124	67	51	55	72	41	57	65	43	72	67	51	
	Emergency Department Utilization per 1000 MM, age 0-17 - Medicaid	79	53	34	48	58	31	41	48	31	56	52	36	
	Emergency Department Utilization per 1000 MM, age 18+ - Medicaid	162	84	64	69	84	50	72	85	52	95	86	66	
	Potentially Avoidable ED Visits Percent - Medicaid	21%	18%	11%	21%	21%	16%	15%	16%	16%	19%	19%	15%	
	Potentially Avoidable ED Visits Percent, age 1-17 - Medicaid	31%	24%	N/A	25%	30%	22%	18%	20%	24%	24%	24%	20%	
	Potentially Avoidable ED Visits Percent, age 18+ - Medicaid	17%	15%	12%	16%	15%	13%	13%	13%	13%	15%	15%	13%	

Washington Health Alliance Community Check-Up, 2016

Medicaid Plans

Worse than average Better than average

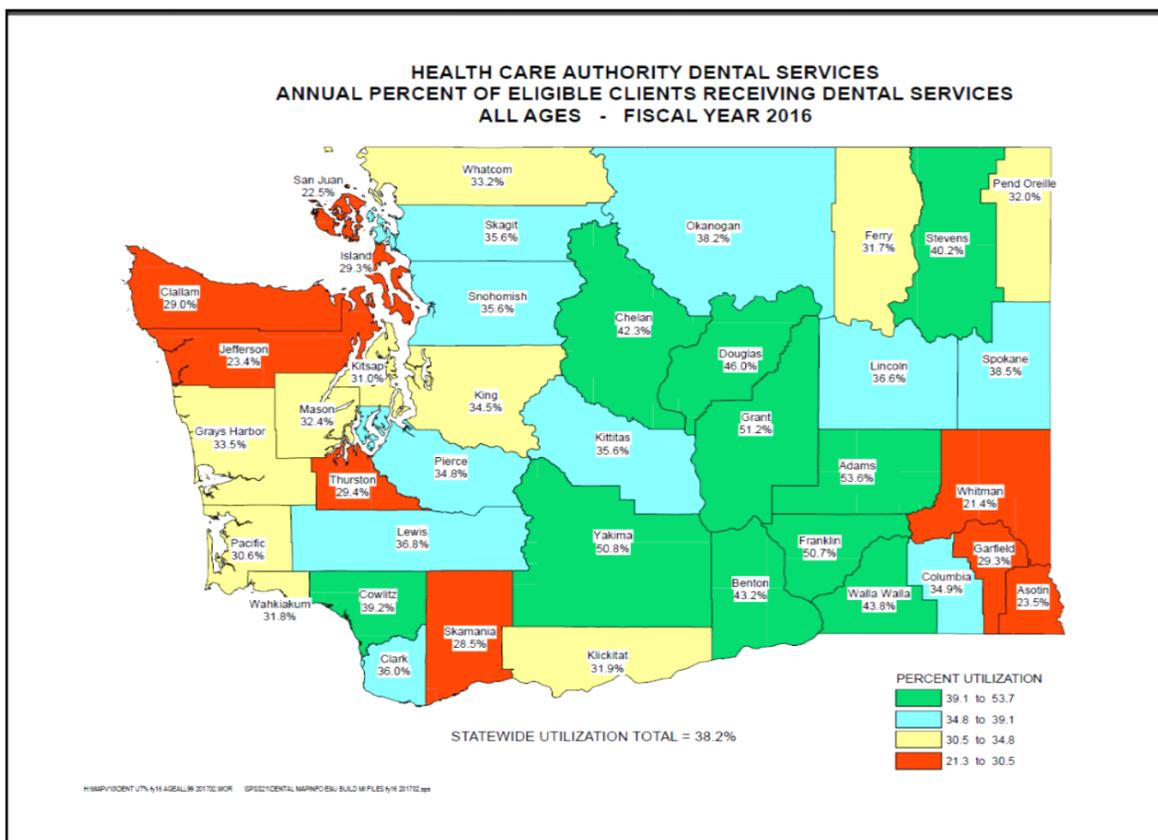
Measure	Asotin		Benton		Columbia		Franklin		Garfield		Kittitas		Walla Walla		Whitman		Yakima		GCACH		WA State	
	Rate	Rating	Rate	Rating	Rate	Rating	Rate	Rating	Rate	Rating	Rate	Rating	Rate	Rating	Rate	Rating	Rate	Rating	Rate	Rating	Rate	
Access to Care	Access to primary care (ages 12–24 months)	93%	Average	90%	Average	N/A	N/A	87%	Average	N/A	N/A	95%	Better	93%	Better	87%	Average	95%	Better	92%	Better	89%
	Access to primary care (ages 2–6 years)	82%	Better	80%	Better	81%	Average	78%	Better	66%	Average	81%	Better	81%	Better	79%	Better	79%	Better	79%	Better	75%
	Access to primary care (ages 7–11 years)	89%	Average	88%	Better	92%	Average	89%	Better	87%	Average	88%	Average	90%	Better	90%	Average	87%	Average	88%	Better	86%
	Access to primary care (ages 12–19 years)	91%	Better	87%	Average	88%	Average	87%	Average	100%	Better	90%	Average	91%	Better	90%	Average	87%	Average	87%	Average	86%
	Access to primary care (ages 20–44)	79%	Better	77%	Better	85%	Better	75%	Better	68%	Average	82%	Better	75%	Average	73%	Average	74%	Average	75%	Better	71%
	Access to primary care (ages 45–64)	78%	Average	77%	Average	93%	Better	75%	Average	84%	Average	83%	Average	76%	Average	79%	Average	74%	Average	76%	Average	75%
	Access to primary care (ages 65+)	89%	Average	86%	Average	72%	Average	88%	Better	N/A	N/A	88%	Average	79%	Average	83%	Average	85%	Average	85%	Average	84%
Potentially Avoidable Care	Appropriate testing for children with sore throat	N/A	N/A	60%	Worse	N/A	N/A	58%	Worse	N/A	N/A	77%	Average	71%	Average	51%	Worse	73%	Better	67%	Average	66%
	Avoiding antibiotics for adults with acute bronchitis	N/A	N/A	21%	Average	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	33%	Average	30%	Average	30%
	Avoiding antibiotics for children with URI	68%	Worse	83%	Worse	N/A	N/A	89%	Worse	N/A	N/A	96%	Average	95%	Average	86%	Worse	93%	Average	90%	Worse	93%
	Avoiding X-ray, MRI and CT scan for low-back pain	N/A	N/A	72%	Average	N/A	N/A	76%	Average	N/A	N/A	66%	Average	80%	Average	N/A	N/A	78%	Average	77%	Average	77%
Potentially avoidable ER visits	25%	Worse	24%	Worse	17%	Average	25%	Worse	17%	Average	17%	Average	16%	Better	16%	Better	23%	Worse	23%	Worse	19%	
Behavioral Health	Mental health services for adults	46%	Average	50%	Better	35%	Worse	41%	Worse	44%	Average	47%	Average	52%	Better	48%	Average	40%	Worse	45%	Worse	46%
	Mental health services for children	64%	Average	66%	Better	59%	Average	58%	Worse	61%	Average	69%	Better	67%	Better	67%	Average	62%	Average	63%	Average	63%
	Substance use disorder services for adults	23%	Average	26%	Worse	20%	Average	27%	Average	N/A	N/A	30%	Average	19%	Worse	21%	Worse	29%	Average	26%	Worse	28%
	Substance use disorder services for children	N/A	N/A	32%	Average	N/A	N/A	29%	Average	N/A	N/A	36%	Average	30%	Average	N/A	N/A	24%	Worse	27%	Worse	36%
Chronic Disease Management	Blood sugar (HbA1c) testing for people with diabetes	61%	Average	59%	Average	N/A	N/A	62%	Average	N/A	N/A	61%	Average	65%	Average	56%	Average	58%	Worse	60%	Average	63%
	Eye exam for people with diabetes	82%	Better	65%	Average	N/A	N/A	58%	Average	N/A	N/A	81%	Better	64%	Average	67%	Average	66%	Average	65%	Average	63%
	Kidney disease screening for people with diabetes	82%	Average	75%	Average	N/A	N/A	72%	Average	N/A	N/A	60%	Average	57%	Worse	67%	Average	70%	Average	70%	Average	71%
	Managing medications for people with asthma	N/A	N/A	59%	Average	N/A	N/A	60%	Average	N/A	N/A	56%	Average	64%	Average	N/A	N/A	51%	Worse	55%	Average	60%
	Spirometry testing to assess and diagnose COPD	N/A	N/A	39%	Better	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	24%	Average	28%	Average	22%
	Statin therapy for patients with cardiovascular disease	N/A	N/A	19%	Average	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	11%	Worse	15%	Average	20%
	Staying on antidepressant medication (12 weeks)	N/A	N/A	55%	Average	N/A	N/A	56%	Average	N/A	N/A	49%	Average	55%	Average	N/A	N/A	52%	Average	54%	Average	58%
	Staying on antidepressant medication (6 months)	N/A	N/A	38%	Average	N/A	N/A	38%	Average	N/A	N/A	N/A	N/A	48%	Average	N/A	N/A	35%	Worse	38%	Average	42%
Medication Management	ADHD medication generic prescriptions	89%	Better	80%	Better	81%	Average	81%	Average	76%	Average	85%	Better	78%	Average	84%	Better	89%	Better	85%	Better	78%
	Antidepressant medication generic prescriptions	96%	Worse	99%	Worse	100%	Average	99%	Worse	100%	Average	98%	Worse	100%	Average	97%	Worse	100%	Average	99%	Worse	100%
	Cholesterol-lowering medication generic prescriptions	95%	Average	97%	Average	100%	Average	98%	Average	100%	Average	83%	Worse	98%	Average	100%	Average	95%	Average	96%	Average	96%
	High-blood pressure medication generic prescriptions	99%	Average	98%	Worse	100%	Average	97%	Worse	100%	Average	100%	Average	100%	Average	100%	Average	99%	Average	99%	Average	99%
	Monitoring patients on high-blood pressure medications	N/A	N/A	82%	Average	N/A	N/A	79%	Average	N/A	N/A	N/A	N/A	85%	Average	N/A	N/A	83%	Average	82%	Average	82%
	Stomach acid medication generic prescriptions	100%	Better	91%	Better	100%	Better	97%	Better	97%	Average	98%	Better	90%	Average	85%	Average	92%	Better	92%	Better	89%
	Taking cholesterol-lowering medications as directed	N/A	N/A	58%	Average	N/A	N/A	53%	Average	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	53%	Average	55%	Average	57%
	Taking diabetes medications as directed	N/A	N/A	41%	Average	N/A	N/A	47%	Average	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	48%	Average	45%	Average	45%
Taking hypertension medications as directed	N/A	N/A	53%	Average	N/A	N/A	64%	Average	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	57%	Average	58%	Average	59%	
Preventive Care	Adolescent well-care visits	39%	Average	37%	Worse	28%	Worse	41%	Average	27%	Worse	41%	Average	40%	Average	49%	Better	39%	Worse	39%	Worse	41%
	Breast cancer screening	N/A	N/A	27%	Average	N/A	N/A	32%	Average	N/A	N/A	N/A	N/A	26%	Average	N/A	N/A	25%	Average	27%	Average	27%
	Cervical cancer screening	65%	Average	59%	Better	42%	Average	60%	Average	N/A	N/A	68%	Better	61%	Better	50%	Average	62%	Better	60%	Better	55%
	Chlamydia screening	N/A	N/A	49%	Average	N/A	N/A	51%	Average	N/A	N/A	39%	Worse	50%	Average	45%	Average	56%	Better	53%	Average	51%
	Colon cancer screening	53%	Average	52%	Better	N/A	N/A	48%	Average	N/A	N/A	47%	Average	44%	Average	33%	Average	42%	Average	45%	Average	43%
	Well-child visits (ages 3-6 years)	59%	Average	57%	Average	55%	Average	58%	Average	N/A	N/A	54%	Average	66%	Better	60%	Average	59%	Average	58%	Average	58%

GCACH includes Klickitat

Cross-system outcome measures for adults enrolled in Medicaid - 2015

Source: DSHS RDA

	GCACH	WA State	
HCBS and Nursing Facility Utilization Balance	93%	92%	
Mental Health Treatment Penetration - Broad Definition	41%	43%	●
Percent Arrested	7%	6%	●
Percent Employed	57%	50%	
Percent Homeless - Broad Definition	9%	12%	
Plan All-Cause 30-Day Readmission	13%	16%	
Psychiatric Inpatient 30-Day Readmission	11%	13%	
Substance Use Disorder Treatment Penetration	24%	27%	●



Service Contracting Entity: Medicaid Enrollees with Mental Health Service Needs
Medicaid Coverage Population: All Medicaid
Performance Measure: Percent Arrested
 Dual Eligibles Included? Yes
 Third-party coverage included? Yes
 Age group 18+

November 9, 2016

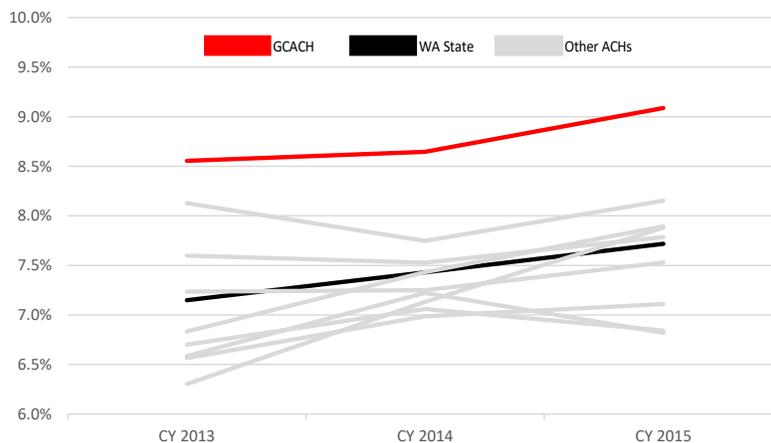
Accountable Community of Health	CY 2013	CY 2014	CY 2015
	1/13-12/13	1/14-12/14	1/15-12/15
Statewide	7.1%	7.4%	7.7%
Better Health Together	6.8%	7.4%	7.9%
Cascade Pacific Action Alliance	6.3%	7.1%	7.9%
Greater Columbia	8.6%	8.6%	9.1%
King	7.2%	7.2%	7.5%
North Central	8.1%	7.7%	8.2%
North Sound	7.6%	7.5%	7.8%
Olympic	6.7%	7.1%	6.8%
Pierce	6.6%	7.0%	7.1%
SW WA Regional Health Alliance	6.6%	7.2%	6.8%
	7.1%	7.4%	7.7%



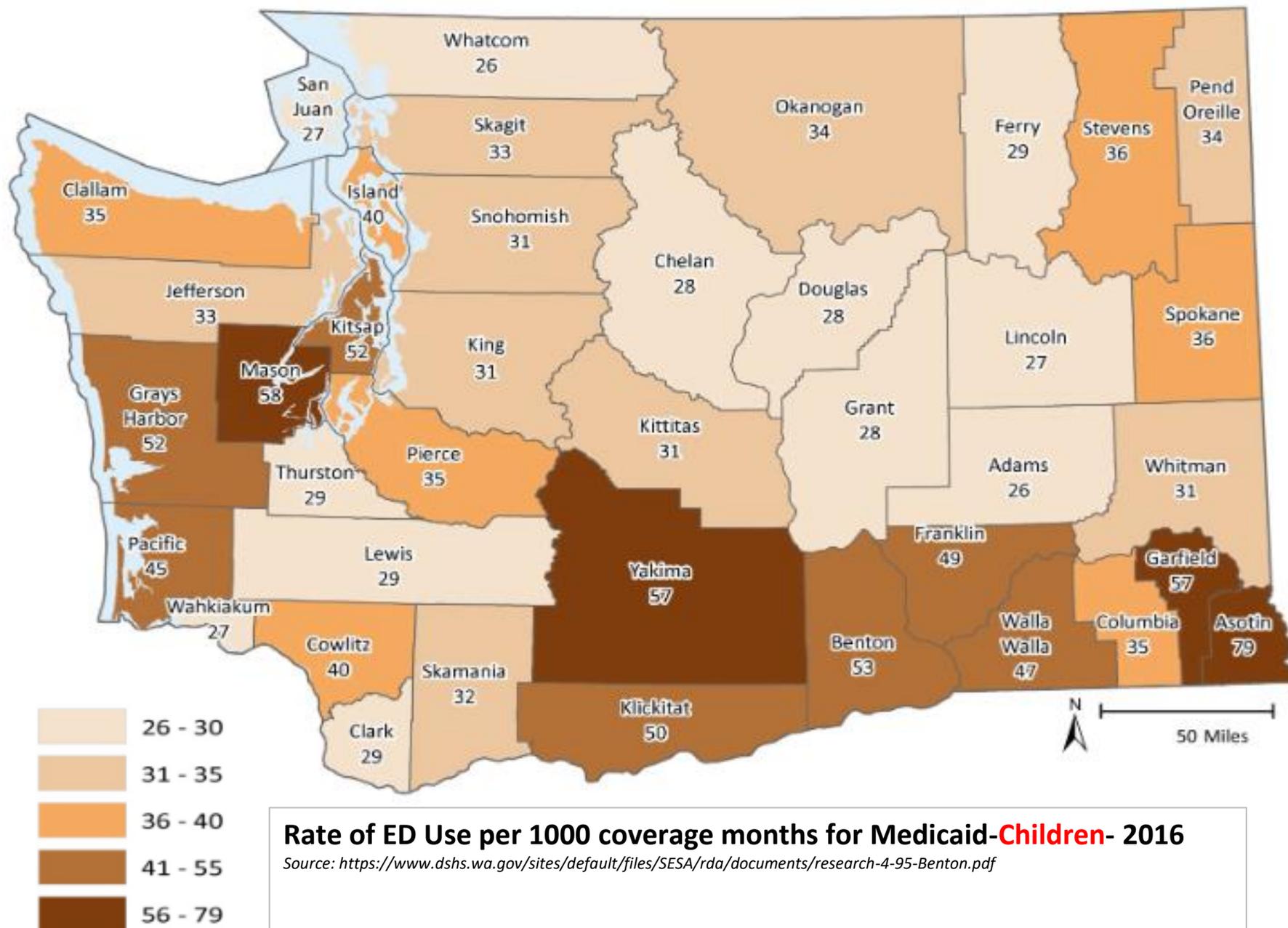
Accountable Community of Health	CY 2013		CY 2014		CY 2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
Statewide	14,579	203,952	24,640	331,686	30,806	399,174
Better Health Together	1,713	25,071	3,013	40,547	3,884	49,195
Cascade Pacific Action Alliance	1,458	23,132	2,622	36,770	3,494	44,339
Greater Columbia	1,895	22,151	3,245	37,532	4,191	46,118
King	3,456	47,765	5,510	76,001	6,740	89,523
North Central	513	6,311	808	10,430	1,025	12,573
North Sound	2,255	29,679	3,756	49,899	4,702	60,388
Olympic	735	10,970	1,275	18,061	1,499	21,907
Pierce	1,768	26,937	2,924	41,857	3,608	50,744
SW WA Regional Health Alliance	786	11,936	1,487	20,589	1,663	24,387

NOTES:

Different coverage groups have significantly different characteristics and experiences. Regions vary in the share of their caseloads comprised of different coverage groups. Reviewing trends and regional differences by major coverage group supports more valid comparisons of client experiences across regions. See the public reporting website for detailed information about measure specifications, attribution of clients to service contracting entities and guidance on interpretation of measure results. Information in subgroups with fewer than 10 clients in the denominator is suppressed.

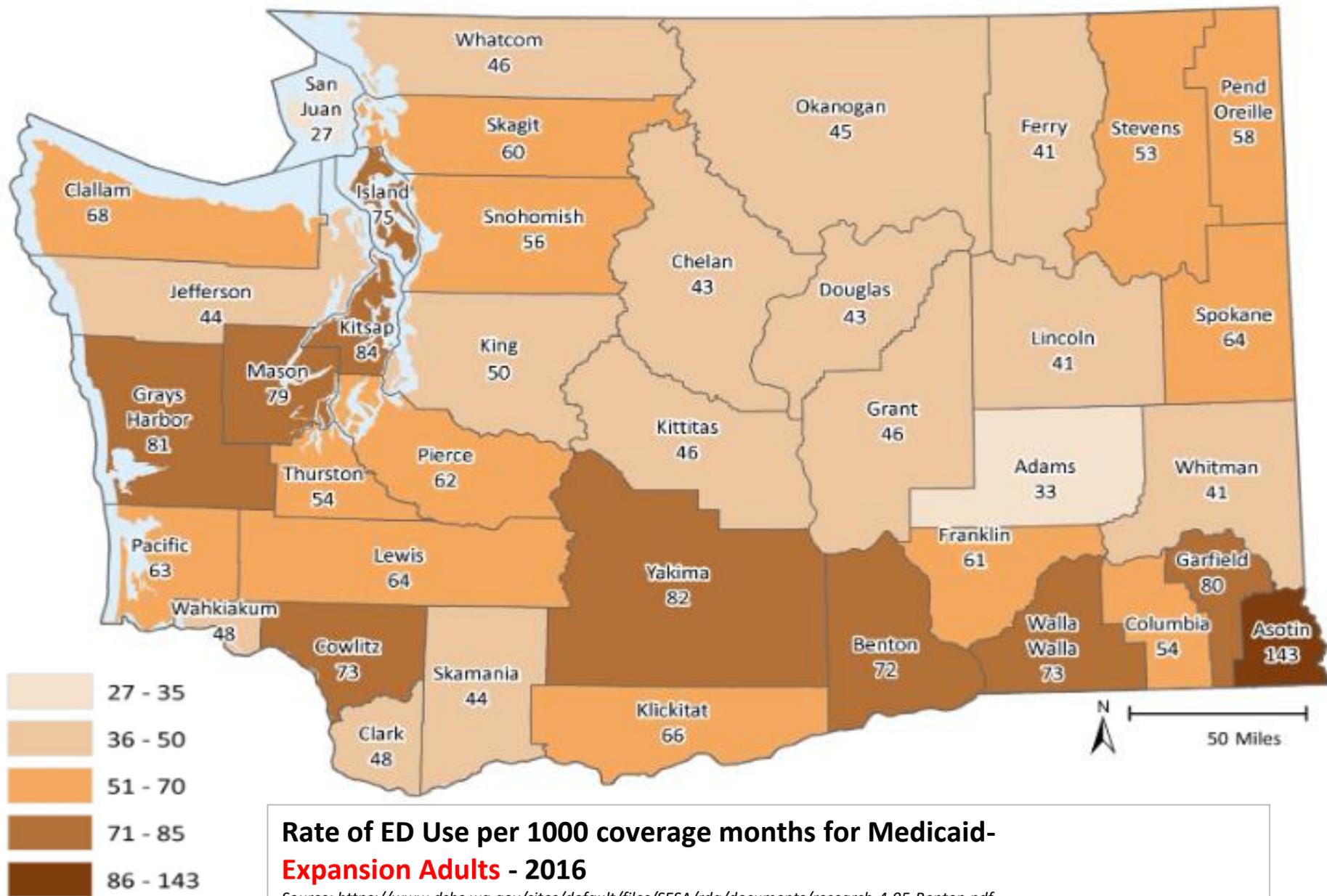


Emergency Department Utilization per 1000 Coverage Months - Medicaid



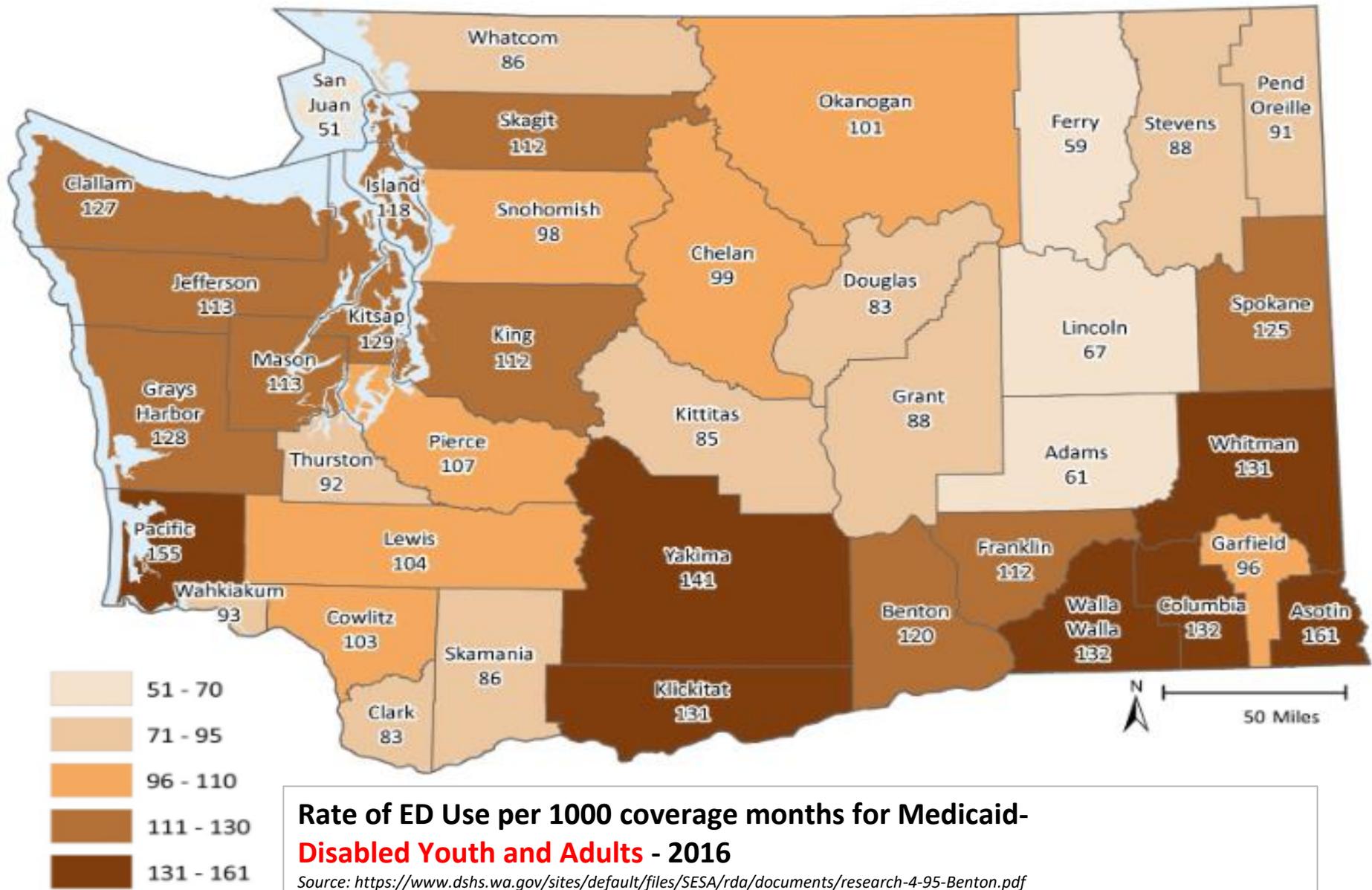
Rate of ED Use per 1000 coverage months for Medicaid-Children- 2016

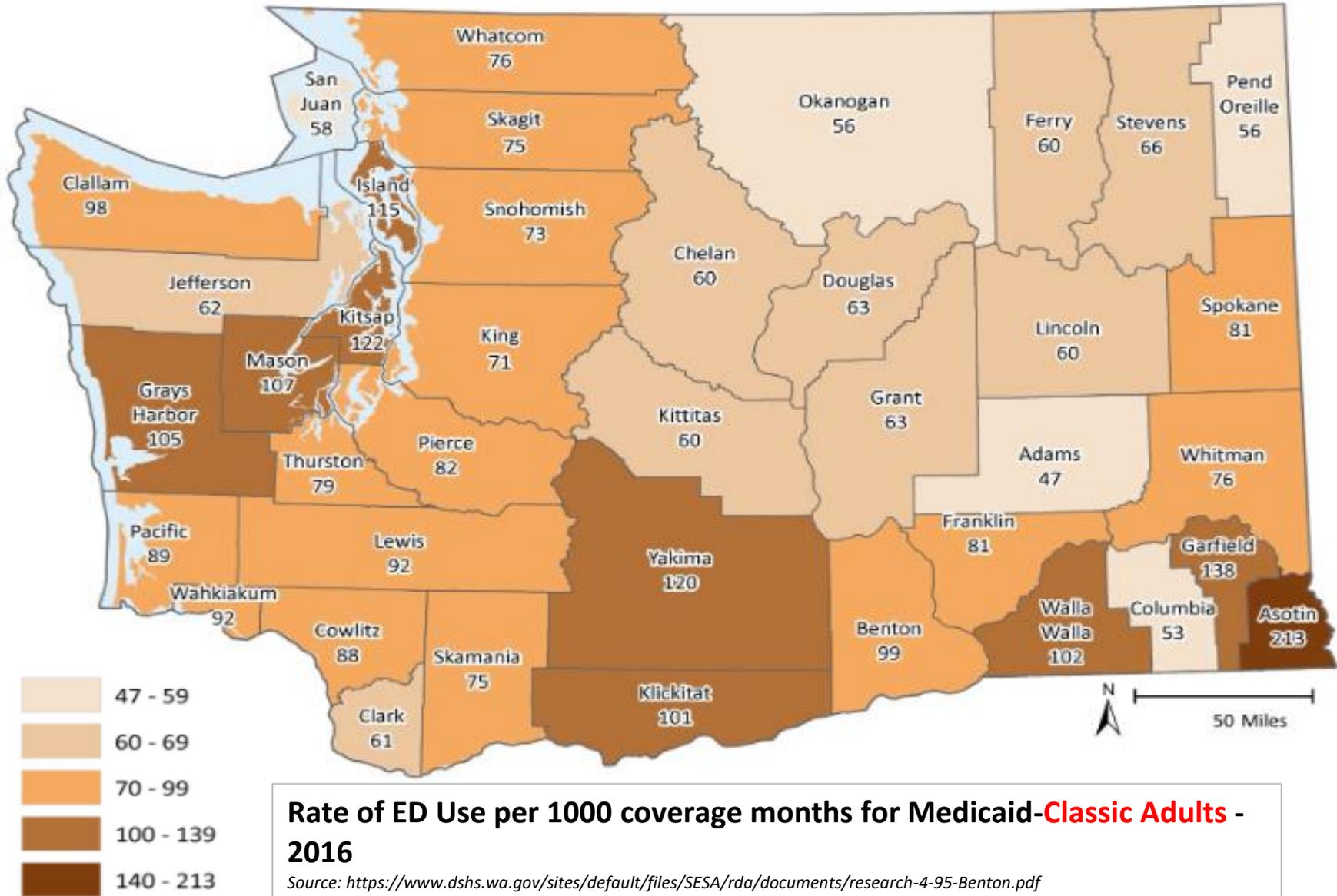
Source: <https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-4-95-Benton.pdf>



Rate of ED Use per 1000 coverage months for Medicaid-Expansion Adults - 2016

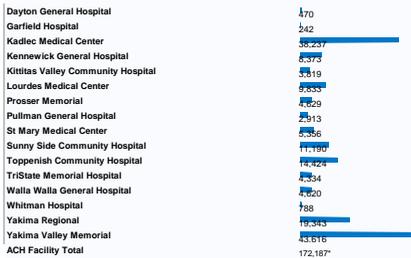
Source: <https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-4-95-Benton.pdf>





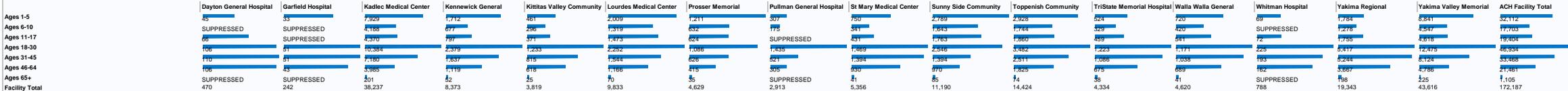
ED Utilization of Medicaid Recipients Using Hospitals in Greater Columbia During Oct 1, 2015-Sep 30, 2016

COUNTS BY HOSPITAL



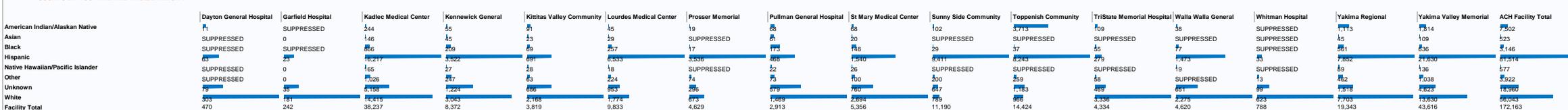
* The data bars display the distribution of ED visits visually among acute care hospitals in Greater Columbia.

COUNTS BY HOSPITAL AND AGE GROUP



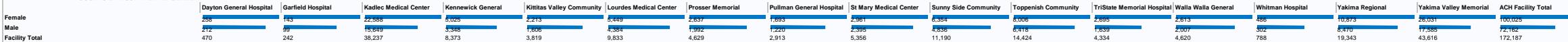
* The data bars display the age distribution of ED visits visually within each hospital.

COUNTS BY HOSPITAL AND RACE/ETHNICITY



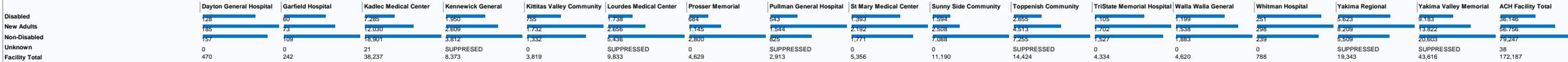
* The data bars display the race/ethnicity distribution of ED visits visually within each hospital.

COUNTS BY HOSPITAL AND GENDER



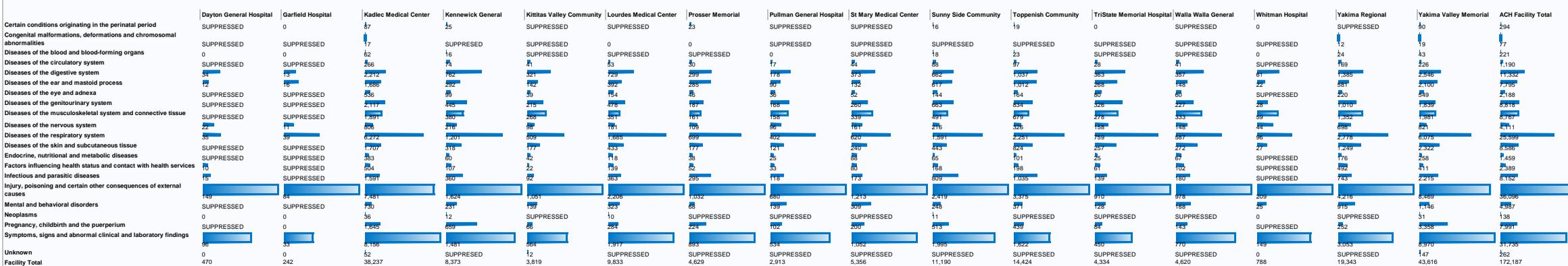
* The data bars display the gender distribution of ED visits visually within each hospital.

COUNTS BY HOSPITAL AND COVERAGE GROUP



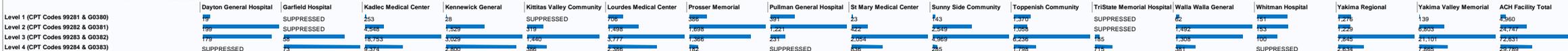
* The data bars display the distribution of ED visits by coverage group within each hospital.

COUNTS BY HOSPITAL AND ICD10 DISEASE CATEGORIES
(Based on Primary Diagnosis Causing the ER Encounter)



* The data bars display the distribution of ED visits visually by diagnosis group within each hospital.

COUNTS BY HOSPITAL AND TRIAGE LEVELS



Level 5 (CPT Codes 99285 & G0384)	3	40	3,030	381	SUPPRESSED	595	25	SUPPRESSED	284	73	135	271	88	SUPPRESSED	206	1,480	6,776
Other (All Other CPT Codes)	SUPPRESSED	SUPPRESSED	2,279	606	1,624	871	872	1,026	1,727	5,171	3,827	5,165	1,282	582	6,153	6,228	33,284
Facility Total	470	242	38,237	8,373	3,819	9,833	4,629	2,913	5,356	11,190	14,424	4,334	4,620	788	19,343	43,616	172,187

* The data bars display the distribution of ED visits visually by triage groups within each hospital.

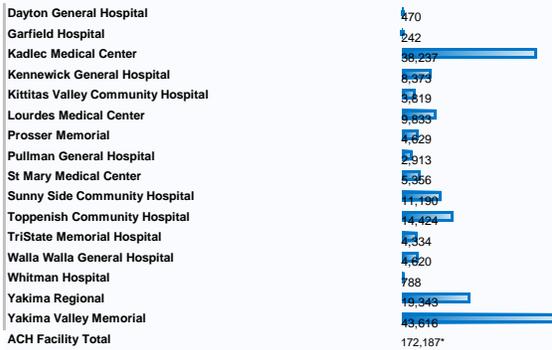
NUMBER OF ED VISITS BY WA STATE ZIPCODES WITH 10 OR MORE VISITS

Residential Postal Zip Codes of ED Utilizers	Counts (N 10+)
98902	20,356
99301	18,522
98901	15,788
99336	15,415
99362	7,645
98944	7,498
98951	7,403
98908	6,553
98948	6,407
99337	5,398
98903	5,173
99354	4,404
99352	3,977
99403	3,850
98930	3,582
98942	3,564
98926	2,805
99350	2,229
98932	2,185
99320	2,001
99163	1,786
99353	1,703
98936	1,428
98935	1,381
99324	1,355
98952	1,350
98953	1,337
99338	1,236
98947	878
98937	676
98938	653
99328	556
99349	547
99323	484
98933	482
99111	365
99343	361
99348	348
99347	335
98923	327
98921	321
99326	286
98922	269
98904	247
99344	246
99402	220
98939	209
99361	186
98837	172
98934	155
99201	143
99102	138
98801	131
99130	120
99330	119
99207	117
99360	110
99202	104
98507	98
98620	93
99143	84
99208	84
99004	76
99363	74
98104	73
98201	73
98101	71
98404	71
99161	69
98802	68
98907	65
99205	64
99216	63
98661	61
98920	61
99206	59
99329	56
98225	55
98584	55
98632	55
98932	54
99321	54
99033	52
98444	51
98003	47
98273	46
98503	46
98682	46
99125	46
99223	46
98002	44
99179	44
98992	43

98271	42
98366	42
98204	41
98223	39
99224	39
98943	38
98848	37
99113	37
98023	36
98229	36
98312	36
98405	36
98909	36
98946	36
99346	36
98520	35
99170	35
98258	34
98362	34
98118	33
99218	33
99335	33
98001	32
98031	32
98106	32
98532	32
98226	31
98382	31
98499	31
98941	31
99149	31
99217	31
98272	30
98823	30
99171	30
99302	29
99401	29
98208	28
98857	28
98203	27
98233	27
98512	27
98531	27
98940	27
98198	26
98367	26
98597	26
98684	26
99204	26
98030	25
98042	25
98178	25
98168	24
98270	24
98374	24
98950	24
98058	23
98134	23
98371	23
98391	23
98501	23
99212	23
98502	22
98665	22
98052	21
98277	21
99158	21
98248	20
98387	20
98408	20
98626	20
98466	19
98422	18
98498	18
98012	18
98108	17
98247	17
98284	17
98418	17
99169	17
99357	17
98264	16
98290	16
98390	16
98577	16
98639	16
98855	16
99345	16
98010	15
98055	15
98166	15
98230	15
98296	15
98310	15
98373	15
98445	15
99003	15
99156	15
98022	14
98274	14
98361	14

ED Utilization of Medicaid Recipients Using Hospitals in Greater Columbia During Oct 1, 2015-Sep 30, 2016 Demographic Analysis

COUNTS BY HOSPITAL



* The data bars display the distribution of ED visits visually among acute care hospitals in Greater Columbia.

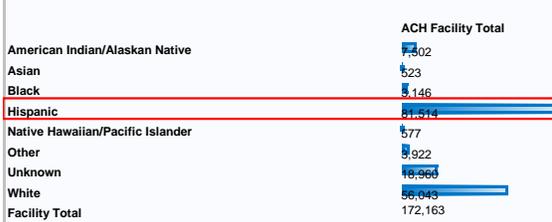
COUNTS BY HOSPITAL AND AGE GROUP



* The data bars display the age distribution of ED visits visually within each hospital.

An HCA analysis requested by the GCACH examined ED usage for the Medicaid population for the time period October 1, 2015-September 30, 2016. Most Medicaid ED visits appear to be concentrated in young adults (ages 18-30). This is a high-utilizing for WA State overall as well. However, there was a far lower proportion of adolescents (ages 11-17) with high ED utilization compared to the statewide total.

COUNTS BY HOSPITAL AND RACE/ETHNICITY



* The data bars display the race/ethnicity distribution of ED visits visually within each hospital.

There might be some misconception that Hispanics are the more frequent utilizers of the ED when compared to non-Hispanics. Data seems to confirm that many Medicaid ED visits originate from the Hispanic population. However, the proportion of overall ED visits tied to Hispanics in the GCACH (47%) is less than the proportion this sub-population makes up in the GCACH (50%). This might corroborate national research on high-cost, high-utilizing populations, which tend to be older, female, white, less educated, low-income and having fair or poor self-reported health.

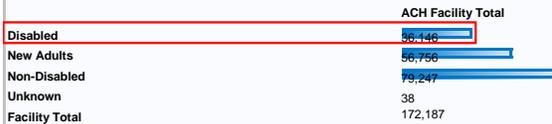
COUNTS BY HOSPITAL AND GENDER



* The data bars display the gender distribution of ED visits visually within each hospital.

The proportion of ED visits from female clients (58%) outnumbered those from male clients, which corresponds to what national research indicates as typical, while this portion is greater than the proportion of females in the GCACH population (53%). The GCACH has abnormally high ED utilization, which may be coming from a high number of "super-utilizers" (those with five or more visits per client). Research on super-utilizers indicates they consist of a higher percentage of female users than the normal population.

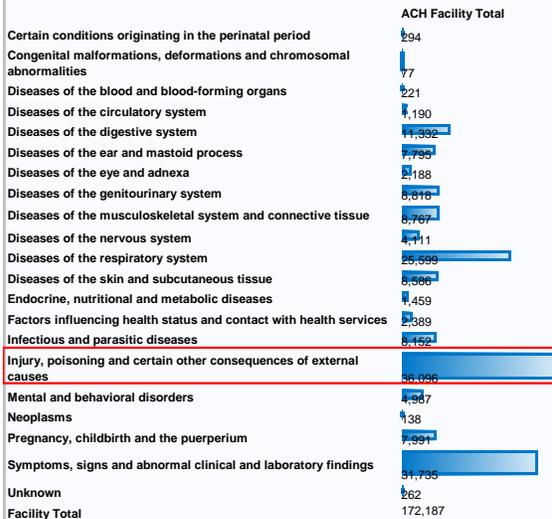
COUNTS BY HOSPITAL AND COVERAGE GROUP



* The data bars display the distribution ED visits by coverage group within each hospital.

The proportion of ED visits linked to disabled clients (21%) far outnumbers the proportion of that sub-population (7%) in the GCACH overall, which is considered to be normal.

COUNTS BY HOSPITAL AND ICD10 DISEASE CATEGORIES (Based on Primary Diagnosis Causing the ER Encounter)



* The data bars display the distribution of ED visits visually by diagnosis groups within each hospital.

There are a high number of ED diagnoses for injuries and poisonings from external causes. Many of these could be attributed to substance abuse (e.g. opioid) or alcohol overdoses. This high number is proportional to fatalities for these underlying causes and appears to be consistent with similar fatality rates in other ACHs.

COUNTS BY HOSPITAL AND TRIAGE LEVELS

ACH Facility Total

Level 1 (CPT Codes 99281 & G0380)	4,960
Level 2 (CPT Codes 99282 & G0381)	24,747
Level 3 (CPT Codes 99283 & G0382)	72,691
Level 4 (CPT Codes 99284 & G0383)	29,789
Level 5 (CPT Codes 99285 & G0384)	6,776
Other (All Other CPT Codes)	59,264
Facility Total	172,187

* The data bars display the distribution of ED visits visually by triage groups within each hospital.

Approximately 17% of visits were classified as Level 1 and Level 2. Triage level can act as a proxy for patient severity with Levels 1 and 2 being least severe. Ideally, we would like to see most visits categorized as Levels 3-5, which indicates appropriate use of the ED (assuming there is no upcoding). A large grouping of visits in levels 1 and/or 2 might indicate that there are a large number of patients visiting the ER who might be more suitable for primary care, urgent care or even self-management. This could lead to educational opportunities at the individual or community level. This insight is based on experience examining historical ED utilization and working with Consistent Care, a statewide care coordination agency.

Snapshot of Homelessness in Washington State for January 2016

Based on Total Basic Food Population

Includes recipients, denials, closings, and associated household members

Unstably Housed and Homeless Persons, by Household Type and County

County / State	Total Homeless	Child Only	Parenting Teens	Youth (18-24) w/o Children	Adults (25+) w/o Children	Single Parent with Children	Two Parents with Children	Unknown	Population (4/1/2016 estimate)	Homeless Rate Per 1000	Graph
Asotin	725	-	-	107	377	176	65	-	22,150	32.7	
Benton/Franklin	3,822	*	*	708	1,790	947	366	*	279,170	13.7	
Columbia	77	-	-	11	28	24	14	-	4,050	19.0	
Garfield	37	-	-	*	17	*	*	-	2,200	16.8	
Kittitas	526	*	-	90	278	108	49	-	43,710	12.0	
Walla Walla	1,122	*	-	189	543	290	99	-	60,730	18.5	
Whitman	284	*	-	45	119	95	24	-	47,940	5.9	
Yakima	6,774	*	-	1,024	3,310	1,720	706	*	250,900	27.0	
GCACH	13,367	N/A	N/A	2,174	6,462	3,360	1,323	N/A	710,850	18.8	
Washington State	141,464	248	41	20,630	77,014	31,028	12,481	22	7,183,700	19.7	

Source: <http://www.commerce.wa.gov/wp-content/uploads/2015/11/hau-hmis-snapshot-homelessness-1-2016.pdf>

Source: http://www.ofm.wa.gov/pop/april1/ofm_april1_population_final.pdf

NOTES: "Homeless or Unstably Housed" refers to all homeless and all unstably housed, including couch surfing. "Homeless Only" is a subset of "homeless or unstably housed" and refers only to unsheltered clients or those living in emergency shelter. "New" homelessness refers to clients who are homeless in the current month but not in the month previous, while "continuing" refers to all homeless clients. There might be larger numbers for "homeless only" columns because a transition from "unstably housed or homeless" to "homeless only" is counted as "new" homelessness. Columns cannot be added across rows because the continuing and "Homeless or Unstably Housed" categories include new and "Homeless Only" categories, respectively. Household classification is derived from the HUD categories of "Households without children," "Households with at least one adult and one child," and "Households with only children." HUD classified households do not necessarily correspond to Basic Food assistance units (AUs). The housing data fields used in this report are updated at initial application, with a change in circumstance, and semi-annually at the mid-year review, for as long as the client's Assistance Unit is receiving basic food benefits.

Run Date 2016-07-11

Opioid Use, Medicaid population

Source: Providence Core Starter Kit

■ Worse than WA State average ■ Better than WA State average

Washington State, Fiscal Year 2016, Medicaid only population with full medical eligibility, Medicaid eligibles excluding dual Medicare eligibles, third party liability and partial medical eligibility

GREATER COLUMBIA ACH Category	Ns (Total number under the strata)										% (Percentages)			
	All Medicaid Opioid Users	Opioid Users with no Cancer Diagnosis history	Heavy Opioid Users	Users of opiates for >30 days	Heavy Opioid Users with no Cancer Diagnosis History	Medicaid Users of opiates for >30 days with no Cancer Diagnosis History	Diagnosis of Opioid Abuse/Dependence	Medication Assisted Treatment (MAT)		Medicaid Opioid Prescribing Providers	% Heavy Opioid Users	% Users of opiates for >30 days	% MAT With Buprenorphine	% MAT With Methadone
								Buprenorphine	Methadone					
Measure Number ->	1	2	3	4	5	6	7	8	9	10	(5)/(2)	(6)/(2)	(8)/(7)	(9)/(7)
Overall	34,720	30,964	6,889	7,649	5,922	6,242	4,184	664	200	1,267	19.13%	20.16%	15.87%	4.78%
Gender Female	22,057	19,418	4,372	4,802	3,714	3,829	2,310	310	109		19.13%	19.72%	13.42%	4.72%
Gender Male	12,663	11,546	2,517	2,847	2,208	2,413	1,874	354	91		19.12%	20.90%	18.89%	4.86%
Age Bands Ages 0-9	490	482	SN	SN	SN	SN	13	0	0		#VALUE!	#VALUE!	0.00%	0.00%
Age Bands Ages 10-19	3,802	3,660	629	50	600	44	82	SN	0		16.39%	1.20%	#VALUE!	n/a
Age Bands Ages 20-29	8,141	7,765	1,655	735	1,552	677	904	204	41		19.99%	8.72%	22.57%	4.54%
Age Bands Ages 30-39	7,265	6,649	1,435	1,614	1,297	1,422	1,215	241	62		19.51%	21.39%	19.84%	5.10%
Age Bands Ages 40-49	4,854	4,177	1,007	1,700	841	1,394	695	83	32		20.13%	33.37%	11.94%	4.60%
Age Bands Ages 50-59	4,777	3,745	1,049	1,962	758	1,493	649	50	32		20.24%	39.87%	7.70%	4.93%
Age Bands Ages 60-69	1,916	1,409	424	853	275	615	229	SN	16		19.52%	43.65%	#VALUE!	6.99%
Age Bands Ages 70-79	30	25	SN	11	SN	SN	0	0	0		#VALUE!	#VALUE!	#DIV/0!	#DIV/0!
Age Bands Ages 80+	14	13	SN	SN	SN	SN	0	0	0		#VALUE!	#VALUE!	#DIV/0!	#DIV/0!
Race/Ethnicity Non Hispanic White	17,557	15,275	3,653	5,054	3,075	4,076	2,900	516	133		20.13%	26.68%	17.79%	4.59%
Race/Ethnicity Non Hispanic AI/AN	1,574	1,449	212	286	185	251	190	SN	12		12.77%	17.32%	#VALUE!	6.32%
Race/Ethnicity Non Hispanic Black	717	643	139	164	117	135	108	SN	SN		18.20%	21.00%	#VALUE!	#VALUE!
Race/Ethnicity Hispanic	12,886	11,824	2,457	1,756	2,181	1,469	773	95	43		18.45%	12.42%	12.29%	5.56%
Race/Ethnicity Other/UNK	1,986	1,773	428	389	364	311	213	26	SN		20.53%	17.54%	12.21%	#VALUE!

WASHINGTON STATE

WASHINGTON STATE Category	Ns (Total number under the strata)										% (Percentages)			
	All Medicaid Opioid Users	Opioid Users with no Cancer Diagnosis	Heavy Opioid Users	Users of opiates for >30 days	Heavy Opioid Users with no Cancer	Medicaid Users of opiates for >30 days	Diagnosis of Opioid Abuse/Dependence	Medication Assisted Treatment (MAT)		Medicaid Opioid Prescribing Providers	% Heavy Opioid Users	% Users of opiates for >30 days	% MAT With Buprenorphine	% MAT With Methadone
								Buprenorphine	Methadone					
Measure Number ->	1	2	3	4	5	6	7	8	9	10	(5)/(2)	(6)/(2)	(8)/(7)	(9)/(7)
Overall	258,254	226,817	53,784	52,664	45,398	41,924	51,798	5,121	8,617	12,921	20.02%	18.48%	9.89%	16.64%
Gender Female	159,912	138,513	33,193	32,644	27,771	25,529	26,533	2,605	4,605		20.05%	18.43%	9.82%	17.36%
Gender Male	98,342	88,304	20,591	20,020	17,627	16,395	25,265	2,516	4,012		19.96%	18.57%	9.96%	15.88%
Age Bands Ages 0-9	3,513	3,403	20	40	17	29	166	0	0		0.50%	0.85%	0.00%	0.00%
Age Bands Ages 10-19	22,040	21,208	3,723	227	3,565	196	624	14	SN		16.81%	0.92%	2.24%	SN
Age Bands Ages 20-29	51,888	49,499	10,686	3,546	10,105	3,245	12,311	1,604	1,800		20.41%	6.56%	13.03%	14.62%
Age Bands Ages 30-39	56,924	51,968	11,885	9,955	10,630	8,689	14,986	1,882	2,866		20.45%	16.72%	12.56%	19.12%
Age Bands Ages 40-49	39,479	33,818	8,417	11,240	6,912	9,197	8,180	682	1,344		20.44%	27.20%	8.34%	16.43%
Age Bands Ages 50-59	41,095	31,825	9,392	15,395	6,817	11,451	7,652	351	1,245		21.42%	35.98%	4.59%	16.27%
Age Bands Ages 60-69	17,436	12,357	4,221	7,088	2,741	4,950	2,848	82	519		22.18%	40.06%	2.88%	18.22%
Age Bands Ages 70-79	264	196	57	51	34	35	SN	0	0		17.35%	17.86%	SN	SN
Age Bands Ages 80+	115	93	23	23	15	19	SN	0	0		16.13%	20.43%	SN	SN
Race / Ethnicity Non Hispanic White	163,351	141,277	34,129	38,921	28,316	30,778	37,827	3,806	6,549		20.04%	21.79%	10.06%	17.31%
Race / Ethnicity Non Hispanic AI/AN	9,748	8,841	1,821	2,156	1,604	1,795	3,407	525	523		18.14%	20.30%	15.41%	15.35%
Race / Ethnicity Non Hispanic Black	20,131	18,085	4,180	3,350	3,599	2,713	3,023	131	535		19.90%	15.00%	4.33%	17.70%
Race / Ethnicity Hispanic	37,201	33,966	7,596	4,447	6,779	3,649	3,668	382	517		19.96%	10.74%	10.41%	14.09%
Race / Ethnicity Other/UNK	27,823	24,648	6,058	3,790	5,100	2,989	3,873	277	493		20.69%	12.13%	7.15%	12.73%

1: Any Medicaid only client with at least one claim for prescription opioids (Generic Product Identifier (GPI)=65) excluding MAT treatment

2: Uses HCA definition for cancer diagnosis (ICD9 140-239 and ICD10 C00-C99) over a 2-year claim history

3: >=50 MED (morphine equivalency dose) calculated as average daily MED based on all the opioid scripts of the Medicaid client in the year; Based on the CDC definition of MED

4: Based on a cumulative days supply of over 30 days in measurement year

5: Uses HCA definition for cancer diagnosis (ICD9 140-239 and ICD10 C00-C99) over a 2-year claim history and >=50 MED (morphine equivalency dose) calculated as average daily MED based on all the opioid scripts of the Medicaid client in the year; Based on the CDC definition of MED

6: Uses HCA definition for cancer diagnosis (ICD9 140-239 and ICD10 C00-C99) over a 2-year claim history and Based on a cumulative days supply of over 30 days in measurement year

7: Diagnosis of opioid abuse/dependence using appropriate ICD9 & ICD 10 codes in 2 year claim history

8: Limited to those with a diagnosis of opioid abuse/dependence and dosage forms of Buprenorphine (Suboxone etc., defined by GPIs) and Methadone (Healthcare Common Procedure Coding System (HCPCS)=H0020) indicated for medication assisted treatment (MAT)

9: Limited to those with a diagnosis of opioid abuse/dependence and Methadone (Healthcare Common Procedure Coding System (HCPCS)=H0020) indicated for medication assisted treatment (MAT)

10: Any Medicaid provider prescribing opioids

All Opioids - Prescription and Illicit - Fatal Overdoses
Greater Columbia ACH

Geography: County, Time Period: 2011-2015

Source: Washington Tracking Network: <https://fortress.wa.gov/doh/wtn/WTNPortal/>

County	Count	Age Adjusted Rate
WA State Total	3480	9.7
Asotin	12	10.7
Benton	76	8.6
Columbia	2	16.4
Franklin	17	4.4
Garfield	0	0
Klickitat	5	4.7
Walla Walla	23	7.9
Whitman	11	7
Yakima	64	5.4

All Opioids - Prescription and Illicit - Fatal Overdoses

Geography: County, Time Period: 2011-2015

Created: 11/14/2017

 Worse than WA State average  Better than WA State average

GCACH County Demographic Profile Summaries

	Asotin	Benton	Columbia	Franklin	Garfield	Kittitas	Walla Walla	Whitman	Yakima
County Demographics	Older, Caucasian, disabled	Younger, high Hispanic, population growth	Small population, older, disabled, rural	Younger, high Hispanic, low English proficiency, families with children, very rapid growth	Very small population, older, disabled, Caucasian, 100% rural,	Slightly older, Caucasian, rural, population growth	Hispanic population,	Proportionally large middle-age population, Caucasian, rural,	Younger, large American Indian, large Hispanic, families with children, lower English proficiency, more rural
Social & Economic Factors	Low income, less educated, children in poverty, injury deaths	Wealthier, children in poverty,	Low income, children in poverty, injury deaths	Higher unemployment, lower graduation rate, children in poverty, lower social mobility	Lower income, children in poverty,	Lower income, income inequality, some injury deaths,	Lower income, some children in poverty, injury deaths,	Low income with income inequality,	Low income, unemployment, lower graduation, many children in poverty,
Health Behaviors	Obese, physically inactive, injuries and alcohol-impaired deaths, teen births (white),	Obese, physically inactive, alcohol, teen births	Smoking, obesity, physically inactive, high alcohol-impaired deaths, limited access to healthy foods,	Obese, physically inactive, high STI, very high teen births, limited access to healthy food,	Obese, smoking, physically inactive, very limited access to healthy foods,	Some obesity, poor food environment,	Some physical inactivity, some limited access to healthy foods, overdose drug deaths,	Some limited access to healthy foods, excessive drinking, high STI,	Smoking, obese, physically inactive, much higher alcohol-related deaths, much higher STIs, much higher teen births
Clinical Care	Dental shortage, low well-child visits, low immunizations, high ED visits,	PCP shortage, dental shortage, mental health shortage, many preventable hospital days, low well-child visits, poor anti-depressant medication management, high ED visits, poor adult SUD services,	Dental shortage, mental health shortage, low mammogram screening, poor adult mental health services, low well-child visits,	High uninsured, PCP shortage, dental shortage, mental health shortage, ,many preventable hospital days, poor anti-depressant medication management, high ED visits, poor adult and child mental health services,	PCP shortage, dental shortage, behavioral health shortage, low well-child visits, high ED visits,	PCP shortage, dental shortage, behavioral health shortage, preventable hospital days, low well-child visits, low immunizations,	Some uninsured, poor adult SUD services,	PCP shortage, dental shortage, mental health shortage, preventable hospital days, , poor anti-depressant medication management, low immunizations, poor adult SUD services,	Much higher uninsured, PCP shortage, dental shortage, behavioral health shortage, many more preventable hospital stays, low well-child visits, poor anti-depressant medication management, high ED visits, poor adult mental health services, poor children SUD services, poor chronic disease management,
Health Outcomes	High mortality, self-reported health is poor, diabetes, asthma	Diabetes	High premature death rate, self-reported health is poor, diabetes	Self-reported health is poor,	Diabetes	Asthma	High premature death rate, self-reported poor physical health,	self-reported poor physical and mental health,	Much higher premature deaths, much higher self-reported poor physical health, diabetes