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

Revised
October 18, 2017
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## PROJECT PLAN TEMPLATE OVERVIEW

<table>
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<tr>
<th>Sub-Section</th>
<th>Response Format</th>
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<td>Implementation Approach and Timing</td>
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**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

<table>
<thead>
<tr>
<th>ACH</th>
<th>SW Washington ACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Dawn Bonder</td>
</tr>
<tr>
<td>Phone Number</td>
<td>360-553-1845</td>
</tr>
<tr>
<td>E-mail</td>
<td><a href="mailto:Dawn.bonder@southwestach.org">Dawn.bonder@southwestach.org</a></td>
</tr>
</tbody>
</table>

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

Describe how the ACH has used data to inform its project selection and planning.

As part of project selection and design, the Southwest Accountable Community of Health (SWACH) is using data to:

- Identify health care and community needs, gaps, and potential disparities
- Explore populations in order to inform the theory of action and understand project impact
- Identify partnering providers and organizations and engage stakeholders

SWACH began by reviewing community health needs assessments (county, regional, and hospital) to understand areas of high regional need, with a focus on community input (e.g., surveys, listening sessions). These existing assessments provided a solid foundation for understanding the community and potential avenues for ACH projects, as well as context for administrative data.

In May 2017, SWACH established the Data and Learning Team (DLT) as part of its governance structure; the DLT supports data-driven decision-making by reviewing and interpreting available information, identifying data gaps and needs, and making recommendations to the RHIP Council and SWACH leadership (see SWACH-Appx-1-DLT-Materials-20171116.pdf for the DLT charter, current roster, and October meeting materials).

DLT members have the ability to go back to their own organizations or partners to further explore data, or bring data forward to supplement the discussion. For example, MCO DLT members have been most helpful in providing learnings from internal analyses around high-risk pregnancy, opioids, and utilization.

SWACH’s process for using data has been iterative. For example, RHIP Council members provided suggestions for potential populations or data to explore. Staff compiled available information for DLT discussion and internal planning. At that point, concepts may be refined at the DLT, partners may explore their own organizational data to inform the discussion, additional questions might be asked, etc., and then the refined concept or recommendation presented to the RHIP Council.

As part of this process, the DLT and the RHIP Council have adopted data-informed criteria as part of the project selection and decision-making process (table below). While not every decision must meet all of these criteria, they provide a helpful framework to guide discussion and recommendations.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Key Questions</th>
</tr>
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</table>
| Need     | • Does the priority population disproportionately experience poor health outcomes?  
           • Are there subgroups that experience disparities?  
           • Is there a gap in existing services to effectively address these outcomes? |
| Impact   | • Is there a strong potential for the project / strategy to improve outcomes for the priority population in 2-3 years? |
Is the priority population large enough for improvements to drive community-wide outcomes?

What data currently exist to explore the priority population, track outcomes, and evaluate impact?

One example of how SWACH has used data to guide initial planning is by reviewing publicly available and HCA-provided data products to identify high volume providers and potential partner organizations who serve significant numbers of Medicaid beneficiaries (see SWACH-Appx-2-Providers-20171116.pdf). This helps guide the universe of partners who could be involved in which projects, and it ensures that SWACH is not missing anyone for inclusion in workgroups or other project planning.

To inform project selection, SWACH reviewed available data to understand current regional performance on the Pay For Performance (P4P) measures and which measures fell into which project areas. This review, coupled with a more detailed look at measure denominator populations, helped inform SWACH strategies for project selection. It also helped staff and workgroups find alignment between the selected projects and develop an interconnected project framework in which no one project is disconnected from the overall transformation design.

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.).

SWACH has used a variety of data sources to identify regional health needs and to inform project selection and planning. These sources range from publicly available reports and dashboards (e.g., Healthier Washington Data Dashboard, Community Checkup, Healthy Youth Survey fact sheets) to data HCA released specifically for ACH planning purposes (e.g., RHNI “starter set” data files, provider reports, measure decomposition files, see SWACH-Appx-3-Data-Sources-20171116.pdf for additional detail on data sources SWACH utilized.)

Local partners also provided data to support planning, primarily in response to specific questions. Some examples include:

- Clark and Skamania County Sheriff’s Offices shared jail booking and release data
- Council for the Homeless provided information on housing hotline call volume and disposition, and point-in-time homelessness counts
- MCOs shared information on high risk pregnancy and NICU utilization
- Klickitat Father’s House Fellowship Peer Support Services shared their opiate usage survey

Clark County Public Health has been a key partner in accessing and providing additional analysis on public health data sets including Behavioral Risk Factor Surveillance System (BRFSS) and vital records. Clark County Public Health was also able to access and analyze Klickitat and Skamania county data on behalf of the region. These data were particularly helpful for shaping the chronic disease project and exploring pregnant women and prenatal care initiation to inform the target population for care coordination. Clark County Syringe Program also shared data on Naloxone distribution and reported overdose reversals.

SWACH also had conversations with potential partners around data capacity – understanding what is being collected, or key indicators, and understanding how easy it might be to report out (e.g., conversations with Clark County Fire and Rescuer highlighted the National Emergency Medical Services Information System (NEMSIS) data). Understanding local data capacity will be critical in supporting implementation and ongoing monitoring efforts throughout the MTP period.
In addition to these state or local data sources, SWACH occasionally turned to national reports or published research for findings that could be applied locally, or could provide context to more region-specific data. For example, MACPAC and CHCS both have reports on co-occurring behavioral health and physical health conditions that were utilized for workgroup discussion prior to HCA releasing the Category 1 Behavioral Health and Chronic Conditions data file. And finally, staff were actively involved in community meetings and individual conversations with partners, providers, and community members, including the community listening session and key informant interviews for rural feedback. Project planning is ongoing. As SWACH moves into conducting a current state assessment and implementation planning, these structures and data sources will be revisited and refined, and supplemented with stakeholder and community feedback.

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 process methods used.

About the Region
The SWACH region covers an estimated 504,350 people (6.9% of Washington’s population), spanning 4,200 square miles across three diverse counties: Clark (urban), Klickitat (rural), and Skamania (frontier). All three counties border the Columbia River and Oregon, and significant portions of Klickitat and Skamania counties are parts of the Gifford Pinchot National Forest, resulting in smaller populations concentrated along the river. Major industries include healthcare and the public sector (local government, public education, social services) in Clark County, the public sector and tourism in Skamania, and agriculture and tourism in Klickitat. The population is less racially and ethnically diverse than the statewide population: more than 90% of residents in Klickitat and Skamania are white. Klickitat has a slightly higher percentage of American Indian / Alaska Native residents than the state population, and Clark has slightly higher percentage of Native Hawaiian / Pacific Islanders. A quarter of the population is under age 18.

Median household income for the region is at or below the statewide average ($64k), ranging from $64k in Clark to $50k in Klickitat. Almost a quarter of children in Klickitat County are living in poverty.

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In 2015, 3.6% of SWACH Medicaid members were homeless at least one month during the year, and data from the Council for the Homeless’ housing hotline indicate an uptick in the first part of 2017 (compared to the first part of 2016) of individuals who are being discharged from the hospital or jail/prison to the streets.6

Access to food is also a known challenge for SWACH residents. The 2016 Healthy Columbia Willamette Community Health Needs Assessment identified this as one of the important needs for Clark County in particular, along with not eating enough healthy foods; the 2016 PeaceHealth Community Health Needs Assessment also identified food insecurity among children as a major concern for Clark County.7 The 2016 Gorge Wide Food Survey found that 1 in 5 individuals ran out of food and 1 in 3 were worried about running out.8 More than a third of students across the region are eligible for free or reduced price lunch, and more than 20 people per 100 receive food stamps (SNAP).9

The SWACH region has a higher 5-year graduation rate than the state (84-86%, compared to 82%), and fewer than 5 percent of students drop out without completing high school. However, chronic absenteeism is a known problem that local school districts and community partners are working to address.10 In addition, a majority of kindergarteners entering school in the region are not ready in at

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6 Percent homeless data for CY 2015, from RDA Measure Decomposition files, provided by HCA July 2017. Council for the Homeless housing hotline information provided via email exchange with Kate Budd, Council for the Homeless, Oct 24, 2017.


9 SNAP and free or reduced price lunch data from DSHS County Risk Profiles https://www.dshs.wa.gov/sesa/research-and-data-analysis/county-and-state

10 Education data from the Office of the Superintendent for Public Instruction and DSHS County Risk and Protection Profiles
least one of six domains. These kindergarten deficits are difficult to make up and can lead to lower levels of high school completion and vulnerabilities later in life.\textsuperscript{11} SWACH residents have lower arrest rates (for both adolescents and adults) than the statewide average; however, both Clark and Klickitat counties have higher rates of adult prisoners in the state correctional system than the state average\textsuperscript{12}.

### Medicaid Beneficiary Population Profile

As of September 2017, SWACH serves approximately 133,000 Medicaid beneficiaries, accounting for 7\% of statewide enrollment. Twenty-seven percent of Clark County residents rely on Medicaid for their health insurance, similar to the statewide average (26\%), and ranging from 21\% in Skamania to 32\% in Klickitat. The majority of SWACH’s Medicaid population resides in Clark County.\textsuperscript{13} The majority of SWACH’s Medicaid population (87\%) is enrolled in managed care organizations, primarily Molina Healthcare (68\%), followed by Community Health Plan of Washington.\textsuperscript{14}

SWACH’s Medicaid population is predominantly white (70\%), non-Hispanic (65\%) and English-speaking (89\%), and is generally less diverse than the statewide Medicaid population. Skamania and Klickitat Counties are slightly less racially diverse than Clark County. SWACH’s Medicaid population is slightly more female (53\%) and slightly younger (48\% of covered lives are < age 19).\textsuperscript{15}

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\textsuperscript{11} Only 36.6\% of students in Evergreen School District, and 31.8\% in Vancouver School District are ready for kindergarten, compared to 47.4\% statewide. Kindergarten readiness drops to 16.9\% in Goldendale District. Oct 2016 data, from Office of Superintendent of Public Instruction. Online at http://www.k12.wa.us/DataAdmin/PerformanceIndicators/Kindergarten.aspx.

\textsuperscript{12} Arrest data from the DSHS County Risk Profiles https://www.dshs.wa.gov/sesa/research-and-data-analysis/county-and-state; additional context provided by Clark and Klickitat county sheriffs’ offices.


\textsuperscript{14} Medicaid enrollment data from Apple Health enrollment reports, September 5, 2017. Available online at https://www.hca.wa.gov/about-hca/apple-health-medicaid-reports#apple-health-enrollment-reports

Medicaid Beneficiary Population Health Status
Prevalence of Chronic Conditions
SWACH’s general population has similar, or just slightly higher rates of physical health/chronic conditions than statewide, although there is underlying county variation (see table below). In general, rates of chronic conditions are higher in Klickitat and Skamania than in Clark, with the exception of asthma and diabetes, which are higher in Clark.\(^{16}\)

Angina data for Skamania suppressed due to small numbers.

Looking more specifically at the Medicaid population, the prevalence of asthma, diabetes, and depression (based on diagnostic coding) is slightly lower in SWACH members than statewide, with some potential disparities suggested (e.g., American Indian/Alaska Native and Vietnamese-speaking members have the highest rates of diabetes, women have higher rates of depression, etc.).\(^{17}\)

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\(^{16}\) 2014-2016 Behavioral Risk Factor Surveillance System survey data, provided by Clark County Public Health on behalf of Clark, Klickitat, and Skamania Counties, October 4, 2017.

Additional data provided by HCA indicate that cardiovascular diseases, gastrointestinal diseases, pulmonary diseases, and metabolic diseases are some of the most frequent chronic conditions experienced by SWACH members. Measures of disease management indicate that SWACH Medicaid members experience similar quality of care to the statewide Medicaid population. SWACH is the highest performing ACH on measures such as antidepressant medication management and medication management for people with asthma, but falls slightly below the state average on measures such as the comprehensive diabetes care composite.

Regional performance does mask some underlying geographic variation: for example, Klickitat’s rate for antidepressant medication management (acute) is 47%, compared to 56% in Clark, and 55% for SWACH; Klickitat’s rate for comprehensive diabetes care: eye exams is 8%, compared to 37% in Clark, and 35% for SWACH. Regional performance may also mask potential racial and ethnic disparities: American Indian / Alaska Native and Spanish-speaking members have lower rates of eye exams; multiracial members have the lowest rates of HbA1c testing; Black members have lower rates of antidepressant medication management (acute), etc.

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18 Category 1 Behavioral Health and Chronic Conditions data file, provided by HCA Sept 29, 2017. Data based on CDSP diagnostic grouping, through June 2016.


Prevalence of Behavioral Health Conditions
According to ACH profiles provided by DSHS, approximately 25% of the SWACH population that is jointly served by HCA-DSHS were diagnosed with a mental illness in the last 24 months, with depression and anxiety disorders being the most prevalent. 18% of the population were diagnosed with a serious mental illness, and just under 10% had at least one indicator of substance use disorder treatment need (6.7% have co-occurring mental health and substance use disorder diagnoses, compared to 7.7% statewide).21 Additional data provided by HCA confirm that just under 10% had at least one indicator of substance use disorder treatment need. The data also provide additional insight into co-occurring conditions: approximately 5.7% of SWACH Medicaid members have co-occurring mental health AND substance use disorder treatment need and approximately 4.5% have co-occurring mental health AND substance use disorder treatment need AND one or more chronic condition.22

Despite nearly a quarter of the population having some mental health diagnosis in the past 24 months, SWACH’s treatment penetration rates are low (and have been declining over the past three years). SWACH is the lowest performing ACH for mental health treatment penetration.23 SWACH also has low rates for Medication Assisted Therapy for individuals with opioid use disorder: only 8% access MAT with buprenorphine, and 11% MAT with methadone.24

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22 Category 1 Behavioral Health and Chronic Conditions data file, provided by HCA Sept 29, 2017. Data through June 2016.


24 RHNI “starter kit” data provided by HCA, April 25, 2017.
There are approximately 14,000 Medicaid opioid users in the SWACH region. The majority (87%) do not have a cancer diagnosis, and are non-Hispanic, white members (76%). 20% are considered heavy opioid users, and 18% chronic users.25

Health Behaviors
Population health data indicate that risky health behaviors, particularly tobacco use, are common across the SWACH region. The 2016 Healthy Columbia Willamette CHNA identified cigarette smoking, alcohol, and marijuana use as specific issues for teenagers, as well as cigarette smoking among pregnant women.26 Maternal smoking during pregnancy in both the general population and Medicaid is higher across the SWACH region than statewide, and highest for Medicaid in Klickitat and Clark (17.4% and 16.9% respectively).27

Adult current smoking rates range from 17% in Clark to 25% in Klickitat, compared to 15.6% statewide, and the rates of 10th and 12th graders who smoked cigarettes in the past 30 days were higher across the region than statewide, and highest in Klickitat specifically.28 Healthy Youth Survey data also indicate that 26% of 12th graders in Klickitat County experience binge drinking, compared to 16% in Clark and 18% statewide.29

Vital Statistics
The 2016 Healthy Columbia Willamette CHNA identified the leading causes of morbidity and mortality in Clark County (general population) and prioritized based on racial and ethnic disparities, gender disparities, worsening trends, worse rate at the county level when compared to state, a high proportion of the population affected, and severe health consequences. These include:

<table>
<thead>
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<th>Morbidity</th>
<th>Mortality</th>
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<tr>
<td>Asthma in adults</td>
<td>Alcohol-induced</td>
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<tr>
<td>Bladder cancer incidence</td>
<td>Alzheimer’s disease</td>
</tr>
<tr>
<td>Chlamydia incidence</td>
<td>Breast cancer among women</td>
</tr>
<tr>
<td>Chronic Hepatitis C incidence</td>
<td>Chronic liver disease and cirrhosis</td>
</tr>
<tr>
<td>Depression in teens and adults</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Kidney/renal pelvic cancer incidence</td>
<td>Drug-induced</td>
</tr>
<tr>
<td>Lung, Trachea, bronchus cancer incidence</td>
<td>Heart disease</td>
</tr>
<tr>
<td>Melanoma (skin) cancer incidence</td>
<td>Lung, trachea, bronchus cancer</td>
</tr>
<tr>
<td>Obesity/overweight in teens and adults</td>
<td>Lymphoid, hematopoietic, related tissue cancer</td>
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<tr>
<td>Preterm births</td>
<td>Non-transport accidents (falls, unintentional poisoning)</td>
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<tr>
<td>Thyroid cancer incidence</td>
<td>Suicide</td>
</tr>
</tbody>
</table>

25 Ibid.
29 2016 Healthy Youth Survey. https://www.askhys.net/
30 Deaths are categorized according to the underlying (or primary) cause of death on the death certificate.
2015 vital records data indicate that leading causes of death are similar across Clark, Klickitat, and Skamania counties: malignant neoplasms, followed by heart disease.31

**Utilization**

SWACH Medicaid members have lower rates of Emergency Department (ED) utilization than statewide (39 visits per 1,000 member months compared to 51, and 42 visits compared to 54 statewide when mental health and chemical dependency visits are included). However, regional performance masks potential disparities: ED utilization rates are highest in Klickitat, and higher for American Indian / Alaska Native and Black members, as well as Arabic-language speaking members.32

Of these ED visits, 16% were for conditions that could have been managed in primary care settings (just below the statewide average: 17%). These potentially avoidable ED visits were consistent across the SWACH region, although higher for women, Asian and Native Hawaiian / Pacific Islander and Multiracial members, and Spanish-speaking members.33

In 2015, a Washington Health Alliance report looking at potentially avoidable ED visits found that the rate was higher for Medicaid members living in Skamania and Klickitat, which may be partially due to the geographic distance to access services.34

In addition to geographic distance to providers, SWACH has known inadequacies in access to behavioral health and primary care services. See access to care section below.

**Providers Serving the Medicaid Population**

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31 Washington Tracking Network, Leading Causes of Death by County Age-Adjusted Rate per 100,000, 2015.


The SWACH region includes:
- Two federal designated rural health clinics (Klickitat Valley Health Family Medicine and NorthShore Medical Group) and one federally qualified health center (Sea-Mar, multiple sites across region)
- One tribal health clinic (Cowlitz). The clinic, which is physically located within SWACH, is an outpost of the larger clinic located in Longview and served fewer than 500 Medicaid members in 2016
- Four hospitals (two in Clark County, and two critical access hospitals in Klickitat County)

<table>
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<th>Hospital</th>
<th>% of SWACH Inpatient Admissions</th>
<th>% of SWACH ED Visits</th>
</tr>
</thead>
<tbody>
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<td>PeaceHealth SW Medical Center</td>
<td>44.9</td>
<td>41.6</td>
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<tr>
<td>Legacy Salmon Creek</td>
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<td>38.2</td>
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<td>Legacy Emmanuel (OR)</td>
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<td>OHSU (OR)</td>
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<td>Providence (OR)</td>
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<td>MidColumbia Medical Center (OR)</td>
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<td>Klickitat Valley</td>
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<td>Legacy Good Samaritan (OR)</td>
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<td>Skyline</td>
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While the majority of SWACH Medicaid member hospital inpatient and ED visits are at facilities in Washington, a small but significant number of admissions and visits occur in Oregon. This might be because almost a third of the workforce in Clark and a quarter in Klickitat and Skamania are working outside of Washington.

It may also be because the health systems serving SWACH often have facilities in both states and patients (particularly in Skamania and Klickitat) may be seen across the river, especially for specialty care.

All of Klickitat County is a designated medically underserved population, and a portion of southwestern Clark County is a designated underserved area for primary medical care. Klickitat and Skamania counties, as well as portions of Clark are all primary care health professional shortage areas. Skamania in particular has a low ratio of physicians and primary care physicians providing direct patient care (see chart below). Additionally, every physician in Skamania is age 55 or older, and therefore, may be closer to retirement.

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35 2016 utilization data from Provider Report Outpatient and ED Tables reports, HCA.
37 Key Informant Interviews conducted with Skamania county residents October 2017 indicated the need for more doctors in Stevenson and how members currently travel to Oregon to receive services.
Crisis behavioral health services are provided by Clark County Crisis Services and Skamania County Behavioral Health. Crisis stabilization services for adults are available through Columbia River Mental Health Services. Catholic Community Services and Daybreak Youth Services provide crisis stabilization services for youth. PeaceHealth SW Medical Center in Vancouver and Telecare Corporation offer inpatient psychiatric beds in the region for adults, while Daybreak Youth Services offers co-occurring inpatient and residential detox services for youth throughout the region.\(^{40}\) Klickitat County residents generally receive inpatient services in Yakima County through Comprehensive Healthcare. Lifeline also offers residential and outpatient substance use disorder services, including MAT.

See Appendix 2 (SWACH-Appx-2-Providers-20171116.pdf) for a list of the physical health providers and behavioral health providers that saw at least 500 SWACH Medicaid beneficiaries in 2016, based on provider billing for professional services.

As of 2012, Skamania County also had a low ratio of dentists per 100,000 population: 34, compared to 63 in Clark and 34 in Klickitat. Anecdotal information from Klickitat providers indicate that their Medicaid population generally goes without dental care. The entire SWACH region’s dentists-to-population ratio is below the statewide (71 per 100,000).\(^{41}\) See Appendix 2 (SWACH-Appx-2-Providers-20171116.pdf) for a list of dental providers that saw at least 1,000 SWACH Medicaid beneficiaries in 2016.

**Community Based Resources**


There are a variety of community-based organizations in the SWACH region that serve the Medicaid population across a number of domains. This information has been further categorized by SWACH staff to help inform project planning (see SWACH-Appx-4-Community-Resources-20171116.pdf).

While Council for the Homeless and the Vancouver Housing Authority are serving the region, they are unable to meet demand: 2-1-1 Info statewide quarterly reports indicate that low income housing, rent payment assistance, and emergency shelters were the top three searches on their website, and housing and emergency shelters were 5.9% and 11.7% of the unmet needs in the first part of 2017. More specific to the SWACH region, housing services were the top request in Q2 2017, specifically related to rent payment assistance and low income housing. Housing requests represent the largest number of unmet community needs (including potential service gaps for homeless motel vouchers). More than half of 2-1-1 callers in the region are on Medicaid and a quarter report current homelessness.

Nutrition assistance also remains a priority: the Clark County Food Bank distributes 6 million pounds of food and 5 million meals / year, and food pantries and food stamp services are among the top 10 service requests for 2-1-1 callers in the SWACH region.

Transportation, utility assistance, and legal / public safety services were also areas of high unmet community need in the region. The need may be unmet because community organizations are at capacity, or because services do not exist within the community.

**Access to Care**

SWACH has known inadequacies in access to behavioral health and primary care services. SWACH is the lowest performing ACH on the child and adolescent access to primary care practitioners, and adult access to preventive / ambulatory health services also lags behind state performance. SWACH also has low rates of well child visits for children ages 3-6, particularly in Skamania (46%).

Between 2015 and 2016, Clark County saw a decline of almost 20% in adult access to primary care visits (compared to 5% decline statewide, and a 4% decline in Klickitat County).

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42 The most complete documentation of available resources is maintained by Southwest Washington 2-1-1 Info. A list of agencies by county and category is available online [https://docs.google.com/spreadsheets/d/1OB62Z-cy3FACHRvuALRv8gmiCuwPcBx0JSTkolP7qQ/edit?ts=59e93d88#gid=1986364147](https://docs.google.com/spreadsheets/d/1OB62Z-cy3FACHRvuALRv8gmiCuwPcBx0JSTkolP7qQ/edit?ts=59e93d88#gid=1986364147)

43 Washington Information Network 2-1-1 Quarterly Newsletter, April – June 2017. [http://211info.org/reports](http://211info.org/reports)

44 2-1-1 Info Southwest Washington quarterly report, April – June 2017. [https://static1.squarespace.com/static/5491c902e4b0d409ad77f2e4/t/5981285059cc68f7e07fa9/1501636689415/SouthwestWashington_Q4_FINAL.pdf](https://static1.squarespace.com/static/5491c902e4b0d409ad77f2e4/t/5981285059cc68f7e07fa9/1501636689415/SouthwestWashington_Q4_FINAL.pdf)

45 Ibid.


Community feedback indicates that some individuals may be avoiding their primary care providers or not making medical appointments because of increased drug testing and changes related to opioid prescribing, as well as the lack of support in navigating the health system (e.g., case managers). 48 SWACH is also the lowest performing ACH on the mental health treatment penetration measure (40.2% in 2015), and is lower than the state average on measures of follow-up care after emergency department visits for mental illness and alcohol/substance use. 49

These indicators confirm community feedback, including the survey of Clark residents as part of the 2016 Healthy Columbia Willamette CHNA (access to physical, mental, and/or oral health care was identified as the fourth most important issue that needed to be addressed to make the community healthy). This was echoed in a number of other recent community assessments. 50 Lack of access to prescribers, particularly for mental health, was highlighted at the community listening session. We heard several experiences of people having to wait more than two months to fill prescriptions, and ending up in jail because they were unable to remain stabilized without their medication. 51

<table>
<thead>
<tr>
<th>Primary care access measures for SWACH and WA State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child and adolescent access to primary care (all ages)</td>
</tr>
<tr>
<td>85%</td>
</tr>
<tr>
<td>89%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>30-day follow up measures for SWACH and WA State</th>
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</thead>
<tbody>
<tr>
<td>Follow-up after discharge from ED for mental health</td>
</tr>
<tr>
<td>69.7%</td>
</tr>
<tr>
<td>72.0%</td>
</tr>
</tbody>
</table>

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48 SWACH Medicaid Transformation Project Community Listening Session, October 23, 2017


Access to dental care is also a known issue in the region for SWACH Medicaid beneficiaries: approximately 50% of children and adolescents (ages 0 – 20) and 80% of adults (21+) had no dental utilization at all in FY 2016, and only a fraction of adults had any preventive services. Interviews with Skamania residents indicated that people are having to travel to Washougal or Camas for dental care.

While approximately a third of children ages 6-9 who were at elevated risk received dental sealants, less than one percent of children received fluoride varnish in primary care settings, indicating much room for improvement.

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.

In addition to the capacity and access gaps and services described in the Community-Based Resources and Access to Care sections above, there are several other known gaps in the region (described below). SWACH has not fully quantified to what extent providers and partners are meeting all of these gaps and will continue to explore this as part of the current state assessment in early 2018.

Known barriers to access include workforce capacity; length of time to access appointments, particularly psychiatric services; transportation; affordability of health care; geographic distance (particularly for more rural areas); hours of operation; lack of culturally and linguistically-appropriate services; and difficulty navigating a bifurcated system.

Culturally-Specific Services

Language and cultural barriers were raised multiple times in a recent community listening session. Community members noted repeatedly that providers don’t “look like us” or speak the same language. One participant mentioned how difficult it is to get basic referral information in different languages, and that people are not accessing available community resources because materials are only available in English. Conversations with the NAACP also highlighted concerns that there are

53 Key Informant Interviews conducted with Skamania county residents, October 2017.
54 FY 2016 dental sealant and fluoride varnish data provided by Washington Dental Foundation, April 2017.
55 Access to health care, affordable health care, and culturally competent services were identified as prioritized issues through stakeholder and resident interviews, surveys, and listening sessions. 2015 Clark County Community Health Assessment. https://www.clark.wa.gov/sites/default/files/dept/files/public-health/data-and-reports/clarkcha2015.pdf
not enough mental health providers of color, and that this is a gap in the community feeling comfortable accessing services. This may explain some of the demographic and language-based disparities in access and quality measures noted above.

Timely Appointments
Washington’s 2016 Consumer Assessment of Healthcare Providers and Systems (CAHPS) statewide reports for Molina and Community Health Plan of Washington (CHPW), the two MCOs with the majority of Medicaid enrollment for the SWACH region, indicate that 74.9% of Molina members and 66.8% of CHPW adult members reported they could get appointments for routine care as soon as they needed, and 71% of Molina members and 69.7% of CHPW members reported they could get appointments to specialists as soon as needed.57 The 2016 Columbia Gorge Community Health Assessment survey found that 53% of respondents in Klickitat and 55.5% in Skamania reported they needed specialist care.58

Transportation
The same survey found that transportation access was the second most common basic need individuals were going without, particularly for medical care. Ten percent of survey respondents in Klickitat and 19% in Skamania reported they went without transportation.59 This is likely a primary driver in the low rates of access to preventive and primary care services, especially in the rural communities.

While medical transportation for Medicaid members in the region is available from the Human Services Council, out-of-area transportation (i.e., if a medical service is not available in the local community) requires pre-authorization by a doctor, with at least 7-14 days for approval recommended.60 For Klickitat and Skamania residents, who are more likely to need to travel outside of their local area for services, this is an additional barrier that requires navigation and planning, and may also be affected by cultural or language barriers.

Workforce
In addition to the provider shortages discussed above, the SWACH region is experiencing difficulties recruiting qualified candidates for a number of health professional positions, including registered nurses, nurse practitioners, and licensed practical nurses. For example, SeaMar has leveraged loan reimbursement programs to attract providers, but still face difficulties recruiting candidates. Organizations are also reporting an increased demand for these provider types, as well as medical assistants.61 Community members have also highlighted the need for more peers and community health workers.62

59 Ibid.
60 Human Services Council Medicaid Medical Transportation and Health Care Authority Non-Emergent Medical Transportation http://www.hsc-wa.org/services/medicaid-medical-transportation and https://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage/transportation-services-non-emergency
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

<table>
<thead>
<tr>
<th>Domain 2: Care Delivery Redesign</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ 2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)</td>
</tr>
<tr>
<td>☑ 2B: Community-Based Care Coordination</td>
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<tr>
<td>☐ 2C: Transitional Care</td>
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<tr>
<td>☐ 2D: Diversions Interventions</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Domain 3: Prevention and Health Promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ 3A: Addressing the Opioid Use Public Health Crisis (required)</td>
</tr>
<tr>
<td>☐ 3B: Reproductive and Maternal and Child Health</td>
</tr>
<tr>
<td>☐ 3C: Access to Oral Health Services</td>
</tr>
<tr>
<td>☑ 3D: Chronic Disease Prevention and Control</td>
</tr>
</tbody>
</table>


- 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.
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).
Vision Statement

Aligning with the Healthier Washington priorities, Southwest Washington ACH (SWACH) convenes partners to create sustainable, equitable, and innovative care that continuously improves the overall health and well-being of the communities we serve, striving to create and maintain the healthiest region in the state.

The MTP will provide SWACH the opportunity to convene and support regional, multi-sector, collaborative partners to use regional data to focus on whole person care, addressing the social determinants of health, and rewarding quality and value. This will result in improved outcomes, lower costs, improved health of the population across the region, and a more satisfied, effective workforce, with a specific focus on advancing equity. SWACH will use data to drive policy changes that address up, mid, and downstream issues across the three counties in the region. Addressing workforce issues, adopting and implementing population health management strategies, and supporting providers in shifting to value-based care will provide the infrastructure to support and sustain transformation.

SWACH will evolve into a regional asset, providing long-term coordination and alignment focused on achieving the Quadruple Aim post-Medicaid Transformation Project (MTP).
SWACH’s overall strategy focuses on transforming systems which affect a large percentage of the population currently experiencing the most profound health inequities and disparities in the region: health care delivery, community social services, law enforcement and justice, and emergency services.

SWACH will:

- Serve as the long-term structure for continued, authentic community and consumer engagement
- Elevate and integrate social determinants of health and equity as critical components of an effective and efficient health care delivery system
- Build a stronger bridge between clinical and community providers
- Make strategic investments in prevention and recovery
- Strive to align MTP work with related efforts and investment flows to maximize impact and achieve results

By building upon its early progress integrating physical and behavioral health care across the region, and developing a community care coordination system, SWACH will create a collaborative framework to address the region’s health and healthcare needs and priorities. SWACH will bring regional health care delivery partners, community-based partners, local and state governmental partners, Medicaid beneficiaries, Managed Care Organizations (MCOs), Tribal partners, and other stakeholders together to reexamine how each care delivery and service setting can transform to achieve the quadruple aim.

Using regional data and the MTP performance metrics as a guide, we will transform care and service delivery settings by working with each individual setting to define the transformation activities and
commitments necessary to articulate the appropriate activities within each setting’s walls as well as how each setting will interact with its partner settings across the care and service delivery spectrum.

The transformation activities and commitments will be included as contractual requirements, which SWACH refers to as the Transformation Rules of Engagement, for each participating provider working with SWACH on the MTP (See Attachment SWACH-Att-1-Driver-Diagrams-20171116.pdf, “Strategic Aims and Drivers”).

Our multi-stakeholder data and learning team, clinical integration committee, community care coordination, and opioid workgroups have used regional data to recommend specific interventions to address access to care, clinical integration, chronic disease management, opioid use and its impact, care transitions, diversion to the best care setting, oral health, and reproductive and maternal and child health. Through our Behavioral Health Advisory Committee (BHAB) and our community engagement and outreach work, SWACH has solicited input and lived experience to validate these recommendations. These recommended interventions will form the basis for our Transformation Rules of Engagement which will continue to be refined during the implementation planning process.

Using our MTP and Integrated Managed Care (IMC) incentives SWACH will provide the necessary infrastructure, services, and resources to support care and service delivery setting transformations under the MTP by ensuring alignment and focus on addressing social determinants of health, whole person care, and value-based payment. SWACH believes building a strong, sustainable foundation for transformation using the MTP incentive funding will enable the region to achieve its vision to create and maintain the healthiest region in the state. We intend to use the implementation planning phase to finalize actionable strategies with multi-sector buy-in, that are clearly connected to output, outcome, and impact measures (See Big Dot Metrics in attachment SWACH-Att-1-Driver-Diagrams-20171116.pdf).

Our transformed approach will ensure people receive the best care in the most appropriate setting, from an individual, organizational, and population health perspective, and will provide the mechanism to achieve improved outcomes across the region. By transforming care and service delivery settings, we believe the improved outcomes our approach will demonstrate will be valuable to patients, providers and payers across the spectrum, not just those within the Medicaid system, ensuring the sustainability of these transformations beyond the MTP.

Project Selection Process

The SWACH Regional Health Improvement Plan (RHIP) Council created a two-level project selection criteria model to develop recommendations for the Project Portfolio to the Board of Trustees:

Threshold Criteria:
- Alignment with regional health priorities, ACH mission, values;
- Ability to address documented need without duplication of efforts;
- Impact on Medicaid lives and return-on-investment within 2 - 3 years;
- Ability to spread work and scale project across the region; and
- Readiness to implement the project.

Next Level-Criteria:
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Key Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Equity</td>
<td>Does the project reduce health disparities and/or advance health equity? Does it address/support social determinants (underlying community conditions)? Does it support the health outcomes of a group of Medicaid individuals?</td>
</tr>
<tr>
<td>Data and Measurement</td>
<td>Will the project use data to define the target population, share learnings, and measure outcomes? Can outcomes be measured with current data sources? What data are needed to evaluate the project’s impact? Is the appropriate data and analytic infrastructure in place or available?</td>
</tr>
<tr>
<td>Legal</td>
<td>Does the enacting organization have the legal authority? Is future litigation a concern if the project is implemented?</td>
</tr>
<tr>
<td>Widespread Support</td>
<td>Is the project controversial? What do key stakeholders think? Is there a good state of readiness (passion, will) and ease of communication (messaging) or is there a reason to delay action?</td>
</tr>
<tr>
<td>Practicality</td>
<td>Does the project build on existing efforts? Is there a clear role for SWACH? Is the strategy self-sustaining or does it require ongoing resources (implementation, enforcement)?</td>
</tr>
<tr>
<td>Social</td>
<td>Is there a clear connection to improved quality of life/community health and community values? Is the project multi-sector in nature? Are there potential unintended consequences? Is there a clear community engagement strategy?</td>
</tr>
<tr>
<td>Earnings Potential</td>
<td>Does the project have a high earning potential based on HCA incentive payment weighting formula?</td>
</tr>
</tbody>
</table>

SWACH’s whole-population vision is achieved by policy and system level change being the foundation of transformation across care and service delivery or health system settings. We have ensured this by embedding these components as core criteria (outlined above) for projects selected.

Our committees and workgroups (clinical integration, care coordination, opioid, data and learning) conducted environmental scans to assess the current state of resources and gaps in the region across all eight project areas. These groups evaluated the projects by comparing data from our Regional Health Needs Assessment and the environmental scans against the above criteria and made project selection recommendations to the RHIP Council. The BHAB and our community engagement sessions and key informant interviews provided additional feedback and input to the RHIP Council for project selection. Based upon the regional data, community input, and our governance bodies’ desire to maximize the potential for transformation, the RHIP Council originally recommended a six-project portfolio: Integration, Community Care Coordination, Transitional Care, Diversions, Opioids, and Chronic Disease Management and Prevention. The workgroups and RHIP Council also recommended aspects of the oral health project and the reproductive and maternal health project be incorporated into the Transformation Rules of Engagement for implementation.

The recent announcement of reduced MTP funds prompted the RHIP Council to recommend a more focused, targeted Project Portfolio. The four areas selected represent foundational initiatives based upon regional health needs and stakeholder input. However, the RHIP Council recommended SWACH, through its project work and other activities, meaningfully address the issues represented by the four project areas not selected: oral health, reproductive and maternal child health, transitions of care, and diversions in the Transformation Rules of Engagement.

The Board of Trustees unanimously adopted the recommendations of the RHIP Council.
Shared Interventions, Resources and Infrastructure

As detailed above, SWACH is taking a systems approach, transforming care and service delivery settings to partner more collaboratively and effectively. In this model, our Transformation Rules of Engagement will map activities to appropriate care and service delivery settings ensuring significant overlap for shared interventions, resources, and infrastructure.

Proposed Interventions Across All Settings:

- Awareness and sensitivity education and training (cultural, equity, behavioral health);
- Pathways HUB for target populations;
- HIE/EHR strategy to coordinate care (primary care, behavioral health, SUD, ED, EMS, CBOs, etc.);
- Adopt and implement telehealth and mobile services;
- De-escalation training and techniques; recovery oriented care;
- Clinical practice change management and skill building (Strategic Improvement Team);
- Consistent use of two or more approved validated instruments to screen for behavioral health conditions and/or substance use disorder;
- Screen for tobacco use and offer cessation counseling to smokers;
- Commitment to inquire about access and care for oral health and develop referral patterns;
- Commitment to encourage pediatric and adolescent well-child visits;
- SBIRT (Screening, Brief Intervention, and Referral/Provide to Treatment) for common behavioral health conditions and substance use disorders

The above-listed interventions will be shared via the Transformation Rules of Engagement and will require all participating providers to adopt as a requirement of the MTP, regardless of care or service delivery setting.
Shared Resources:

- Data Analytics (CORE)
- Learning Lab through Strategic Improvement Team
- Tools and Technical Assistance to support:
  - Science of Improvement
  - Facilitation, Coaching, Training, Consultation
  - Accountability training
  - Performance Technology
  - Change Management
  - Population Health Management (HIE/HIT)
  - Workforce Development strategies
  - Contracting / Billing / VBP
  - Communication strategies
  - Care of the Provider education and strategies
  - Policies and Procedures
  - Transformation Rules of Engagement deployment
  - Self-monitoring and reporting
  - Pay for reporting tools and capabilities (worksheet and electronic reporting questionnaire/survey with metrics and definitions)

Shared Infrastructure:

- ACH Staff
- Data Analytics Platform
- Pathways HUB
- Practice Transformation Hub
- Strategic Improvement Team (Improvement Advisors – clinical and non-clinical)
- Population Health Management System
- Self-monitoring and reporting tools

Shared resources and infrastructure will be provided by SWACH. These services will be funded through the designated Systems Capacity Building (SCB) Fund. SWACH staff and sub-contracted service providers will be assigned to partnering providers post-contract execution, as appropriate.

**Improvement to region-wide health outcomes**

By tailoring the project toolkit approaches of the selected projects to address SWACH’s regional needs, SWACH will develop targeted strategies focused on improving region-wide health outcomes. Using our self-monitoring and reporting tools, partnering providers will work with strategic improvement advisors, supplied by SWACH, on quality improvement cycles to drive toward the outcome measures. Monthly, we plan to track our Big Dot Metrics (See Attachment SWACH-Att-1-Driver-Diagrams-20171116.pdf, “Strategic Aims and Drivers”) to benchmark progress against state-level measures. Our systems approach will allow SWACH to work with partnering providers to target activities appropriate to each care and service setting, focusing on meeting or exceeding MTP performance metrics as demonstration of improved outcomes.

**Improvement to region-wide quality, efficiency, and effectiveness of care processes**
SWACH plans to use an improvement framework based upon the IHI Science of Improvement Model and has been partnering with Pierce County ACH to develop the strategy to support continuous quality improvement capabilities and capacity within the partnering provider organizations. SWACH plans to use a Strategic Improvement Team (internal ACH resource) and a Quality and Continuous Improvement Committee (external resource made up of quality improvement experts from regional partnering providers) to ensure improved region-wide quality, efficiency, and effectiveness of care processes. The improvement framework ensures the testing and feedback loop supports the progression toward improved population level outcomes.

The Strategic Improvement Team will:

- Build science-based improvement capability at provider, team, clinic, and system levels;
- Ensure quality improvement knowledge and skills training are provided to participating providers and health care workforce;
- Ensure the capability of teams to use advanced improvement methods that guide and support front-line improvement for participating providers;
- Ensure shared learning system is accelerating implementation, spread of work, and increase of innovative approaches to improving health outcomes;
- Provide a clear roadmap for how organizations using Lean and Six Sigma can use the science of improvement to accelerate results;
- Ensure participating providers and partners have the tools they need to achieve outcomes;
- Ensure participating providers are proficient at reporting on ACH and MTP-level reporting requirements;
- Ensure participating providers have pay for reporting tools and capabilities in place (excel worksheet and electronic reporting questionnaire/survey with metrics and definitions) and report on a monthly, quarterly and annual basis; and
• Ensure capture of various partners’ data including administrative data, and data from MCOs, CCS (Pathways) platform and Chronic Disease, etc. and compile (with CORE’s oversight) for regional dashboard.

Improvement Advisors will consistently work to improve the quality, efficiency, and effectiveness of care while moving partnering providers toward independence by supporting their modified roles and practice changes to ensure sustainability of the changes. The change management processes deployed will transition the partnering provider from dependence on the Improvement Advisor to independence by building capacity within the participating providers’ organizations. By building capacity, the participating provider will have a plan to move away from higher levels of support from the Improvement Advisor so that the provider, over time, will implement new concepts, models, and techniques internally with their own, in-house improvement experts building capacity and long-term sustainability.

SWACH will also seat a Quality and Continuous Improvement team, comprised of multi-sector stakeholders with backgrounds in quality and clinical quality improvement (Lean, Six Sigma, Science of Improvement, Kaizen, etc.) to vet the work of the SWACH Strategic Improvement Team and the products emanating from the team’s work to ensure alignment with the regional vision and acceptance from the partnering providers.

**Advancing Health Equity**

SWACH intends to address health equity through a multi-pronged approach including the implementation of the MTP projects themselves.

As demonstrated by our merger with the Health Living Collaborative of SW Washington (HLC), SWACH understands the importance of advancing health equity and the impact it will have in the success of our work. HLC is a community-driven coalition that works together on upstream initiatives that promote health equity and strengthen communities. Some of the sectors HLC’s 60+ partners represent are health care, public health, social services, education, a tribal nation, housing services, and transportation.

To ensure individuals facing the greatest health disparities inform the community needs assessment and improvement opportunities, SWACH has focused on engaging multi-sector partners representing the cultural, linguistic, and geographic diversity of SWACH Medicaid members. Through our community engagement efforts across the region, we have been able to provide authentic community input and lived experience to inform discussions and decisions regarding project selection, target populations, and selected approaches.

As SWACH has made preliminary decisions regarding target populations for its selected projects, intentional focus on the opportunity to advance health equity has been central. We understand that without the quadruple aim we will not achieve equity. One of the leading criteria applied when choosing target populations and required project elements has been, and will continue to be, advancing health equity. We will continue to review if proposals address the social determinants of health. SWACH posed three questions before proposing target populations and strategies:

- Does the target population disproportionately experience poor health outcomes?
- Are there subgroups within the population that experience disparities?
- Is there a gap in existing services that could effectively address these outcomes?
SWACH will use data wherever possible to accurately measure impact across demographics. By looking at data for Clark, Skamania, and Klickitat Counties, and their Medicaid beneficiaries, SWACH is targeting efforts that will have the greatest impact on health equity. This emphasis on equity will continue through project planning and implementation.

SWACH’s Community Pathways Hub is expected to be an additional thread across all demonstration projects that contributes to advancing health equity. For example, the opportunity to leverage and expand the role of community health workers through this evidence-based, community care coordination model will deepen beneficiaries’ access to culturally and linguistically responsive care. When SWACH created its Request for Proposals (RFP) for Care Coordination Agencies (CCAs), it required potential Hub partners demonstrate a commitment to health equity. Furthermore, the ACH invited Community Health Workers to be members of the RFP review team to ensure community perspective informed the CCA decision-making process. As a result, the three successful CCAs (SeaMar, Council for the Homeless, and Community Voices are Born) chosen for the initial Pathways Hub pilot are trusted community partners with deep experience in supporting the diverse cultural, linguistic, and geographic needs of SWACH Medicaid members.

SWACH is also working to deepen its impact on health equity through MTP activities. We plan to work toward ensuring:

- Community trainings in multiple languages and across diverse cultural and geographical community sites;
- A trauma-informed lens is applied to transformation settings;
- Workgroups, committees, and governing bodies receive training on diversity, equity, and inclusion;
- An equity lens is developed and applied to policies/procedures/systems;

Source: Adapted from Ruth Manchanda, Health Means Institute for Healthcare Improvement. Updated: 11/09/2017
Cultural humility and trauma informed care are incorporated as essential components of the Strategic Improvement Team’s work; and

Diverse community partners define the needed resources to strengthen community resilience and that these needs are addressed through the Community Resiliency Fund.

**Community Resiliency Fund**

**Role and business model as an integral, sustainable part of the regional health system**

SWACH views itself as an integral, sustainable part of the regional health system. As a neutral party, with the ability to add value in ways other health system players cannot, SWACH is well positioned to:

- Convene care and service delivery partners, payers, governmental agencies, Tribal nations, and patients to transform the regional health system to deliver whole-person, integrated care;
- Identify and leverage other dollars for braided funding opportunities;
- Support care and service delivery partners with financing, workforce development, regional population health management systems, and assistance in transitioning to value-based contracting;
- Partner with consumers by engendering trust and amplifying the voice of those most impacted;
- Focus on social determinants of health through education, communication, and connectivity with and throughout the care and service delivery settings;
- Implement strategies to address social determinants of health;
- Support learning and shared decision making to identify policy challenges and barriers and impact change; and
- Enhance experience, quality, and value for health improvement.
SWACH will pursue multiple avenues to develop a sustainable business model to continue its role post-MTP. SWACH expects to see diversified revenue streams from:

- Pathways HUB
- Strategic Improvement Services
- Service Line Contracting
- Shared Savings
- Philanthropy
- Grants
- Partners outside the Medicaid market

We believe success during the MTP will cement our value to the regional health system and provide for new and innovative opportunities in the future.

**Phase II gaps and/or areas of improvement**

Feedback on our Phase II Certification application indicated a lack of clarity on RHIP Council project selection process and the role of the Board. The process for project selection is detailed above, as is the role the Board played in approving the RHIP Council recommendation for our project portfolio. We believe we expanded upon our priorities and how we will use the MTP to drive achievement of those priorities.

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**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

SWACH is a Washington state non-profit corporation, with a 501 3 (c) designation from the Internal Revenue Service. The corporation’s governance structure represents an intentional design created to fulfill fiduciary and legal obligations and sustain successful relationships and accountability among diverse partners beyond the Medicaid Transformation Project (MTP). Governance bodies are comprised of representatives from health care delivery providers, community-based organizations, local governmental agencies, Managed Care Organizations (MCOs), and community members who are guided by a community-driven, region-wide vision for sustainable, equitable, and innovative care.

Cognizant of the need for both legal accountability and governance of the non-profit organization, as well as the need to meet MTP requirements, the SWACH governance structure provides for both, while meeting all Standard Terms and Conditions (STCs) under the MTP. The Board of Trustees (Board) is a policy board with ultimate fiduciary accountability for the organization. The Board has delegated the operational work for the MTP to the Regional Health Improvement Plan (RHIP) Council. The RHIP Council has been tasked with reviewing the recommendations of subject-matter specific workgroups, community input, and staff recommendations, and developing MTP recommendations to the Board. This structure allows the RHIP Council members to fully represent their constituencies, sectors, and counties to ensure the MTP activities are feasible and have the required buy-in and commitment of partners to be implemented successfully. Furthermore, this allows the Board to avoid many conflict of interest issues by allowing members to serve as individuals, not as representatives of constituencies.

The interconnected governance structure depicted in the attached diagram is comprised of the following bodies: Board, with an Executive Committee and Finance Committee; RHIP Council, Data and Learning Team (DLT), Behavioral Health Advisory Board (BHAB), Clinical Integration Committee, Community Care Coordination and Opioid Workgroups, and the HLC Policy Committee (See SWACH-Att-2-Governance-Structure-20171116.pdf). The Board will be seating an Incentive & Investments Committee, a Quality and Continuous Improvement (QCI) Committee; an HIE/HIT Task Force; and an HLC Committee in early 2018.

Board of Trustees: The Board has fiduciary duty and full accountability for all decisions of the corporation, and trustees serve as individuals in a traditional nonprofit board capacity. The Board meets monthly in open meetings.

• Executive Committee: The Board has authorized its Executive Committee, comprised of the Chair, Vice Chair, Secretary, and Treasurer, to conduct corporation business requiring timely action between Board meetings.
• **Finance Committee**: The Board has delegated review of financial transactions to the Treasurer and the Finance Committee. The Treasurer and CFO review the Finance Committee meeting topics and financial statements with the Board at the monthly meetings.

**Regional Health Improvement Plan Council (RHIP)**: Cross-sector, cross region members from the health care delivery system, including physical, behavioral, and oral health, MCOs, early childhood, K-12, and post-secondary education, housing, criminal justice, public health, and community stakeholders. The RHIP Council captures local expertise, and the work currently underway in the region, to give a cohesive view of the regional picture. The RHIP Council receives input and recommendations from the community, BHAB, DLT, and Workgroups from which it develops recommendations to the SWACH Board.

• **RHIP Cabinet**: The RHIP Council has a Cabinet comprised of Co-chairs and two additional RHIP Council members who review agendas and communications between RHIP Council monthly meetings.

**Behavioral Health Advisory Board (BHAB)**: The BHAB, comprised of 50% consumers, many of whom have behavioral health diagnoses or family members with behavioral health diagnoses, is a source of rich community wisdom. Board members utilize Medicaid, Medicare, and Veteran’s Administration benefits, commercial insurance, and some are uninsured, and all provide direct feedback on behavioral health and substance use care delivery issues and barriers. In addition to guiding the distribution of block grant funds, the BHAB provides deep, authentic, lived experience as a lens for SWACH’s work.

**Clinical Integration Committee**: Comprised of a group of leaders and providers that provide behavioral, physical and general health care in SWACH and understand the key components and barriers of healthcare transformation. The Workgroup uses regional data and expertise to recommend specific interventions and shared learning to collectively understand system and policy barriers or innovations to address access to care, clinical integration, chronic disease management, opioid use and its impact, care transitions, diversion to the best care setting, oral health, and reproductive and maternal and child health.

**Community Care Coordination Workgroup**: Comprised of a broad set of stakeholders and partners including: physical health providers, hospital systems, behavioral health providers, community-based organizations, representatives from county government, MCOs, and the criminal justice system. This workgroup has supported the environmental scan and community mapping exercises to identify potential areas of overlap or duplication as part of the Pathways HUB planning process.

**Opioid Workgroup**: Comprised of multiple partners engaged in opioid-related work or expertise throughout the region. These include physical health providers, hospital systems, behavioral health providers, community-based organizations, representatives from county government, MCOs, and the criminal justice system. The Workgroup’s function has been to leverage existing efforts and expertise, fill gaps, avoid duplication, and target areas that require additional focus and resources to address the prevention and treatment, from an individual and health system perspective, of opioid use, addiction, treatment, and recovery.

**HLC Policy Committee**: Provides overall analysis and leadership on policy and system change strategies. Its work will include making recommendations to HLC partner organizations and building support for the
policy agenda. This committee’s work focuses on organization, local, and state level policy. To date, the policy focus areas are: health, prevention, equity, and affordable housing. The committee is comprised of 9-13 organizational and community partners, CHWs, and community members. We plan to have cross-membership between this committee and the RHIP Council to ensure policy considerations are included in SWACH work and we can ensure we fulfill our role in communicating policy barriers and challenges.

The HLC Policy Committee has a representative on the WA State Prevention Alliance, focusing on advocating for policies aimed at preventive measures. SWACH is one of the only ACH currently represented on this collaborative, and has a member on the Steering Committee.

Committees in Development (Operational Q1 2018)

**Incentive & Investments Committee:** Will provide guidance and direction for MTP related funds flow and investment strategies. The Committee will develop policies and guidelines for the use of the Systems Capacity Building Fund, submit recommendations to the Board regarding distribution of funds to partnering providers, and provide recommendations on the management of the Community Resiliency Fund. The Board is currently developing this committee and will make decisions about the composition and formal charge by January 2018.

**Quality and Continuous Improvement (QCI) Committee:** Will be comprised of clinical transformation experts and leaders from the region and provider organizations, charged with monitoring continuous quality improvement, program management, and overall success of meeting clinical outcomes and care delivery redesign. The QCI Committee will partner with the Data and Learning Team (DLT) and the ACH Strategic Improvement Team to utilize the self-monitoring tools and resources to drive improvement across care settings. The QCI Committee will provide information and feedback to the Clinical Integration Committee and Incentives & Investments Committee.

**Health Information Exchange and Health Information Technology (HIE/HIT) Task Force:** Will be comprised of CIO/CTOs from partnering providers; this Task Force will support the development and oversight of the population health management system (PHMS) strategy. This group will provide recommendations on infrastructure and technology strategies to the Incentives & Investments Committee for necessary technology planning, purchasing, training, technical assistance, and on-going maintenance and support for participating providers in the PHMS realm.

**HLC Committee:** Provides overall direction to HLC. This includes providing recommendations on community engagement efforts. The group will be comprised of 7-13 members from cross-sector organizational partners, community and advocacy groups, CHWs, and community members who represent different ages, disability status, race/ethnicity, and socioeconomic status and are deeply connected to the community. This committee will ensure HLC work is aligned with MTP work and reaching more deeply into our communities beyond the MTP.

**Operational Support Teams:**

**Data and Learning Team (DLT):** Comprised of data and analytic expertise from regional cross-sector partners. The DLT supports data driven decision-making by reviewing and interpreting existing data and reports, identifying data gaps and data sharing needs, and making recommendations regarding project selection and focus, and target population selection, to workgroups and governance bodies. The DLT will
look at performance data and share recommendation with the Strategic Improvement Team and the QCI Committee.

**Community Engagement System:** SWACH’s community engagement strategy stems from our merger with the existing Healthy Living Collaborative of SW Washington. HLC’s Community Health Workers (CHWs) and Community Health Workers and Peer Support (CHAPS) networks are in communities and neighborhoods, working within our most vulnerable and marginalized communities across the region. SWACH has incorporated HLC as the community outreach and engagement arm for our work under the MTP and more broadly across the region.

HLC has developed trusted relationships with its over 60 organizational partners. HLC brings a network of partners who have a history of being solution oriented, collaborative, and effective in addressing health and social issues across our region.

The 40+ CHW and CHAPS network members share their learnings, input, and feedback with our workgroups, committees, and governance bodies to provide authentic, lived experience to enrich the statistical data. The CHW and CHAPS network members are members of the communities from which we seek to learn. We do not ask community members to come to us; we meet them where they are comfortable and safe, which provides for more candid and honest input.

SWACH’s Community Engagement Coordinator attends the meetings of other community-based organizations and advocacy groups to share information about SWACH and the MTP and to learn the concerns and issues facing the various constituencies across the region.

HLC’s CHW and CHAPS networks support SWACH as host for community conversations with Medicaid beneficiaries who understand firsthand the difficulties in navigating a fractured healthcare system. These networks contribute their expertise to the shared learning and action structure in the same way providers share their perspective and expertise, ensuring a more complete vision of whole person health and validation of activities designed to advance health equity.
Financial

The Board, working with the ACH executive staff and finance committee, develops the annual budget for the organization’s fiscal year. Board approved policies govern the authority of ACH staff to make financial commitments without specific approval and when commitments need to be approved by the Board.

The Board is currently developing a process for distributing MTP incentive funding. In accordance with the recommendations from the RHIP Council and SWACH executive leadership, funds flow guiding principles and a high-level allocation methodology has been approved and is more fully articulated in the Funds Allocation section.

An Incentives & Investments Committee will be seated in early 2018 and charged with developing policies for allocating the Systems Capacity Building Fund and the specific criteria by which partnering provider incentives will be distributed.

Partnering Providers will be required to sign a contract with SWACH detailing the specific responsibilities for which they agree to be held accountable and the terms and conditions upon which they will earn incentive payments (Transformation Rules of Engagement). Contracts will be clear on the roles and responsibilities of the parties and have breach, cure, and termination provisions. We anticipate contracting to take place in early Q2 of 2018.

Clinical

The Clinical Integration Committee, staffed by an ACH employee who is a behavioral health provider, is comprised of representatives of physical and behavioral health providers, hospitals, and MCOs serving over 90% of the Medicaid population across our three-county region. Using claims data provided by HCA, SWACH identified the clinical providers across the region serving the Medicaid population and recruited them to join the MCOs on this important workgroup. The Clinical Integration Committee has engagement from providers who work in large, small, urban, and rural settings across all three of the region's counties. This group has chosen the clinical approaches for work under the MTP and will have primary responsibility for finalizing the Transformation Rules of Engagement for clinical care settings. In partnership with the ACH Strategic Improvement Team and the QCI Committee, the Clinical Integration Committee will monitor clinical outcomes and the initiatives to improve those outcomes. SWACH may share a Medical Director with Pierce County ACH in the future.

Community

SWACH’s community engagement program, the Health Living Collaborative of SW Washington (HLC) is charged with ensuring robust, authentic community and consumer engagement. SWACH received a $40,000 grant from the United Way of the Columbia Willamette to develop and implement an equity lens for SWACH’s work. The HLC Policy Committee will provide oversight for this work and SWACH Vice President of Partnerships, Policy, and Equity will directly oversee the community engagement, policy, and equity work under the supervision of SWACH’s CEO. The BHAB will work in partnership with the HLC Committee to ensure additional consumer and lived experience is incorporated into recommendations.

Data
SWACH has contracted with Providence’s Center for Outcomes-based Research and Evaluation (CORE) for data measurement and analytics services. CORE scientists and statisticians are supported by data collection experts and experienced qualitative researchers. CORE co-staffs the DLT and provides data interpretation and use guidance. DLT findings are shared with workgroups, committees, and governance bodies for data-driven decision-making. CORE is developing a self-monitoring and reporting system which will enable SWACH to closely track partnering provider performance and provide data for the Strategic Improvement Team and QCI Committee, as well as the partnering providers themselves.

**Program management and strategy development**

SWACH’s CEO is responsible for ensuring appropriate organizational capacity and administrative support for regional coordination and communication across the region. The CEO reports directly to the Board. The Board, in partnership with the CEO sets organizational strategy and holds the CEO accountable for implementing the strategy. The CEO is reviewed annually through a review process which includes evaluations from stakeholders and staff.

**Governance Changes**

As of October 1, 2017, SWACH officially merged with HLC, making HLC the community engagement, policy, and equity arm of SWACH. The merger terms included the agreement to seat a HLC Committee and HLC Policy Committee to provide oversight and direction to the work of the HLC and inform the work of SWACH. The HLC Policy Committee is seated, and we are currently conducting an open application process and expect to have the HLC Committee seated by January 2018.

**Phase II Certification Areas of Improvement**

Our Phase II Certification feedback indicated a desire to better understand how organizations/sectors that make up the RHIP Council were identified as having the greatest connection to the region and impact on the ACH meeting its mission and goals. RHIP Council members were initially chosen through an open application process in December 2016. Over 30 applications were received and the selection committee (chosen by the Board) developed and applied selection criteria tied to the organization’s vision, mission, and goals. The selection committee sought representation across sectors and geographies, as well as a broad array of criteria. After selecting the initial members, the RHIP Council noted gaps in the membership and in partnership with SWACH staff, engaged in targeted recruitment to round out the RHIP Council members. Ongoing recruitment and additions will be made throughout the MTP to ensure representatives necessary to our work are engaged and involved.

**Oversight of Partnering Providers**

Partnering provider participation and performance will be monitored by SWACH staff through the self-monitoring system. In partnership with the Strategic Improvement Team and the Quality and Continuous Improvement Committee, low-performing providers will be engaged in improvement cycles to increase their performance. Providing partners who cease to participate with SWACH will be subject to the termination or breach terms contained in their contract.
Community and Stakeholder Engagement and Input

Describe the ACH’s community and stakeholder engagement and input. In the narrative response, 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**

Our approach is driven by our belief in a community engagement system that is embedded throughout our work. This system enables us to learn and act together with the community; not only to choose, plan, and implement our Transformation Projects, but in all the work of SWACH. We have built a community engagement infrastructure to authentically engage the community in all efforts to address up, mid, and downstream issues across the region to enable all residents to have access to quality care and improved health outcomes in cost effective ways.

SWACH has endeavored to define community engagement with the broadest possible lens. We have done significant outreach to and engaged with the following types of stakeholders across the region:
Solicitation of robust public input into project selection and planning

SWACH pursued a multi-pronged approach for soliciting public input on project selection and planning. Cognizant of the differences among our counties and the inevitable variance in effectiveness of any one strategy, SWACH approached soliciting and collecting public input in the following ways:

- Established workgroups and committees were asked to consult with colleagues and partners to bring input and feedback to the group for consideration and discussion. During the project selection and planning process, workgroups and committees were meeting in frequent intervals. Recommendations from the workgroups and committees were included in the project plan recommendations to the RHIP Council;

- The monthly RHIP Council meetings were open to the public, including a public call-in/web conference line, and non-RHIP Council member participants were invited to freely participate in discussions and provide feedback at meetings. Meetings were advertised in the Columbian newspaper, on the SWACH website, and through requests to partners and stakeholders to share meeting information. The project selection and planning recommendations made to the board included community input such as the need to incorporate key elements of the projects not selected in the MTP work;

- The monthly Board of Trustees meetings were advertised in the Columbian newspaper and open to the public, including a public call-in/web conference line, and two opportunities for public comment were provided (one at the beginning of the meeting and one at the end of the meeting). Meetings were noted on the calendar on the SWACH website;

- Behavioral Health Advisory Board (BHAB) meetings provided an opportunity for volunteer community members to share input on the MTP selection and planning process. Particular attention was given to the input regarding culturally specific training for providers;
• Our Community Health Workers (CHWs) and Community Health Advocate and Peer Support (CHAPS) network, on the ground and working within our most vulnerable and marginalized communities across the region on an ongoing basis, ascertained input as seen through the eyes of those utilizing the systems we seek to transform. CHWs and CHAPS then shared this input with SWACH to provide authentic, lived experience that guided our work and enriched the statistical data. The CHW/CHAPS process is a continuous communication loop;

• Our Community Listening Session provided rich feedback and input that was captured and shared with workgroups, committees, and governing bodies for consideration in MTP project selection and planning. This event was heavily advertised through our partners and stakeholders, as well as the Clark County information listserv;

• Key informant interviews were held with community leaders and Medicaid beneficiaries in our more rural and less populated areas of the region (Skamania and Klickitat Counties) with input shared with workgroups, committees, and governing bodies. These interviews corroborated the input we received from BHAB, CHW and CHAPS Network, and listening session;

• Healthy Skamania (a Collaborative group who share the common goal of promoting health and wellness in Skamania County) meetings solicited input and feedback monthly.

• Partners and stakeholders across the region were interviewed for resource assessments, environmental scans, and current state information and their critical input and feedback was shared with workgroups, committees, and governing bodies.

Utilizing these approaches, SWACH achieved broad outreach to clinical care and service delivery partners, community-based organizations, local governmental entities, Tribes, local agencies, advocacy groups, and the public at large. As this was an ongoing process, ample opportunity to provide input throughout a six-month period was provided.

SWACH posted its RHIP Council and Board meeting agenda, materials, and minutes on its website for public viewing. The logic and rationale for decisions can be seen from these materials.

Concerns and questions from community stakeholders were addressed by SWACH staff follow-up to understand the concern/question, and then triaged to the appropriate workgroup, committee, and/or governing body for further discussion. SWACH staff ensured follow-up with community stakeholders.

**Key elements of Project Plan shaped by community input**

• Opioid Project

Community input provided the direction and strategies for project planning for the required opioid project. The Opioid Workgroup is comprised of representatives from a broad spectrum of community stakeholders including primary care clinics, hospitals, behavioral health settings, substance use disorder settings, public health, schools, community coalitions, managed care organizations, corrections, and community based organizations. Workgroup representatives engaged in a robust process to review, discuss, and prioritize best strategies through which SWACH will address the opioid epidemic in the region. Workgroup members convened five times and engaged in regular email communications over two and a half months to finalize recommendations for SWACH work to address prevention, treatment,
OD prevention, and recovery. The Workgroup was aided by data analysis from the Data and Learning team and by lived experiences shared by CHWs, CHAPS network members, and stakeholders working in the addiction and treatment sector. Project planning, chosen approaches and strategies, and initial implementation planning has been done by these community volunteers. The Workgroup’s recommendations were adopted by the RHIP Council and approved by the Board.

- **Community Paramedicine**

Clark County Fire and Rescue, District 12, approached SWACH to share the information and planning they have completed to date around development of a Community Paramedicine Program. Clark College and the Clark Regional Emergency Services Agency (CRESA) have had conversations with District 12 and SWACH agreed to complete an additional environmental scan of the community to refine the scope and identify key partners to aid in planning for a community paramedicine program in Clark County. Workforce development strategies and target population identification were refined by community partners engaged in community paramedicine program planning in Clark County. The input of District 12, Clark College, and CRSEA encouraged the inclusion of Community Paramedicine in project planning.

In interviews to develop an environmental scan of Skamania and Klickitat counties, rural and frontier partners also expressed a desire to develop community paramedicine as a rural solution to diversion from acute settings of care and from jail. Rural community stakeholders expressed concern about transportation and a lack of resources in the rural and frontier areas of the region, resulting in poor access to necessary health care services. The provider partners in the area voiced their support of community paramedicine as the most logical solution for addressing diversion issues and SWACH agreed a community paramedicine program in rural and frontier areas would require a unique plan. Community leaders in Skamania and Klickitat identified the names of key community partners for further interviews and input. SWACH has decided not to pursue Diversion as a MTP, but is committed to including community paramedicine diversion strategies as part of its work in our other project areas, specifically Opioids, Chronic Disease Prevention and Management, Community Care Coordination, and Clinical Integration.

- **Community Listening Session Input**

SWACH held a successful community listening session attended by community members from varied backgrounds, neighborhoods, and cultures, many who were Medicaid beneficiaries, as well as potential partnering providers and SWACH staff. The community listening session focused on soliciting direct feedback on project selection planning of five transformation projects. SWACH developed a facilitation guide, which included open ended questions to elicit feedback on the project areas. Each participant participated in two small group discussions to provide input on the project plans (Facilitation guide and complete notes are found in SWACH-Att-3-Public-Input-20171116.pdf). The rich feedback was reviewed by SWACH staff and shared with workgroups, committees, and the RHIP Council.

Examples of input incorporated into the project plans:

- The need to provide more culturally specific services;
- Success of peers/CHWs in providing support and connection in ways traditional providers often cannot;
- Identification of community organization and places where individuals and families receive assistance (this information both provided confirmation and helped to identify new potential partners);
- Reaffirmed lack of regional Medicaid health care providers is an issue, not only for beneficiary access, but also how this need is overwhelming existing providers (quadruple aim);
- Identified need for more information from a specialized source for chronic condition(s); and
- Language barriers prohibit people from getting or properly utilizing care.

- **Project Language**

During an outreach session with a community advocacy group, SWACH learned the use of the term “Demonstration,” when used with health care, is offensive to the African American community. Given the nation’s long history with medical experimentation on African Americans, the use of this term may be a barrier to engaging this population in our work. SWACH has removed the word demonstration from our vernacular and instead use Medicaid Transformation Project or MTP in our communications and references for all work going forward.

**Continued Public Engagement**

SWACH intends to continue to use and strengthen the strategies and mechanisms defined above throughout the MTP. We hope to attract non-Medicaid providers to our work to better align with the broader health care system. As we spread our community engagement program through our Healthy Living Collaborative (HLC) program into Skamania and Klickitat Counties, we expect a more robust penetration of CHW and CHAPS network activities. We have Community Listening Sessions planned to occur quarterly with an opportunity to complete an online survey in addition to or in place of attendance to ensure as wide a reach as possible. We plan to have our DLT and Strategic Improvement Team work with our community engagement system to ensure we are including authentic, lived experience in analyzing performance and creating improvement cycles. SWACH will continue to solicit feedback and input on how we can better engage our community stakeholders.

SWACH will also begin an 18-month stakeholder engagement process to define a vision for community health and resiliency for the region. We expect this process to provide rich input and engagement opportunities throughout the MTP.

- Describe the processes the ACH used, and will continue to use, to engage local county government(s) throughout the Demonstration period.

SWACH has worked with county departments in the following ways:

**Clark County**

- Clark County Public Health
  - Co-leading the DLT with SWACH
  - Critical partner on Chronic Disease Prevention and Control and Opioids Projects
  - RHIP Council Membership
  - Present at Public Health Advisory Board Meetings
- Participate in SW WA Regional Health Care Advisory Committee (Clark and Skamania)
• SWACH CEO has met with all County Councilors individually to discuss MTP work
• SWACH Vice President for Clinical Integration meets with Director of Clark County Community Services regularly to discuss Integrated Managed Care
• Corrections department participates in DLT, Opioid Workgroup
• Behavioral Health Capacity Building Committee (Clark and Skamania Counties, MCOs, ACH, BH-ASO)
• Support for Crisis Center

Skamania
• Partner/member Clinical Workgroup
• Partner/Member Community Care Coordination Workgroup
• Board of Trustees member
• Healthy Skamania meetings

Klickitat
• Klickitat County Public Health Department – RHIP Council member

SWACH intends to nurture its relationships with the counties and to find more opportunities to work in partnership. We believe planning for the distribution of the IMC incentive funds will provide a good platform on which to align our vision and work.

Phase II Certification Areas of Improvement

Our Phase II Certification feedback noted a lack of specificity regarding the list of successes for meaningful community engagement. SWACH viewed engagement of community groups (e.g. LULAC, NACCP, Free Clinic, AAA) as evidence of interest and excitement for the work ahead. For SWACH, meaningful community engagement referred to a multi-prong approach that has been enhanced to go deeper into the community. We have utilized community listening sessions and key informant interviews to elicit specific feedback from the Medicaid population. These sessions provided staff and providers an opportunity to hear candidly from the community where individuals felt safe. We received positive feedback from participants stating they felt heard and they wanted the opportunity for more community listening sessions. We intend to have quarterly sessions beginning in January 2018.

Feedback also included a lack of specificity regarding provider engagement activity and input outside of the formal governance structure. SWACH has engaged potential partnering providers, both clinical and community-based, through activities such as:

• Environmental scanning meetings with Clark, Skamania, and Klickitat providers;
• Presentations for local Clark, Skamania, and Klickitat County meetings with stakeholders, providers and community groups focused on their community’s health;
• Staff participation with partnering provider efforts such as the Klickitat Valley Health opioid taskforce meeting;
• Participation in Healthy Skamania meetings each month as a conduit between the local provider community, stakeholders, CBOs and the ACH;
• In person 1:1 meetings with potential providers;
• In person 1:1 meetings with allied providers, such as Clark College and Lower Columbia College;
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?
  o If applicable, provide examples of at least three key elements of the Project Plan that were informed by tribal input.
  o 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

Current tribal and Indian Health Care Provider (IHCP) engagement and collaboration efforts

Tribal and Indian Health Care Provider (IHCP) engagement and collaboration has been guided by Steve Kutz, Director of Health and Human Services of the Cowlitz Nation and a member of the SWACH Board of Trustees. Steve has served as our primary Tribal representative and connection point with the Cowlitz Nation.

We have struggled to engage with the Yakama Nation. We have been pursuing a formal introduction, but have not yet been offered the opportunity.

We have been in contact with the Northwest Portland Area Indian Health Board (NPAIHB) to request data to align and complement our existing regional data specific to Tribal health needs and disparities.

Through conversations with the Health Care Authority and other educational opportunities, SWACH has identified the following considerations with respect to tribal and IHCP engagement:

• The Federal Trust responsibility and the legal obligation of the federal government to provide health care for all American Indians/Alaskan Natives (AI/AN) and how the MTP intersects and...
interacts with the relationship between Indian Nations, the state government, and federal government, including the role ACHs play;

• Access to and ownership of tribal and IHCP specific data can be problematic, based on the historical context of how data has been obtained and used to marginalize or eradicate certain populations; and

• Culturally-specific, responsive and authentic behavioral health interventions are critically important, as AI/AN populations see some of the largest disparities in behavioral health outcomes, which arise from intergenerational trauma and high levels of adverse childhood experiences (ACEs)

We understand Tribal communities struggle with capacity issues and we intend to go to these communities, and to support their engagement and involvement to the greatest extent desired the Tribes. SWACH recognizes that we do not have the solution to these challenges and/or considerations, but we will be sensitive and appropriately responsive when planning and implementing MTP plans.

Identifying tribal and IHCP priorities

• SWACH staff has been recruiting Cowlitz Tribal representation for workgroups, committees, and governance bodies to supplement the support Steve Kutz provides. To date, we have received input on tribal/IHCP priorities through contacts with the Deputy Director of Health and Human Services for the Cowlitz Nation, the Program Coordinator for Health and Human Services for the Cowlitz Nation, and the Health Director of the Cowlitz Nation.

• SWACH’s community outreach and engagement have identified Community Care Coordination and Chronic Disease Management and Prevention as project areas with overlapping priorities for the Tribe.

Elements of the Project Plan informed by tribal input

• Awareness and Sensitivity Training

All participating partners will be required to complete awareness and sensitivity training to ensure care will be culturally-specific, appropriately responsive, and authentic.

• Community Care Coordination

Members of the Cowlitz Nation struggle with transportation to Clark County for services given the lack of available public transportation. We have noted this and will look to address transportation issues in our Community Care Coordination HUB.

• Chronic Disease Management and Prevention

Data suggests focusing on chronic disease management could improve outcomes for the Tribal population. Our workgroups welcome Tribal input to craft specific activities for the Transformation Rules of Engagement to improve the chronic disease management protocols for Tribal members. Also, through our work with the Healthy Living Collaborative (HLC) we have identified that the Cowlitz Tribe recently lost funding for a diabetes prevention program. We are interested in helping the Tribe utilize
the specific approaches of the MTP Chronic Disease Management and Prevention work planned to be implemented by SWACH.

Phase II Certification areas of improvement

Phase II certification feedback noted no area for improvement. One deficiency noted regarded the implementation of the Tribal Implementation Committee. No designee to the Tribal Implications Committee has been made by the Tribe. The Executive Committee has not determined any SWACH action to date to have a negative impact or consequence AI/AN populations.

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

Management and Oversight of Funds Flow Process

High-level decisions about the distribution of DSRIP funds have been made by the Board of Trustees. DSRIP incentives will be distributed among four categories:

- ACH Management and Administration
- Community Resiliency Fund
- Systems Capacity Building Fund
- Provider Payments

ACH Management and Administration funds will be distributed to the ACH and managed and overseen by the Board of Trustees via its annual budgeting approval process and expended pursuant to ACH policy.

SWACH intends to engage in coalition building to formulate a framework for distributing the Community Resiliency Fund. With direction of the Board of Trustees, SWACH plans to lead the region to develop a regional vision – a north star which will guide long-term investment to truly impact upstream issues. SWACH intends this work to begin in Q1 of 2019 and continue through the end of Q2 of 2020. This 18-month stakeholder engagement/coalition building process will provide a strong roadmap for the investments necessary to achieve the region’s vision. Given the percentages
allocated to the Community Resiliency fund, and the timing of the cash flow, we do not anticipate significant enough funds in this category to implement projects until the end of the MTP.

The Board of Trustees is developing a policy to govern the distribution of the Systems Capacity Building Fund and will establish an oversight committee (Incentives & Investments Committee) to implement the policy and oversee all decisions regarding incentive fund distribution. For expenditures related to system capacity building, the committee will review expenditures proposed to be paid from the fund pursuant to the final, adopted policy. The Board anticipates a policy and decision on whether the oversight committee is a Board committee, or committee comprised of non-Board members by January 31, 2018.

SWACH will work with our workgroups, the community, and our governing bodies, using our guiding principles, to further develop how incentives will be distributed to participating providers.

Once we finalize the Transformation Rules of Engagement, and the ACH-level reporting and performance metrics, we will have the information necessary to design a model to distribute the earned incentives going to providers. Input received thus far has focused on rewarding providers serving large numbers of Medicaid beneficiaries and those meeting and exceeding performance goals.

Roles and Responsibilities for Managing the Funds Flow Process

As with all decisions regarding the MTP, the various governance bodies of the organization will ensure transparency and engagement in managing the funds flow process. The Board of Trustees is ultimately responsible for the oversight of the funds flow process.

The Incentives & Investment Committee will use our funds flow guiding principles (see Funds Flow Distribution section below), to develop policies for the ultimate methodology for incentive payment distribution for approval by the Board. The workgroups, committees, and RHIP Council will provide input and feedback on policy proposals from the Incentive and Investment Committee. The policies will detail the allowable expenditures and methodology for determining those expenditures, timing of distribution of funds, and documentation of accomplishments/reporting required from partnering providers to receive funds. The policies will also include a mechanism for a partnering provider to appeal a funding decision. MTP contracts between SWACH and partnering providers will contain these policies and expectations. Contracts will also articulate partnering providers’ rights to be informed of performance issues jeopardizing their receipt of incentive payments or distributions from the SCB Fund.

The Finance Committee of the Board will review the distribution instructions given to the Financial Executor to ensure they are compliant with the Board approved policies.

Stewardship and Transparency

SWACH intends to use our funds flow guiding principles (see Funds Flow Distribution section below), coupled with checks and balances from our oversight committees (see Roles and Responsibilities section above) to ensure proper stewardship of all DSRIP incentive funds.

SWACH will prepare and disseminate biannual reports detailing its success in meeting pay for reporting and performance measures and VBP incentives and the associated amounts of incentives
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

Project Design Funds

To date, SWACH has used project design funds to:

- Hire staff;
- Rent office space;
- Purchase office furniture;
- Purchase computers and IT equipment;
- Rent meeting space;
- Travel to meetings;
- Pathways HUB (Technical assistance, consulting)
- Procure legal and accounting services;
- Procure consulting services;
- Conduct community outreach and engagement; and
- Implement a communications strategy.

The Board of Trustees approved using design funds to fund a pilot and create a training program for implementing EDIE/Pre-manage with three behavioral health provider organizations in Clark County. These funds will reimburse the three organizations for the staff time needed for training and shared learning workgroup commitments. The pilot and training will run from November 1, 2017 through June 30, 2018.
The Board of Trustees had originally approved utilizing the $6M in design funds in a 4:2 ratio: $4M to the ACH to use for ACH administration expenses and $2M to be utilized to assist providers in planning for and implementing MTPs, including provider engagement, community engagement, HIT/HIE, training, technical assistance, workforce development, and pilots. Upon the recent disclosure regarding the decrease in DSRIP funding, the Board approved a 5:1 ratio, with $5 M to the ACH to be used throughout the MTP timeframe, and $1M for planning and implementation to partnering providers.

**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**

**Funds Flow Distribution**

Three factors have influenced SWACH’s Funds Flow Distribution model:

- Delivery System Reform Incentive Payment (DSRIP) Definition
- Guiding Principles
- Lessons Learned

DSRIP programs are part of Section 1115 waivers and work by providing funding to states to support providers in changing and improving care delivery to Medicaid enrollees.

- Under DSRIP programs, payments to providers are linked to performance on certain quality and cost metrics, focusing on infrastructure development, delivery system design, population health management, and clinical outcomes.

- The focus of early years of DSRIP programs is typically on infrastructure development and system design, and the metrics are often process-based.

- In later years, the focus shifts to outcomes-based metrics that assess clinical or population health improvements.63

With input and direction from its workgroups, the community, and governance bodies, SWACH developed funds flow guiding principles.

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Guiding Principles:

- Equitable
- Sustainable
- Transformative
- Transparent
- Locally Responsive

SWACH also met with four Participating Provider Systems (PPSs) currently implementing a Medicaid DSRIP project in New York state. In sharing lessons learned, these PPSs were consistent on several points:

- Funds required for infrastructure and capacity building and system design should not be distributed directly to providers, but paid by the DSRIP management organization (PPS in NY, ACH in WA);
- It is extremely difficult to estimate the needs and expenses of the work ahead (the known unknowns) while in the planning phase; and
- Ensure funds will be available for costs not currently anticipated because there will be many (unknown unknowns).

Based upon the DSRIP definition, the guiding principles, and the learnings from New York, SWACH has developed a framework for funds flow process for distribution, approved by the Board of Trustees, that initially allocates funds to one of four categories:
The specific percentages of total incentive dollars proposed across the 5-year MTP projects are illustrated in the table below.

<table>
<thead>
<tr>
<th>Category</th>
<th>Y1</th>
<th>Y2</th>
<th>Y3</th>
<th>Y4</th>
<th>Y5</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACH DSRIP Management(^64)</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Community Resiliency Funds(^65)</td>
<td>10%</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>Systems Capacity Building(^3)</td>
<td>60%</td>
<td>60%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
</tr>
<tr>
<td>Paid out to Partners(^3)</td>
<td>20%</td>
<td>20%</td>
<td>25%</td>
<td>30%</td>
<td>35%</td>
</tr>
</tbody>
</table>

**Project Management and Administration**

SWACH will supplement the planning and design funds with a consistent percentage of project incentive funds each year of the MTP. These funds will continue to support the administrative expenses of the ACH, including:

- Project management;
- Staff support for workgroups and committees;
- Staff support for governance bodies;
- Pathways HUB administration;
- Support for workforce development;
- Support for population health management;
- Support for value-based contracting;
- Community engagement; and
- Communications.

**Provider Engagement, Participation and Implementation**

Given the New York DSRIP learnings, SWACH has designed a framework that ensures providers will have MTP and transformation costs covered to the greatest extent possible. Instead of disbursing funds meant to cover infrastructure costs directly to partnering providers for these expenses, SWACH’s System Capacity Building Fund will pay for these expenses to ensure we have engaged providers, participating fully, who can implement the *Transformation Rules of Engagement* and be high performers in the pay for reporting and performance incentive program.

SWACH will work with partnering providers to help them understand their roles based upon their care or service delivery setting, assess their resources, identify their gaps, and suggest options for solutions.

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\(^64\) 10% of maximum dollar amount of all incentives available each year

\(^65\) Percentages of earned dollar will be allocated based on the funds remaining
These costs will be estimated organization by organization, and each partnering provider will have their needs covered based upon the policy governing the use of System Capacity Building funds approved by the Board of Trustees.

SWACH intends to use the Systems Capacity Building Fund to support partnering providers in the following areas:

- Care and service delivery setting transformation training, coaching, facilitation, and technical assistance;
  - Change management
  - Revenue cycle management
  - Supply chain management
  - Intake/discharge protocols
- Strategic Improvement/quality improvement activities
- Population health management systems (EHRs, HIE, etc.);
- Value-based payment technical assistance and preparation;
- Workforce development, including salary reimbursement;
- Assistance with lost revenue; and
- Support in training and education on preventing provider fatigue.

Provider Performance and Quality Incentive Payments

SWACH’s funds flow framework will distribute pay for reporting and performance incentives to partnering providers based upon the model approved by the Board of Trustees. SWACH (in partnership with two other ACH’s) engaged KPMG Management Consultants (KPMG), based upon their previous experience working with DSRIP programs and MTPs in other states, to develop a model for the allocation Project Incentive Funds to partners including traditional Medicaid providers, non-traditional Medicaid providers and Tribes. This model is in development and will look at paying incentives based upon factors such as level of engagement and participation, level of success with both MTP and ACH-level criteria and number of Medicaid lives served. Funds paid to partnering providers under this category will come with no expectation for specific use once received by a partnering provider, although it is our hope partnering providers will use these incentive funds to offset any costs or expenses not covered by payments from the Systems Capacity Building Fund and to continue transformation efforts post-MTP.

Health Systems and Community Capacity Building

SWACH will also use its Systems Capacity Building fund at a broader level beyond the Provider Engagement, Participation and Implementation payments. This will include state and region-wide workforce development (versus the practice level workforce development referred to above) such as developing a Community Health Worker training program for Pathways, state and region-wide HIE/HIT strategies (versus partnering provider level HIT/HIE investments), and state and region-wide value-based payment activities. We continue to work with our ACH and state partners to define areas where collaboration will bring economies of scale and better outcomes. Collaborating on HIT/HIE strategies, Pathways technology, data collection and analytics, and reporting platforms are areas of interest to SWACH.

- 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.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
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</table>

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

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

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

| DATE (month, year) | March 30, 2016 |

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

| DATE (month, year) | February, 2018 |

- 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

Integrated Managed Care (IMC) Incentives

SWACH is in an interesting position with respect to IMC Incentives. Clark and Skamania Counties were early adopters of IMC, completing the financial integration as of March 30, 2016. Since April 1, 2016, these counties have been financially integrated and behavioral health services have been paid to providers by either Molina Healthcare or Community Health Plan of Washington (CHPW). By February 2018, when SWACH is estimating receipt of the IMC incentives, Clark and Skamania providers will be approaching their second-year functioning in an IMC environment. The counties and behavioral health providers have made great strides in transitioning to IMC, and do not require the same level of technical assistance and training as providers in regions just beginning their transition activities.

As an early-adopter, SWACH has begun work on clinical integration and this is an area where we have identified great need for provider assistance. Many regional behavioral health providers are just implementing electronic health records (EHR). This can be a great asset to our efforts to clinically integrate physical and behavioral health providers, however the success with implementation and use of these records, and assisting providers in gaining access to HIE capabilities will affect our outcomes.

During SWACH’s implementation planning period, we will conduct a needs assessment of providers with respect to clinical integration as part of both the MTP bi-directional integration work and the IMC work. This assessment will be done as a two-step process: a provider survey followed by an in-person assessment by the SWACH Chief Information and Technology Officer (CITO). Once the needs assessment has been completed and compiled (March 2018), SWACH will present the results to the HIE/HIT Task Force for input and feedback. Recommendations will be made by the Task Force regarding action steps and the use of the IMC incentive funding distribution. We anticipate these funds supporting providers with training and assistance with EHRs, implementation of Pre-manage/EDIE, costs associated with HIE, and cost reimbursement to cover employee training and loss of productivity during the implementation phases.

SWACH will also review capacity building requests from behavioral health providers in conjunction with the counties, the MCOs, and the BH-ASO.

Klickitat County was designated a transitional county until mid-2017 when they formally moved into the SWACH region for purposes of the MTP. Klickitat has since submitted a letter of intent to be a
mid-adopter, and we anticipate its transition in January 2019. SWACH will help the Klickitat providers transition to IMC by providing technical assistance and training on billing and revenue cycle skills, as well as supporting these practices in clinical integration. We are planning a meeting with the county and providers in early 2018 to discuss a plan for assessing providers needs during the transition period. Our information to date shows only one behavioral health provider in Klickitat County, and we will ensure it has the support it needs to meet the transition timelines.

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 in order 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 refers 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:**
Capacity Building

Capacity building in the three Domain 1 focus areas will support all SWACH selected projects by ensuring partnering providers have the necessary skills and infrastructure to transform care and service delivery settings to offer whole person care in a pay for value environment. The three Domain 1 focus areas are inextricably linked and together will provide a strong foundation for transformation efforts.

For partnering providers to successfully transition from fee-for-service to value-based contracting, provider organizations will require specific capabilities:

- Establish appropriate governance and organizational processes;
- Engage individual providers within their organizations;
- Develop care coordination and management;
- Develop and use technology and data analytics; and
- Develop links to community-based organizations to address the social determinants of health.

Capacity building in the three Domain 1 focus areas will assist partnering providers in developing VBP capabilities and offering whole-person care. For example:

- Investments in population health management systems will provide the capability to capture and analyze data for performance measurement and integrated care, care coordination and management, and links to community-based organizations to address social determinants of health.

- Investments in workforce development will provide a foundation to governance and organizational processes, engaging with individual providers, care coordination and management, use of technology and data analytics, and links to community-based organizations to address social determinants of health.

Investments

SWACH has identified the following investments and infrastructure necessary to carry out the projects in domain 2 and 3:

- ACH Administration
- Awareness and Sensitivity Education and Training (cultural, equity, behavioral health)
- Training, Technical Assistance, Transformation Coaching
- Pathways HUB Technology, Training, Administration
- HIE/HIT/Population Health Management Systems
- Validated Screening Tools and Instruments
- Lost Revenue Support
- Data and Analytics
- Strategic Improvement Team
- Self-monitoring system
- Reporting platform
- Workforce
- Provider Engagement
- Partner Engagement
• Community Engagement
• Communications

SWACH intends to make investments in the above-listed requirements to support our partnering providers in transitioning to a value-based contracting environment where they will be paid for high-value, whole-person, integrated care.

**Value-based Payment Strategies:**

DSRIP is a temporary source of funding to support health care transformation under the MTP. To make transformation sustainable, SWACH must ensure MCOs (as well as other payers - Medicare, commercial plans) are embracing alternative payment methodologies through VBP to financially reward and sustain delivery system changes.

**2017 Provider VBP Survey**

SWACH supported and promoted the request to complete the 2017 Provider VBP survey by contacting providers in the region serving the Medicaid population and requesting each organization complete the survey in a timely manner. An email request was made to the ACH contact(s) in each organization asking them to forward to the appropriate department in the organization, and our CEO followed up with a phone call. We did prevail upon a few providers to complete the survey; however, the response rate was far below our expectations. Our follow up with organizations not completing the survey indicated a hesitancy based upon uncertainty regarding sharing MCO contracting details and a concern about sharing proprietary information.

**Current State of VBP Among the SWACH Providers**

Providers across the region have been somewhat forthcoming, anecdotally, with respect to their individual MCO contract models. The larger providers seem to already have some VBP contracts in place. Shared savings is the most popular model; bonus for performance was the next most common. There is one large provider with a fully capitated contract for approximately 8,000 Medicaid members. The few medium and small providers with VBP contracts are using a performance bonus model. Smaller practices and behavioral health practices do not have VBP contracts. Community based organizations, traditionally not reimbursed by Medicaid, are uncertain how they will be included in a value-based model. Additionally, behavioral health providers are concerned about value-based contracting given their inexperience with member attribution and appropriate VBP models for this type of care.

The information shared with us from providers tracks consistently with the 2017 VBP Provider Survey.

**The Next 12 Months**

During our information sessions with providers, we have been reinforcing the VBP targets and the MTP requirements contained therein. Providers understand the MTP requires MCOs to pay 90% of the dollars paid to providers pursuant to VBP contracts, but their comfort level and understanding of how this will impact their practices varies greatly depending on practice size, sophistication of provider organization, and provider type. Behavioral health providers are most concerned with how VBP contracts will work as they are just adjusting to payment through the MCO and have not have experience with member
Over the next 12 months, providers will look to SWACH to act as a convener and educator to help them understand the skills and capabilities they will need to be successful in a VBP environment.

**Current barriers and enablers to VBP adoption driving change**

Providers have shared a wide range of barriers; the following have been reported most often:

- Lack of interoperable health information systems;
- Lack of cost data to assess contracting arrangements;
- Lack of confidence in attribution of members;
- Lack of interest in accepting risk;
- Inability to adequately understand and analyze contracting arrangements; and
- Misaligned quality definitions and/or measurement, especially between Medicaid, Medicare, and commercial payers.

The MCOs have been the driver of the shift to VBP thus far. SWACH intends to work closely with the MCOs to ensure providers have a better understanding of VBP and the skills, technology, and capabilities necessary to succeed in VBP contracting arrangements.

**Regional Strategies to support attainment of, and readiness to, achieve VBP targets**

To date, SWACH has been working with regional MCOs and the Washington State Medical Association, the Washington State Hospital Association, and Clark County Medical Association to engage and educate providers regarding VBP and MTP. SWACH intends to undertake the following to pave the road to a successful value-based system:

- Assess regional current state (Feb 2018)
  - State of partnering provider capabilities and readiness
  - Gaps in partnering provider capabilities and readiness
  - Patterns: regional, provider type, provider size, provider payer mix
- Identify provider needs at regional level (March 2018)
  - Common gaps/needs
  - Most pervasive gaps
- Determine feasibility of broad-based solutions (April 2018)
  - Regional Solutions
  - Statewide/Multi-ACH solutions
- Develop strategies and plans to address needs/gaps (May 2018)
  - Leverage existing/developing resources
  - Leverage MCO and other payer programs
- Leverage DSRIP and other programmatic resources to support efforts (ongoing)
  - ACH will use care and service delivery setting model to establish cohorts of providers based upon assessed VBP capabilities for shared learning
- Develop ongoing assessment mechanism (Feb 2018)
  - Partner with MCOs to develop tracking mechanism
- Monitor progress (ongoing)

**ACH’s Role in Supporting Providers in transitioning to VBP**
SWACH will fill several roles in supporting partnering providers in the transition to VBP arrangements:

- **Convener**
  - Connecting partnering providers with one another, with new potential partners, and MCOs to find regional solutions

- **Educator**
  - Ensure partnering providers are aware of State’s VBP targets and different VBP models;
  - Ensure partnering providers have access to resources and information on VBP readiness;
  - Ensure provider and non-provider partners understand capabilities needed for VBP
  - Partner with HCA, MCOs, and others to apprise SWACH on changes and progress to allow SWACH to provide accurate and useful information

- **Developer of Regional Strategy**
  Through implementation of the strategies listed above, and partnership with MCOs, the Practice Transformation Hub, and SWACH’s Strategic Improvement Team, SWACH will ensure partnering providers have access to training, coaching and technical assistance to develop the following capabilities necessary for success in a VBP arrangement:

  - **Governance and Organization**
    - Leadership buy-in and organizational vision
    - Workforce development
    - Effective practice management system
    - Revenue cycle management
    - Performance management
    - Legal evaluation and contract management
    - Change management

  - **Provider Engagement**
    - Staff education
    - Provider network identification and engagement
    - Referral management
    - Engagement with and links to non-physician staff/organizations
    - Co-location (if applicable)
    - Performance feedback and management

  - **Care Coordination/Management**
    - Single point of assessment
    - Coordination of care/services across specialties and sites of care
    - Development of comprehensive care plans
    - Patient engagement
    - Evidence-based case management

  - **Technology and Analytics**
    - Data aggregation
    - Data exchange and interoperability
    - Evidence-based population health management systems
    - Performance monitoring
o Links to Social Determinants of Health
  a. Patient social needs assessment
  b. Knowledge of and access to services and organizations
  c. Integration into clinical and care management protocols
  d. Development of value case for addressing social needs
  e. Social services referral staff/programs

• Advocate for and Champion of Practice Transformation
  o Provide support to and advocate on behalf of partnering providers in context of
devolving VBP capabilities (e.g., support aligning quality measures or increasing access
to data)

• Driver of Sustainable Reforms
  o Support developing partnering provider capabilities without increasing overall system
costs
  o Ensure activities are in line with MCOs direction on VBP

SWACH’s model of approaching projects as interwoven activities and interventions among and across
care and service delivery settings, will align VBP strategies by transforming partnering providers
individually as well as collectively, offering opportunities for MCOs to more easily pay for true value.
SWACH is very cognizant of the need to set expectations and criteria for performance in line with MCO
needs and plans, but also with the expectations of other payers such as Medicare and commercial plans,
to avoid burdening providers with non-aligned expectations. Other strategies, such as grouping
providers in cohorts, based upon their capabilities and goals, will allow SWACH to align activities and
strategies to create opportunities for shared learnings and grow the relationships among partnering
providers.

Workforce Strategies:

Preliminary considerations and approach to adapting workforce strategies across all selected projects

SWACH is cognizant of the crucial role workforce training and development will play in successful
transformation. Success with the MTP will entail a retraining of the current healthcare workforce to
function in an integrated system paying for value rather than services. SWACH approaches MTP work
from a care and service delivery setting approach. We will look at workforce needs setting by setting,
not project by project. We will look to identify the workforce needs to build more efficient, effective
care and service delivery settings, including the changes necessary to meet MTP outcomes for the
selected projects, as well as those aspects of care critical to successful transformation outside the four
selected projects.

SWACH will need to partner across sectors and care and service delivery settings to transform the
current workforce, grow the workforce, both in existing and new roles, train the workforce for
transformed care and service delivery, and improve workforce satisfaction to keep providers in their roles.

SWACH will:

- Convene local resources and support their engagement in SWACH planning and deployment;
- Develop relationships and coordinate with local health facilities, providers, employers, CBOs, MCOs, and other partners;
- Use local expertise and available TA, materials, and templates to develop SWACH specific plans;
- Identify SWACH-specific resource, TA, and curriculum needs, requirements, and plans;
- Develop local deployment plan to address both short and long-term needs; and
- Other actions identified by SWACH/HCA/Workforce SME’s/ACH Collaboration.

Identification of Workforce Capacity and Gaps

SWACH will identify the workforce necessary to support transformation activities by:

- Assessment and analysis of current data sources:
  - RHNI
  - Health Workforce Councils

**Elements of Workforce Planning**

- Needs assessment: Common ACH needs, resources, strategies
- Plan Design and Evaluation
- Develop partnerships
- Communication/Best Practice Sharing

Implement workforce plan
- Training
- Alternative training options
- Education partnerships
- Transformation support

- Sentinel Network
- WA Behavioral Health Workforce Assessment
- Workforce Development Councils – statewide and regional entities, Health Profession Opportunity Grants

- UW Center for Health Workforce Studies
  - Health Resources and Services Administration (HRSA) funded Allied Health Workforce Research Center

Source: Adapted from Healthier Washington
• Develop research and analytics of health workforce supply and demand

• Area Health Education Centers
  o Recruitment and retention strategies for rural/ underserved populations
  o Data support

• Department of Health Workforce Supports
  o State Office of Rural Health
  o Office of Health Professions–scope of practice, qualifications, WA Administrative Code expertise
  o Topic expertise and targeted training resources
  o Community Health Worker training and practice integration

• Allied Health Center of Excellence
  o Connector between industry and the 34 CTC system colleges, Hospital Employee Education and Training (HEET) grants

• Practice Transformation Support Hub
  o Coach clinics and behavioral health agencies to extend social work, RN and other profession skills to practice at top of licensure and adopt team based care
  o Workflow telehealth/telepsychiatry, clinical screening/tracking, care coordination, other new processes
  o Support on issues presenting barriers to practice transformation

- Inventory of Regional Provider Capabilities and Needs
- Compare Regional Needs with Needs of other ACHs to promote cross-region solutions
- Utilize the expertise of our Clinical Integration Committee and other partners and stakeholders to assess potential activities and solutions

Early in 2018, SWACH will conduct a Partnering Provider Assessment which will include a baseline workforce assessment across clinical and community-based care settings for each partnering provider. The Partnering Provider Assessment will deepen our knowledge of workforce capacity and gaps, allowing SWACH to tailor our assistance.

**Considering and prioritizing advancement of statewide and regional innovation and approaches in workforce capacity development**

SWACH envisions prioritizing and utilizing all available statewide resources for training and technical assistance on integrated, whole-person care, team-based care, cultural competency, and health literacy. This strategy will allow us to make effective use of provided resources and more easily align with the other ACH regions across the state.

SWACH further envisions our Clinical Integration Committee and other clinical partners assisting us in developing customizations to the statewide resources and regional workforce training, and in understanding the level of education and comfort providers have with stigma reduction, trauma-
informed care, and the elements of the IHI Workforce Model, “Improving Joy in Work.”66 We intend for this framework to improve access to care by reducing provider burnout and keeping our experienced providers practicing in the region.

SWACH is further prioritizing the advancement of statewide and regional innovations to workforce capacity development by planning for an active role in the statewide workforce forum that will be established for ACHs and subject matter experts. The forum will facilitate collaboration on shared approaches, tools, resources, planning, and deployment across ACHs.

SWACH is currently utilizing tools and guidance provided by workforce subject matter experts and HCA consultant, Manatt, in our regional project and implementation planning. We intend to continue to utilize the tools and look forward to additional tools and guidance emanating from the statewide workforce forum. Our workgroups, Strategic Improvement Team, and Quality & Continuous Improvement Committee will use statewide templates and resources in our regional needs assessment and planning efforts.

SWACH will nurture the strong partnerships we have developed at state and federal levels such as with the Washington State Department of Health in aligning expertise and resources from the Practice Transformation HUB, Transforming Clinical Practice Initiative - Pediatrics (P-TCPi), Office of Rural Health, and Health Living Collaborative and CHW and Peer Support efforts.

SWACH will also pursue strategies intended to be responsive to equity and cultural competency of health workers to increase the diversity among those offering care and services.

**Population Health Management Systems:**

SWACH’s approach to expanding population health management systems (PHMS) across all projects will focus on:

- Identifying, assessing, and educating partners on the technology solutions available to increase the interoperability of PHMS;
- Increasing health information exchange to provide better intelligence for partners across the region for whole person care, integration, quality improvement, and value-based purchasing;
- Implementing care coordination systems to include both clinical and social elements of data to improve whole person health; and
- Improving telecom connectivity in rural areas.

SWACH’s approach to using PHMS across all projects will focus on:

- Collecting data for reporting;
- Analyzing data for business intelligence;
- Developing Quality Improvement strategies;
- Health information exchange to support integration and coordination;
- Driving value-based payments;
- Risk stratification for resource prioritization;
- High risk patient identification and action;
- Advancing use of registries;
- Care coordination; and
- Telehealth

SWACH’s approach to supporting and maintaining PHMS across all projects will focus on:

- Assessment of critical needs and options
- Vendor procurement, management, and coordination;
- Vendor accountability;
- Partner Technical Assistance;
- Partner Training; and
- Partner Financial Support.

SWACH’s approach to population health management encompasses strategies to successfully capture and collect data, analyze data and exchange data, utilizing the most efficient, cost-effective, and wide-reaching technology to accomplish implementing these categories of work. Our approach includes:

- Employment of a Chief Information and Technology Officer (CITO – shared with Pierce County ACH);
- Contract with Providence CORE for data services;
- Establishing an HIT/HIE Task Force comprised of CIO/CTO level participants from participating providers/partners, staffed by CITO;
- Establishment of a Systems Capacity Building (SCB) Fund to provide resources for technology planning, purchasing, training, technical assistance, and on-going maintenance and support for participating providers; and
- Adoption of proven-technology systems that allow for new and innovative strategies.
This approach will ensure interoperable technology that supports the region’s transformation work and goals will be identified, procured, and implemented to enable SWACH to successfully achieve outcome metrics.

Next steps for PHMS work:
- Field Assessment (January 2018)
- Convene HIT/HIE Task Force (January 2018)
- Compile Assessment Responses (February 2018)
- Assess Options for PHMS (March 2018)
- Prioritize Recommendations (March 2018)
- Begin Development of Implementation Plan (April 2018)

SWACH encourages HCA to collaborate with the ACHs to develop standardized reporting tools for the MTP. Offering our partners a standard data collection framework will enhance participation and lessen the burden on the providers and the ACHs. It would also offer HCA an opportunity to streamline its reporting requirements to CMS. This will be especially helpful for those providers who cross ACH regions and do not want to have varied reporting requirements. SWACH looks forward to continuing to work with HCA on the HIT/HIE strategic roadmap and to partner on strategic initiatives that will allow us to leverage capabilities in place today, as well as those that will emerge in the future.

### Identifying PHMS

SWACH has begun to identify PHMS currently in use in the region through an initial, informal survey of potential partnering providers to ascertain the predominant EHR and exchange technologies in use across our three-county region. Most of our large systems and provider organizations are utilizing Epic as an EHR (PeaceHealth, Legacy, Providence, Kaiser, Vancouver Clinic, and One Community Health). Our largest FQHC (SeaMar) is using separate EHRs for physical and behavioral health (Allscripts and Cerner, respectively). Other providers are utilizing a myriad of EHR platforms, with varied versions of those platforms appearing across the region. To date, other than the prison system, we have not identified potential partnering clinical providers with no EHR capabilities, however we have identified challenges with internet connectivity in our rural/frontier sectors in Skamania and Klickitat Counties. These issues range from no high-speed connectivity to a complete lack of connectivity. These variations require technological solutions which will support interoperability and increased sharing of information to support our system transformation efforts. Additionally, most community based organizations have no capacity to collect or share information electronically.

To date, we have identified the following health information sharing systems in use in the region:
- Care Anywhere (EPIC)
- Care Everywhere (EPIC)
- EDIE/Pre-manage (CMT)
- Clinical Data Repository (OHP)
- Direct Secure Messaging
- Reliance e-Health Collaborative

We have also identified other technologies in use nationally that could serve our region: Carequality and Commonwell.
Next steps include a deeper assessment of partnering providers to ascertain more detailed information, including information on the use and satisfaction of the above-listed systems and providers’ views on these systems’ capabilities, capacity, and gaps. This assessment will be released in January 2018 with a one-month response window, to allow for follow-up inquiry. Our CITO and the HIT/HIE Task Force will assess responses. Based upon evaluation of the assessment, SWACH may develop a Request for Information for more detail from the service providers of health information systems currently in use in the region, as well as for other options not currently in use in the region. SWACH intends to play a convener/coordinator role to find the best options for technology solutions and to work with our individual provider organizations to implement these solutions.

PHMS Across all Stakeholders

Successful interoperability and health information sharing requires the commitment of provider organizations expected to use the technology. SWACH is cognizant that success in this area will require a thoughtful and transparent stakeholder engagement process. SWACH intends to convene an HIT/HIE Task Force comprised of CIO/CTO leadership from partnering providers to review the assessment data and evaluate the potential opportunities for robust health information sharing to support implementation of the regional transformation strategies. This Task Force, reporting to the Regional Health Improvement Plan (RHIP) Council will ensure robust partner engagement to understand the benefits and implications of any technology decisions across our partnering provider spectrum. Selection of technologies to increase health information exchange will need to leverage prior investments, align the needs of the providers across the region, regardless of payer mix, and develop strong working agreements for how technology and information will be shared and used.

SWACH understands how vital health information exchange is to our success with the MTP, but also for the spread and sustainability of transformation across the health care delivery system spectrum. It is this core belief which underlies our decision to employ a CITO and to allocate MTP and Early Adopter incentive dollars to the SCB Fund will ensure SWACH can implement the technology approaches necessary to ensure MTP success, including laying the foundation for clinical integration, care coordination, and value-based contracting.

SWACH intends to use the SCB Fund to provide technical assistance, training, and coaching to partnering providers to ensure each organization can fully participate in decision-making regarding HIT/HIE investment and use, as well as successfully implement solutions. Additionally, SWACH recognizes the enormity of the requirements with which our clinical providers must comply: HEDIS, NCQA, MACRA, MIPS, MCO contract requirements, and each organization’s individual goals and targets, to single out a few. SWACH will support providers in adopting and using more advanced technology solutions that do not increase administrative burdens.

As an example, SWACH is working with the Department of Health (DOH), Qualis, Collected Medical Technologies (CMT), and three regional behavioral health providers on a pilot program implementing EDIE/Pre-Manage in behavioral health practices. We are using the pilot to develop a training and coaching module for use with behavioral providers across our region, and throughout the state. It is SWACH’s hope to be ready to implement the use of EDIE/Pre-Manage within the other behavioral health practices across our region beginning in July 2018. This functionality will allow hospitals to notify behavioral health and physical health providers to share critical information about patients who have been admitted, discharged, or transitioned from a hospital setting. This functionality will support all four of our projects.
Lastly, SWACH is mindful that technology is a fast-paced environment with changes in capabilities, functionality, regulation, and cost occurring daily. SWACH intends to bring a forward-looking perspective to the conversation on HIT/HIE; recognizing new technologies and regulations will continue to emerge throughout the coming years. SWACH wants to assist our region in understanding what is just around the corner and help it to make the most cost-effective and efficient decisions possible to avoid implementing strategies that will be obsolete before they are fully implemented.

SWACH is watching the emergence of Fast Healthcare Interoperability Resources (FHIR) standards which describe data formats and elements, and an Application Programming Interface (API) for exchanging clinical data contained in EHRs. One of FHIR’s goals is to facilitate interoperability between legacy health care systems to make it easier to provide health care information to health care providers and individuals on a wide variety of devices from computers to tablets to cell phones, and to allow third-party application developers to provide medical applications which can be easily integrated into existing systems. The Office of the National Coordinator for Health IT (ONC) is piloting models for using FHIR and it is widely believed FHIR will become a required standard for all certified EHR products in the near-term future. Required implementation of FHIR would drastically change the region’s approach to HIT/HIE. This technology would increase interoperability and potentially negate the need for health information exchanges or repositories. This could drastically change how providers use and exchange information and SWACH intends to be an education resource for providers on this front to help guide them in technology decision making.

Prioritizing the advancement of statewide and regional innovations and approaches

The more prevalent the HIT/HIE technology, the more beneficial it will be to our work. SWACH will prioritize those statewide and regional innovations and approaches to HIT/HIE that deliver the greatest value to our partnering providers and the region. The HIT/HIE Task Force will provide a forum to analyze assessment responses and filter the data to support decision-making. SWACH understands that the best technology solution is the one that brings the most value to the individual partners as well as the region as a whole.

SWACH intends to use the HIT/HIE Task Force to develop a two-dimensional prioritization methodology; first to prioritize by value of a statewide versus regional solution. Value will include determining a technology’s ability to solve the most pervasive problems shared by the most partners across the region. The second element of prioritization will be the cost and feasibility of the solution. SWACH seeks to help providers use technology to drive innovations as well as solve problems, and will continue to use the HIT/HIE Task Force to tease out new strategies for utilizing technology.

Continued involvement with the HCA HIT/HIE strategic roadmap efforts, stakeholder engagement opportunities, and a focus on emerging standards and technologies, will allow SWACH to provide technology solutions to support the MTP and the region well beyond the MTP. SWACH intends to continue to partner and collaborate with other ACHs and will assist in the proliferation of technology solutions that can be shared across the state.
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.

<table>
<thead>
<tr>
<th>Project Plan Portfolio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 2: Care Delivery Redesign</td>
</tr>
<tr>
<td>☒ 2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)</td>
</tr>
<tr>
<td>☐ 2B: Community-Based Care Coordination</td>
</tr>
<tr>
<td>☐ 2C: Transitional Care</td>
</tr>
<tr>
<td>☐ 2D: Diversions Interventions</td>
</tr>
<tr>
<td>Domain 3: Prevention and Health Promotion</td>
</tr>
<tr>
<td>☐ 3A: Addressing the Opioid Use Public Health Crisis (required)</td>
</tr>
<tr>
<td>☐ 3B: Reproductive and Maternal and Child Health</td>
</tr>
<tr>
<td>☐ 3C: Access to Oral Health Services</td>
</tr>
<tr>
<td>☐ 3D: Chronic Disease Prevention and Control</td>
</tr>
</tbody>
</table>

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**

Whole person health requires clinical integration of behavioral health and physical health. SWACH will support the region’s collective vision for clinical integration by investing in building resources to share patient information, coordinate clinical and community-based care in new ways, and focus on accountability for outcomes, thus transforming existing relationships and developing a workforce trained to operate in a team-based environment.

Data shows individuals with a serious mental illness have limited access to primary care and are more likely to utilize the emergency department (ED) and inpatient services at higher rates than those without serious mental illness. Furthermore, on average, this group has increased rates of acute and chronic health conditions and is more likely to die 25 years earlier than the general population. Our region’s decision to implement an integrated service delivery model supports providing the most appropriate care, at the right time, and in the most appropriate setting for Medicaid beneficiaries. Currently, SWACH Medicaid beneficiaries (adults ages 18-64) with any mental health need, including serious mental illness proxy, substance use disorder (SUD) treatment need, and co-occurring mental illness (MI)/SUD were more likely to have 3 or more ED visits in a 12-month period. Individuals with co-occurring MI/SUD were most likely to have 3 or more ED visits, which is why SWACH will focus on this sub-group of individuals as one of potential target populations for the bi-directional clinical integration Medicaid Transformation Project (MTP).

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68 Substance Abuse and Mental Health Services Administration. (2014). Mental and Substance Use Disorders, Rockville, MD: Substance Abuse and Mental Health Services Administration. [www.samhsa.gov/disorders](http://www.samhsa.gov/disorders)

69 Measure Decomposition file provided by HCA / RDA, CY 2015 data for SWACH.

70 Measure Decomposition file provided by HCA / RDA, CY 2015 data for SWACH. Additionally, Medicaid beneficiaries (adults ages 18-64) with co-occurring MI/SUD were also more likely to have a hospital readmission within 30 days. In 2016, there were approximately 13,325 admissions for 104,160 Medicaid beneficiaries in SWACH. Approximately 5% of those admissions were for the broad diagnostic category ‘mental and behavioral disorders’.
According to national data, over 60% of adults with a diagnosable mental health disorder do not receive mental health services\textsuperscript{71} and almost 90% of individuals with a substance use disorder do not receive appropriate specialty treatment.\textsuperscript{72}

According to SWACH profiles provided by The Washington Division of Social and Health Services (DSHS), approximately 25% of SWACH Medicaid population being jointly served by Health Care Authority (HCA) and DSHS were diagnosed with a mental illness in the last 24 months, with depression and anxiety disorders being the most prevalent. Furthermore, 18% of the population was diagnosed with a serious mental illness, and just under 10% had at least one indicator of SUD treatment need (6.7% have co-occurring mental health and substance use disorder diagnoses, compared to 7.7% statewide).\textsuperscript{73}

<table>
<thead>
<tr>
<th>Percent of Medicaid members diagnosed with a mental illness for SWACH and WA State</th>
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</thead>
<tbody>
<tr>
<td>Total diagnosed with mental illness</td>
</tr>
<tr>
<td>Psychotic disorder</td>
</tr>
<tr>
<td>Mania and bipolar disorder</td>
</tr>
<tr>
<td>Depression disorder</td>
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<tr>
<td>Anxiety disorder</td>
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<tr>
<td>ADHD</td>
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<tr>
<td>Adjustment and stress disorder</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>SWACH</th>
<th>WA State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total diagnosed</td>
<td>25.6%</td>
<td>27.1%</td>
</tr>
<tr>
<td>Psychotic disorder</td>
<td>2.4%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Mania and bipolar disorder</td>
<td>3.4%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Depression disorder</td>
<td>14.7%</td>
<td>14.7%</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>15.8%</td>
<td>15.8%</td>
</tr>
<tr>
<td>ADHD</td>
<td>5.2%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Adjustment and stress disorder</td>
<td>2.6%</td>
<td>2.7%</td>
</tr>
</tbody>
</table>


\textsuperscript{72} Levit, K.R. et al. “Future Funding for Mental Health and Substance Abuse: Increasing Burdens for the Public Sector.” Health Affairs. Web Exclusive, 7 October 2008, w513-22

\textsuperscript{73} DSHS RDA ACH Profiles for Southwest WA, FY 2016. Available online at https://www.hca.wa.gov/assets/program/SW-wa-future.xlsx
Additional data provided by HCA confirms that just under 10% of SWACH Medicaid population had at least one indicator of substance use disorder treatment need, and provides additional insight into co-occurring conditions: approximately 5.7% of SWACH Medicaid members have co-occurring mental health AND substance use disorder treatment need and approximately 4.5% have co-occurring mental health AND substance use disorder treatment need AND one or more chronic condition(s).

Despite nearly 25% of the population having some mental health diagnosis in the past 24 months, SWACH’s treatment penetration rates are low (and have been declining over the past three years). SWACH is the lowest performing ACH for mental health treatment penetration (40.2% in 2015).

Through clinical integration, accessing behavioral health services in the primary care setting will begin to address this rate.

As an early adopter of Fully Integrated Managed Care (FIMC), our region is positioned to enhance the clinical integration of physical and behavioral health already underway because we have cleared the important hurdle of integrating financial models of health care purchasing. Our MTP work will support the goal of clinical integration by using the available incentive funding for planning and implementation of the changes necessary to fully integrate across provider settings.

The bi-directional integration project supports health transformation for the Medicaid population in several ways. By providing integrated services in both Behavioral Health (BH) and Primary Care (PC) settings, timely access to needed services becomes more routine over time. Moreover, early identification of behavioral health conditions leads to earlier treatment; this will have a positive impact on an individual’s overall health while also lowering the cost of care. Another key element to integrated care is the ability for providers to communicate health information effectively. SWACH will develop implementation strategies with participating providers to increase their capacity to exchange health information. This will allow the often fragmented care delivery system to more effectively coordinate care among providers, resulting in better quality care for beneficiaries. As clinical practices increase their capability to share information and develop population health strategies that leverage technology, we will develop a road map for providers to increase value to health care purchasers.

SWACH is working collaboratively with other efforts in the region to implement clinical practice transformation. SWACH’s collective impact strategy is to build and add value to efforts currently underway in the region. For example, SWACH intends to add financial resources, collaborative partnership development, training and technical assistance, data collection and analytics support, and strategic improvement coaching. SWACH has developed a process to ascertain from providers which practice transformation efforts they are currently implementing in their practices. The information

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74 Category 1 Behavioral Health and Chronic Conditions data file, provided by HCA Sept 29, 2017. Data through June 2016.
75 Penetration rate data from DSHS 1519 reporting available online, https://www.dshs.wa.gov/sesa/research-and-data-analysis/cross-system-outcome-measures-adults-enrolled-medicaid-0 as well as historical measure performance data provided by HCA on September 7, 2017.
will be inventoried and cataloged, and the workgroup and governance structure will determine how SWACH can add value to existing initiatives alongside our MCO partners, Practice Transformation Hum, and Qualis Health to develop and aligned targeted support strategy.

SWACH has developed a working partnership with the Pediatric-Transforming Clinical Practice Initiative (P-TCPI). The regional coordinator for the project has worked directly with SWACH Vice President of Clinical Integration and the Clinical Integration (CI) Committee to leverage both initiatives, collaborate with provider organizations involved in both initiatives, and create a shared learning environment via the CI Committee. SWACH has also been meeting with other organizations who have enrolled their practices in P-TCPI, learning which stages of change they are in and having strategy sessions to align efforts through both initiatives. There are various practices in the region that have implemented elements of integration strategies and SWACH will be developing a matrix of levels of integration based on the SAMSHA Six Levels of Integration to guide strategic plans and support provider movement along the continuum of integration.

In the first part of DY 2, all participating providers will be subject to a comprehensive practice assessment. Through the assessment process, SWACH will learn more about the various projects and partnerships that are in place. SWACH will use this information to inform implementation planning and ensure we are not duplicating efforts.

The CI Committee has committed to supporting the entire Medicaid population in our approach to bidirectional integration. The committee has also expressed their support to address integration in all behavioral health and primary care settings that serve Medicaid, acknowledging that each setting will implement strategies for targeted sub-populations at various stages.

### Overview of Medicaid Population in SWACH

<table>
<thead>
<tr>
<th></th>
<th>Klickitat</th>
<th>Skamania</th>
<th>Clark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>21,026</td>
<td>11,339</td>
<td>459,495</td>
</tr>
<tr>
<td>% Medicaid</td>
<td>32%</td>
<td>22%</td>
<td>27%</td>
</tr>
<tr>
<td>Medicaid Lives(^6)</td>
<td>6,817</td>
<td>2,455</td>
<td>123,608</td>
</tr>
</tbody>
</table>

When considering the target population for Project 2A, all Medicaid beneficiaries are included, currently about 133,000 people, with a focus on sub-populations who have been diagnosed with behavioral health conditions, including mental illness and/or substance use disorder, opioid use disorder and/or chronic health conditions. According to our preliminary analysis, about 4% of the SWACH Medicaid population had an SUD diagnosis, a mental health diagnosis, and at least one chronic condition diagnosis (approximately 5000 people). The Data and Learning team (DLT) will provide further insight and analysis to the CI Committee regarding which specific conditions drive higher utilization of services, provide recommendations to the CI Committee, and provide support to clinical practices through their implementation planning process.

SWACH conducted outreach with PC and BH Medicaid providers over the last year, in both our rural and urban communities, as the primary provider types needed for engagement in project 2A. SWACH is also partnering with the hospital systems in the region along with leadership at the two Medicaid health plans that are contracted in the region. We also consider our partners at Qualis Health, AIMs

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\(^6\) Apple Health Enrollment Reports. Measure period May 2017
Center and Department of Health (DOH) critical to our alignment efforts in the region to provide technical expertise based on years of clinical change management strategies and national experience integrating clinical settings. The CI Committee liaisons with the other SWACH workgroups and coordinates strategies with each committee/workgroup to develop cross-project alignment. This includes critical community based organizations (CBO) who are deeply involved in the Community Care Coordination project development and are key partners in developing project alignment strategies and implementation strategies.

The PC and BH providers began participating in the CI Committee when it was established in the spring of 2017. While the CI Committee is designed around BH and PC settings and has 28 representatives who serve Medicaid, the committee will leverage the overall SWACH governing structure, that includes a wide cross-sector representation well beyond the clinical setting. The CI Committee charter outlines the committee’s responsibility for developing the necessary regional strategies, resources and implementation strategies necessary to move the entire region toward a more capable integrated continuum of services. For the integration of clinical services between BH and PC, having both types of practices involved in the planning, development, training, implementation, monitoring, shared learning, and continuous quality improvement is critical to successfully bridge the gaps between the settings that have historically existed.

Project 2A (Bi-directional Care Integration) is built upon five core concepts of integration that have been identified by the CI Committee and that are fundamental in the evidence-based practices and strategies of the Collaborative Care Model and the Bree Collaborative. The core concepts go beyond a single project and provide a foundational path for sustainable integration beyond the project timeline. The Committee selected five core concepts as the core concepts that SWACH will use to develop the implementation plans and direct resources toward. They include:

1) Offering enhanced development of integrated care teams
2) Ensuring that behavioral health and primary care become routine services, including health screenings, regardless of setting
3) Sharing of clinical information across settings
4) Implementing strategies and systems to increase capacity to support population health management
5) Utilizing data to provide accountable care

Crucial to SWACH’s strategy of five core concepts of integration, rather than a specific clinical model, is the implementation of a flexible approach toward integration, allowing providers to build upon their integration efforts that are currently underway. This approach will offer all Medicaid providers, regardless of size or scope, the ability to incrementally increase their capacity to provide integrated clinical services.

To align the region with a common language around state of readiness and organizational goals, SWACH will utilize the SAMSHA Six Levels of Integration to conceptualize readiness, strategic goals, and progress. The SAMSHA model provides a systemic organizational structure to implement a variety of clinical integration strategies in different clinical settings, for different sub-populations and provider types. Because SWACH is taking a flexible approach toward clinical models of integration, having a conceptual tool to organize the region along a continuum of integration will be useful for supporting change across settings.
Allowing the implementation of key concepts common to both the Bree Collaborative recommendations and the Collaborative Care Model, based on a provider’s readiness and consistent with their strategic plans, enables SWACH to support positive movement along the continuum of integration without dictating which integration model a provider must use. By encouraging providers to choose the integration model best suited to their readiness and strategic plans – whether it be the Bree Collaborative or Collaborative Care Model - the ACH can support movement along the continuum of integration. Through building a strong foundation of core concepts, this approach becomes the architectural framework for scalable and sustainable change.

Adding SWACH investments for health information exchange (HIE) capacities, ongoing training and workforce development, collaborative partner development, and financial resources contributes to the scalability and sustainability of integration.

SWACH will be considering the level of impact on target populations and the project outcomes, through a data-driven approach as well as utilizing stakeholder and beneficiary engagement. SWACH will use data to understand the disparities that exist within the region to ensure equity to all project populations. Through our design and implementation stages, SWACH will support regional partnerships and delivery system collaborations and begin to develop strategies to address the variables that contribute to the inequities noted in the data. SWACH has hosted Medicaid beneficiary listening sessions which enabled SWACH to look beyond the data and receive direct input as we consider the potential impact system changes will have on individuals and families.

SWACH is working in partnership with multiple community organizations and community groups to develop an equity lens to inform our overall work. This is an extensive piece of work, supported by additional grant dollars from United Way, Northwest Health Foundation and partner organization funds. We will be bringing in the Center for Equity and Inclusion, a nationally known group, to support the development of this work as well.

Part of our role as an Accountable Community of Health is convening and we plan to continue to share our learning from this process with our partners working on the Medicaid Transformation Project (MTP). SWACH is committed to continuing to offer our equity and social justice 8-hour training sessions for all our partners. Many have already completed this training but SWACH continues to receive growing interest and has identified the need for more training. Our partners have provided very positive feedback about this training.

We realize that developing our equity lens will take time and in the meantime, we plan to use the Center for Racial Justice Innovation’s “Racial Equity Impact Assessment Guide” as a set of questions we will bring to our decision-making tables (work groups, RHIP, Board, staff) to inform our work as we take the proper time and process to develop our own equity lens, tools, and community buy in.

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**

SWACH has a variety of committees, one of which is the CI Committee. Every member of the committee has made a significant commitment to the CI Committee and the organizations they represent have been dedicated to serving the Medicaid population for many years. The committee is currently represented by 27 individuals who are all Medicaid providers in the community or represent an organization that provides Medicaid services. The following list includes the organizations that are represented, accounting for over 90% of the Medicaid lives covered in the region.
SWACH is developing binding provider participation contracts that will require providers’ commitment to serve the Medicaid population. Financial incentives for partnering providers will be tied, in part, to Medicaid lives served, and offering further commitment to serving Medicaid enrollees.

SWACH began an organizational effort to create the CI Committee in the spring of 2017 after meeting with potential providers and their leadership teams. SWACH worked directly with the Behavioral Health Alliance in the region and they self-selected providers to participate on the committee and represent the alliance.

The CI Committee developed and approved a charter to help guide the groups work. The Charter stipulates that the objective of the committee is to provide input and guide regional strategies, which ensures that SWACH and its partners can learn, plan, and act collectively to achieve bidirectional clinical integration throughout the regional service area. Pursuant to the CI Committee Charter, the committee’s guiding principles are:

- Support planning and implementation of the project through a whole person care lens that is flexible enough to meet needs of all participating providers, sustainable beyond the demonstration period, and values partnerships and collaborations.
- Encourage shared decision-making among all SWACH partners
- Develop projects which address health inequities among residents in the SWACH region
- Promote collaborative, collective processes from multiple organizations and sectors
- Value integrity and agree to uphold all SWACH standards, privacy laws, and other human rights as applicable
- Support the goals of the triple aim of health care reform and the Healthier Washington initiative, including the Medicaid Transformation Project.
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

The SWACH region is in the early adopter FIMC region in Washington. The Medicaid providers in the region now have almost two years of experience in the FIMC payment environment. The experience has provided an opportunity to develop a fuller understanding of an individual’s whole person health care needs and an ability to leverage population health data in new and important ways. Bridging the care gap between physical health providers and behavioral health providers, by removing the payment silos, is an important asset of the region that is made possible through integrated managed care funding. Moreover, in October 2017 Klickitat County submitted a binding letter of intent to be a mid-adopter and will join the southwest Washington early adopter counties in January 2019.

Our region is led by innovative and visionary leaders who have deep roots in the community and have been providing evidence based and person-centered care to the Medicaid population with robust dedication for years. The prevailing ethos of the region is collective collaboration, and SWACH views this as a significant asset. These community leaders also have the support of our elected county leaders, who ultimately led the way toward FIMC, and saw the benefits of this transformation years ago. SWACH will build upon the region’s leadership, for example to support the development of train the trainer models, best practice change models, and provider champions.

CBOs that serve the Medicaid population are a key asset to the community. The CBOs are instrumental partners in creating the shared regional vision of integrated whole person health. Leveraging the contributions of CBOs in all design and implementation phases of the MTP will increase the clinical practice setting’s ability to connect with CBOs and address the social determinants of health needs of the Medicaid population. Agencies that provide housing, employment and peer-run supports, advocacy groups, and population specific support groups, are
considered vital partners and the assets they bring to the transformation projects will be critical to the success of the projects.

There are several challenges that the MTP will attempt to address but they will not be addressed through a single project. The ability for providers to implement a real time Health Information Exchange (HIE) is one challenge that the MTP project will address. Another challenge is the development of patient registries to manage populations. The region will pilot the use of EDIE/PreManage with the three largest behavioral health agencies (BHA) beginning in Q4 of 2017. With the support of Qualis Health HUB, HCA’s Analytics, Interoperability, and Measurement (AIM), HCA FIMC team, and our managed care partners, the region will establish a PreManage/EDIE HIE Learning Collaborative in 2018 to advance the use of EDIE/PreManage, develop an EDIE/PreManage Roadmap Toolkit and develop strategies to integrate EDIE/PreManage region-wide. The integration of EDIE/PreManage into the healthcare delivery ecosystem will provide an opportunity for clinical settings to share standardized care plans, manage and monitor populations, track individuals across settings and advance existing electronic health record (EHR) capabilities through real time interfaces. With the support of our allied partners, technical assistance can be provided to develop and implement the use of patient registries and electronic clinical information-sharing.

Our community of providers has identified workforce as a priority that needs to be addressed. There are several strategies to address workforce needs. SWACH has developed a Psychiatry/ARNP Workforce Capacity Workshop that includes Washington State University, University of Washington, Oregon Health and Science University, Peace Health Medical Residency Program, key regional Behavioral Health Agencies (BHA) and two managed care plans. This group will leverage SWACH’s convening role to increase residency options for students in our region, develop a best practice model for residents working in CBOs and develop creative strategies, such as loan repayment programs, to promote the retention of residents and thus improve access to care. We will also address workforce issues by looking at provider work satisfaction issues to prevent provider burnout.

The CI Committee has identified bi-directional integration models that provide the greatest opportunity for success must include care managers and/or care coordinators. For example, building on Snyder Nardone continuum of integration model, it is known that care coordination is the top priority for transforming healthcare according to the Institute of Medicine.77 During SWACH led listening sessions, many beneficiaries echoed the need to have support from their providers navigating a complex health care system. To meet this pending care coordination workforce need, SWACH has engaged the following agencies to develop strategies to help address this issue:

- Allied Health Center of Excellence
- Area Health Education Center for Western Washington
- Clark College
- Lower Columbia College
- Washington Association of Community and Migrant Health Centers
- Washington State Board for Community and Technical Colleges
- Workforce SW Washington

SWACH will continue to develop partnerships and provide shared learning opportunities for the community to develop this new workforce. SWACH presented at the semi-annual Statewide Workforce Education Council meeting sponsored by the Washington State Board for Community and

Technical Colleges to advance the needed workforce demands that are on the horizon and create engagement strategies for college programs to meet the upcoming workforce changes.

**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**

SWACH intends to use multiple data sources, provider, stakeholder and staff expertise, coupled with peer learning to support monitoring and quality improvement efforts across its project portfolio. SWACH envisions a project monitoring and continuous improvement infrastructure and process to support achieving the outcomes of the MTP portfolio, along with a region-wide system of care, working in tandem to achieve our targeted goals.

The process for project monitoring and continuous improvement relies on several core components including: strong infrastructure of timely data, continuous data monitoring and analysis, a Strategic Improvement Team, and reporting at multiple levels including providers, community, ACH governance, and HCA reports. Each of these components is described further below (see Figure 1).

*Figure 1: Process for Monitoring and Continuous Improvement*
The data infrastructure to support monitoring and continuous improvement will complement existing data assets (such as the Healthier Washington Data Dashboards) and will build upon “point of care” population health management system inputs needed for projects. Among the incoming data in Figure 1 are the identified data sources associated with 1) pay for reporting (P4R) and pay for performance (P4P) metrics and 2) key data identified by the Clinical Integration committee and the SWACH Strategic Improvement Team needed for analysis to support program implementation, monitoring, continuous improvement, evaluation/sustainability, and spread.

SWACH has contracted with the Providence Center for Outcomes Research & Education (CORE) to design and run the monitoring system. The system will bridge all partner organizations by collecting, storing, aggregating, analyzing, and reporting key data elements from each partner/data source, serving as a HUB for all quality and monitoring activities.

Adjustments to implementation timelines will be triaged through this system and course corrected wherever possible. Implementation progress and status of timelines will be monitored by SWACH with clear lines of communication and accountability between partnering providers, ACH staff, CORE, and our ACH governance body.

If timelines still cannot be met, SWACH will communicate reasons why timelines weren’t met, a plan for adapting the timeline, and prevention/risk mitigation strategies will be shared with other programs where appropriate.

The Strategic Improvement Team (SI Team) will drive quality improvement strategies with providers. The SI Team will consist of Improvement Advisors certified by the Institute for Health Improvement (IHI). This team will create and run a unified system of rapid cycle feedback and quality improvement across the organizational partners and to ensure successful progress toward milestones and that outcomes and reporting is done in a timely and quality manner. This system will incorporate a comprehensive shared learning system that follows the best practice of a “plan, do, study, act” (PDSA) continuous quality improvement process.
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.

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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.

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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
SWACH will achieve project sustainability through a shared regional commitment to deliver health care through a whole person perspective. As mentioned in the above sections (project selection and expected outcomes), SWACH will support this vision by investing in building resources to share patient information, coordinate clinical and community-based care in new ways, and focus on accountability for outcomes, thus transforming existing relationships and developing a workforce trained to operate in a team-based environment.

SWACH will foster the development of a roadmap toward VPB and provide the resources necessary for providers to operate effectively in a value-based payment environment by investing in additional infrastructure and capacities. This will be critical to our sustainability efforts. SWACH has also been partnering with statewide workgroups regarding state Medicaid codes for Collaborative Care to help finance and sustain integrated care. We are working alongside our managed care partners to leverage the billing and coding work that has developed out of SB 5779 along with developments for new billing codes in rural health clinics and FQHCs. We are participating in the statewide Medicaid Value Based Payment workgroup and bringing together partners to develop strategies that provide movement along the VPB continuum from paying for volume to paying for value. Through an aligned strategy with the health plans and scaling successful integration models, by the end of the MTP, our region will be well positioned to provide effective, clinically integrated care which will be measured, in part, by our success in meeting MTP outcomes and progress toward achieving the quadruple aim.

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

<table>
<thead>
<tr>
<th>Domain 2: Care Delivery Redesign</th>
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<tbody>
<tr>
<td>☐ 2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)</td>
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<tr>
<td>☒ 2B: Community-Based Care Coordination</td>
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<td>☐ 2C: Transitional Care</td>
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<td>☐ 2D: Diversions Interventions</td>
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<th>Domain 3: Prevention and Health Promotion</th>
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<tr>
<td>☐ 3A: Addressing the Opioid Use Public Health Crisis (required)</td>
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<tr>
<td>☐ 3B: Reproductive and Maternal and Child Health</td>
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<td>☐ 3C: Access to Oral Health Services</td>
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<td>☐ 3D: Chronic Disease Prevention and Control</td>
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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.

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:
  o Describe the project’s anticipated target population. How many individuals does the ACH anticipate reaching through the project?
  o What types of partnering providers are involved in this project thus far, and why are they critical to the success of the project?
  o How did the ACH consider the level of impact when selecting the project’s anticipated target population? (e.g., geography, subgroups, etc.)
  o 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

Rationale for Project Selection and Expected Outcomes

Although current care coordination efforts in the Southwest Washington region have improved care for many, a community-based care coordination approach has the potential to play a critical role in ensuring individuals with health and/or social needs connect to quality, preventive care and evidence-based interventions and services to improve their overall health outcomes. Expected outcomes will be achievement of the quadruple aim: better care, less cost, better member experience for the target population, and better provider experience.

The siloes and fragmented approaches to care coordination which currently exist often result in duplication of services, ineffective interventions, and uncoordinated care. For example, an individual involved in multiple systems may have 3 or 4 care managers assigned to them – one from each sector of need (i.e., mental health, housing, social services, or primary care) with no single identified point of accountability; while others may have no care management support and are left to navigate a very complex system on their own.

For those who struggle with the social determinants of health in our region (unmet basic needs, housing insecurity, low income, lack of transportation options, and food insecurity) there are greater barriers to accessing the care and social service supports they need. The following data from the Regional Health Needs Inventory provides information on those who experience the social determinants of health:

• Almost a quarter of children in Klickitat County are living in poverty (24%), compared to 15% of children in Clark, and 16% statewide.
• Unemployment is also higher in Skamania (5.7%) and Klickitat (5.8%) than in Clark (5%), or compared to the state average (5%).78

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• According to census data, almost 40 percent of Clark County residents spend at least 30% of their income on housing (compared to 33% in Klickitat, and 28% in Skamania),
• In 2015, 3.6% of SWACH Medicaid members were homeless at least one month during the year, and data from the Council for the Homeless’ housing hotline indicate an uptick in the first part of 2017 (compared to the first part of 2016) of individuals who are being discharged from the hospital or jail / prison to the streets.79
• The 2016 Gorge Wide Food Survey found that 1 in 5 individuals ran out of food and 1 in 3 were worried about running out.80 More than a third of students across the region are eligible for free or reduced cost lunch, and more than 20 people per 100 receive food stamps (SNAP).81

Project Justification, Regional Priorities, Sustainable Health System Transformation

The SWACH Pathways Community Hub project (HUB) seeks to reduce health disparities by providing community-based, culturally competent, and person-centered care coordination for targeted, vulnerable populations in our region. The Pathways Hub Model is an evidence-based and nationally endorsed model for the assessment and coordination of services that are critical for improving health outcomes, including medical (e.g., physical, behavioral, substance abuse and oral health), social, environmental, and educational services.

The HUB infra-structure provides tools and strategies necessary to ensure at-risk individuals in a community are served in a timely, coordinated manner, and utilizes a trained and expanding community health worker (CHW) workforce to do so. The HUB ensures persons and populations within the region it serves are connected to meaningful health and social services that contribute to positive health outcomes. As an evidenced-based, outcomes-focused model, Pathways HUB addresses a regional need; ensuring targeted populations receive assistance connecting to, and appropriately utilizing, services and care.82,83,84,85 Community care coordination is a key SWACH strategy that will drive improved health outcomes.

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81 SNAP and free or reduced price lunch data from DSHS County Risk Profiles https://www.dshs.wa.gov/sesa/research-and-data-analysis/county-and-state
85 Zeigler B, Redding S, Leath B, et al. Guiding principles for data architecture to support the Pathways Community

ACH Project Plan Template (October 16, 2017)
outcomes, health equity, and system savings. These strategies are critical to the sustainability of health system transformation; improved health outcomes, decreases in health inequities, and system savings will support value-based contracting, an underpinning to the sustainability of the MTP work.

The Pathways Hub will further support the sustainability of the health system transformation by serving as the community’s driving force for breaking down silos, coordinating needed supports beyond the walls of health care, and advancing improvements in overall health and disparities. The HUB will serve as a core SWACH program, creating cohesion and linkages across Medicaid, including the region’s other MTPs. Ultimately the HUB will be available for use with all payers in the region to further support the sustainability of system transformation.

**Coordination with Other Efforts**

The HUB will help avoid duplication of effort in care coordination and keep individuals from falling through the cracks. To avoid duplication, the Pathways Community Hub model of care will provide “air traffic control,” or an overall centralized and standardized system, with processes and resources to track detailed outcomes of those being served, as well as a method to tie payments to outcomes.

The HUB will be the only proposed HUB within the SWACH region. We have shared with partners our intent to be the regional certified HUB and we know of no other entities planning to seek this designation. There is no overlap with any nearby HUB service areas. The nearest existing Hubs are in Hood River, Oregon, operated by One Community Health and the Project Access Now (PANOW) Hub, which operates in Multnomah (Portland), Washington, and Clackamas counties, in Oregon. There are no service area overlaps and the SWACH VP of Community Care Coordination has developed collaborative relationships with these neighboring Hubs. The Hub model also has the unique strength to reach out to Medicaid members who currently do not have a primary care provider and who are not accessing the benefits for which they are eligible. The HUB connects members into systems of care, allowing the individual to identify and prioritize their needs and tie those needs to evidence-based care pathways. The HUB model will promote care coordination across the continuum of health services for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their whole health.

SWACH has been working closely with our MCO partners to ensure a bi-directional referral system between Pathways and the Health Home model of care currently being utilized across the state. We believe there are opportunities for Pathways and Health Homes to operate in a complementary manner and look forward to working with our Health Homes Care Coordinating Organizations (regional CCOs participate on our Workgroups and Governance Structures) and MCOs to design an implementation strategy that uses both systems’ assets as effectively as possible.

**Project Scope and Target Population**

SWACH will serve as the Community Pathways Hub, providing implementation training, development of workflows and policies related to HUB operation, and provide critical tools such as the HUB IT platform to track resources, referrals, outcomes, and share information. The HUB IT platform (the Pathways HUB Connect database), will identify and eliminate duplication of services and allow for the improvement of health outcomes across defined service areas and populations. The HUB will support partnering
Integral community partners were identified through community engagement and an environmental scan process. Partners were identified based upon the number of Medicaid beneficiaries served, types of services offered, and their opportunity to reach beneficiaries experiencing care coordination needs. Once partners were identified, they were invited by SWACH to form a Community Care Coordination (CCC) Workgroup, charged with assisting in the development of CCC project planning, recommendation of initial target population, and identification of potential CCA and referral partners. The CCC Workgroup, with information and support provided by SWACH’s Data and Learning Team (DLT), determined the initial target population for the SWACH Pathways Community HUB project:

- Individuals (18+) with multiple conditions

Our working definition for multiple conditions is an individual who experiences a chronic physical health and a behavioral health condition (behavioral health condition is a mental health and/or substance use condition).

Initial data from HCA indicates that as of June 2016, approximately 5.69% of SWACH Medicaid members (or just over 6,000 members) meet this criterion.

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Data from HCA Cat 1 Behavioral Health and Chronic Conditions data file, released 9/29/17

The working definition SWACH uses is based on HCA / RDA grouper and diagnostic categories, as outlined in the HCA Cat 1 Behavioral Health and Chronic Conditions data file documentation:

- Physical health diagnosis – SWACH is using the HCA/RDA flag for individuals who have at least one chronic condition, as identified by the UCSD Chronic Illness and Disability Payment (CDPS) model. This includes disease groups such as cancer, cardiovascular disease, diabetes, pulmonary disease, gastrointestinal disease, and more.
- Mental health diagnosis – SWACH is using the HCA/RDA flag for individuals who presented at any point in the prior 24 months with a mental illness diagnosis, using the CDSP model. According to HCA documentation, this group includes diagnoses such as mania and bipolar disorder, psychotic disorder, depression disorder, anxiety disorder, ADHD, and adjustment and stress disorders.
Substance use disorder diagnosis – SWACH is using the HCA/RDA flag for individuals who presented at any point in the prior 24 months with at least one instance of need for SUD treatment, based on medical claims, target encounters, and arrest indicators. Additional documentation on SUD available online: https://www.dshs.wa.gov/resa/research-and-data-analysis/cross-system-outcome-measures-adults-enrolled-medicaid

SWACH anticipates refining the population further in coming months as we finalize our target populations, particularly related to physical health diagnoses. We will be exploring narrowing the population from any individuals with physical health diagnoses as identified by the CDSP model to those individuals with specific chronic conditions. We will be looking for alignment with the target populations for other projects, particularly the chronic disease project, and exploring those chronic conditions that have the highest burden in our region (e.g., cardiovascular disease, pulmonary disease, diabetes).

With the help of the CCC Workgroup, SWACH released a Request for Applications to identify potential CCAs who currently serve this population and have interest in partnering to implement the Pathways Community Hub model in the region. Five community partners responded and through a collaborative scoring committee process, three community based agencies were selected: Sea Mar, Community Voices Are Born (CVAB), and Council for the Homeless. These organizations are assets in our region, connected to the identified population, have experience with a CHW workforce and are willing to help find, treat and measure the outcomes for the identified population through the Pathways Hub model. Each CCA will dedicate 2 CHWs and one .5 FTE Supervisor to Pathways model implementation.

SWACH proposes at least 350 individuals to be served by the initial 3 contracted CCAs in DY2. Initial caseload targets will be discussed in collaboration with the 3 pilot CCAs after CHW and Pathways implementation training in January 2018. As the current care coordination model Health Homes (HH) targets a similar acute population, SWACH has engaged Molina and other Health Homes providers to refine the target population using the PRISM score determination as referral criteria and ability of HH to serve as referral partner and develop a bi-directional referral process.

**Level of Impact**

SWACH intends to begin implementation of the Pathways Community HUB in Clark County, where selected CCA partners have agreed to begin training for implementation and are closest to the largest numbers of the identified target population. Clark is also the largest county, with most covered Medicaid lives (93%). After initial pilot implementation, the HUB plans to extend to additional populations, scaling the model to grow into Skamania and Klickitat, to address the multitude of needs in the rural and frontier areas of our region. As the HUB extends further throughout the region, we are committed to alignment with local, community-based agency partners to expand care coordination services to all regional communities and members.

**Equity**

SWACH Medicaid beneficiaries by county

<table>
<thead>
<tr>
<th>County</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Clark</td>
<td>93%</td>
</tr>
<tr>
<td>Klickitat</td>
<td>5%</td>
</tr>
<tr>
<td>Skamania</td>
<td>2%</td>
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SWACH is working in partnership with multiple community organizations and community groups to develop an equity lens to inform our overall work. This is an extensive piece of work, has been funded with additional grant dollars from United Way, Northwest Health Foundation, and leveraged partner organizations’ funds. We will partner with the Center for Equity and Inclusion, a nationally recognized organization, to support the development of this work. In our role as a convener, we plan to continue to share our learning from this process with our partners working on the MTP. We are also committed to continuing our equity and social justice 8-hour training for all partners. Many partners have completed this training and we continue to receive growing interest and identified need. Our partners have provided very positive feedback about this training as demonstrated by their desire to train their organizations at large. SWACH realizes that developing an equity lens will take time, however, we plan to use the Center for Racial Justice Innovation, Racial Equity Impact Assessment Guide, as a set of guiding questions to use as a lens for our decision-making tables (workgroups, RHIP, Board, staff) to inform our work as we take the proper time and process to develop our own equity lens, tools, and community buy in.

SWACH is also working to deepen its impact on health equity through project level strategies. One strategy identified through the CCC Workgroup, is to ensure the CCAs contracted with the ACH have the following qualities:

- Able to serve individuals in multiple languages and across diverse cultures
- Utilize a trauma-informed lens in their interactions and treatment of individuals served
- An equity lens is applied to the CCA and HUB policies/procedures/systems (e.g., hiring processes established that enhance diversity and inclusion in the workplace)
- Diverse community partners define the needed resources to strengthen the community referral network

**Lasting Impact**

SWACH is committed to ensuring all projects are implemented with the intent to provide lasting impact. SWACH Community Pathways HUB will support this commitment by working with the broader network to address barriers to care. The HUB not only works with contracted CCAs to increase connections to care, but also with specific providers of health, behavioral health, and social services to address any identified barriers, improve education for community members, reduce “no shows,” and to identify any issue that may prevent a community member from receiving an appropriate intervention or connected pathway to needed social services. The HUB also provides technical assistance to CCAs to address barriers and capacity issues. Reaching out to service providers and addressing issues of quality and barriers is an important aspect of care coordination. Data obtained by the HUB will additionally identify incomplete or partially completed Pathways to inform regional needs and barriers to be addressed by SWACH Community Resiliency funds, or other means identified by our regional partners.

The Pathways HUB is a direct link to Value-based Payments by supporting the target population through pathways that ensure providers and beneficiaries access services appropriately. Pathways ensures payment is based upon outcomes, not services, providing a direct link to value.

Through the implementation of a Pathways Community HUB, SWACH expects to gain deep experience with community-level care coordination, strengthened partnerships across referring entities and care coordination agencies, and a heightened experience with tracking data and outcome-based payment.
## 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**

**Partnering Providers**

Through a regional environmental scan, SWACH has identified and engaged community-based organizations and clinical providers interested in improving community care coordination. Through these efforts, SWACH has developed a Community Care Coordination (CCC) Workgroup, which convenes monthly to aid in the implementation of the SWACH Pathways Community Hub. The CCC Workgroup represents various perspectives to inform health services (e.g., public health, health care providers, payers, community members, behavioral health organizations, and community-based health organizations), as well as other community and sector perspectives (e.g., housing, education, social services, criminal justice, transportation, food security).

As implementation continues, the Community Care Coordination Workgroup will evolve into a Community Advisory Council, which will include at least one representative from the following:

- Community Health Workers, Advocates and Peers serving the region
- Medicaid managed care organizations serving the region
- Health care providers practicing within the region
- Health systems and hospitals operating within the region
- Behavioral health organizations serving the region
- Community-based health organizations

The Community Advisory Council is a requirement for Pathways Community Hub Certification and the SWACH HUB Community Advisory Council will plan to have regular members, with ad hoc members joining as needed to provide input for quality assurance, specific policy discussion, or other issues. The current CCC Workgroup has adopted a charter, with guidelines and principles which support the overall mission and vision of SWACH and is aligned with the principles of Medicaid Transformation.

The SWACH CCC Workgroup also finalized the Care Coordination Agency Application, which was recently released through an RFA process, to engage potential Community Care Coordination Agencies (CCAs) in the region who may be interested in contracting with SWACH to implement the Pathways model. Based on environmental scan criteria, the application process attracted and identified 5 potential CCAs. SWACH convened a guest panel Scoring Committee (consisting of 1 SWACH RHIP Council Member, 1 MCO staff, 2 SWACH staff, 1 Medicaid community member, and 2 referral partners/CCC workgroup members (who did NOT apply to be a Care Coordination Agency)). The Scoring Committee evaluated and prioritized CCA applicants who demonstrated service and connection to Medicaid community members. Additional points were also awarded to those applicants who currently employ Community Health Workers (CHWs) and Peers. Selected CCAs were Sea Mar, Council for the Homeless and Community Voices Are Born (CVAB). All three agencies serve a significant portion of the target population: Medicaid members who experience multiple chronic conditions. By January 2018, SWACH Pathways Community Hub will secure contracts with the 3 selected CCAs which will include a commitment to SWACH’s *Transformation Rules of Engagement* and to service of the target Medicaid populations.
Contracts will be secured with HUB referral partner organizations by March of 2018. Ongoing monitoring and continuous quality improvement will also provide oversight of providers to ensure they are serving Medicaid populations and implementing strategies aimed at reaching the desired outcomes for the HUB’s targeted Medicaid populations. As the largest MCO in our region, Molina has provided much support in the form of data and learnings from care coordination models currently in place (Health Homes). Collaborating to inform which populations are targeted by Health Homes will help SWACH implement our Pathways Community HUB with target population refinement and bi-directional referral development. This collaboration additionally ensures Health Homes are engaged to appropriately refer community members to the correct care coordination resource. State-wide collaboration with Health Home providers and payors has already resulted in clarification of roles and referral process refinement.

**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**

**Assets**
SWACH staff have met with Pathway model developers and have gained enhanced knowledge of the Pathways Community Hub model implementation, often providing technical assistance and shared learnings to other ACHs. SWACH has additionally contracted with national experts, and the model developer, to ensure implementation success. In addition to these organizational assets, SWACH convened a Community Care Coordination Workgroup to help identify regional assets which will play key roles in the implementation of the Pathways Community HUB:

- Currently, there are several outreach and care coordination programs in the region addressing the health and social needs of Medicaid and other low-income populations. The network brings significant expertise in both clinic and community-based care coordination and strategies for reaching at-risk populations. Health Homes partners are engaged and offer much support to implementation, including bi-directional referral refinement and learned strategies.

- Regional stakeholders have been testing pilot projects utilizing shared data systems, such as the EDIE/Pre-manage system, to create mechanisms for shared care planning as well as conducting regular shared case staffing for the highest utilizers of the Emergency Department (ED) in effort to provide more community based services and reduce ED utilization.
Interoperability of data systems: The Pathways Community HUB model brings with it data technology to support “coordinating the care coordinators” and assuring pathways are complete and outcomes are met. Coordinated Care Solutions (CCS) is the proprietary owner of the data system and assures that the HUB will have interoperability with the numerous other data systems that exist within our region. While the implementation and learning of the Pathways Community HUB data system may add additional administrative burden to providers, SWACH is committed to providing support and is additionally contractually supported by CCS throughout implementation and Y2.

SWACH is now partnered with the Healthy Living Collaborative of SW Washington (HLC), an organization which has been working for many years to expand a community-based workforce that includes Community Health Workers, Peer Support Specialists, and other community connectors. SWACH plans to strengthen and build upon this network to advance implementation of the Pathways Community HUB model.

SWACH is also on course to contract with 3 community based Care Coordination Agencies, recently recommended and selected through an open RFA process. The three organizations chosen also represent assets to our region’s implementation of the Pathways Community HUB:

- **Sea Mar Community Health Centers** a community-based organization committed to providing quality, comprehensive health, human, housing, educational and cultural services to diverse communities, specializing in services to Latinos. In addition to its core medical, dental, behavioral health and substance abuse services, Sea Mar offers a wide range of social services. These services include care coordination and care management, a Health Homes program, preventative health services, health education and nutritional counseling, Spanish language radio programming, affordable housing, pharmacies, long term care and home care. Sea Mar partners with other health and community organizations across its service area. In all counties it serves, Sea Mar staff represents the organization in a variety of regional efforts addressing health care access on the local level, and participates in regional, state and national community health care collaborations to ensure the needs of its patients and clients are met. Sea Mar served 33,616 patients in Clark County in 2016, and completed 108,996 total visits overall, and 80% of patients served are covered by Medicaid.

- **Community Voices Are Born (CVAB):** a community-based, peer-run organization committed to sharing hope and empowering individuals. As an organization of people living in mental health and addiction recovery, the heart of CVAB is peer-to-peer support for people wanting to experience healing, recovery and wellness, especially those who are vulnerable or in crisis. CVAB takes a strengths-based approach to holistic beings. CVAB intends to ensure quality community-based peer services of all types are delivered throughout Washington. CVAB supports some of the most vulnerable and at-risk individuals in Southwest Washington. The majority of CVAB participants are individuals working toward or living in recovery (MH/SUD); this includes people who are houseless and un- or under-employed. CVAB serves people from all walks of life, without judgment of who comes through their doors. CVAB serves a Medicaid population (68% of those served).
- **Council for the Homeless (CFTH):** a nonprofit organization that provides community leadership, compelling advocacy and practical solutions to prevent and end homelessness in Clark County. CFTH provides outreach and navigation assistance to households who are living on the street or in a car/RV to conduct assessments and gather necessary documentation. Community outreach focuses on those who are chronically homeless and unlikely to access assistance through traditional access points. CFTH also provides home visits through its diversion coaching efforts, to ensure housing stability, address any rising crises and ensure the landlord-tenant relationship is stable. Of those served in the last year, 88% self-reported receiving Medicaid through CHPW or Molina.

**Challenges and Barriers**

- **Siloed systems in a diverse region**
  - SWACH region includes a mix of urban, suburban, rural, and frontier communities. The regional needs and providers that serve the communities are both unique and often overwhelmed. Many providers have served their communities with some form of care coordination as part of their service delivery model. The Pathways Community HUB implementation will need to coordinate with and assure there is not duplication with current community resources, while also ensuring the uniqueness of various community providers remains in-tact and access to resources become available as soon as possible through implementation.

- **Working in coordination with clinic-based models**
  - Pathways Community HUB brings an innovative approach to care coordination that adds processes outside of the clinic walls and engages more deeply with individuals at risk using trusted members of the community who are culturally and linguistically similar. That said, one challenge will be implementing the Pathways Community HUB model in a way that does not duplicate or interfere with clinic based care coordination but rather enhances it, adds value to the care delivery team, and builds strong, bi-directional partnerships between clinics and community. One component of this is being mindful as to how community-based care coordinators will interact with and collaborate with clinic staff and how accountability will be assured when more than one provider entity is involved. Building confidence in the Community Health Worker workforce is imperative to the potential growth of the workforce, as well as the success of the Pathways Community HUB.

- **CCA preparedness**
  - SWACH has identified multiple potential challenges that must be addressed to ensure the successful implementation and impact of the Pathways Community Hub model in our region. The first anticipated challenge is the expected learning curve for CCAs who are accustomed to providing care coordination services in a different manner (i.e., not previously using community-level care coordination or Pathways). Participating CCAs will need to learn new ways of assessing data, working with external partners, and getting paid based on outcomes versus services provided. These organizations will also have to adapt to being held accountable by an external HUB organization.
• Data platform and interoperability
  
o Another potential challenge for improving outcomes and lowering costs via the Pathways Community Hub model is the very specific HIT/HIE needs of the model. The HUB technology/data platform must allow for accurate and timely documentation for all the Pathway activities. In addition, the data platform must optimize interoperability with statewide and regional data systems to ensure maximal effectiveness in improving health outcomes.

• Finance Model
  
o Care Coordination/Pathways is an integral tool of value-based payment and supports the shift from volume to value. However, sustainability is dependent on the state’s and Payers’ collective willingness to engage in designing a mutually agreed upon funding model for Pathways.

Mitigating Risk and Overcoming Barriers

SWACH will work to overcome these challenges and barriers in several ways:

1. Establishing a Pathways Community Advisory Council

   Ensuring the council has diverse representation from the various parts of our region, including partners and community members from rural and frontier areas. Engaging rural and frontier residents to understand their current experience of care coordination will aid in the scaling and expansion planning for the HUB beyond pilot implementation. This engagement will help avoid duplication with current community resources, aid in the coordination with current clinic based models, while also ensuring the uniqueness of various community providers remains in-tact to serve those in rural and frontier communities.

2. Monitoring growth and capacity of pilot CCAs

   SWACH is working with selected pilot CCAs to ensure there are clear expectations and understanding for how the model works, including the specific role of the CCA, value-based payment methodologies, and expectations. This additional step prior to contracting will help to ensure a shared understanding of roles, responsibilities and key model components to ensure a positive working relationship and ability to maximally improve health outcomes. Starting small with an initial pilot will help to gain experience and meaningfully address initial barriers that can be addressed prior to scale-up. This will also allow us to assess community partners’ ability to expand beyond Clark County. As the HUB scales to expand beyond Clark County, ensuring partnering providers have the resources needed, strengthening their capacity and identification of new potential CCAs will be crucial to meeting the risks of expansion.

3. Developing the Workforce
SWACH will ensure a well-developed CHW workforce to meet the needs of the rural and frontier areas of our region and provide community and provider education to understand the role of the CHW workforce in community care coordination.

4. Aligning Implementation Efforts

Ensuring implementation efforts are aligned to initiate National Certification as a Pathways Community HUB offers several advantages: A framework for standardizing how community care coordination services are organized, delivered, measured, and financed; Tools, metrics, and mechanisms developed that can be used to monitor, assess, and evaluate various aspects of community care coordination services; and clear demonstration of outcomes and accomplishments. Professional champions and consultants can also provide education and training on the benefits of the Pathways model to the overall system of care.

5. Partnering with other ACHs

Work with partnered ACHs to share learnings of implementation, particularly those who share similar geographical areas.

6. Data platform and interoperability

SWACH has chosen to work with Care Coordination Systems (CCS) to develop the Pathways Community HUB data platform. CCS has already developed a platform specific to the Pathways model and therefore brings tremendous experience to the needs of a new, developing HUB. Additionally, CCS has worked with multiple EHR systems to create some level of interoperability. Work is already underway to create linkages between CCS, EDIE, Pre-Manage, the criminal justice system electronic health system, and beyond.

7. Finance Model

SWACH will continue our efforts with MCOs to arrive at a mutually agreeable and feasible financing mechanism for the Pathways HUB. We will also continue to advocate for the inclusion of Pathways HUB outcome payments in Total Cost of Care so it will be included in premium. Pathways is consistent with paying for outcomes and value – it should be included as an expense covered by Medicaid premium.

Monitoring and Continuous Improvement

SWACH envisions a project monitoring and continuous improvement infrastructure and process to support achieving the outcomes of the MTP portfolio, coupled with a region-wide system of care, working in tandem to achieve our targeted goals. The process for project monitoring and continuous improvement relies on several core components including: strong infrastructure of timely data, continuous data monitoring and analysis, an Strategic Improvement Team, and reporting at multiple levels including providers, community, ACH governance, and HCA reports. Each of these components is described further below (see Figure 1).

**Figure 1. Process for Monitoring and Continuous Improvement**
The data infrastructure to support monitoring and continuous improvement will complement existing data assets (such as the Healthier Washington Data Dashboards) and will build upon “point of care” population health management system inputs needed for projects. Among the incoming data in Figure 1 are the identified data sources associated with 1) pay for reporting (P4R) and pay for performance (P4P) metrics and 2) key data identified by the CCC Workgroup and the SWACH Strategic Improvement Team needed for analysis to support program implementation, monitoring, continuous improvement, evaluation/sustainability, and spread.

SWACH has contracted with the Providence Center for Outcomes Research & Education (CORE) to design and run the monitoring system. The system will bridge all partner organizations by collecting, storing, aggregating, analyzing, and reporting key data elements from each partner/data source, serving as a HUB for all quality and monitoring activities.

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

**Plan for monitoring project implementation progress, including addressing delays in implementation**

Adjustments to implementation timelines will be triaged through this system and course corrected wherever possible. Implementation progress and status of timelines will be monitored by SWACH with clear lines of communication and accountability between partnering providers, ACH staff, CORE, and our ACH governance body.

If timelines still cannot be met, SWACH will communicate reasons why timelines weren’t met, a plan for adapting the timeline, and prevention/risk mitigation strategies will be shared with other programs where appropriate.

**Plan for monitoring continuous improvement, supporting partnering providers and determining whether SWACH is on track to meet expected outcomes**

The Strategic Improvement Team (SI Team) will drive quality improvement strategies with providers. The SI Team will consist of an Improvement Advisors certified by IHI. This team will create and run a unified system of rapid cycle feedback and quality improvement across the organizational partners and to ensure successful progress toward milestones and that outcomes and reporting is done in a timely and quality manner. This system will incorporate a comprehensive shared learning system that follows the best practice of a “plan, do, study, act” (PDSA) continuous quality improvement process.

In addition, the Pathways HUB model and data collection tool using the CCS platform will be explicitly developed to allow for real-time assessment of Pathways outcomes and provide SWACH the opportunity for addressing challenges as they arise. The system will be informed by key planning inputs that better position SWACH to invest in and provide supports to providers and organizations, ensuring they are meeting the goals of each phase. It will be designed with multiple-stakeholder input and clear lines of accountability of key roles/people and ACH governance groups. This system will incorporate tools for data collection and monitoring that are dynamic and flexible, calibrated to effectively meet the needs for each evolving stage of the MTP for each project area.

Participating providers will be required to participate in learning collaboratives convened by SWACH where they will share and benefit from the collective learnings and experiences of their regional peers.

**Plan for addressing strategies that are not working or not achieving outcomes**

The comprehensive shared learning system, PDSA continuous improvement process, and CCS platform will support SWACH and our partners to rapidly identify opportunities for course correction and adjusting strategies to meet our targeted outcomes.
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.

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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.

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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

Project Sustainability

Strategy for long-term project sustainability
The Pathways Community Hub model is rooted in the principal of payment for outcomes. From the start, SWACH will be working with MCOs, other potential payers, and other agencies to establish sustainable funding for the program and care coordination agencies that will continue beyond the MTP period. Robust reporting and analysis will enable us to demonstrate the direct cost savings achieved by health systems and MCOs and the improved health outcomes of members.

Although we intend the HUB to initially be implemented with a blend of ACH earned MTP dollars, as well as MCO payment, a break-even year is anticipated by year 2 and it is projected the HUB will begin to generate revenue, be self-sustaining, and pay CCAs bonus payments for exceptional performance. In years 3 on, additional revenue earned beyond what is needed to sustain the HUB will be re-invested into community resiliency projects, identified by data collected by the HUB.

Ultimately, HUB certification standards require that contracts with the HUB tie fifty percent of all payments to an individual’s intermediate and final Pathway outcomes. SWACH hopes to be able to achieve this goal by utilizing the Strategic Improvement Team to implement process improvement and change management strategies to support partners to make sustainable change. Providers will also be supported so that they may meet established success measures and outcomes. In addition to achieving self-sustainability by the end of the MTP, the HUB anticipates being in the position to provide system-level data to non-traditional payers and sectors (those outside of healthcare, e.g. housing, private business, government, etc.) - as the number of incomplete or partially completed Pathways will inform assessment of regional needs and barriers - to pay for care coordination and tracking of Pathways which may be of interest to those entities.

**Beyond MTP**

The HUB’s ability to blend funding and provide value-based, outcome payments to contracted Care Coordinating Agencies will aid the HUB’s ability to expand to vulnerable populations and address specific issues related to the social determinants of health. SWACH intends to capitalize on the opportunity of the Medicaid Transformation Project funds to aid in the implementation and capacity building of a community asset that will help transform care for Medicaid beneficiaries – and the community at large.

### Transformation Project Description

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

<table>
<thead>
<tr>
<th>Domain 2: Care Delivery Redesign</th>
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<tbody>
<tr>
<td>☐ 2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)</td>
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<tr>
<td>☐ 2B: Community-Based Care Coordination</td>
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<td>☐ 2C: Transitional Care</td>
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<td>☐ 2D: Diversions Interventions</td>
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Domain 3: Prevention and Health Promotion

☒ 3A: Addressing the Opioid Use Public Health Crisis (required)
☐ 3B: Reproductive and Maternal and Child Health
☐ 3C: Access to Oral Health Services
☐ 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

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

No magic bullet exists for addressing the opioid epidemic. Programs and services must address the epidemic by weaving together to form an integrated net of prevention for people at risk of opioid abuse and a blanket of support for people struggling with opioid use. SWACH proposes a multi-sector, multi-pronged approach to address the epidemic with a focus on prevention, treatment, overdose prevention and recovery. Opioid strategies will be integrated across SWACH’s concurrent projects of Bidirectional Integration, Community-Based Care Coordination and Chronic Disease Management.

High levels of opioid prescriptions and opioid availability have contributed to an increase in rates of addiction, overdose, and the use of non-prescription street drugs. Since 1999, the amount of
prescription opioids in America quadrupled and the number of opioid overdoses in America have closely correlated, quadrupling as well to epidemic levels.\textsuperscript{86} Non-medical use of prescription opioids is linked to increased street drug use and is the gateway for four out of every five new heroin users.\textsuperscript{87} The devastation to human lives aligns with increased health care utilization and costs. Adults with substance use disorder treatment needs are 3.5 times more likely to have three or more ED visits in a year.\textsuperscript{88}

SWACH covers geographically diverse urban, rural and frontier populations, all hit hard by the opioid epidemic. Data availability differs across communities. Nationally, death from opioid OD is 45 percent higher in rural areas than urban areas.\textsuperscript{89} Rural counties in our region have seen increases of 221.6\% in Skamania and 48.5\% in Klickitat of publicly funded treatments involving opioids between 2002 and 2013.\textsuperscript{90} In primarily urban Clark County, opioid related death rates increased by over 40\% and opioid related hospitalizations increased by over 200\% in the last 10 years.\textsuperscript{91}

We anticipate SWACH’s opioid project will provide long term support for Medicaid members using opioids in the following ways:

1) Reduction in amount and duration of opioids prescribed and promotion of alternative pain management strategies with long term impacts of declining rates of Opioid Use Disorder (OUD) and opioid overdose.

2) Increased outreach as well as education and treatment access to persons who use opioids through capacity development of peer support services, care coordination, and community based organizations serving as treatment access and referral points.

3) Improved care and treatment penetration for persons with OUD through SWACH strategies and projects enhancing cross-continuum collaboration and increasing capacity in clinical settings to manage persons with OUD.

4) A reduction in overdoses and ED utilization rates for persons with OUD resulting from increased treatment penetration and naloxone distribution, together with the web of support provided the SWACH project portfolio.

2.2 \textbf{How will the ACH ensure the selected project is coordinated with, and does not duplicate, existing efforts in the region?}

In June of 2017, when SWACH convened an opioid workgroup, no regional opioid taskforce was in place.

\textsuperscript{86} Commission on Combating Drug Addiction and the Opioid Crisis -Report to President 2017

\textsuperscript{87} https://www.samhsa.gov/data/sites/default/files/DR006/DR006/nonmedical-pain-reliever-use-2013.htm

\textsuperscript{88} HCA / RDA Measure Decomposition file, provided August 2017. Data for CY 2016, adult Medicaid users with 3 or more ED visits in the past year.

\textsuperscript{89} http://nashp.org/intervention-treatment-and-prevention-strategies-to-address-opioid-use-disorders-in-rural-areas/

\textsuperscript{90} http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2015-01.pdf

\textsuperscript{91} Saving Lives with the Opioid Overdose Prevention Program In Clark County, WAState: WA Type: Model Practice Year: 2016- http://cabarrus.nc.networkofcare.org/ph/model-practice-detail.aspx?pid=5914#.Wd6-etRVC8k.email
SWACH convened the opioid workgroup to guide planning, ensure coordination, avoid duplication and guide implementation efforts for opioid strategies. The opioid workgroup meets monthly at minimum and represents a broad array of settings and stakeholders engaged in opioid work. Opioid workgroup members represent primary care clinics, hospitals, behavioral health settings, alternative or complementary medicine physicians, substance use disorder settings, public health, schools, community coalitions, managed care organizations, corrections, and community based organizations. Workgroup expertise has informed an environmental scan of opioid efforts across the region.

The opioid workgroup identified and prioritized top opioid strategies for SWACH. The process utilized a criteria matrix with six key criteria for project selection and prevention of duplication:

<table>
<thead>
<tr>
<th>Community Readiness: Will potential partners be ready to take this on?</th>
<th>True Need: Does it connect to a high magnitude of documented need (without duplication or intense competition of existing efforts)?</th>
<th>Impact/Scale: Does it affect a large number Medicaid covered lives and will it provide a return-on-investment within 2-3 years?</th>
<th>Spread: Does it engage across the region?</th>
<th>Actionable: Is it an actionable strategy? Is it ready to be implemented immediately?</th>
<th>Measurements Alignment: Does it support the measurements for which the ACH will be accountable?</th>
</tr>
</thead>
</table>

Moving forward SWACH will continue to ensure coordination and prevent duplication:
- Ongoing SWACH opioid workgroup guidance, information sharing, collaboration.
- Klickitat Valley Health Opioid Taskforce to address needs and opportunities specific to rural/frontier communities.
- SWACH to convene advisory groups of setting specific champions to represent six settings: primary care, hospitals, behavioral health, SUD, dental, community. Advisory groups to lead and ensure coordination of setting specific integration of opioid strategies.
- SWACH community engagement team to gain input from regional Medicaid populations ensuring community defined needs are being met and prevent duplication.

2.3 Anticipated target population. How many individuals does the ACH anticipate reaching through this project?

The target population is Medicaid clients without a cancer diagnosis who use opioids, particularly those with opioid use disorder (OUD). A subset target population is Medicaid members with a diagnosis of opioid abuse who are not receiving medically assisted treatment (MAT).
In 2016, 12,234 Medicaid members in the SWACH region used opioids and who did not have a cancer diagnosis. 92 2,288 had a diagnosis of opioid abuse. 81.8 percent of these, 1,872 persons, were not receiving MAT. 93

We anticipate that this project will have broad impact as increased regional focus on coordination, collaboration, efficiency and practice alignment will extend beyond the Medicaid population to benefit all persons who use opioids.

What types of partnering providers are involved in the project thus far, and why are they critical to the success of the project?

Thus far, regional Medicaid providers have partnered with SWACH to guide opioid project planning through workgroup and committee participation. Opioid workgroup participants represent primary care, hospitals, behavioral health, substance use disorder, public health, schools, community coalitions, managed care organizations, corrections, and community based organizations. Project success requires collaboration across settings and opioid strategies must synergistically weave together in support of whole person care.

- Care delivery providers (primary care, hospital, dental, behavioral health, and substance use disorder settings) are critical for informing integration of clinically based strategies (e.g. opioid prescribing, PMP utilization, MAT initiation and management, Naloxone distribution etc.)
- Community based organizations are critical for community based strategies (e.g. increased access points to treatment, opioid education, recovery support, care coordination, community mobilization etc.)
- Managed Care Organizations are critical for coordination, scale and sustain strategies that will ensure long term project impact beyond the scope and timeline of the MTP.

SWACH opioid workgroup represented by Medicaid providers and organizations that provides Medicaid services.

- Community Health Plan of WA
- United
- Cowlitz Tribal Treatment
- Consumer Voices are Born
- Peace Health Medical Group
- Klickitat Valley Health
- Lifeline Connections
- Columbia River Mental Health
- Clark County Corrections
- Clark County Public Health
- Molina
- ESD 112
- Clark County Department of Community Services
- Comprehensive Healthcare
- SeaMar Community Health Centers

92 HCA/ Starter Set Data Files/Opioid Tab/Medicaid Users with no Cancer History. FY 2016.

93 HCA/ Starter Set Data Files/Opioid Tab/Diagnosis History of Opioid Abuse / Medically Assisted Treatment-Buprenorphine, Methadone. FY 2016.
How did the ACH consider the level of impact when selecting the project’s anticipated target population?

SWACH anticipated target populations are Medicaid clients without a cancer diagnosis who use opioids, with a sub-population of those with opioid use disorder who are not receiving MAT treatment. The project’s level of impact will be regional, as the opioid response for these populations needs improvement across all three SWACH counties. The level of impact will also be transformational as, to best serve the target populations, provider partners across the region will need to work toward greater collaboration and integration across care and community settings. As such, the impact of the opioid project at a foundational level will be determined synergistically with concurrent SWACH projects (bidirectional integration, care coordination, chronic disease management) working toward the MTP’s overarching goal of system transformation.

To serve the target populations, SWACH selected four related approaches with anticipated impacts at regional and system transformational levels.

1) Prevention - Improve Opioid Prescribing Practices / Decrease Opioids in Community

Our community has been flooded with opioids. In the SWACH region there were 408,673 unique opioid prescriptions in 2014 as compared to a total population of 475,019 (ratio of 0.9 / person). 94

In 2014, for example, there were 388,999 opioid prescriptions in Clark County compared to a total population of 442,800 in 2014, almost one prescription for every person (Ratio of 0.88 opioid prescriptions per person). In Skamania there were 10,907 unique opioid prescriptions compared to a population of 11,370. In Klickitat there were 8,767 unique opioid prescriptions compared to a population of 20,849 (see charts below).

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14,066 SWACH Medicaid members use opioids, representing more than one in ten of the region’s 134,745 Medicaid members. Persons prescribed opioids are at increased risk for developing OUD, the likelihood ranging from a threefold increase for acute low dose opioids to a 122-fold increase for chronic high dose opioids.  

A) SWACH will support provider adherence to opioid prescribing guidelines, in particular to HCA regulations for opioid prescriptions for Medicaid patients effective November 1, 2017.

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Washington State Interagency Guideline on Prescribing Opioids for Pain

ACH Project Plan Template (October 16, 2017)
B) SWACH will support PMP usage to inform opioid management. Statewide, only 30% of prescribers and 51% of pharmacists are registered for the state’s PDMP.  

C) Nationally, death from opioid OD is 45 percent higher in rural areas than urban areas. SWACH will support telehealth in rural/frontier counties with limited resources and rising rates of opioid use. 2016 student surveys of 8th and 10th graders in Skamania and Klickitat show rates of non-medicinal opioid use in the last 30 days higher than state average. Reflecting the general increase in opioid usage, between 2002 and 2013 there were increases of 221.6% and 48.5% in Skamania and Klickitat respectively in publicly funded treatments involving opioids.

Healthy Youth Survey 2016

30-day (non-medical) use of prescription drugs:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Klickitat County</th>
<th>Skamania</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>6.1%</td>
<td>7%</td>
<td>5.2%</td>
</tr>
<tr>
<td>10</td>
<td>15%</td>
<td>8%</td>
<td>7.9%</td>
</tr>
</tbody>
</table>

D) Research shows that patients are often prescribed more opioids than consumed, for example up to three times more opioids than are consumed after orthopedic surgery. Very few have any counseling regarding the safe disposal of unused narcotic medicines and there is limited access to medication disposal. It is hard to know the impact that this has had on the amount of medication available for overuse and diversion, but it is likely to be very significant. Sixty-three percent of heroin using clients at the region’s harm reduction center reported using prescribed opiates before becoming heroin addicted.

SWACH will work with partners to create greater access for the community to dispose of opioids. Currently there are limited medication disposal sites and two annual drug take back events. Reports from the department of community services, prevention coalitions, the syringe exchange, and medical providers suggest the need for increased drug take back opportunities. A recently installed med safe collection program at Klickitat Valley Hospital, for example, was discontinued because overwhelming response was greater than capacity.

2) Treatment – Expand access to MAT
81.8 per cent of Medicaid members with a diagnosed opioid use disorder in the SWACH region are not receiving MAT. Anecdotal reports from providers suggest that opioid use disorder is under-diagnosed and treatment penetration rates are likely lower than data suggests. Patients receiving MAT cut their risk of death from all causes in half.

A) SWACH will support efforts to increase numbers of MAT providers. Increasing regional capacity for long term management of patients on MAT has been identified as a top priority by the opioid workgroup. Clark County currently has 13 prescribers waivered to offer MAT -buprenorphine. In Skamania and Klickitat two prescribers are currently waivered to offer MAT- Buprenorphine. Access is lower than the numbers indicate as many waivered providers do not prescribe MAT.

B) SWACH intends to work with partners to increase sites where MAT can be initiated with a focus on EDs, hospitals, jails, and syringe exchanges as prime locations. SWACH anticipates high impact for target populations as these locations see high numbers of people with OUD.

- Hospitals: Between 2000 and 2014 the rate of opioid related in-patient hospital stays in Washington increased by 60.1%, the fourth highest increase in the country.
- Jails: People with OUD leaving jail without MAT are at higher risk of overdose due to decreased tolerance over the time incarcerated.
- Syringe Exchange: The syringe exchange in Clark County served about 1400 individual clients in the last year.

C) SWACH intends to increase access points to treatment through capacity development of select community based organizations for outreach and engagement. CBOs whose work overlaps with high numbers of persons with OUD will be prioritized (e.g. child welfare services, WIC programs, housing and homeless agencies).

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102 HCA/ Starter Set Data Files/Opioid Tab/Diagnosis History of Opioid Abuse / Medically Assisted Treatment-Buprenorphine, Methadone. FY 2016.
103 For example, conversation with CMO of area FQHC 10.19.17
104 https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm57675
105 https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator
107 http://www.hcup-us.ahrq.gov/faststats/landing.jsp
109 Clark County Public Health – Syringe Services Program. Kari.Haecker@clark.wa.gov October 2017
D) SWACH will support peer services and greater integration of peer support services in the continuum of care. Peer support services overcome barriers of stigma and increase likelihood of connection to treatment.110

3) OD Prevention - Increase Distribution of Naloxone
Ensuring at risk individuals receive take home naloxone and supporting education will reduce overdoses and save lives.111 2016 Clark County data shows 245 opioid related ED visits and 111 opioid related hospital stays. In that same year there were 40 opioid related deaths by overdose. (Data unavailable for Klickitat and Skamania). 112 Naloxone rapidly reverses opioid overdoses and keeps alive the chance for a person with OUD to access treatment and recovery. We are not aware of any system-wide approach in our region to ensure all at-risk individuals receive naloxone.

SWACH will work with partners across care and community settings to increase distribution of Naloxone.

4) Recovery- Enhance the provision of peer based recovery support services
Opioid addiction is a chronic condition and there is need for long term management to support recovery. Peer support specialists can be a cost-effective approach to working with people over a long period of time to help keep their lives stabilized and prevent relapse.113 Peer support services are effective in outreach, facilitating engagement and connection to treatment. Peers bridge barriers of stigma associated with opioid use and promote a sense of belonging within the community. 114

Peer services available through behavioral health agencies are limited in Clark County115 and unavailable in Skamania or Klickitat. Increased peer support services are needed:

- Upstream- increased peer support services for outreach and engagement of persons with OUD on the streets, in courts, in jails.
- Within the treatment system – increased peer support services in OUD treatment programs both in-patient and out-patient, in ED’s, in pain management clinics. Integrating peers into care settings such as the ED has been proven successful for engagement in recovery services.116
- Post treatment- increased peer support for long term recovery support, connection to the recovery community, life-skills development.

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110 https://www.elementsbehavioralhealth.com/recovery/benefits-of-peer-recovery-support-systems/
112(file:///C:/Users/eric.scott/AppData/Local/Temp/Temp1_wa_ach_drug_quarterly_dash_2017q1.html#dashboard
113 http://kbia.org/post/why-peer-support-playing-growing-role-addiction-recovery#stream/0
114 https://www.samhsa.gov/recovery/peer-support-social-inclusion
115 Anecdotal from CEO of CVAB 10.20.17
116 http://www.addictionpolicy.org/single-post/2017/02/02/AnchorED-Rhode-Island
SWACH intends work with partners to establish access to peer support services across care settings.

### Opioid Project Expected Impact and Outcomes

<table>
<thead>
<tr>
<th>Increase in:</th>
<th>Reduction in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Number of prescribers trained on evidence based prescribing guidelines</td>
<td>• Quantity of opioids in community</td>
</tr>
<tr>
<td>• Number of prescribers using the PMP</td>
<td>• Opioid overdose ED visits</td>
</tr>
<tr>
<td>• Access to telehealth to support OUD prevention and treatment in rural and</td>
<td>• Opioid OD deaths</td>
</tr>
<tr>
<td>underserved areas.</td>
<td>• Prescription-opioid related inpatient stays</td>
</tr>
<tr>
<td>• Number of providers certified to prescribe OUD medications</td>
<td>• High-dose chronic therapy</td>
</tr>
<tr>
<td>• Opioid treatment penetration</td>
<td>• Concurrent sedative prescriptions</td>
</tr>
<tr>
<td>• Sites providing access to MAT</td>
<td></td>
</tr>
<tr>
<td>• Community based organizations serving as education and referral sites</td>
<td></td>
</tr>
<tr>
<td>• Access to and use of naloxone to reverse overdoses</td>
<td></td>
</tr>
</tbody>
</table>

### How will the ACH ensure that health equity is addressed in project design?

In addressing the opioid epidemic, SWACH acknowledges that the “War on Drugs” has had disproportionate adverse impact on some communities, particularly those of color. It is important that supportive interventions recommended now not inadvertently replicate that pattern. A central guiding principle of the opioid workgroup, captured in the opioid workgroup charter, is a commitment to equity. Opioid workgroup membership includes the director of diversity for PeaceHealth, the health system serving the largest volume of Medicaid patients in the region.

SWACH partners with multiple community organizations and community groups to develop an equity lens to inform overall work. For this extensive piece of work, SWACH brought in grant dollars from United Way, Northwest Health Foundation and leveraged partner organization funds. SWACH will be bringing in the Center for Equity and Inclusion, a nationally known group, to support the development of this work.

As we take the proper time and process to develop our own equity lens, tools, and community buy in SWACH plans to use the Center for Racial Justice Innovation, Racial Equity Impact Assessment Guide, as a set of questions we will be bringing to decision-making tables (workgroups, RHIP, Board, staff) to inform the SWACH work.

**To support broad-reaching, system-wide transformation, projects must improve the efficiency and quality of care for the ACH’s 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.**
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:
  o Describe the ACH’s general approach to accomplishing requirements.
  o Include resources to be deployed to support partnering providers, anticipated barriers/challenges and ACH tactics for addressing them.
  o Specify which evidence-based approach option(s) will be used for the project.
  o 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**

- *Demonstrate how the ACH has included partnering providers that collectively serve a significant portion of the Medicaid population.*

SWACH has a variety of committees and workgroups, one of which is the Opioid Workgroup. SWACH began an organizational effort to create the opioid workgroup in the spring of 2017 after meeting with potential providers and their leadership teams. SWACH sent out invitations to a...
broad swath of providers and community stakeholders serving the Medicaid population. Participants in the opioid project represented a care and community spectrum including primary care clinics, hospitals, behavioral health settings, substance use disorder settings, public health, schools, community coalitions, managed care organizations, corrections, and community based organizations.

Every member of the workgroup and the organizations they represent have been dedicated to serving the Medicaid population for many years. The workgroup is currently represented by 27 individuals who are all Medicaid providers in the community or represent an organization that provides services to Medicaid members. The following list are the organizations that are represented:

- Community Health Plan of WA
- United
- Consumer Voices are Born
- Peace Health Medical Group
- Klickitat Valley Health
- Lifeline Connections
- Columbia River Mental Health
- Clark County Corrections
- Clark County Public Health
- Molina
- ESD 112
- Clark County Department of Community Services
- Comprehensive Healthcare
- SeMar Community Health Centers
- North Shore Medical Group
- Our Klickitat Prevention Coalition
- Healthy Living Collaborative
- ShareHouse
- Klickitat & Lyle Against Substance Abuse Coalition (KLASAC)
- SW Washington League of United Latin American Citizens
- Cowlitz Tribal Treatment

Additionally, SWACH has established a partnership relationship with more than 100 agencies in the region. SWACH will leverage these relationships as appropriate to support continued planning and implementation of the opioid project.

- Describe process for ensuring partnering providers commit to serving the Medicaid population.

SWACH is developing binding provider participation agreements that will require providers’ commitment to Medicaid. Financial incentives for partnering providers will be tied, in part, to Medicaid lives served, offering further commitment to serving Medicaid.

- 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.

SWACH reached out and on-boarded potential partners and community stakeholders to the opioid project, involving them in workgroups and committees as appropriate. As noted above, the opioid workgroup represents a broad spectrum of care and social services.
The opioid workgroup developed a charter to help guide work and ensure partnering provider engagement. The charter stipulates workgroup participation to provide input and guide regional strategies to ensure that SWACH and its partners can learn, plan, and act collectively to reduce opioid-related morbidity and mortality throughout the regional service area. The charter further stipulates that opioid workgroup participants support steps critical to project success including: needs assessment, project selection, measure selection, program implementation, self-monitoring, reporting, and evaluation efforts.

As outlined in the charter, the opioid workgroup’s guiding principles are:

- Encourage shared decision making among all SW ACH partners;
- Develop projects which address health inequities among SW ACH region residents;
- Promote collaborative, collective processes from multiple organizations and sectors;
- Value integrity and agree to uphold all SW ACH standards, privacy laws, and other human rights as applicable; and
- Support the goals of the triple aim of health care reform and the Healthier Washington initiative, including the Medicaid Transformation Demonstration Project.
- Use of recommended plans to guide implementation: 2016 Washington State Interagency Opioid Working Plan; Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan
- Application of an Equity and Social Justice (ESJ) lens to projects.

In addition to the opioid workgroup, SWACH will develop advisory groups specific to clinical and community settings as focus shifts from opioid project design to implementation. SWACH will identify key organizational leadership and setting-specific champions to be involved in planning and decision making for setting-specific partnership agreements and implementation strategies. By end of DY2, Q2 SWACH will secure written commitments from implementation partners.

- Describe how the ACH is leveraging MCOs’ expertise in project implementation, and ensuring there is no duplication.

The Opioid Workgroup has representation from the MCO’s serving the region: Molina, CHPW and United. SWACH has also developed a coordinated alignment meeting that meets each month to ensure that the health plans, our TA partners and SWACH are in alignment, can leverage expertise across domains and strategize collectively about opportunities.

**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.
**Assets, Challenges and Mitigation of Identified Barriers**

**Prevention - Community Systems and Social Services**

**Assets: Community Systems and Social Services** Substance abuse prevention and education efforts in schools and community groups are active in all three counties. Prevention coalitions engagement include One Prevention Alliance, Connect Evergreen, BattleGround, West Van for Youth, Unite! Washougal, Our Klickitat, CPAKC (Coalitions Preventing Abuse in Klickitat County), and Klickitat & Lyle Against Substance Abuse Coalition (KLASAC). Prevention coalitions work with Educational Service District 112. ESD 112 has created a toolkit with videos for educating parents on opioid prevention. ESD 112 also provides prevention services and employs or contracts for Prevention/Intervention Specialists (PI’s) to be placed in schools across the region. The Prevent Coalition recently received a grant for prevention work in Clark, Skamania and Klickitat to support expansion of Drug Take Back events and create a social marketing campaign to raise awareness of the dangers of opioid and prescription drug misuse.

**Challenges: Community Systems and Social Services:** Disproportionate county populations and differences between urban and rural contexts present equity challenges and require contextually based approaches to project implementation. In 2016 Clark County had a Medicaid population of 123,608 persons and the majority of regional resources to address the opioid crisis. Klickitat and Skamania had 6,817 and 2,455 members respectively, are primarily rural counties, and have more limited social services and resources serving largely decentralized populations. Challenges in the rural areas include issues of poverty and isolation by distance, lack of basic utilities, transportation, no central news source, unreliable internet and cell service.

**Strategy for Mitigation - Community Systems and Social Services:** SWACH will leverage its role as a convener to support development of an Opioid Taskforce to address challenges and opportunities for ACH project implementation specific to the context of our rural/frontier communities. The work will be championed by two local physicians: Dr. Michael Garnett, family physician with Klickitat Valley Health is an active member of the opioid workgroup. He has engaged Dr. Witherrite to serve as a champion in White Salmon. Dr. Witherrite is a family physician with North Shore Medical Group and, until recently, the sole provider offering MAT in Klickitat or Skamania County.

**Prevention - Prescribing Guidelines**

**Assets- Prescribing Guidelines** 1) Anecdotal reports from primary care and hospital partners (including PeaceHealth, Skyline, KVH, SeaMar CHC) on opioid prescribing guidelines in the region suggest there is variance in established protocols and adherence. Recent regional and statewide efforts to support adherence to evidence based opioid prescribing guidelines have taken place. In 2015 The Healthy Columbia Willamette Collaborative (HCWC) developed prescribing guidelines that have been adopted by hospitals in Clark County including Peace Health and Legacy. More recently, the Health Care Authority implemented clinical policy around opioid prescribing for non-cancer pain that applies to all Medicaid members to begin in November 2017.

**Challenges- Prescribing Guidelines** 1) There is a lack of alignment around a single set of guidelines and there is variance in levels of adherence to guidelines across settings. Providers who have invested

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118 HCA/ Starter Set Data Files/Medicaid Enrollment by MCO Tab/ FY 2016.
in a particular approach to opioid guidelines may be reluctant to change. Providers may be reluctant to absorb the time and costs necessary for instituting and managing prescribing practices, protocols and quality improvement initiatives. 2) Providers have expressed concern about inefficiencies in utilizing the PMP as it is currently available. In opioid workgroup meetings, the PMP has been called “clunky” and “time intensive” and “problematic” as it is not linked to EHRs. 3) There are few alternatives to opioids for treatment of legitimate chronic pain patients. Limited Medicaid reimbursement for providers of alternative therapies is a barrier to their proliferation and utilization.

**Strategy for Mitigation - Prescribing Guidelines** - 1) SWACH will adopt a flexible approach to working with partnering organizations to ensure adherence to evidence based prescribing guidelines without requiring a singular approach. SWACH will provide support in training, technical assistance and workforce development to mitigate barriers of cost and time for partners. 2) SWACH will partner with the Washington State Medical Association to support adoption of a physician-driven peer to peer QIP model to improve opioid prescribing.119 3) SWACH intends to work with the state to support Health Information Technology improvements that will integrate the PMP with electronic health records. In practices where this is not an option, SWACH will support development of workforce capacity, workflows, and protocols to bring greater efficiency to checking the PMP. 4) Alternative pain management programs (physical therapy, chiropractic, naturopathy, etc.) are scarce but do exist in the region. The ACH intends to work with MCO’s to explore payment reimbursement models that support alternative therapies.

**Treatment- Access to MAT**

**Assets- Access to MAT: Rural** - Treatment assets are available in Clark County but less so in Skamania and Klickitat. We know of only two providers waivered to offer MAT in our rural/frontier counties.

**Assets- Access to MAT: Urban** - In Clark County, MAT is available to Medicaid members at Lifeline Connections, Columbia River Mental Health and Kaiser Permanente Department of Addiction Medicine. Peace Health provides MAT for its primary care Medicaid members. SeaMar Community Health Centers is in process of developing MAT services. Cowlitz Tribal Treatment currently offers substance use disorder treatment without medication in Clark County, will serve MAT patients who are connected to a provider, and has developed MAT services at their site in Tukwila. Treatment access for the region has been enhanced by a State Target Response (STR) grant to Lifeline Connections to establish a “Hub and Spoke” model in Clark County. Hub and Spoke models support increased access to opioid treatment and MAT through contracted partnerships between a hub, that provides at least two MAT medications, and community agencies that provide treatment, outreach, education, referral and follow up services. Clark County jail is one spoke, has provided continuation of MAT for inmates, and intends to develop a MAT initiation program for inmates.

**Challenges- Access to MAT: Regional**

Few clinicians have gotten certified to prescribe MAT medications. SAMSHA’s registry identifies only 13 MAT providers within a 50 mile radius of Vancouver in Clark County.120 Only two providers are

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119 Jeb Shepard, Associate Director of Policy and Regulatory Affairs, WSMA. jeb@wsma.org 10.24.17

120 https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator?distance%5Bpostal_code%5D=&distance%5Bsearch_distance%5D=50&distance%5Bsearch_units%5D=mile&field_bup_physician_city_value=Vancouver&field_bup_physician_us_state_value=WA=&Apply
waivered to offer MAT services in Skamania and Klickitat. There is a need for workforce development to support long term management of persons with OUD. Barriers to increasing numbers of MAT providers include: 1) Time and cost to get certified- an eight hour course is required for MD’s and DO’s, a three day course is required for ARNP’s or PA’s. Providers are not reimbursed for taking the course. 2) Limited support for physicians or inclination to work with patients with OUD due to stigma and prevalence of confounding conditions associated with opioid addiction.

**Challenges - Access to MAT: Rural** Klickitat and Skamania Medicaid members have limited access to MAT. Comprehensive Healthcare offers treatment services for substance abuse in Klickitat but does not offer MAT in Klickitat. Comprehensive does provide methadone treatment at their site in Yakima, approximately 90 miles from Klickitat.

**Challenges - Access to MAT: Urban** According to the CEO of Columbia River Mental Health, which provides MAT services, treatment penetration is a challenge. Utilization of existing MAT services in Clark County is not yet at full capacity. Outreach and consequent engagement in treatment to persons with OUD must improve to ensure MAT services are fully utilized. Peer support services, effective in engaging persons with OUD in treatment, are not reimbursed under current Medicaid payment structures.

**Strategy for Mitigation - Access to MAT**
To address identified barriers SWACH initiatives will include the following:
1) Increase outreach and engagement through partnership and capacity building of CBO’s to recognize, educate and refer persons with OUD to treatment.
2) Increase outreach and engagement through increased utilization of peers across settings. Peers can bridge the barriers of stigma and distrust that prevent many persons with OUD from seeking services. We will partner with peer support services to increase workforce capacity and to develop partnerships and protocols with care settings so that more peers are available as resources in primary care, hospitals and ED’s. We intend to work with MCO’s to consider payment reimbursement plans for peer SUD services, potentially modelling after current peer reimbursement models for mental health services.
3) Partner with MCO’s and care settings to increase the number of MAT providers in primary care settings and to ensure they are supported. We will work with partners to support providers through evidence based models for successfully treating substance abuse in primary care. Partners might work within a “Hub and Spoke” model or they may implement the “Massachusetts Model” in which a nurse case manager works with a MAT prescribing provider to manage their panel. The Massachusetts Model has proven to be cost effective and, as of 2013, had a 67 percent success rate in keeping persons with OUD in treatment for at least a year. We intend to work with partners and MCO’s to consider funding flows that align with VBP, support the increase in utilization and number of MAT providers, and support management of larger panels of persons with OUD.

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122 Ct.LaBelle et al / Journal of Substance Abuse Treatment 60 (2016) 6-13

*ACH Project Plan Template (October 16, 2017)*
4) Partner with care settings and community partner to increase the number of MAT initiation sites in the region. Hospitals, ED’s, the syringe exchange, and jails are all prime locations for MAT initiation.
5) Increase support, capacity and confidence around opioid management in care settings and among providers through trainings and technical assistance on prescribing practices and opioid management.

OD Prevention- Increase Distribution of Naloxone

**Assets-OD Prevention** Clark County Public Health needle exchange offers naloxone. Clark County’s Department of Community Services has programs to provide naloxone to Clark County and Battleground police.

**Challenges- OD Prevention**
1. Attitudes toward persons with OUD that equate naloxone distribution as condoning of illegal drug use.
2. Development of sustainable funding models for purchasing and distributing naloxone beyond the MTP.
3. Concerns as to matters of liability for naloxone distribution in various care settings including behavioral health, primary care, hospitals and ED’s.

**Strategy for Mitigation- OD Prevention**
1. SWACH intends to work with ESD-112 and prevention coalitions to support community education efforts that align with current guidance from the American Society of Addiction Medicine to treat OUD as a chronic disease as opposed to a choice.
2. In the transition to Value Based Payment, SWACH intends to work with community partners and MCO’s toward development of sustainable funding models for Naloxone distribution as well as increased sites distributing the medication. Increased naloxone distribution supports VBP metric goals such as decreasing ED utilization.
3. SWACH will facilitate trainings and technical assistance to address concerns about liability and support protocols for increased distribution of naloxone across care settings.

Recovery – Support for Peer Services

**Assets - Recovery:** Clark County has a strong recovery community which SWACH will leverage to enhance and expand peer support services. Consumer Voices are Born (CVAB) is located in Clark County and is the only peer run organization from board down in the state doing direct services under contract with MCOs or BHOs. Many behavioral health agencies in Clark County have peers working for them. Other assets actively supporting recovery include twelve step programs, recovery programs at the Veterans Administration, youth focused recovery services (Transitional Youth), recovery focused housing (Fairhaven, Oxford House), faith based organizations (New Heights, Grace Ministries, Living Hope, Open House Ministries) and a recovery focused café (Kleen Street). In Klickitat, there are peer counselors available through Father’s House Fellowship and a narcotics anonymous program.

**Challenges- Recovery:** There will be challenges to ensure appropriate administrative capacity to expand existing programming and peer support services. Challenges exist in rural areas as there are fewer established peer services in Klickitat and Skamania. Behavioral health agencies in Skamania and Klickitat do not have peers working for them.

**Strategy for Mitigation- Recovery:** We intend to partner with existing peer support services to explore avenues of sustainable growth with the objective of expanding capacity of peer services in the region. Leveraging the organizational knowledge and advising capacity of established peer support organizations, we intend to develop, scale and sustain peer support services in rural/frontier areas.
**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**

**Monitoring and Continuous Improvement**

SWACH envisions a project monitoring and continuous improvement infrastructure and process to support achieving the outcomes of the MTP portfolio, coupled with a region-wide system of care, working in tandem to achieve our targeted goals. The process for project monitoring and continuous improvement relies on several core components including: strong infrastructure of timely data, continuous data monitoring and analysis, a Strategic Improvement Team, and reporting at multiple levels including providers, community, ACH governance, and HCA reports. Each of these components is described further below (see Figure 1).
Figure 1. Process for Monitoring and Continuous Improvement

The data infrastructure to support monitoring and continuous improvement will complement existing data assets (such as the Healthier Washington Data Dashboards) and will build upon “point of care” population health management system inputs needed for projects. Among the incoming data in Figure 1 are the identified data sources associated with 1) pay for reporting (P4R) and pay for performance (P4P) metrics and 2) key data identified by the Opioid Workgroup and the SWACH Strategic Improvement Team needed for analysis to support program implementation, monitoring, continuous improvement, evaluation/sustainability, and spread.

Metrics to track progress and outcomes identified for the opioid project vary by approach and may include but are not limited to:

**Prevention:**
- Number of hospitals/clinics who have policies and procedures regarding opioid prescribing guidelines.
- Number of health care providers, by type, trained on the AMDG’s/CDC opioid prescribing guidelines.
- Number of hospitals/clinics who have policies and procedures in place to receive opioid variance reports.
- Number of variance reports received.
- Patients on high-dose chronic opioid therapy by varying thresholds
- Patients with concurrent sedative prescriptions
- Number of hospitals/clinics who have policies and procedures regarding telehealth.
- Number of providers trained in the use of telehealth for opioids.
- Number of hospitals and clinics that check PMP before prescribing opioids
- Number of hospitals and clinics registered for facility level access to state PMP
- Number of queries to the PMP before implementation
- Number of queries to the PMP during and after implementation
- Number of facilities with EHR’s that link to the PMP
- Number of drop boxes for medication disposal
Treatment:
- Number of hospitals/EDs/clinics/CBOs with policies and procedures for initiating MAT for individuals with OUD
- Contracts between MAT initiating agencies and community MAT providers in place
- Number of patients by setting who are initiated on MAT and received supporting education
- Numbers of patients who are initiated on MAT who receive follow-up care from a community partner
- Number of patients receiving MAT
- Number and location of providers with a DEA number that provide patient care waivered to provide MAT services (before, during and after project)
- Number and location of waivered providers providing MAT services (before, during and after project)
- Number of referrals to MAT treatment (before, during and after project)
- Number of CBO’s trained to engage and educate persons with OUD
- Number of CBO’s that refer to treatment

OD Prevention:
- Number of hospitals/clinics/CBO’s that have performed a gap analysis and assessment of resources for prescribing/distributing naloxone.
- Number of hospitals/clinics/CBO’s that have policies and procedures for prescribing/distributing naloxone in place.
- Number of hospitals/clinics/CBO’s prescribing/distributing naloxone.
- Number of patients on high-dose opioid therapy who were also prescribed naloxone.
- Number of patients who present to the ED with an opioid use disorder (OUD) or overdose event who were prescribed naloxone.
- Number of patients who present in hospital with an opioid use disorder (OUD) or overdose event who were prescribed naloxone.
- Number of persons at CBO’s with OUD who were provided naloxone.
- Opioid overdose deaths.

Recovery:
- Number of peers engaged in SUD support
- Number of peers who have received recovery training
- Number of agencies across settings who have established access to peer support services

SWACH has contracted with the Providence Center for Outcomes Research & Education (CORE) to design and run the monitoring system. The system will bridge all partner organizations by collecting, storing, aggregating, analyzing, and reporting key data elements from each partner/data source, serving as a HUB for all quality and monitoring activities.

In addition, SWACH will continue in sharing information with other ACHs and participates in a weekly opioid project meeting to facilitate peer learning. This forum includes opportunities for discussion around models and strategies for effective systems of monitoring and continuous improvement. For example, a recent presentation by the Washington State Medical Association (WSMA) focused on a peer to peer Quality Improvement Plan (QIP) around improved opioid prescribing as well as opportunities for collaboration on this QIP model and information sharing between ACH’s and the WSMA. The forum has also jointly explored the “6 Building Blocks” for opioid management in primary care which includes models for monitoring and continuous improvement (see chart below).124 Challenges, solutions and best practices in monitoring and improvement will be an ongoing subject for shared learning in collaboration across ACH’s.

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Plan for monitoring project implementation progress, including addressing delays in implementation

Adjustments to implementation timelines will be triaged through this system and course corrected wherever possible. Implementation progress and status of timelines will be monitored by SWACH with clear lines of communication and accountability between partnering providers, ACH staff, CORE, and our ACH governance body.

If timelines still cannot be met, SWACH will communicate reasons why timelines weren’t met, a plan for adapting the timeline, and prevention/risk mitigation strategies will be shared with other programs where appropriate.

Plan for monitoring continuous improvement, supporting partnering providers and determining whether SWACH is on track to meet expected outcomes

The Strategic Improvement Team (SI Team) will drive quality improvement strategies with providers. The SI Team will consist of Improvement Advisors certified by IHI. This team will create and run a unified system of rapid cycle feedback and quality improvement across the organizational partners and to ensure successful progress toward milestones and that outcomes and reporting is done in a timely and quality manner. This system will incorporate a comprehensive shared learning system that follows the best practice of a “plan, do, study, act” (PDSA) continuous quality improvement process.

Participating providers will be required to participate in learning collaboratives convened by SWACH where they will share and benefit from the collective learnings and experiences of their regional peers.

Plan for addressing strategies that are not working or not achieving outcomes

The comprehensive shared learning system, PDSA continuous improvement process, and ongoing opioid related peer learning across ACH’s will support SWACH and our partners to rapidly identify opportunities for course correction and adjusting strategies to meet our targeted outcomes.

If the SI Team, Quality and Continuous Improvement Committee, and Care Coordination Advisory Committee determine course correction is not possible, they will refer their findings to the RHIP Council.
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.

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<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
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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.

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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

Sustainability through advances in Population Management:
Advances in health information technology will sustain opioid project impacts beyond the MTP period. SWACH will focus on enhanced utilization of the PMP for opioid management and together with partnering providers, managed care organizations, the state and other ACH stakeholders will work towards:

1) Making the PMP more user-friendly by integrating it into electronic health records.
2) Enhancing the PMP to ensure real time information sharing on opioid overdoses
3) Ensuring that dental is included in efforts to enhance PMP utilization
4) Developing capacity to mine and analyze data in the PMP to better measure impact and achievement towards VBP targets.

**Sustainability through building Workforce Capacity:**
SWACH will ensure sustainability of clinical opioid management efforts by championing evidence based models and requiring partners to make and monitor lasting system changes that support integration and collaboration across settings. SWACH will work with partners to identify workforce needs and provide necessary training and technical support. We intend to mitigate costs associated with development of new policies, protocols, infrastructure and workforce capacity expansion. We will work closely with MCOs and other partners to consider how new payment models can sustain these new structures. SWACH intends to support workforce capacity development as related to:

1) Improving provider capacity to adhere to evidence based opioid prescribing practices—particularly in primary care, dental, and hospital settings.
2) Increasing access to treatment through capacity development of peer support services to contract and collaborate with care settings.
3) Increasing access to treatment through capacity development of CBO’s to create infrastructure supporting identification, education and referral of persons with OUD.
4) Increasing access to and management of treatment by increasing prescribers in our region who offer MAT in acute and primary care settings.
5) Providing support for implementing new positions/staff responsibilities that improve outcomes related to opioid management models: for example, supporting a position in primary clinics responsible for checking PMPs and communicating with provider; or supporting the nurse care manager position fundamental to the “Massachusetts Model” of providing MAT in primary care settings.
6) Increased collaboration across settings and across concurrent SWACH projects to achieve greater outcomes. For example, development of workforce capacity through training and technical assistance to effectively integrate care coordination and bidirectional care in the approach to opioid management.

**Sustainability through achieving Payment for Performance targets**
- SWACH will work with partnering agencies to enhance outreach efforts and lower barriers for persons with OUD to enroll in insurance and engage in primary care services. Anecdotal reports from providers, including at the syringe exchange, indicate that significant numbers of persons with opioid use disorder remain uninsured and/or unengaged with primary care. They therefore wait to seek treatment and utilize costly emergency services for their health care needs. SWACH intends to support a shift towards greater health outcomes and increased sustainability through a focus on enrollment and engagement of persons with OUD who are not receiving MAT.
SWACH intends to support sustainability through demonstration of opioid project cost effectiveness and success in achieving P4P targets. At 1,786 people, the target population of Medicaid members diagnosed with OUD who are not receiving MAT is relatively small. However we know that, nationally, approximately five percent of the utilizers of health care services population account for almost half (49 percent) of total health care expenses. We also know that people with unmet OUD treatment needs are high utilizers of health services and at least three times more likely to have multiple ED visits (3 or more) a year. In 2015 the costs to insurance companies were more than five times higher for patients with diagnoses of opioid abuse or dependence than for those with any other diagnoses. We therefore anticipate the impact of opioid projects to be significant on outcome metrics as treatment penetration increases. We intend to work with MCO’s and other stakeholders to develop payment models that sustain the impacts of our projects beyond the MTP.

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

**Project Plan Portfolio**

<table>
<thead>
<tr>
<th>Domain 2: Care Delivery Redesign</th>
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<tbody>
<tr>
<td>☐ 2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)</td>
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<tr>
<td>☐ 2B: Community-Based Care Coordination</td>
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<tr>
<td>☐ 2C: Transitional Care</td>
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<td>☐ 2D: Diversions Interventions</td>
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<tr>
<th>Domain 3: Prevention and Health Promotion</th>
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<tbody>
<tr>
<td>☐ 3A: Addressing the Opioid Use Public Health Crisis (required)</td>
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<tr>
<td>☐ 3B: Reproductive and Maternal and Child Health</td>
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<tr>
<td>☐ 3C: Access to Oral Health Services</td>
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<tr>
<td>☒ 3D: Chronic Disease Prevention and Control</td>
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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.

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125 HCA/ Starter Set Data Files/Opioid Tab/Diagnosis History of Opioid Abuse. FY 2016.
127 HCA / RDA Measure Decomposition file, provided August 2017. Data for CY 2016, adult Medicaid users with 3 or more ED visits in the past year.
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.

<table>
<thead>
<tr>
<th>ACH Response</th>
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<tr>
<td><strong>Project Description and Justification</strong></td>
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<tr>
<td>SWACH has identified Chronic Disease Prevention and Control as a priority for the region and will focus on sustained implementation of the evidence-based Chronic Care Model across diverse care settings. The Chronic Care Model will serve as a key driver to ensure integration of health system and community-based approaches to improve health outcomes for Southwest ACH Medicaid beneficiaries, with a focus on those individuals experiencing the greatest level of disease burden.</td>
</tr>
<tr>
<td><strong>Justification for selecting project and how it addresses regional priorities</strong></td>
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<tr>
<td>SWACH Medicaid beneficiaries face a heavy burden of chronic disease and health disparities. As identified through the Regional Health Needs Inventory, 33,250 Medicaid members in SWACH have been diagnosed with mental illness and 13,300 Medicaid members have at least one indicator of substance use disorder (SUD). Among adults in SWACH, 29% have hypertension, 11.1% have a diagnosis of cardiovascular disease, 7% have a diagnosis of Type 2 Diabetes, and 1.1% have cancer. As of June 2016, 4.7% of the SWACH Medicaid population had a behavioral health diagnosis and substance abuse and at least one chronic disease. Almost a third of SWACH members have a BMI of 30 or higher. Columbia Gorge CHNA, which covers Klickitat County, found that two out of three residents were obese. Obesity is a known risk factor for diabetes, cardiovascular conditions, and cancer.</td>
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<tr>
<td>Social determinants of health drive premature mortality in chronic disease sufferers. Hispanic and Black individuals with chronic disease in SWACH have more complications due to lack of access to...</td>
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preventative health care.129 16% of emergency room visits are preventable130, which further suggests access issues. Clark County’s provider to individual ratio is 1510:1, and Skamania and Klickitat (frontier and urban, respectively) struggle with access issues as well. 50% of SWACH residents spend 30% of income or more on housing, and over 20% report food insecurity in Clark and Klickitat counties, with 53% reporting food insecurity in Skamania.131

This project choice was vetted through extensive community conversations, including monthly meetings of SWACH’s RHIP council beginning last spring. We have involved hospital systems, physical care providers, behavioral health providers, substance abuse disorder providers, emergency services organizations, community-based organizations, representatives from county government, Managed Care Organizations (MCOs) and the criminal justice system in these discussions. SWACH intends to create and analyze a setting-specific provider survey that will further inform our planning and implementation. The Chronic Care Model has been noted to dovetail perfectly with work already underway in the region, and presents an opportunity to deepen impact for Medicaid enrollees living with or at risk for chronic disease in SWACH.

- 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

Through prioritization of the Chronic Care Model, SWACH will support sustainable health system transformation for the target populations in the following ways:

- Expand the necessary infrastructure to assess approaches that have been effective, as well as identify additional needed capacity/resources across the Pierce County community
- Align chronic disease and prevention efforts across health system and community partners that allows for greater efficiency and deepened impact
- Extend intentional focus on specific subpopulations experiencing the greatest health disparities
- Build experience with the use of data, HIT resources and QI tools across regional providers and organizations
- Deepen experience with VBP contracting among providers and community based organizations related to chronic disease prevention
- Transform systems of care to produce meaningful health improvements
- Build capacity and communication through attention to recruitment, retention, and development of providers in alignment with the Quadruple Aim
- Support upstream initiatives to positively affect social determinants of health

How SWACH will ensure project coordinates with and doesn’t duplicate existing efforts

129 PeaceHealth Southwest CHNA, 2016


131 Please see RHNI for additional data sources

ACH Project Plan Template (October 16, 2017)
Throughout planning for the Chronic Disease Prevention and Control project, SWACH has worked to ensure coordination and avoid duplication by its broad engagement with a multitude of partners and community members. To gain a deeper understanding of work underway and the needs in the community, we began an environmental scan of our partners about their work in chronic disease and prevention to learn about the successes they’ve had, the obstacles they’ve faced and to discuss solutions for moving forward. We will design and analyze setting-specific provider surveys to determine readiness and capacity. We are also gathering information to ensure we aren’t adding unnecessary layers to the work of providers and CBOs, but are filling gaps. During the planning period, we will continue to convene groups of providing partners on a regular basis to ensure we are not duplicating existing efforts and that SWACH’s work complements and enhances existing initiatives to address chronic disease and prevention.

**Anticipated Project Scope**

We envision SWACH’s Chronic Disease Prevention and Control Project will be focused on implementation of Wagner’s evidence-based, Chronic Care Model across care settings for a set of targeted populations. This project will be centered on the following drivers of change:

- Adoption of SWACH’s Transformation Rules of Engagement ensuring consistent guidelines across regional partners
- Implementation of CDSM interventions (or elements specific to setting)
- Provision of support for effective complex care and disease management for targets
- Utilization of RHIP Council & Clinical Integration Taskforce to support interventions

As participants in the Chronic Disease Prevention and Control project, prospective Transformation Partners must decide on 1) the target population(s) they will focus upon, as well as 2) the change strategy they will implement from a list of the Chronic Care Model elements, including:

1. **Systems of care:** promote effective improvement of strategies aimed at comprehensive system change, encourage open and systematic handling of errors, provide incentives based on quality of care, develop agreements that facilitate coordination of care across organizations
2. **Self-management support:** train providers and staff on helping patients with self-management goals, using evidence-based self-management tools, using group visits to support self-management, set and document self-management goals collaboratively with patients, follow-up and monitor self-management goals; seek to break down barriers to utilization of community health workers as part of a treatment team; actively promote evidence-based self-management education for patients as part of whole person care
3. **Delivery system design:** use planned interactions to support evidence-based care, ensure regular follow-up by care team, define roles and tasks of team members, provide clinical case management services for complex patients with coordination
4. **Decision support:** embed evidence-based guidelines into daily clinical practice, integrate specialty expertise in primary care, share evidence-based guidelines and information with patients
5. **Clinical information systems:** provide timely reminders for providers and patients for recommended care, identify relevant subpopulations for proactive care, facilitate individual
patient care planning, share information with patients and providers to coordinate care, monitor performance of practice team

6. **Community Based Resources**: encourage patients to participate in effective community programs for partnerships with community organizations to support and develop interventions that fill gaps in needed services.

In addition to these Chronic Care Model elements, each Transformation Partner can choose optional activities such as implementation of the Stanford Chronic Disease Self-Management Program, Million Hearts Campaign, CDC National Diabetes Prevention Program, and/or partner with Community Paramedicine. Finally, all Transformation Partners will need to identify an HIE/EHR strategy to better coordinate community linkages and will also be required to participate in the SWACH Pathways Community Hub.

Many of our community collaborators have instituted chronic disease management systems and protocols. The Vancouver Clinic, PeaceHealth, Legacy, and Kaiser have “swim lanes,” planned encounters, chronic disease nurse managers and social workers, and preventative care reminder systems in place. The Vancouver Clinic has a dedicated Transition Program which serves complex chronic disease populations to prevent hospital readmission. We will strive to align with these programs.

One of the leading approaches that SWACH will undertake to advance the communities’ work in chronic disease prevention and control is through the implementation of the ACH’s Strategic Improvement (SI) Team. The Southwest Accountable Community of Health is adhering to the principles of science of improvement, shared learning and the building of improvement capabilities through our development of a SI Team that will ensure our regional work is driven by improvement science. The SI Team will coordinate with SWACH’s Chief Information & Technology Officer to ensure population health strategies including HIT/HIE will support our providers that span the spectrum of care beyond the primary care setting.
**Anticipated Target Population**

The Southwest ACH has used a multi-phase process to identify target populations for the Chronic Disease Prevention and Control project. With the help of Providence’s Core team and the SWACH Data and Learning Team (DLT), workgroup and council members were asked to identify populations according to need and potential for impact. Subsequently, the following three criteria were applied to the identified populations to isolate the best-suited target population(s) for the initial Hub pilot:

- **Need:** Does the priority population disproportionately experience poor health outcomes? Are there subgroups within the population that experience disparities? Is there a gap in existing services that could effectively address these outcomes?
- **Impact:** Is there strong potential for the project/intervention to improve outcomes for the population in 2-3 years? Is the priority population large enough for improvements to drive community-wide outcomes?
- **Data feasibility:** What data currently exist to explore the priority population, track outcomes, and evaluate impact?

Because of these assessments and a deep look at regional data, a set of priority populations with multiple chronic care conditions were identified as the target populations for this project, including:

- Adults with diabetes (particularly Type 2)
- Children and adults with obesity
- Adults with hypertension and cardiovascular disease

**Involvement of Partnering Providers**

Partnering providers have been engaged in the development of SWACH’s Chronic Disease Prevention and Control project through extensive community meetings, participation in discussions and decision-making through ACH workgroups and councils, and through direct outreach from ACH leadership to get a deeper understanding of priorities, capacity, and needed resources. The RHIP Council includes both MCO’s in the region (Community Health Plan of Washington and Molina), the FQHC (Sea Mar), representatives from Vancouver Clinic, PeaceHealth, Kaiser, and Legacy, the Clark and Skamania County Departments of Health, diabetes educators, Council for the Homeless of Clark County, the Vancouver Free Clinic, the Area Agency on Aging and Disabilities, Community Voices are Born, and other CBO’s, Clark College, Washington State University, and others. In addition to these broad engagement efforts, a partner inventory survey will be disseminated to further assess interest and capacity among partnering providers.

**Level of Impact**

Through extensive regional partners and organizations serving the cultural, linguistic and geographic diversity across the Southwest ACH, SWACH expects to have significant improvement on performance metrics identified for the Chronic Disease Prevention and Control project area, including a reduction in health disparities. These metrics include:

- Emergency Department Visits per 1,000-member months
- Child and Adolescents’ Access to Primary Care Practitioners
- Comprehensive Diabetes Care: Eye Exam (retinal) performed
- Comprehensive Diabetes Care: HbA1c
• Comprehensive Diabetes Care Medical Attention to Nephropathy
• Inpatient Hospital Utilization
• Statin therapy for patients with cardiovascular disease

Through this project, we anticipate reaching 6000 Medicaid lives.

Social determinants of health drive chronic disease. 20% of the population in Clark County, 52% in Skamania County, and 23% in Klickitat County report food insecurity. According to the 2015 United Ways of the Pacific Northwest ALICE report, (ALICE stands for Asset Limited, Income Constrained, Employed) report, 33% of all households are either in poverty or are ALICE. These are families that are employed but cannot afford basic household expenses such as housing, child care, and health care. By far, the most pressing issue in our region is access to care. SWACH has the highest population-to-provider ration in the state. SWACH’s acquisition of the Healthy Living Collaborative with its mission of policy initiatives and community health workers, its capacity as a convener, its ability to increase HIT/HIE infrastructure in the region, and commitment to upstream health initiatives—all contribute to addressing regional health priorities.

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

Health equity has been a foundational element in Southwest ACH’s chronic disease and prevention project design and planning. To ensure that individuals facing the greatest health disparities inform the assessment of priorities and needed resources in the community, SWACH has focused on engaging multi-sector partners representing the cultural, linguistic, and geographic diversity of Clark, Skamania, and Klickitat County Medicaid members. These representatives have directly informed discussions and decisions regarding the Chronic Care Model selection, identification of target populations, and ACH rules of engagement for the chronic disease prevention and control project.

Rates of cardiovascular disorders are higher in Klickitat and Skamania, while diabetes rates are higher in Clark County. American Indian/Alaska native and Vietnamese-speaking members have higher rates of diabetes. Women across the region have higher rates of depression. Almost a third of SWACH members across the region have a BMI of 30% or above. Access to care in rural and frontier areas (Klickitat and Skamania) presents a health disparity that will require innovation and dedication—and possibly telemedicine and Community Paramedicine.

SWACH’s Community Pathways Hub is expected to be a critically important asset for the successful pursuit of improved health outcomes for individuals at risk for or experiencing chronic disease. Our approach to community-based care coordination through the Pathways Hub Model represents another opportunity for addressing health equity for individuals with chronic disease. For example, the opportunity to leverage and expand the role of community health workers through this evidence-based, community care coordination model will deepen beneficiaries’ access to culturally and linguistically responsive care.

In addition to SWACH’s development of the Chronic Disease and Prevention project, we are also working to deepen our impact on health equity through additional cross-cutting strategies. SWACH has brought in additional grant dollars from United Way, Northwest Health Foundation and leveraged partner organization funds. We have sponsored, and will again, an 8-hour health equity training for all our partners. In addition, SWACH will ensure that:

- Community trainings are available in multiple languages and across diverse cultural and geographical community sites
- A trauma-informed lens is applied to all the project designs (as informed through partnership with the Clark County Health Department which brings deep expertise in this area)
- The Board of Trustees receives intensive training on diversity, equity and inclusion
- An equity lens is applied to ACH policies/procedures/systems (e.g., hiring processes established that enhance diversity and inclusion in the ACH workplace)
- Cultural humility and trauma informed care are incorporated as essential components of the Strategic Improvement Team’s work
- Diverse community partners define the needed resources to strengthen community resilience and that these needs are addressed through SWACH’s Community Resilience Fund.

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

Because of SWACH and partnering provider’s focus chronic disease and prevention through the MTP, the following lasting impacts are expected which will benefit the region’s overall Medicaid population:

- Deepened capacity and expanded skills related to continuous quality improvement
- Expanded infrastructure and resources (workforce, HIT/HIE, VBP contracts) to support system transformation that addresses chronic care prevention and treatment
- Deepened partnerships across health systems and the community, with aligned focus for target populations and improvement efforts
- Community resources that are focused on addressing the health needs of individuals and populations facing the greatest health disparities
- Expansion of capacity through convening universities, medical schools, health care providers and systems, to uncover barriers to recruitment, retention, and the Quadruple Aim
- Provision of workforce development aimed at breaking down professional silos and encouraging use of non-physician members to the limit of their professional scope

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**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:
  o Describe the ACHs general approach to accomplishing requirements.
  o Include resources to be deployed to support partnering providers, anticipated barriers/challenges and ACH tactics for addressing them.
  o Specify which evidence-based approach option(s) will be used for the project.
  o 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**

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

Based on analysis of provider claims data provided by HCA, SWACH is working with partnering providers representing the highest Medicaid billers in each major setting (primary care, mental health/substance abuse, inpatient and ED). Three of the main health systems who care for most Medicaid beneficiaries in the region, Rose, PeaceHealth, and SeaMar, are at some stage of
implementing chronic disease management into their practices. All are interested in participating in the CDM project.

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

In DY2, Q2 2018, SWACH will secure Memoranda of Understanding or Agreement from partnering providers that will include a commitment to SWACH’s Transformation Rules of Engagement and to serving the target Medicaid populations. SWACH’s plan for ongoing Monitoring and Continuous improvement will also provide ongoing oversight of providers to ensure that they are serving Medicaid populations and implementing strategies that are working to reach the desired outcomes for the target Medicaid populations.

**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**

SWACH has established the Clinical Integration Committee to engage a broad spectrum of partnering providers in the identification of regional needs and development of the proposed project to date. It is anticipated that a subgroup of this committee will be formed to examine chronic disease prevention and treatment strategies and setting-specific integration. Our deep partnerships with providers, health systems, community-based organizations and other stakeholders will remain a focus throughout the planning period. Our RHIP Council has broad representation from stakeholders across the region.

SWACH engagement strategies will also ensure that alignment with other efforts in the region and broader engagement with state and local officials is attained.

**How SWACH is leveraging MCO’s expertise in project implementation, and ensuring there is no duplication**

SWACH has been working with MCOs in multiple ways to leverage their expertise, identify areas of alignment, and ensure there is no duplication. MCOs have been active participants across all SWACH councils and workgroups. Through these roles, MCOs have directly informed discussions and decisions pertaining to the Chronic Care Model adoption, identification of target populations, and development of the ACH rules of engagement for chronic disease prevention and control Transformation Partners.

In addition to this intentional and broad engagement, SWACH has met with Molina, and intends to coordinate with Community Health Plan of Washington, and have identified the following opportunities for deepened and coordinated work: 1) assessment and support to expand provider readiness for VBP contracts, 2) optimization of data sharing to inform monitoring and continuous quality improvement, 3) provider support regarding utilization of data to inform quality improvement efforts, 4) provider support regarding adoption of effective strategies to improve patient engagement, and 5) coordination between the Pathways Community Hub and Health Home models to ensure that members needs are being met, duplication is avoided, and value-based payment methodologies are advanced.
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**

**Assets SWACH and regional partnering providers will bring to the project**

Southwest ACH will bring substantial assets and supports for regional advancement of the Chronic Care Model through our upcoming Strategic Improvement Team. The SI Team will support “practice transformation” by utilizing Improvement Advisors to leverage current technical assistance resources, facilitation and capabilities.

The SWACH team brings extensive knowledge about the Pathways Community Hub Model which will be an important foundation and thread for the region’s work to advance chronic disease prevention and control. The ACH has already invested substantial time and financial resources to ensure the successful implementation of the Pathways Hub Model, including early development of the Pathways IT platform, preparation for certification, and approaches to budget forecasting and sustainability.

Clark and Skamania Counties became early adopters of the FIMC project in April of 2016. Our region is positioned to enhance the adoption of chronic care models because we have cleared the important hurdle of integrating financial models of health care purchasing. The region prioritized the clinical integration of services in 2014 and the current work of the ACH will enhance adoption of chronic care disease prevention and treatment by capitalizing on this enhanced provision of services.

The Healthy Living Collaborative, with its policy focus on social determinants of health and its mission of training and supporting the work of community health workers, was acquired by SWACH in October of 2017. The Collaborative has deep relationships with virtually all partners engaged in chronic care in the region. The ACH will be able to leverage this community access, coupled with the DOH and its prevention-focused upstream initiatives related to worksite wellness, community gardens, Veggie RX, housing, and access to affordable health care.

SWACH also has an eager network of behavioral health/substance use disorder providers, community based organizations and emergency medical service providers ready to partner in new ways to support the management of people with chronic disease. Examples of the assets by provider type include:

**Physical Care/Primary Care Providers:**
PeaceHealth, Legacy, SeaMar, and the Vancouver Clinic are interested in participating in this project and will dedicate leadership and staff to ensure success. They all identify critical partnerships with community based organizations, diabetes educators, community and hospital based education services, pharmacies, housing services, and environmental partners. Although Planned Parenthood does not currently provide chronic disease management services, they recognize the key role they could play in delivering preventive care and early identification of chronic conditions to their patients. This is an opportunity for SWACH to broker relationships between partnering providers to better serve PP’s patient base and improve access and equity. There is opportunity to expand these services to other conditions.

**Behavioral Health/Substance Use Disorder Providers:**
Community Services Northwest, Lifeline, Columbia River Mental Health Services, Sea Mar: Interest exists but there is a lack of understanding about the critical link behavioral health and substance use disorder providers play in managing chronic disease. According to the 2001-2003 National Comorbidity Study Replication (NCS-R), more than 68% of adults with a mental illness diagnosed by a structured interview reported a concomitant medical condition. 133 Opportunity exists for SWACH to encourage/incentivize BH/SUD partnership with primary care providers and increase involvement in the chronic disease management project through its Clinical Integration Project, the Opioid Project, and coordination with the Pathways Hub.

**Community-based and Emergency Service Organizations:**
Community Voices Are Born, Planned Parenthood, Area Agency on Aging and Disabilities, Coalition for the Homeless: All are interested in participating but need help building partnerships with clinical partners. Opportunity exists for SWACH to target people with co-occurring behavioral health and chronic disease at syringe exchange, through the Harm Reduction Center of the Clark County Department of Health, and Emergency Medical Services agencies in SWACH. Battleground Fire #3 has indicated interest in piloting a Community Paramedicine model to extend service provision. This project overlaps with SWACH’s care coordination project – the Pathways Hub model. The region will pilot the use of EDIE/PreManage with the three largest BHA’s, beginning in Q4 of 2017. The integration of EDIE/PreManage into the healthcare delivery ecosystem will provide an opportunity across care settings and advance EHR capabilities through real-time interfaces. SWACH’s acquisition of the Healthy Living Collaborative, with its workforce of community health workers, provides an opportunity for delivering self-management strategies and navigation for chronic disease management and prevention.

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

After listening to our Provider Community, one of the biggest barriers to achieving this goal is the uneasiness of payment reform and fatigue from competing improvement concepts and programs. This stems from the lack of a common framework, roadmap, cohesive technical support, and coherent payment models for practice transformation. Additional barriers that have been identified include:

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:

- Stigma: the experience of chronic disease, especially for marginalized populations, presents a challenge for improving their care and requires a coordinated, culturally responsive and trauma-informed approach
- Data sharing and communication: these elements are critical for all aspects of the Chronic Care Model and current infrastructure does not meet the full needs of partnering providers
- Existing workforce skills and capacity are unable to keep up with demand and type of care that is called for. SWACH has the highest ratio of individuals to providers in the state—1510-1.
- The social determinants of health- and coordination of needs outside of the health care delivery system remain foundational elements of achieving improved health of targeted populations and are not reimbursable within traditional financing models. Our community is rent-burdened—50% spend more than 30% of their incomes on housing.
- Lack of integrated services or well- coordinated care
- Poor alignment between incentives and quality measures make sustained attention or deep impact difficult to achieve
- Startup costs for building the technical infrastructure to support integration

SWACH strategy for mitigating the identified risks and overcoming barriers

The design of the Strategic Improvement Team has been carefully crafted to provide the technical assistance, infrastructure, and community expertise needed to address the barriers identified in the community. Specifically, through development of the Strategic Improvement Team, SWACH will launch a learning lab that can begin to identify and address shared barriers and approaches to addressing them. In addition, this team will allow SWACH to leverage (link or develop) the following tools and technical assistance that will be vital for advancing Chronic Disease Prevention and Control:

- Facilitation, Coaching, Training, Consultation
- Accountability
- Performance Technology
- Change Management
- Population Health Management (HIE/HIT)
- Workforce Development strategies
- Contracting / Billing / VBP
- Communication strategies
- Policies and Procedures
- Rules of Engagement deployment
- Self-monitoring and reporting partner
- Convening groups and “matchmaking”
- Emphasis on the Quadruple Aim
• 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

SWACH envisions a project monitoring and continuous improvement infrastructure and process to support achieving the outcomes of the MTP portfolio, coupled with a region-wide system of care, working in tandem to achieve our targeted goals. The process for project monitoring and continuous improvement relies on several core components including: strong infrastructure of timely data, continuous data monitoring and analysis, a Strategic Improvement Team and reporting at multiple levels including providers, community, ACH governance, and HCA reports. Each of these components is described further below. (See Figure 1.)

Figure 1. Process for Monitoring and Continuous Improvement

The data infrastructure to support monitoring and continuous improvement will complement existing data assets (such as the Healthier Washington Data Dashboards) and will build upon “point of care” population health management system inputs needed for projects. Among the incoming data in Figure 1 are the identified data sources associated with 1) pay for reporting (P4R) and pay for performance (P4P) metrics and 2) key data needed for analysis to support program implementation, monitoring, continuous improvement, evaluation/sustainability, and spread. SWACH has contracted with the Center for
Outcomes Research & Education (CORE) at Providence Health & Services to design and run the monitoring system.

**Plan for monitoring project implementation progress, including addressing delays in implementation**

The SWACH monitoring and continuous improvement system will incorporate key process measures and milestones for Chronic Disease Prevention and Control project implementation, as shown in Figure 1. Adjustments to implementation timelines will be triaged through this system and course corrected wherever possible. Implementation progress and status of timelines will be monitored by the ACH with clear lines of communication and accountability between partnering providers, ACH staff, CORE, and our ACH governance body.

If timelines still cannot be met the ACH will communicate a plan back to the state regarding reasons why timelines weren’t met, a plan for adapting the timeline, and preventing/risk mitigation strategies will be shared to other programs where appropriate.

**Plan for monitoring continuous improvement, supporting partnering providers and determining whether SWACH is on track to meet expected outcomes**

The Strategic Improvement Team (SI Team) will drive quality improvement strategies with providers. The SI Team will consist of Improvement Advisors certified by IHI. This team will create and run a unified system of rapid cycle feedback and quality improvement across the organizational partners and to ensure successful progress toward milestones and that outcomes and reporting is done in a timely and quality manner. This system will incorporate a comprehensive shared learning system that follows the best practice of a “plan, do, study, act” (PDSA) continuous quality improvement process.

In addition, the Pathways HUB model and data collection tool using the CCS platform will be explicitly developed to allow for real-time assessment of Pathways outcomes and provide SWACH the opportunity for addressing challenges as they arise. The system will be informed by key planning inputs that better position SWACH to invest in and provide supports to providers and organizations, ensuring they are meeting the goals of each phase. It will be designed with multiple-stakeholder input and clear lines of accountability of key roles/people and ACH governance groups. This system will incorporate tools for data collection and monitoring that are dynamic and flexible, calibrated to effectively meet the needs for each evolving stage of the MTP for each project area.

Participating providers will be required to participate in learning collaboratives convened by SWACH where they will share and benefit from the collective learnings and experiences of their regional peers.

**Plan for addressing strategies that are not working or not achieving outcomes**

The comprehensive shared learning system and PDSA continuous improvement process will support SWACH and our partners to rapidly identify opportunities for course correction and adjusting strategies to meet our targeted outcomes.
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.

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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.

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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**

*Southwest ACH strategy for long-term project sustainability*

SWACH is working closely with partners to build internal capacity and capabilities that will lead to long-term system transformation about chronic disease prevention and control. SWACH is facilitating new linkages between providers and CBOs and expects that these partnerships will become part of the infrastructure and an accepted way of doing business within the Chronic Care Model. In addition, SWACH is working with providers to move from volume to value to transform practices. To do this, SWACH and its Strategic Improvement (SI) Team will utilize a variety of process improvement and change management strategies to support practices to make sustainable change. They also will support providers to help them meet established success measures and outcomes.
The ACH will foster the development of the needed pathways and support the needed tools for providers to operate effectively in a value based payment environment. This effort will be critical to our sustainability efforts. We have been partnering with statewide workgroups regarding state Medicaid codes for Collaborative Care to help finance and sustain integrated care. We are working alongside our managed care partners to leverage the billing and coding work that has developed out of SB 5779 along with developments for new billing codes in rural health clinics and FQHCs. Through an aligned strategy with the health plans and scaling successful integration models, by the end of the demonstration our region will be well positioned to provide effective clinically integrated care, and provide the scaffolding for chronic disease prevention and treatment.

SWACH’s Community Resilience Fund is a key sustainability strategy. During the MTP, SWACH will build the vision, strategy, partnerships, and capacity necessary to spearhead this initiative. The Fund will focus on regional, community-led initiatives aimed at strengthening resilience through social determinant investments and key policies and system changes for overall population health. The Community Resilience Fund will deepen and strengthen existing investments as well as provide a model for future investments, one that builds off SWACH’s infrastructure and vision and is adaptive to the changing landscape.

Chronic conditions account for 75% of the nation’s aggregate health care spending. Poor coordination of care often involves multiple providers and organizations with no single entity coordinating care. “Patients with highly fragmented care experienced more than twice as many PCP visits as those with better care coordination. They visited specialists six times as often and were also more likely to visit more primary care providers than their peers.” Coordination through community health workers and the Pathways hub could provide cost savings over the long term which could sustain the chronic disease prevention and treatment initiative. HIT/HIE infrastructure and memoranda of understanding among providers could provide real-time monitoring that could lead to reduced cost and improved outcomes. Community commitment through the Healthy Living Collaborative to upstream health initiatives like community gardens, workplace wellness, and walkable, safe streets could lead to chronic disease prevention and amelioration of its effects.

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

Through our work, SWACH is seeking not to solely fund projects, but to build a model for our region to create a healthier community. We see promise in an approach that starts with the Medicaid program, and spreads to Medicare and to the commercial market. We expect that our deep collaboration with providers, CBOs and other stakeholders will lead to transformation and set a standard for the health landscape in our region and our state.

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134 [www.cdc.gov/chronicdisease/overview/index/htm](http://www.cdc.gov/chronicdisease/overview/index/htm)
### SUPPLEMENTARY MATERIALS CHECKLIST

#### SECTION I: ACH-LEVEL

<table>
<thead>
<tr>
<th><strong>Regional Health Needs Inventory</strong></th>
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<tbody>
<tr>
<td><strong>ACH Theory of Action and Alignment Strategy</strong></td>
<td></td>
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<tr>
<td>☒ 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.</td>
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<tr>
<td><strong>Governance</strong></td>
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<tr>
<td>☒ Attachment(s): Visual/chart of the governance structure</td>
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<tr>
<td><strong>Community and Stakeholder Engagement and Input</strong></td>
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<tr>
<td>☒ Attachment(s): Evidence of how the ACH solicited robust public input into project selection and planning</td>
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<tr>
<td><strong>Tribal Engagement and Collaboration</strong></td>
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<tr>
<td>☐ Optional Attachment(s): Statements of support for the ACH from ITUs in the ACH region</td>
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<td><strong>Funds Allocation</strong></td>
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<td>☒ Supplemental Data Workbook: Funds Distribution Tabs</td>
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<td><strong>Required Health Systems and Community Capacity (Domain I) Focus Areas for all ACHs</strong></td>
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<td><strong>SECTION II: PROJECT-LEVEL</strong></td>
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<td><strong>Project Selection &amp; Expected Outcomes</strong></td>
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<td><strong>Implementation Approach and Timing</strong></td>
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<td>☒ Supplemental Data Workbook: Implementation Approach Tabs</td>
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Achieve Whole Person Health For SWACH Medicaid Lives utilizing the Quadruple Aim

Types of metrics will include:
- Appropriate utilization of services: emergency department, inpatient, and primary care utilization
- Experience and quality of care
- Timely access to care
- Health outcomes
- Chronic disease
- Social determinants of health
- Per capita and total cost of care

### Strategy 1: Quadruple Aim

<table>
<thead>
<tr>
<th>Strategic Aim</th>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
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| Partnership with Consumers, Community & Providers | Bi-Directional Integration | Implement strategies ensuring ongoing input from consumers, community & providers
| Care Coordination for Populations | Chronic Disease Management for Populations | Implement strategies/models for provider practice improvement & economic alignment with value-based payment standards
| Opioid Interventions | Social Determinants of Health | Develop & manage care coordination Pathways HUB to support regional efforts

#### Big Dot Metrics

- Implement CHW and CHAPS Network
- Utilize Regional Health Improvement Plan Council
- Utilize Clinical Integration Workgroup
- Utilize Opioid Workgroup
- Utilize Community Care Coordination Workgroup
- Utilize Data & Learning Team
- Conduct partner/provider inventory & interviews for portfolio development
- Deep engagement for the implementation design phase
- Develop survey tools for testing & feedback loop
- Track patient satisfaction and care coordination
- Engender trust of the community and amplify the voices of those most impacted

- Implement strategies ensuring ongoing input from consumers, community & providers
- Utilize CHW and CHAPS Network
- Utilize Regional Health Improvement Plan Council
- Utilize Clinical Integration Workgroup
- Utilize Opioid Workgroup
- Utilize Community Care Coordination Workgroup
- Utilize Data & Learning Team
- Conduct partner / provider inventory & interviews for portfolio development
- Deep engagement for the implementation design phase
- Develop survey tools for testing & feedback loop
- Track patient satisfaction and care coordination
- Engender trust of the community and amplify the voices of those most impacted

- Implement strategies/models for provider practice improvement & economic alignment with value-based payment standards
- Support provider champions & engagement through improvement science
- Adopt Transformation Rules of Engagement ensuring consistent guidelines across regional partners
- Build model to include ED/Acute Care, Addiction Medicine, Post Acute Care, EMS, Law Enforcement & Justice Diversion, Care Coordination & MCO/Payer elements
- Adhere to Collaborative Care Model/enhanced collaboration/Bree Collaborative models
- Advance workforce development strategies
- Manage transitions across the care continuum
- Implement oral health strategies within required processes

- Adopt Transformation Rules of Engagement ensuring consistent guidelines across partners
- Implement CDSM interventions
- Provide support for effective complex care and disease management for target populations
- Utilize CHWs, CHAPS network and Clinical Integration Workgroup to support interventions
- Implement diversion strategies within required processes

- Implement Opioid Prescribing Guidelines
- Increase access Medication Assisted Therapy (MAT)/ Naloxone
- Utilize Community Care Coordination (Pathways HUB) for target populations
- Utilize Opioid Workgroup for multi-sector engagement
- Utilize transitions of care for target populations (i.e. skin & soft tissue infections)
- Implement strategies/models for provider practice & economic alignment with value-based payment standards
- Promote Prescription drug Monitoring Program (PMP)
- Explore intersection of diversion and opioid strategies e.g. paramedicine post OD/wound care
- Increase access to peer support

- Implement strategies to address social determinants of health (i.e. housing, transportation, food security, financial health, jail diversion, workforce development, education)
- Educate on communication and connectivity with and throughout the system
Enhance Experience, Quality & Value for Health Improvement

Continuous Process Improvement
- Adopt strategic improvement operations and methodologies
- Establish disciplined reporting standards
- Deploy various process improvement processes and methodologies
- Serve as Improvement advisors to support providers
- Secure & connect practice facilitators to providers to support change

Workforce Development
- Care of the Provider: reducing fatigue; Joy in Work, Champions
- Dignity and Respect in daily work
- Conduct workforce needs analysis
- Partner with state & local level subject matter experts to ensure alignment
- Support interventions that reduce burnout and increase effectiveness of providers and supporting workforce
- Provider satisfaction survey
- Advance workforce development strategies for clinicians and providers
- Advance workforce development strategies for CHWs & paraprofessionals

Value-Based Payments
- Support the advancement of health care reimbursement strategies away from volume of service to paying for quality and outcomes.
- Support the providers so they transition from volume to value in their practices by securing resources to support change and gaps
- Integrate the science of improvement with providers to ensure they have processes in place to support their contracts
- Partner with state & local level subject matter experts to ensure alignment

Population Health Management
- Map and connect data through HIE/HIT to manage the care continuum
- Utilize & connect CCS, EHR, and IT solutions
- Partner with state & local level subject matter experts to ensure alignment
- Map and connect data through HIE to manage the care continuum
- Consistent communication and connectivity for improved delivery of care
- Aligning with state HIE/HIT plan and encourage regional participation in state solution
- Develop a HIE/HIT regional Task Force led by CITO

Integrated Data Support
- Develop data analytic tools and models to identify and stratify high risk populations; measure results
- Map and connect data through HIE to manage the care continuum
- Educate on communication and connectivity
- Contracting with CORE to support data and analytics needs
- Utilize the Data & Learning Team to ensure development and connectivity throughout model

Evaluation
- Evaluate the impact of regional transformation efforts
- Contract with CORE to evaluate regional transformation efforts
**Strategy 2: Shared Learning & Continuous Quality Improvement**

### Strategic Aim

- **Value**
  - Shared Learning, Continuous Improvement, & Community Resiliency

### Big Dot Metrics

- Establish Science of Improvement Learning Lab by X date
- Prepare Strategic Improvement team by X date
- Establish system for seeking and securing braided funding to support social determinants of health investments by X date
- Establish strategic linkages between funding and Community Resiliency Fund by X date
- X of learning collaborative learning sessions
- X of partners engaged in shared learning

### Primary Drivers

- Science of Improvement: Build Capacity and Capability
- Learning & Shared Decision Making

### Secondary Drivers

- Launch Learning Lab through Strategic Improvement Team
- Leverage (link or develop) Tools and Technical Assistance support:
  - Science of Improvement
  - Facilitation, Coaching, Training, Consultation
  - Accountability Preparation
  - Strategic Improvement / Quality Improvement activities
  - Performance Technology
  - Change Management
  - Project Management
  - Population Health Management (HIE/HIT)
  - Workforce Development strategies
  - Contracting / Billing / VBP
  - Communication strategies
  - Support “Care of the Provider”
  - Policies and Procedures
  - Rules of Engagement deployment
  - Self-monitoring and reporting
  - Pay for reporting tools and capabilities (worksheet and electronic reporting questionnaire/survey with metrics and definitions)
  - PDSA, Lean, Six Sigma, Kaizen
  - Regular reporting monthly, quarterly and annual basis

- Build awareness of community, consumer and provider needs
- Address needs with innovative solutions to support partners
- Embrace and share Community Values
- Enhance communication and connections
- Define expectations to support change
- Identify policy challenges and barriers to impact change
- Address & impact social determinants of health
- Braid and leverage funding to improve health and economic stability in region
- Utilize workgroups, RHIP Council, Data & Learning Team, Board Committees and Board
- Host regular collaborative learning sessions, grand rounds and community forums
- Education, training and systems change methodology for regional improvement
Governance Structure

SW ACH Board

- Executive Committee
- Incentives & Investments Committee*
- Finance Committee
- CEO
- Staff
- RHIP Council

- Quality & Continuous Improvement Committee*
- HIT/HIE Task Force*
- Clinical Integration Committee
- Community Care Coordination Workgroup
- Opioid Workgroup
- Behavioral Health Advisory Board
- HLC Committee
- HLC Policy Committee

*To be seated Q1 2018
SWACH Community Engagement Meeting

Date/Time: October 23 5:00-7:00

Audience: Peers, people on Medicaid, or people that work closely with people on Medicaid

Draft Agenda
Welcome and Introductions

Overview/Purpose of Meeting

- Welcome and thank you (Who is the Accountable Community of Health, Opportunity for feedback on Project plans in small group sessions, next steps) First time we have done a community listening session. We are excited to try this out and of course always open to feedback to make it better. Welcome translator:

- Who is the ACH The Accountable Community of Health is dedicated to improving the health of people in Clark, Skamania, and Klickitat counties by decreasing health disparities, improving the efficiency of health care delivery, and empowering individuals and their communities through partnerships. Ensuring that community members are getting the right care at the right place is important to SW ACH. There are many needs in the community and SWACH wants to partner with you to address all of them.

- Focus on the proposed Transformation Projects that can be addressed through the Medicaid Waiver funding.

- To describe the proposed Transformation Projects – and the ways in which they could be important for the community. 6 areas focusing on 5 today

- We realize we will be talking about sensitive topics today, so we ask that you take care of yourself in these conversations. There is no need to disclose personal information or experiences. We will be asking about your family, friends, neighbors or people you work with. Provide an example of what this may look like. Specific feedback on what is working or not is important but take care of yourself. We can ensure people will not share what you share so please take care of yourself.

- Explain break out groups: 2 choices each.

- We also want your feedback on how you or your community might want to be involved in providing feedback and recommendations in the future

- Please sign up if you want to receive on going feedback from us.
Project #1: Integration of Physical and Mental/Behavioral Health and Care Coordination – No wrong door for Care and better communication between doctors and patients

- Set the Scene/What’s the problem:
  - Through a whole-person approach to care, address physical and behavioral health needs in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need.
    - Access to needed care and services is a big problem.
    - Define integration and care coordination. – Better Coordination and communication
    - Describe why should community members care about integration? Anyone getting multiple types of care, lack of communication.
    - Use an example to describe integration: When you feel like every professional is taking care of a different part of your health and no one is talking to one another. So you have to go over the same things a thousand times. For example a counselor or mental health provider would know about your diabetes, and a doc would know about your addiction history.
    - Improve access to care and patient’s care experience by better coordinating care between different provider types

- Potential Questions:
  - Tell me about a time when you, a friend or a family member, or person you are working with could not access the care they/you needed.
  - Tell me about a time when you or someone you know/support could access the care you needed.
  - What is happening when you have a good appointment with your doctor or therapist?
  - What stands between you or the people you support in getting the care you/they need?
  - Would it be helpful if you doctor and mental health and substance providers were communicating more?
  - How would better care coordination help:
    - What would successful care coordination look like?
    - You or a loved one access needed care?
    - Someone that you were working with?

Project #2: Chronic Disease Management and Prevention – Supporting people with conditions related to their heart, like high blood pressure, high cholesterol – too many fats in the blood. Or other conditions like diabetes and obesity.

- Set the Scene/What’s the problem:
  - Coordinated and available services for those living with diabetes, high cholesterol, high blood pressure, and obesity is key to improving community health

- Potential Questions:
  - Where do you, your family or friends currently go to get information on health issues/chronic diseases?
    - Where do people you work with currently go?
Who do you typically talk to about your or your loved ones’ chronic diseases [insert specific diseases]? Probe around doctors, peers, dietitians, etc.

- Who do people you work with typically talk to about chronic diseases?

Have you ever attended any meetings, classes, or workshops on specific chronic disease management and prevention (such as a diabetes prevention program)? If so, which ones? Who hosted them?

- Has anyone that you worked with attended meeting, classes, or workshops on specific chronic disease management and prevention?

Are there any community programs or organizations that you connect with about chronic diseases? If so, what are they and did it work?

- How could information on these diseases be more accessible?

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**Project #3: Opioid - Prevention, Treatment, Overdose Prevention and Recovery supports**

- **Set the Scene/What’s the problem:**
  - People in our communities and across the nation are struggling with addiction to opioids, both prescription narcotics and drugs attained illegally.
  - One of the ways doctors and other medical providers have been told to do is to limit what illnesses narcotics can be prescribed for, how much an be prescribed and for how long.

- **Potential Questions:**
  - How have opioids impacted you, your family members or your neighbors?
  - From your perspective, what does help look like for someone who is struggling with opioid addiction? To a drug that has been prescribed to them? To drugs they get illegally? Is this any different for people who are injecting narcotics?
  - How can the health care system better support those who need opioids such as support with pain management?
  - How can the health care system better support those who are addicted to opioids or in recovery?
  - Are there any community programs that could better support the prevention of opioid misuse and addiction?
  - Are there specific community programs or organizations addressing this problem?
  - What are your experiences about the resources available to help someone struggling with addiction?

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**Project #4: ER Transitions of Care – Reduce avoidable hospital use and ensure people are getting the right care in the right place.**

- **Set the Scene/What’s the problem:**
Ensuring that community members are getting the right care at the right place is important to us; this is even more important when people are transitioning out of the hospital (and jail) back home. First we will talk about ER then Jails.

- Potential Questions:
  - Did you or other people you know go to the Emergency room because you can’t get care in other places? If so how often does this happen?
  - What would ensure successful recovery after a hospital stay for you, loved one, or community member? Or someone that you work with?
  - What resources or information should be provided to someone who is getting out of the hospital?
  - What types of support or follow up should be available for people when they leave the hospital?
  - How can the community better support recently discharged (or released) people?
  - Are there specific community programs or organizations addressing this problem?

Project #4a Jail Transitions of Care – Transition from Jail to community successfully

Okay we have thought about how to support people who are leaving the hospital, now let’s look at people who are being released from jail.

- What types of support or follow up should be available for people being released from jail?
- What resources or information should be provided to someone as they are being released from jail?
- How can the community better support recently released from jail?
- Are there specific community programs or organizations addressing this problem?

Project #5: ER Diversion – Only people who need the Emergency Room are using iter – Right Care Right Time

- Set the Scene/What’s the problem:
  - Promote use of and access to primary care (regular doctor visits) and social services
  - Make sure people are getting the best care possible for their illness. That means only people who need emergency medicine come to the Emergency Room.
  - Promote use of community paramedics (community EMTs who are assigned to follow up with patients after hospital discharge/prevent remittance)

- Potential Questions:
  - Typically, when would you or a loved one go to the emergency room for care?
    - When would someone that you work with go to the emergency room?
  - Typically, where would a community member go if they had an immediate health need arise?
  - How can the doctors and hospitals better promote the use of primary care (or community paramedicine programs) for non-emergency situations?
o Are there supports in the community that could help with this issue?
  o Are there specific community programs or organizations addressing this problem?
  o What are programs support for people that may otherwise end up in jail?

Closing:

What worked and didn’t work?

How would you like to be involved in the future?

Explain different models of engagement.

Sign up for our email list to stay connected.
Community Listening Session on Medicaid Transformation Project
October 23, 2017
YWCA Clark County Community Room

Thank you for participating in the Accountable Community of Health’s Community Listening Session on the Medicaid Transformation Project. Here is a summary of what we learned during the listening session. This information will be shared with the Accountable Community of Health staff, work groups, committees, and boards, so we can better meet the needs of our community.

**Transitional Care**

Successful Pieces needed for transition
- A plan – need to know what’s going to happen, who to report to, etc.
- Housing, safe place to transition to => HUGE
- Understanding the basic needs to be met to break cycle of using hospital/jail for those needs
- Safety
- Lack of Isolation
- Transportation – ability to follow plan provided needs access to transportation
- Means to pay for medication/transportation/child care
- Communication => clear information in your 1st language – cannot comply if they don’t understand conditions/information
  - Means to communicate (e.g. phone)

Support/Follow up
- Timely access to medication and services
- What do you do between discharge and follow up if there is a long wait list
- Case management/check-in system especially for those without built-in support
- Network/Communication between Portland/Oregon and Washington
- Others in community to help/check-in

Jail
- Better Connection/no wait time to get medical/substance abuse treatment needed
- Housing
- Work center/restitution system – step by step reentry to society
- Crisis Intervention Team (CIT) Officers
- Oxford House and Second Step
- Specialty Court – help provide case management support
- Employment resources
  - Expungement system not as good as it could be, stigma follows => landlords and employers – creates barriers
  - Second Chance opportunities, drop the box on applications
- Young people get trapped in cycle
Hospitals
- Additional supports for single moms and families with higher needs
- Longer term follow-up – not just one touch/one week
- Community Health Workers
- Peer support, sobering van

**Diversion**
- Lack of resources for those under 18
- Access to care, to primary care and mental health care
- 24-hour triage center
  - Safe place, centralized resources, integrated services, appropriate location (i.e. near to those who need it but not next to jail)
- Convening service providers to provide input/services
- Mobile resources, mobile kids’ crisis (Beacon)
- Where can people go now if they need services: CVAB, NAMI, YWCA, ER, jail, parks, crisis centers – 1601 E. 4th plain
- Peer support better than Community Health Worker (CHW) to provide help – appropriate/safe/empathetic help
- Help in teams, understanding who to send
- Trauma informed support
- Alternatives for severe mental health crisis to prevent 911 calls as solution when loved one refuses medical/hospital care
  - Knowing/sharing information across systems
  - Definition of crisis outside narrow definition of law
  - Appropriate response
    - Proactive education, wellness plan/advance directive on file with 911 – preemptive plan
- Early intervention
  - Community outreach
  - Designated Mental Health Professional
  - Sheena’s Law - allows officers responding to a threat of suicide to refer the person to a designated mental health professional. That mental health professional can determine whether the person needs more intensive intervention, including involuntary commitment.
  - Joel’s Law - allows a person’s immediate family member, legal guardian, or conservator to petition the superior court for initial detention under certain conditions
  - Ricky’s Law - allows someone to be involuntarily committed for substance abuse treatment if they are at risk of harming themselves
- Systems and Data bases need to talk to each other – linked resources
- Share, Portland Union Gospel Mission and various other shelters, winter hospitality centers
- Bring services to jail – care and education and resources
  - Incentives to participate in voluntary education services that are already in place
• Resources for youth
  o Wrap around support to preemptively address gaps and help kids transition to adulthood
  o Mentoring
  o Ending the silence – NAMI program
  o Parents and Teachers as allies

Opioids

How have opioids impacted you, family, community?
• Stigma has impacts not only on person using opioids but the family.
• People are dying in the community from overdoses
  o Impact on the kids
  o Trauma for the family with few support systems in place
  o Concern over family members/friends getting help for addicted person as they do not want to be seen as a “snitch”; would rather maintain silence than “out” a friend or family member in need

What does help for someone struggling with opioid addiction look like?
• No wrong door – referrals need to happen anywhere and everywhere in the community.
• Need for electronic health records to reduce abuse of drug seeking behaviors.
• Need for family support and education on withdrawal symptoms/behaviors.
• Stigma behind drug use that causes a withholding of information to providers or other people trying to help; will avoid regular medical visits out of fear

Discussion regarding health providers/clinics reducing number of opioid prescriptions and dosage of current prescriptions without providing additional education/support for those impacted by the change
• Education on proper prescription use and alternative therapies is key to avoid confusion, potential addiction, and/or seeking illegal resources to manage pain

Integration
• There are better outcomes with integration, but some people do not like Behavioral Health talking to Physical Health.
• DSHS clients have inconsistent experiences with staff based on race or ethnicity of client. Appears there is no quality control or enforcement of services provided by DSHS staff from office management.
• Transitional care as individuals age-out of services or programs can cause a lapse in care and produce harmful outcomes.
• Lack of case managers is a problem. People need a lot of support to navigate systems. They often need someone to be alongside them every step of the way or they get overwhelmed, frustrated.
• Not enough providers and therapists of color.
• Need to have culture and context specific interventions available to the Medicaid population—people of color “clam up” with providers from the dominant culture
• Mental health medications are very hard to get. Long waits- sometime people never get the medications because they get tired of waiting.
• Observation that people in the community who don’t get mental health care self-medicate with alcohol and drugs.
• Some people will actually offend so that they can go to jail and get services.
• May not be great for a client if they don’t want behavioral health description/diagnosis on their physical health record.
• There is a lack of information or accurate information. For example, “when I call for services, often numbers do not work. Referral sheets are not kept up to date.”
• PeaceHealth does not turn anyone away. Even Hispanic population with documentation in process. PeaceHealth will help you. They say, “we have funding to cover you.” I refer people to PeaceHealth.
• Issue with people not being poor enough to get Medicaid, but not making enough to afford insurance, so they do without health care. There are lots of people falling through the cracks.
• There are times when it would be very helpful for physical health providers to talk with mental health providers. It would help with providing more appropriate medications and treatment plans.
• Problems accessing the care they need—language barrier prominent. Not having information in multiple languages and accessible can cause people not to get care that is available/appropriate to them.
• Concern that integration could lead to more people tracking all the details of your life, which can feel uncomfortable and controlling.
• Good story about access—Kids have seen same Medicaid provider since he delivered them—“he helped raise my kids.” Provider going to graduation of child.

What does access look like in our community?
• Delay in receiving a timely referral unless you present behavior at time of appointment.
• Referrals to specialists seem to happen quickly if someone acts out.
• Sometimes doctors don’t want to give a referral to a specialist. If they don’t give a referral I tell people to go to urgent care to get a second opinion.
• Access- and opioids- policy is that clinics are now drug testing you. It makes you feel uncomfortable- you are seeking help for conditions but being treated like you are drug seeking- treated with suspicion- makes people stop going to get care- this is not helping the process.
• Providers are not great about treating people as humans.
• Not feeling heard or listened to as a person of color
• Hard to get a call back from a doctor. Even if you are a care coordinator.
• It helps to have emergency slots in primary care
• In Portland there is a lot of peer mentoring- peers assist with doctor appointments, dentists, making sure they are supported every step of the way. Have people going alongside other people. Would like to see more supports like this.
• Customer service representative with my insurance was very helpful in identifying available providers who specialize in my condition, and I was able to find a perfect provider for myself.
• Problem with integration- if a person who has legitimate pain, but has been flagged previously for addiction- then the doctor does not prescribe medication.
• Doctors don’t know that much about addiction. They need to understand addiction better.
• Patient’s job is to advocate for themselves - 15-minute appointment is too short. Advocating for longer appointments would help everyone.
• Recovery is a process that involves all areas- all these issues overlap and all need to be addressed to get healthy.
• Having a doctor involved with recovery of Substance Use Disorders helps- because then the discussion is about what this is doing to your liver, not just- don’t do it or you will go to jail.

**Chronic Disease**

Where do you, your family or friends currently go to get information on health issues/chronic disease?

- Dr. office
- Internet – not always reliable source
- Family – reference to similar situations with in family and their experiences, sometimes home remedies suggested – but definitely a strong connection and seen as a trusted source
- Television – drug commercials that contribute to questioning if you have some of these symptoms that you don’t have something serious

What problems have you seen with getting information on Chronic Diseases?

- Language barriers – communication going beyond the basics (beliefs that one dose of medication will cure a chronic condition)
- Lack of convenient affordable care – too much work or money to continue with ongoing appointments
- Working with a manageable solution – example: telling someone to cut out all carbs rather than working with them to make healthy choices.

Who do you typically talk to about your or your loved ones’ chronic diseases?

- Doctor – but question if doctor really pays attention to family history as far as guiding toward preventing similar conditions
- Parents
- Community Leaders
- Community Health Workers
- Need to make connections with people who are knowledgeable about the particular condition to guide behavior in the right direction
- Need more personalized support for areas such as diet change, address ethnic challenges
- Example of doctor giving recommended diet change for daughter – all the recommendations are processed foods, would rather have more information regarding better options to build healthier eating habits

Have you ever attended any meetings, classes or workshops on specific chronic disease management and prevention?
• Feeling that commercial insurance covers more options for this, but limited options for Medicaid recipients
• WIC
• Nurse Family Network
• School has nutrition class
• Adverse result of recent school lunch restrictions – to make sure that schools are varying amount of salt used, etc., have moved from making food from scratch to purchasing prepacked foods – don’t feel like this is good option
• Concern of timing of meals at schools (sometimes lunch is served at 10:30, 11 am) results in kids turning to junk food after school as they are starving by the time they leave school

Feedback on Future Community Engagement Work
Input regarding the meanings behind the Medicaid Transformation Project work, and the pros and cons of today’s session

What worked?
• Talking with people who I didn’t know. It felt safe and comfortable
• Facilitators did a good job
• Awesome questions were asked
• Very diverse, a lot of information, given from different perspectives
• Broke bread then talked (became family then talked)
• Liked that time was set – kept things moving
• Enjoyed listening to everyone’s experiences

What didn’t work?
• Ask more partners to come, more time, go deeper
• In flyer – I was not sure what it was, more clarity
• More opportunities to do this again
• More sessions – wanted and opportunity to go to every session not just two

What does community engagement look like?
• More voices, broad, not a small advisory board
• Ombudsman community involvement
• I’d be encouraged if know people who make binding decision would hear what was said
• Record conversations at each table
• Communicate with broader public
  o Mailing lists
  o Include rural providers
Action From Your Input
Your input from this listening session, including your feedback on the process will be shared with groups and committees working on the Medicaid Transformation Project Plans.

Here are a few highlights that are already impacting the Medicaid Transformation Project Plans:

- We heard the overwhelming need provide more culturally specific services
- The success and need of more peers/CHWs in providing support, referral and connection
- The identification of community organization and places where individuals and families receive help (this information both provided confirmation and helped to identify new “leads”)
- Reaffirmed that the number of providers is a concern, not only is access an issue but that our region’s need may be overwhelming to the existing number of providers. This is a big gap and a primary focus that the ACH needs to provide support in.
- Identified need for more information from a specialized source on chronic condition(s). This is very helpful for the chronic care section of our project plans
- Language barriers prohibit people from getting or properly utilizing care (e.g., thinking one dose of a pill will cure disease.)
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<td>Behavioral Health Advisory Board</td>
<td>10/27/17</td>
<td>Key Informant Interviews SD and MD.</td>
</tr>
<tr>
<td>08/15/17</td>
<td>Behavioral Health Advisory Board</td>
<td>11/09/17</td>
<td>Skamania Klickitat Community Network</td>
</tr>
<tr>
<td>09/19/17</td>
<td>Behavioral Health Advisory Board</td>
<td></td>
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<tr>
<td>10/17/17</td>
<td>Behavioral Health Advisory Board</td>
<td></td>
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<tr>
<td>11/04/17</td>
<td>Behavioral Health Advisory Board</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SW ACH Board of Trustees Meeting  
Thursday, August 17, 2017  
9:00 am – 12:00 pm  
Clark College  
500 Broadway Street, Room 214, Vancouver, WA  
The second floor is accessible from the top floor of the parking garage.

**Teleconference Information:**  
Thu, August 17, 2017 9:00 AM - 12:00 PM PDT  
Please join my meeting from your computer, tablet or smartphone.  
https://global.gotomeeting.com/join/174853325  
You can also dial in using your phone.  
United States: +1 (571) 317-3122  
Access Code: 174-853-325

**MEETING AGENDA**  
(Revised)

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 – 9:10</td>
<td>1st Public Comment Period</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>9:10 – 9:15 Welcome and Attendance</td>
<td>Jon</td>
</tr>
<tr>
<td>2</td>
<td>9:15 – 9:20 Consent Agenda &lt;br&gt;July 20 Minutes</td>
<td>Jon</td>
</tr>
<tr>
<td>3</td>
<td>9:25 – 9:30 Confirmation of Preliminary Budget for Certification Phase II</td>
<td>Jon</td>
</tr>
<tr>
<td>4</td>
<td>9:30 – 9:40 Update on Klickitat County – Mid-Adopter</td>
<td>Dawn</td>
</tr>
<tr>
<td>5</td>
<td>9:40 – 9:50 Review of Tracking Dashboard for August</td>
<td>Dawn</td>
</tr>
<tr>
<td>6</td>
<td>9:50 – 10:30 Demonstration Project Approach – Framework – Part II</td>
<td>Dawn/All</td>
</tr>
<tr>
<td>7</td>
<td>10:30 – 10:50 Review of Maxims 2 and 3 &lt;br&gt;“Navigating the Boardroom” by Dennis D. Pointer.</td>
<td>Jon</td>
</tr>
<tr>
<td>10:50 – 11:00</td>
<td>2nd Public Comment Period</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>11:00 – 11:15 Good of the Order</td>
<td>All</td>
</tr>
</tbody>
</table>

*Red indicates Action Items*
SW ACH Board of Trustees Meeting  
Thursday, September 21, 2017  
9:00 am – 10:30 am  

Clark College  
500 Broadway Street, Room 214, Vancouver, WA  
The second floor is accessible from the top floor of the parking garage.  

**Teleconference Information:**  

Please join my meeting from your computer, tablet or smartphone.  
[https://global.gotomeeting.com/join/802875701](https://global.gotomeeting.com/join/802875701)  
You can also dial in using your phone.  
United States: +1 (872) 240-3412  
Access Code: 802-875-701  

**MEETING AGENDA**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Chair</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 – 9:10</td>
<td>1st Public Comment Period</td>
<td></td>
</tr>
<tr>
<td>1 9:10 – 9:15</td>
<td>Welcome and Attendance</td>
<td>Jon</td>
</tr>
</tbody>
</table>
| 2 9:15 – 9:20 | General Business  
Approve August 17, 2017 Minutes                                       | Jon    |
| 3 9:20 – 9:30 | Design Funds Disbursement                                              | Jon    |
| 4 9:30 – 9:40 | Financial Narrative                                                    | Janice |
| 5 9:40 – 9:45 | Board Member Terms                                                     | Jon    |
| 6 9:45 – 10:15 | Updates  
1. Certification Phase 2 – approved for full $5M  
2. Klickitat has received an extension of time to commit to Mid-adopter status for FIMC. Decision due November 1, 2017.  
3. Demonstration Planning Timeline October 2017 – March 2018  
4. October Board Meeting:  
   a. Budget for Design Funds and balance of fiscal year 2017/18  
   b. Project Plan Approval  
5. November Board Meeting:  
   a. Community Resiliency Fund Governance  
   b. Capacity Building Fund Governance | Dawn   |
<table>
<thead>
<tr>
<th></th>
<th>Time</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>10:15 – 10:25</td>
<td>2\textsuperscript{nd} Public Comment Period</td>
</tr>
<tr>
<td>8</td>
<td>10:25 – 10:30</td>
<td>Good of the Order</td>
</tr>
</tbody>
</table>

*Items in Red Indicate Action Items*
Data & Learning Team – Charter

Purpose

The Data & Learning Team develops data capacities and strategies to ensure that the SW Accountable Community of Health (SW ACH) and its partners can learn, plan, and act collectively to achieve shared goals.

The Data & Learning Team will support SW ACH’s Regional Health Improvement Planning, needs assessment, project selection, measure selection, program implementation, self-monitoring, reporting, and evaluation efforts.

The Data & Learning Team provides data, analytic, and shared learning support to SW ACH’s governance committees, projects, and initiatives, including Community Connections.

Governance

The Data & Learning Team will be led by the SW ACH Executive Director, and will provide recommendations and guidance to the Regional Health Improvement Plan Council, as well as to SW ACH staff.

The Data & Learning Team will be jointly staffed by SW ACH and Providence Center for Outcomes Research & Education (CORE).

The Data & Learning Team will select a chair and co-chair from its membership to help set agendas, facilitate meetings, and ensure overall coordination with SW ACH leadership and other workgroups.
Key Responsibilities

The Data & Learning Team will be responsible for the following:

- Reviewing data to inform SW ACH’s Regional Health Improvement Planning and project selection under the Medicaid Transformation Demonstration;
- Identifying data and analytic needs and capacity to support SW ACH transformation projects, initiatives, policies, and decisions;
- Informing community data infrastructure, collection, analysis, and dissemination decisions for SW ACH projects and initiatives, including Community Connections;
- Collaboratively developing reporting strategies and processes for continuous learning and improvement;
- Monitoring compliance with pertinent data security and privacy regulations as needed;
- Identifying and facilitating reporting of shared outcomes and process measures;
- Facilitating data sharing across partners; and
- Interpreting and translating data and results.

Guiding Principles

The Data & Learning Team will:

- Encourage data-driven decision making among all SW ACH partners;
- Value data that identifies health inequities among SW ACH region residents;
- Promote collaborative, collective processes to collect and analyze data from multiple organizations and sectors;
- Support efforts to use cross-sector data to better understand populations and priorities, including Community Connections;
- Value data integrity and agree to uphold all data standards, privacy laws, and human subject protections as applicable; and
- Support the goals of the triple aim of health care reform and the Healthier Washington initiative, including the Medicaid Transformation Demonstration Project.

[Decision making process TBD]

Membership

The Data & Learning Team will represent various perspectives from health services (e.g., public health, health care providers, payers, consumers, behavioral health organizations, and community-based health organizations), as well as community and other sector perspectives (e.g., housing, education, social services, criminal justice, transportation, food security, and others).

The Data & Learning Team will include at least one representative from the following:

- Medicaid managed care organizations serving the region
- Health care providers practicing within the region
- Health systems and hospitals operating within the region
- Behavioral health organizations serving the region
County public health departments
- Community-based health organizations
- Washington State Health Care Authority
- Multi-sector organizations, such as housing, education, criminal justice, and social service

The Data & Learning Team will have regular members, with ad hoc members joining as needed to provide input for specific discussion or issues. Members will be appointed by the SW ACH Executive Director.

Members of the Data & Learning Team must be willing to work as a team and within their communities to support SW ACH goals. Members should also have:

- Knowledge of and experience with their organization’s or sector’s data, priorities and goals
- Knowledge of and experience with process and outcome measures, measurement strategies
- Content expertise in one or more of the following areas:
  - Health care or public health data
  - Analysis, measurement, and reporting
  - Data infrastructure development
  - Evaluation and self-monitoring
  - Data sharing and privacy regulations
  - Best practices for shared learning

Meetings

Frequency
The Data & Learning Team will meet monthly for several hours. The DLT may meet more frequently if needed to meet timelines and produce deliverables in the short-term.

Members may be asked to contribute additional time or participate in ad hoc working groups related to specific initiatives or issues, which will meet at varying frequencies.

Members may be asked to work outside of meetings within their organizations to provide data, reports, other analytic capabilities, and/or feedback to support SW ACH’s goals.

Location
Meetings will be held in SW ACH region; locations will vary. Meetings will have a call-in and webinar option for remote participation, although in-person participation is encouraged.
Data and Learning Team
Meeting #6 Agenda

Date & Time: October 5, 2017, 11:30 am – 1 pm
In person: SWACH Office, 2404 E Mill Plain Suite 2, Vancouver or
By webinar: [https://global.gotomeeting.com/join/510917181](https://global.gotomeeting.com/join/510917181) | 1.872.240.3212 access code 510917181

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
<th>Presenter</th>
<th>Materials</th>
</tr>
</thead>
</table>
| 3 min | Welcome and Introductions  
*Recap Meeting #5*                                                               | Kassi Miller       | Meeting #5 notes           |
| 15 min| Update on Project Planning  
Review SWACH current thinking around project selection and project strategies – set stage | Sarah Bartelmann  
Kassi Miller | 2 pager summary               |
| 60 min| Priority Populations for Other Projects  
DLT has reviewed priority population options and made recommendations for Pathways / Care Coordination, but also needs to inform population selection for other project areas. | Sarah Bartelmann   | Slide deck                  |
| 10 min| DLT Workplan  
Review upcoming meeting topics and asks for the DLT.                          | Kassi Miller       | Draft workplan             |
| 2 min | Wrap Up / Next Steps                                                        | Kassi Miller       |                            |
Welcome & Introductions

Agenda Review

Goals for Today’s Meeting:
Understand SWACH’s project selection and emerging strategies
Discuss priority populations for other project areas (not Pathways)
Review upcoming topics for future DLT meetings
ACH Updates

• SWACH scored 95.5 / 100 on its Phase II Certification!

<table>
<thead>
<tr>
<th>ACH Phase 2 Certification Score Color Continuum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate</td>
</tr>
<tr>
<td>Better Health Together</td>
</tr>
<tr>
<td>Cascade Pacific Action Alliance</td>
</tr>
<tr>
<td>Greater Columbia ACH</td>
</tr>
<tr>
<td>King County ACH</td>
</tr>
<tr>
<td>North Central ACH</td>
</tr>
<tr>
<td>North Sound ACH</td>
</tr>
<tr>
<td>Olympic Community of Health</td>
</tr>
<tr>
<td>Pierce County ACH</td>
</tr>
<tr>
<td>Southwest ACH</td>
</tr>
</tbody>
</table>

| Theory of Action and Alignment Strategy         |
| Standardized Improvement                         |
| Governance and Organizational Structure         |
| Tribal Engagement and Collaboration             |
| Community and Stakeholder Engagement           |
| Budget and Funds Flow                           |
| Clinical Capacity and Engagement                |
| Data and Analytic Capacity                      |
| Transformation Project Planning                 |

• Workgroup updates
Update on Project Planning
Projects Selected

RHIP Council voted on September 19th to proceed with 6 projects (instead of 8) with the expectation that strategies and work from the two remaining projects will be incorporated (where possible) into the 6 selected projects.

<table>
<thead>
<tr>
<th>Projects Selected</th>
<th>Projects Not Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Integration (required)</td>
<td>• Maternal, Child, and Reproductive Health</td>
</tr>
<tr>
<td>• Care Coordination (Pathways)</td>
<td>• Oral Health</td>
</tr>
<tr>
<td>• Diversion</td>
<td></td>
</tr>
<tr>
<td>• Transitions of Care</td>
<td></td>
</tr>
<tr>
<td>• Opioids (required)</td>
<td></td>
</tr>
<tr>
<td>• Chronic Disease Prevention and Control</td>
<td></td>
</tr>
</tbody>
</table>
Priority Populations for Non-Pathways Projects
Priority Populations

• SWACH must indicate preliminary thinking around priority populations for each project as part of the Project Plan, due Nov 16th.

• Final selection of priority populations not required until Q2 2018.

• HCA has suggested populations for each project as part of the toolkit – starting place for our review / regional customization.
Today

• Review HCA suggested populations, workgroup feedback, and staff recommendations for priority populations for 5 remaining projects.

• Review populations that are part of performance measures.

• Review data where available to inform discussion.

• Consider:
  • Do these recommendations align with your understanding of regional needs?
  • Are we missing any critical populations?
## INTEGRATION

<table>
<thead>
<tr>
<th>HCA TARGET POPULATION</th>
<th>All Medicaid beneficiaries (children and adults), particularly those at risk for behavioral health conditions, including mental illness and/or substance use disorder.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SWACH proposed target population</td>
<td>All Medicaid beneficiaries.</td>
</tr>
</tbody>
</table>
# INTEGRATION: Metrics

<table>
<thead>
<tr>
<th>Performance Metrics</th>
<th>Target Population (Denominator)</th>
<th>Target Population (Numerator)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressant Medication Management</td>
<td>Medicaid adults with a diagnosis of major depression who were newly treated with antidepressant medication</td>
<td>Who remained on their medication for at least 12 weeks; and remained on for at least 6 months.</td>
</tr>
<tr>
<td>Child and Adolescents’ Access to Primary Care Practitioners</td>
<td>Medicaid members ages 12 mo. – 19 years</td>
<td>Who had a visit with a primary care provider (for any reason)</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Eye Exam (retinal) performed</td>
<td>Medicaid adults (ages 18-75) with diabetes</td>
<td>Who had a retinal or dilated eye exam</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: HbA1c testing</td>
<td>Medicaid adults (ages 18-75) with diabetes</td>
<td>Who had their blood sugar tested</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Medical Attention for Nephropathy</td>
<td>Medicaid adults (ages 18-75) with diabetes</td>
<td>Who had a nephropathy screening test</td>
</tr>
<tr>
<td>Depression Screening and Follow-up for Adolescents and Adults</td>
<td>Medicaid members (ages 12+) who had an outpatient visit</td>
<td>Who were screened for clinical depression with a standardized tool AND if positive, received follow up care</td>
</tr>
<tr>
<td>Emergency Department Visits per 1,000 member months (broad)</td>
<td>All Medicaid members</td>
<td>Who had an ED visit for any reason</td>
</tr>
</tbody>
</table>
# INTEGRATION: Metrics

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<td>Follow-up After Discharge from ED for Alcohol or Other Drug Dependence (FOA)</td>
<td>Medicaid members with ED visit with primary dx of alcohol or other drug dependence</td>
<td>Who had an outpatient visit for the same dx within 7 or within 30 days of discharge</td>
</tr>
<tr>
<td>Follow-up After Discharge from ED for Mental Health (FUM)</td>
<td>Medicaid members with ED visit with primary dx of mental health</td>
<td>Who had an outpatient visit for the same dx within 7 or within 30 days of discharge</td>
</tr>
<tr>
<td>Follow-up After Hospitalization for Mental Illness (FUH)</td>
<td>Medicaid members (ages 6+) with an acute inpatient stay for mental health dx</td>
<td>Who had an outpatient visit within 7 or within 30 days of discharge</td>
</tr>
<tr>
<td>Inpatient Hospital Utilization</td>
<td>Medicaid adults with acute inpatient stays</td>
<td>Ratio of observed to expected stays</td>
</tr>
<tr>
<td>Measure in development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Management for People with Asthma (5 – 64 Years)</td>
<td>Medicaid members ages 5-64 with persistent asthma who received medication</td>
<td>Who remained on their medication during the treatment period</td>
</tr>
<tr>
<td>Mental Health Treatment Penetration</td>
<td>All Medicaid members with a mental health service need</td>
<td>Who had any mental health service</td>
</tr>
<tr>
<td>Plan All-Cause Readmission Rate (30 Days)</td>
<td>Medicaid adults with an acute inpatient stay</td>
<td>Who were readmitted within 30 days</td>
</tr>
<tr>
<td>Substance Use Disorder Treatment Penetration</td>
<td>All Medicaid members with a substance use disorder treatment need</td>
<td>Who had any substance use disorder treatment service</td>
</tr>
</tbody>
</table>
All Medicaid Beneficiaries

SWACH region represents approximately 132,000 Medicaid members.

Total enrollment from May 2017 enrollment reports; age breakouts from Sept 2016 Health Washington Data Dashboard
At Risk for Behavioral Health Conditions

Almost **30,000 Medicaid members** in SWACH have been diagnosed with mental illness.

9.3% of SWACH members have substance use disorder treatment need, compared to 11.2% statewide.

And 6.7% have co-occurring substance use disorder and mental illness, compared to 7.7% statewide.

# TRANSITIONAL CARE

<table>
<thead>
<tr>
<th>HCA TARGET POPULATION</th>
<th>Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including beneficiaries discharged from acute care to home, or to supportive housing, and beneficiaries with SMI discharged from inpatient care, or clients returning to the community from prison or jail.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SWACH proposed target population</td>
<td></td>
</tr>
</tbody>
</table>
## TRANSITIONAL CARE: Metrics

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<tr>
<td><em>Measure in development</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Department Visits per 1,000 member months (broad)</td>
<td>All Medicaid members</td>
<td>Who had an ED visit for any reason</td>
</tr>
<tr>
<td>Percent Homeless (Narrow Definition)</td>
<td>All Medicaid members</td>
<td>Who were homeless at least one month</td>
</tr>
<tr>
<td>Plan All-Cause Readmission Rate (30 Days)</td>
<td>Medicaid adults with an acute inpatient stay</td>
<td>Who were readmitted within 30 days</td>
</tr>
</tbody>
</table>
How many people are discharged from hospitals in the SWACH region?

<table>
<thead>
<tr>
<th>Facility</th>
<th>Number of Discharges (Medicaid) (2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legacy Salmon Creek</td>
<td>4,373</td>
</tr>
<tr>
<td>PeaceHealth SW Medical Center</td>
<td>4,337</td>
</tr>
<tr>
<td>Includes psych and rehab discharges</td>
<td></td>
</tr>
<tr>
<td>Klickitat Valley</td>
<td>90</td>
</tr>
<tr>
<td>Skyline</td>
<td>20</td>
</tr>
</tbody>
</table>

2016 CHARS Standard Reporting, DOH
How many people are discharged from jails in the SWACH region?

Skamania County Booking graph:

Skamania County generally releases the same number they book.

Clark County bookings graph:

Number of bookings released from Clark County jail by year:
Includes release by death, transfers to other agencies / prison.
What about people with SMI?

SWACH Medicaid members who were more likely to be discharged from the hospital and then readmitted within 30 days (for any reason) include:

- Adults age 25-34
- Hispanic and Native Hawaiian / Pacific Islander adults
- Disabled adults
- Adults with any mental health need
- Adults with severe mental illness
- Adults with SUD treatment need
- Adults with co-occurring mental illness / SUD
<table>
<thead>
<tr>
<th>DIVERSION</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>HCA TARGET POPULATION</th>
<th>Medicaid beneficiaries presenting at the ED for non-acute conditions, or who access the EMS system for a non-emergency condition, and beneficiaries with a mental health and/or substance use condition coming into contact with law enforcement.</th>
</tr>
</thead>
</table>
| SWACH proposed target population | Medicaid beneficiaries:  
• recently discharged from inpatient hospitalizations  
• With multiple ED visits  
• With multiple 911 calls  
• With multiple conditions (physical, mental, and substance use diagnoses)  

*Potential interest in focusing on aging adults (55+) – is this group primarily duals?*
## DIVERSION: Metrics

<table>
<thead>
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<th>Target Population (Numerator)</th>
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<td>All Medicaid members</td>
<td>Who had an ED visit for any reason</td>
</tr>
<tr>
<td>Percent Homeless (Narrow Definition)</td>
<td>All Medicaid members</td>
<td>Who were homeless at least one month</td>
</tr>
<tr>
<td>Percent Arrested</td>
<td>All Medicaid members</td>
<td>Who were arrested at least once</td>
</tr>
</tbody>
</table>
Medicaid members with multiple ED visits

SWACH Medicaid members who were more likely to have 3 or more ED visits in a year include:

- American Indian / Alaska Native adults
- Black adults
- Disabled adults
- Adults with any mental health need (2x as likely)
- Adults with severe mental illness (2.5x as likely)
- Adults with SUD treatment need (3.5x as likely)
- Adults with co-occurring mental illness / SUD (4.5x as likely)
Potentially preventable ED visits

Potentially avoidable ED visits are higher for:

- Women (18%)
- Hispanic (18%)
- Asian (18%)
- NH/PI (20%)
- Multiracial (21%)
- Spanish speaking (21%)
- Other language (24%)
## SWACH Co-Occurring Conditions

<table>
<thead>
<tr>
<th>Condition Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUD only</td>
<td>2.8%</td>
</tr>
<tr>
<td>SUD and 1 chronic condition</td>
<td>2.3%</td>
</tr>
<tr>
<td>SUD and 1+ chronic condition</td>
<td>4.6%</td>
</tr>
<tr>
<td>MH only</td>
<td>8.1%</td>
</tr>
<tr>
<td>MH and 1 chronic condition</td>
<td>6.1%</td>
</tr>
<tr>
<td>MH and 1+ chronic condition</td>
<td>9.3%</td>
</tr>
<tr>
<td><strong>SUD and MH only</strong></td>
<td>1.2%</td>
</tr>
<tr>
<td>SUD, MH and 1 chronic condition</td>
<td>1.1%</td>
</tr>
<tr>
<td>SUD, MH and 1+ chronic condition</td>
<td>3.3%</td>
</tr>
<tr>
<td><strong>SUD or MH only</strong></td>
<td>9.7%</td>
</tr>
<tr>
<td>SUD or MH and 1 chronic condition</td>
<td>7.1%</td>
</tr>
<tr>
<td>SUD or MH and 1+ chronic condition</td>
<td>10.6%</td>
</tr>
<tr>
<td><strong>1 chronic condition only</strong></td>
<td>15.5%</td>
</tr>
<tr>
<td>1+ chronic condition only</td>
<td>8.7%</td>
</tr>
</tbody>
</table>

As of June 2016, <4% of the SWACH Medicaid population had SUD, mental health, and at least one chronic condition.
Focus on Older Adults

As of August 2017, there were approximately 3,650 partial duals in the SWACH region (<3% of total)
# OPIOIDS

<table>
<thead>
<tr>
<th>HCA TARGET POPULATION</th>
<th>Medicaid beneficiaries, including youth, who use, misuse, or abuse prescription opioids and/or heroin.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SWACH proposed target population</td>
<td>Medicaid beneficiaries who use opioids, particularly those with opioid use disorder (OUD) who are not receiving Medication Assisted Treatment (MAT)</td>
</tr>
</tbody>
</table>
# OPIOIDS: Metrics

<table>
<thead>
<tr>
<th>Performance Metrics</th>
<th>Target Population (Denominator)</th>
<th>Target Population (Numerator)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department Visits per 1,000 member months (broad)</td>
<td>All Medicaid members</td>
<td>Who had an ED visit for any reason</td>
</tr>
<tr>
<td>Inpatient Hospital Utilization <em>Measure in development</em></td>
<td>Medicaid adults with acute inpatient stays</td>
<td>Ratio of observed to expected stays</td>
</tr>
<tr>
<td>Medication Assisted Therapy: with Buprenorphine or Methadone</td>
<td>Medicaid adults with an opioid use disorder diagnosis</td>
<td>Who received MAT with buprenorphine or methadone</td>
</tr>
<tr>
<td>Substance Use Disorder Treatment Penetration (Opioids) <em>Measure in development</em></td>
<td>Medicaid members with a diagnosis of opioid use disorder who have a substance use service need</td>
<td>Who received at least one qualifying service</td>
</tr>
<tr>
<td>Patients on high dose chronic opioid therapy by varying thresholds <em>Measure in development</em></td>
<td>“chronic opioid therapy patients”</td>
<td>Receiving &gt;50 MED or &gt;90 MED doses in a given quarter</td>
</tr>
<tr>
<td>Patients with concurrent sedatives prescriptions <em>Measure in development</em></td>
<td>“chronic opioid therapy patients”</td>
<td>With more than 45 days of sedative hypnotics, benzodiazepines, carisoprodol, barbiturates dispensed in a given quarter</td>
</tr>
</tbody>
</table>
All Opioid Users

Approximately **14,000** Medicaid opioid users in SWACH (11% of all Medicaid members)

Of those...

- **87%** have no cancer diagnosis
- **20%** are heavy opioid users
- **18%** are chronic opioid users

**Medicaid opioid users in the region are...**

- **76%** are non-Hispanic, white
- **22.5%** are ages 40-49
- **18.2%** are ages 30-39
- **63%** are female

*Regional Health Needs Inventory data, fiscal year 2016, provided by HCA*
Those with an Opioid Use Disorder Dx

Approximately **2,200 Medicaid members** with a diagnosis history of opioid abuse / dependence in the past two years (16% of all opioid users)

**Regional Health Needs Inventory data, fiscal year 2016, provided by HCA**
Those with OUD not receiving MAT

Of the 2,200 Medicaid members with a diagnosis history of opioid abuse / dependence in the past two years, approximately 1,786 (81%) are not receiving MAT.

• 174 receiving MAT with Buprenorphine

• 242 receiving MAT with Methadone
## CHRONIC DISEASE

<table>
<thead>
<tr>
<th>HCA TARGET POPULATION</th>
<th>Medicaid beneficiaries (adults and children) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke, with a focus on those populations experiencing the greatest burden of chronic disease in the region.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SWACH proposed target population</td>
<td>Medicaid beneficiaries including adults with diabetes, adults with obesity, and adults with cardiovascular disease.</td>
</tr>
</tbody>
</table>
### CHRONIC DISEASE: Metrics

<table>
<thead>
<tr>
<th>Performance Metrics</th>
<th>Target Population (Denominator)</th>
<th>Target Population (Numerator)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department Visits per 1,000 member months (broad)</td>
<td>All Medicaid members</td>
<td>Who had an ED visit for any reason</td>
</tr>
<tr>
<td>Child and Adolescents’ Access to Primary Care Practitioners</td>
<td>Medicaid members ages 12 mo. – 19 years</td>
<td>Who had a visit with a primary care provider (for any reason)</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Eye Exam (retinal) performed</td>
<td>Medicaid adults (ages 18-75) with diabetes</td>
<td>Who had a retinal or dilated eye exam</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: HbA1c testing</td>
<td>Medicaid adults (ages 18-75) with diabetes</td>
<td>Who had their blood sugar tested</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Medical Attention for Nephropathy</td>
<td>Medicaid adults (ages 18-75) with diabetes</td>
<td>Who had a nephropathy screening test</td>
</tr>
<tr>
<td>Inpatient Hospital Utilization</td>
<td>Medicaid adults with acute inpatient stays</td>
<td>Ratio of observed to expected stays</td>
</tr>
<tr>
<td>Medication Management for People with Asthma (5 – 64 Years)</td>
<td>Medicaid members ages 5-64 with persistent asthma who received medication</td>
<td>Who remained on their medication during the treatment period</td>
</tr>
<tr>
<td>Statin therapy for patients with cardiovascular disease</td>
<td>Male Medicaid members (ages 21-75) and female Medicaid members (ages 40-75) who have clinical ASCVD</td>
<td>Who were dispensed at least one high- or moderate- intensity statin</td>
</tr>
</tbody>
</table>
Adults with Chronic Conditions

Percent of SWACH adult members with chronic disease diagnoses, June 2016

Behavioral Health and Chronic Conditions, HCA September 29, 2017. Data for adults ages 70+ suppressed due to small numbers
Adults with Diabetes & Metabolic Diagnoses

Percent of SWACH adult members with diabetes and metabolic diagnoses, June 2016

- Clark
  - Diabetes: 3.5%
  - Metabolic: 4.8%

- Skamania
  - Diabetes: 3.7%
  - Metabolic: 6.2%

- Klickitat
  - Diabetes: 3.4%
  - Metabolic: 5.2%

- Female
  - Diabetes: 3.8%
  - Metabolic: 4.7%

- Male
  - Diabetes: 3.4%
  - Metabolic: 5.2%

- White, non-Hispanic
  - Diabetes: 3.9%
  - Metabolic: 5.2%

- Hispanic
  - Diabetes: 2.4%
  - Metabolic: 4.0%

- Co-occurring MH
  - Diabetes: 7.6%
  - Metabolic: 10.0%

- Co-occurring SUD
  - Diabetes: 8.0%
  - Metabolic: 14.6%
Upcoming DLT Activities
Anticipated Topics in the Next 6 Months

- Developing current state assessment tools (Nov – Dec 2017)
- Supporting Implementation Plans (due Q2 2018)
- Finalizing priority populations for all projects (due Q2 2018)
- Identifying quality improvement plan metrics
- Informing monitoring system

What else?
Questions?

Contact Kassi.Miller@southwestach.org

More information online at:

Data and Learning Team Meeting #6 Notes

**Date & Time:** October 5th, 2017; 11:30 am – 1:00 pm  
**Location:** SW ACH Office 2404 E Mill Plain Suite 2 Vancouver, remote option cancelled due to audio issues.  
**In attendance:** Kassi Miller, Sarah Bartelmann, Kathleen Lovgren, Alan Melnick, Roxanne Wolfe, Megan McAninch Jones, Jan Wichert (Dialed in but could not participate due to webinar/call cancellation: Laurel Lee, Kelly Utz, Jennifer Lule, Jesse Gelwicks, Kat Ferguson-Mahan Latet)

**Notes**

Due to the webinar being cancelled, the meeting contents were truncated to discuss only priority populations for the 5 selected projects (excluding Care Coordination/Pathways) to ensure no incorrect assumptions are being made by the ACH.

**Priority Populations**

SWACH must indicate preliminary thinking around priority populations for each selected project area as part of the Project Plan, due November 16, 2017. The Data & Learning Team reviewed proposed priority populations from SWACH staff, based on the HCA population notes from the Toolkit, as well as available data to inform any modifications to the proposed populations for inclusion in the Project Plan. Final selection of priority populations will happen by Q2 2018.

| **Clinical Integration** | HCA target population: All Medicaid beneficiaries (children and adults), particularly those at risk for behavioral health conditions, including mental illness and/or substance use disorder.  
SWACH proposed target population: All Medicaid beneficiaries.  
Discussion:  
• What does ‘at risk for behavioral health conditions’ mean?  
  o Request for clarification pending  
• Possible concerns with ‘at risk’ population:  
  o Possibly not feasible, such a large population might be ‘at risk’ (solution: focus on those already diagnosed)  
  o Screening might not reveal true ‘at risk’ (e.g. no recognized screening for anxiety disorder, just a referral system)  
• Are there specific behavioral health conditions we should focus on?  
  o Look at 3+ ED visits data from HCA to check for alignment  
  o Consider ED visits by conditions to further refine this population  
Revised population: All Medicaid beneficiaries, with a specific focus on those who have been diagnosed with behavioral health conditions (specific BH conditions TBD based on review of high utilizer data). |
| **Transitional Care** | **HCA target population:** Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including beneficiaries discharged from acute care to home, or to supportive housing, and beneficiaries with SMI discharged from inpatient care, or clients returning to the community from prison or jail.

**SWACH proposed target population:**

**Discussion:**
- Clarification on slides made during meeting:
  - Slides 14, 18 - SMI: Severe mental illness
  - Slide 16 data include dual-counting (e.g. one patient could be discharged multiple times)
- Group suggested that individuals discharged multiple times per year would be higher-risk and therefore easier population to focus on
- What does ‘transition from jail’ really mean?
  - Getting Medicaid members back into the community
  - Note that there are already a lot of programs that focus on this (e.g. discharge planning), we would conceivably work with these groups, don’t want to duplicate efforts
- Specific populations we might consider?
  - Those at highest risk of being incarcerated (or re-incarcerated) – those with SUD and BH at release from incarceration
  - Keep in mind these populations will likely have overlap with Opiate project (discussed later)
  - Focus on younger adults?

Revised population: Medicaid beneficiaries in transition from intensive settings of care or institutional settings or prison/jail, in particular those individuals with multiple hospital discharges in a year, and those with substance use disorder or behavioral health conditions.

| **Diversion** | **HCA target population:** Medicaid beneficiaries presenting at the ED for non-acute conditions, or who access the EMS system for a non-emergency condition, and beneficiaries with a mental health and/or substance use condition coming into contact with law enforcement.

**SWACH proposed population:** Medicaid beneficiaries who were: recently discharged from inpatient hospitalizations; with multiple ED visits; with multiple 911 calls; and/or with multiple conditions (physical, mental, and substance use).

**SWACH has a potential interest in focusing on older adults (55+), but has questions about whether this group is primarily duals (who are not included in ACH pay for performance metrics).**

**Discussion:**
- Slide 20 population definitions refer to last 12 month period, not lifetime (e.g. homeless for at least one month in the last 12 months)
- Other groups/programs we might partner with? |
| **Opioids** | HCA target population: Medicaid beneficiaries, including youth, who use, misuse, or abuse prescription opioids and/or heroin.  

SWACH proposed population: Medicaid beneficiaries who use opioids, particularly those with opioid use disorder (OUD) who are not receiving Medication Assisted Treatment (MAT).  

Discussion:  
- Note that slides 27 – 29 are only prescription opioids  
- Group would like to know why ACH is not focusing on heroin and fentanyl  
  - Performance metrics are based only on prescription opioid use, which drives ACH focus  

Revised population: no changes to population, however Data & Learning Team identified several potential process metrics that will be needed for implementation monitoring, including provider use of the Prescription Monitoring Program (PMP), naloxone prescribing, and ED visits for overdoses. |
| **Chronic Disease** | HCA target population: Medicaid beneficiaries (adults and children) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke, with a focus on those populations experiencing the greatest burden of chronic disease in the region. |
SWACH proposed population: Medicaid beneficiaries including adults with diabetes, adults with obesity, and adults with cardiovascular disease.

Discussion:
- Group would like to know if the broad diagnosis category ‘cardiovascular disease’ includes hypertension and hyperlipidemia
- Questions around whether ACH is considering COPD/asthma as part of the adults with chronic conditions population
- Specific populations for consideration?
  - ACH will cross reference chronic disease diagnoses (slide 32) across ED use + BRFSS data supplied by public health to ensure we are not missing any potential populations
  - Hypertension is one of the main drivers of ED use at Providence, needs assessment to be shared with DLT

Revised population: Medicaid beneficiaries including adults with diabetes, adults with obesity, and adults with cardiovascular disease (including hypertension and hyperlipidemia) (pending final review of ED utilization and BRFSS data to ensure no other chronic conditions with high regional burden are being left out).

Kassi re-iterated the coming plans for the ACH, with the most crucial piece of the MTDP being the project plan due November 16th.

**Next meeting scheduled for November 2, 2017.**
This document provides a high level summary of SWACH’s current thinking around the Project Portfolio. Selecting the projects is just the initial phase and SWACH will continue to engage with partners to refine approaches and develop more detailed implementation plans in coming months.

### PROJECT PORTFOLIO

<table>
<thead>
<tr>
<th>INTEGRATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
<td>Through a whole-person approach to care, address physical and behavioral health needs in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need.</td>
</tr>
<tr>
<td><strong>Target Population</strong></td>
<td>All Medicaid beneficiaries</td>
</tr>
<tr>
<td><strong>Key Strategies</strong></td>
<td>SWACH will be working to integrate behavioral health into physical health, and physical health into behavioral health at the clinic level.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CARE COORDINATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
<td>Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.</td>
</tr>
<tr>
<td><strong>Target Population</strong></td>
<td>Populations of interest include pregnant women and beneficiaries experiencing multiple conditions (e.g., members have physical health diagnosis AND mental health diagnosis AND substance use diagnosis).</td>
</tr>
<tr>
<td><strong>Key Strategies</strong></td>
<td>SWACH will be implementing Pathways and establishing a Community HUB.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRANSITIONAL CARE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
<td>Reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.</td>
</tr>
<tr>
<td><strong>Target Population</strong></td>
<td><strong>Beneficiaries in transition from intensive settings of care or institutional settings, including those discharged from acute care to home, or to supportive housing, and beneficiaries with SMI discharged from inpatient care or from jail.</strong></td>
</tr>
</tbody>
</table>
### Key Strategies

SWACH will be focusing on improving transitions of care from acute settings (e.g., hospitals) and from jails, building upon current community work and partnership models.

## DIVERSION

<table>
<thead>
<tr>
<th>Objective</th>
<th>Promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Population</strong></td>
<td>Medicaid beneficiaries recently discharged from inpatient hospitalizations, with multiple ED visits, with multiple 911 calls, and/or with multiple conditions (physical, mental, and substance use diagnoses).</td>
</tr>
<tr>
<td><strong>Key Strategies</strong></td>
<td>SWACH will be focusing on diversion from the Emergency Department, and diversion from jails. Strategies will include Community Paramedicine, potentially with a rural focus, and building on existing work with county sheriff’s departments and local police departments.</td>
</tr>
</tbody>
</table>

## OPIOIDS

<table>
<thead>
<tr>
<th>Objective</th>
<th>Reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Population</strong></td>
<td>Medicaid beneficiaries who use opioids, particularly those with opioid use disorder (OUD) who are not receiving Medication Assisted Treatment.</td>
</tr>
</tbody>
</table>
| **Key Strategies** | SWACH will be focusing on the following four strategies:  
(1) Prevention: Promoting use of best practices among health care providers prescribing opioids.  
(2) Treatment: Expanding access to, and utilization of, clinically-appropriate evidence based practices for opioid use disorder treatment in communities, particularly medication assisted treatment (MAT).  
(3) Overdose Prevention: Increasing distribution of Naloxone.  
(4) Recovery: Enhancing / developing or supporting the provision of peer and other recovery support service designed to improve treatment access and retention and support long-term recovery to include connections to social services and social determinants of health. |

## CHRONIC DISEASE PREVENTION AND CONTROL

<table>
<thead>
<tr>
<th>Objective</th>
<th>Integrate health system and community approaches to improve chronic disease management and control.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Population</strong></td>
<td>Populations of interest include adults with diabetes, adults with obesity, and adults with cardiovascular disease.</td>
</tr>
<tr>
<td><strong>Key Strategies</strong></td>
<td>SWACH intends to work with providers to support the implementation of elements of the Chronic Care Model. SWACH will prioritize clinical flexibility within the structure of the models and project planning with mindfulness regarding multi-payer clinical settings.</td>
</tr>
</tbody>
</table>
SWACH will work with community partners to build on self-management resources (such as the Stanford Chronic Disease Self-Management Program, and National Diabetes Prevention Program), including developing stronger peer supports within existing models, and exploring potential opportunities for Community Paramedicine. SWACH will also coordinate with local public health departments on chronic disease prevention strategies.
## SWACH Data & Learning Team Roster

*as of November 2017*

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alan Melnick</td>
<td>Clark County Public Health</td>
</tr>
<tr>
<td>Allen Esaacson</td>
<td>Skamania County Public Health</td>
</tr>
<tr>
<td>Andy Silver</td>
<td>Council for the Homeless</td>
</tr>
<tr>
<td>Corey Cerise</td>
<td>Molina</td>
</tr>
<tr>
<td>Dale Whitley</td>
<td>Council for the Homeless</td>
</tr>
<tr>
<td>Jan Wichert</td>
<td>Vancouver Housing Authority</td>
</tr>
<tr>
<td>Jesse Gelwicks</td>
<td>Kaiser</td>
</tr>
<tr>
<td>Kat Latet</td>
<td>CHPW</td>
</tr>
<tr>
<td>Kathleen Lovgren</td>
<td>Clark County Public Health</td>
</tr>
<tr>
<td>Kelly Utz</td>
<td>Beacon Health</td>
</tr>
<tr>
<td>Laurel Lee</td>
<td>Molina</td>
</tr>
<tr>
<td>Megan McAninch-Jones</td>
<td>Providence</td>
</tr>
<tr>
<td>Megan Winn</td>
<td>Klickitat County Public Health</td>
</tr>
<tr>
<td>Melanie Green</td>
<td>Evergreen Public Schools</td>
</tr>
<tr>
<td>Randy Tangen</td>
<td>Clark County Sheriff’s Office</td>
</tr>
<tr>
<td>Roxanne Wolfe</td>
<td>Clark County Public Health</td>
</tr>
<tr>
<td>Shanda Diehl</td>
<td>Clark College</td>
</tr>
<tr>
<td>Tamara Shoup</td>
<td>Vancouver School District</td>
</tr>
</tbody>
</table>

**Staff**

- Kassi Miller
- Sarah Bartelmann
APPENDIX – PROVIDERS

The table below lists the physical health providers and behavioral health providers that saw at least 500 Medicaid beneficiaries in 2016, based on provider billing for professional services. Member counts are not de-duplicated (i.e., a member that had a visit with both PeaceHealth and Legacy), nor do they reflect members who were empaneled with providers.

<table>
<thead>
<tr>
<th>Physical Health Providers</th>
<th># of SWACH Medicaid beneficiaries seen in 2016</th>
<th>Behavioral Health Providers</th>
<th># of SWACH Medicaid beneficiaries seen in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>PeaceHealth</td>
<td>34,313</td>
<td>Community Services NW</td>
<td>4,962</td>
</tr>
<tr>
<td>Heart &amp; Vascular and lab excluded</td>
<td></td>
<td>PeaceHealth*</td>
<td>2,820</td>
</tr>
<tr>
<td>Vancouver Clinic</td>
<td>28,956</td>
<td>Lifeline</td>
<td>2,681</td>
</tr>
<tr>
<td>SeaMar</td>
<td>19,994</td>
<td>Rehabilitation, SUD</td>
<td>2,681</td>
</tr>
<tr>
<td>Legacy Salmon Creek</td>
<td>8,662</td>
<td>Family Solutions</td>
<td>2,339</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multi-specialty group</td>
<td></td>
</tr>
<tr>
<td>Rose</td>
<td>6,298</td>
<td>SeaMar*</td>
<td>1,904</td>
</tr>
<tr>
<td>Child &amp; Adolescent</td>
<td>6,196</td>
<td>Children’s Center</td>
<td>1,787</td>
</tr>
<tr>
<td>Legacy (clinics, Emanuel, Good Sam)</td>
<td>4,756</td>
<td>Central Washington Comp.</td>
<td>1,525</td>
</tr>
<tr>
<td>Oncology, lab, DME excluded</td>
<td></td>
<td>Residential Treatment Facility</td>
<td></td>
</tr>
<tr>
<td>NorthShore</td>
<td>4,647</td>
<td>Clark County Crisis Services</td>
<td>727</td>
</tr>
<tr>
<td>Klickitat Valley Health</td>
<td>3,698</td>
<td>Central Washington Comp</td>
<td>673</td>
</tr>
<tr>
<td>Excluding EMS</td>
<td></td>
<td>Mental Health Center</td>
<td></td>
</tr>
<tr>
<td>Evergreen Pediatrics</td>
<td>3,374</td>
<td>Skamania County Community Health</td>
<td>616</td>
</tr>
<tr>
<td>Providence</td>
<td>2,418</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart clinic, neurology, psychiatry, lab, and DME excluded</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Lab excluded^63</td>
<td>1,331</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hudsons Bay</td>
<td>1,036</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One Community Health</td>
<td>790</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

62 Physical health beneficiary volume based on 2016 professional claims (in both office and hospital outpatient settings). Lab services and other specialty clinics (where they could be identified) have been excluded. Behavioral health beneficiary volume based on 2016 professional claims, filtered by provider type “agency – community / behavioral health” unless otherwise noted above. Data from Provider Report Tables, HCA, distributed August and September 2017.

63 Kaiser is capitated with Molina and a number of their services show up under lab taxonomy even though they are not lab-related. If reporting on all Kaiser professional services in 2016, 7,677 beneficiaries were seen.
*Number reported is the subset of beneficiaries listed in the physical health column who had a professional services visit for “mental and behavioral disorders” as their diagnostic condition using CDSP grouper.

The table below lists the dental providers that saw at least 1,000 SWACH Medicaid beneficiaries in 2016. This includes FQHCs providing dental services, pediatric dentists, general practice dentists, and dental hygienists, but excludes orthodontics and denturists. There are approximately 100 additional dental providers serving SWACH, ranging from 10 – 900 beneficiaries seen in 2016.64

<table>
<thead>
<tr>
<th>Billing Provider</th>
<th># of Beneficiaries Served (CY 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sea-Mar</td>
<td>6,944</td>
</tr>
<tr>
<td>Smiles Dental</td>
<td>5,241</td>
</tr>
<tr>
<td>A Children’s Dentist</td>
<td>4,189</td>
</tr>
<tr>
<td>Must Love Kids Pediatric Dentistry</td>
<td>3,734</td>
</tr>
<tr>
<td>New Day Community Dental Clinic</td>
<td>2,215</td>
</tr>
<tr>
<td>Gentle Dental of Oregon</td>
<td>2,063</td>
</tr>
<tr>
<td>Affordable Dental</td>
<td>2,033</td>
</tr>
<tr>
<td>DeLuna Kids Dental</td>
<td>1,927</td>
</tr>
<tr>
<td>Dream Team Dental</td>
<td>1,894</td>
</tr>
<tr>
<td>Pleasant Valley Pediatric Dentistry</td>
<td>1,791</td>
</tr>
<tr>
<td>Neil and Hillyard</td>
<td>1,716</td>
</tr>
<tr>
<td>Vancouver Dental Care</td>
<td>1,545</td>
</tr>
<tr>
<td>Steve Marandas DMD</td>
<td>1,423</td>
</tr>
<tr>
<td>Access Dental of Salmon Creek</td>
<td>1,203</td>
</tr>
<tr>
<td>Value Dental</td>
<td>1,170</td>
</tr>
<tr>
<td>Vancouver Pediatric Dentistry</td>
<td>1,166</td>
</tr>
<tr>
<td>Hardie Dentistry for Kids</td>
<td>1,127</td>
</tr>
</tbody>
</table>

64 Dental beneficiary volume based on 2016 dental claims data from Provider Report Tables, HCA, distributed August and September 2017.
APPENDIX – DATA SOURCES

The chart below provides a list of selected data sources that SWACH had utilized as part of project planning to date, as well as indicators for how the data were used.

<table>
<thead>
<tr>
<th>Data Source</th>
<th>RHNI and assessment</th>
<th>Project selection</th>
<th>Identifying key partners</th>
<th>Population selection</th>
<th>Workforce capacity</th>
<th>Project planning / design</th>
<th>Stakeholder engagement</th>
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</thead>
<tbody>
<tr>
<td>Behavioral Risk Factor Surveillance System survey data</td>
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<td>Community Checkup</td>
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<td>• 2016 Healthy Columbia Willamette CHNA</td>
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<td>• 2016 Columbia Gorge Regional CHA</td>
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<td>• 2016 PeaceHealth CHNA</td>
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<td>• 2015 Clark County CHNA</td>
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<td>Community Health Assessment Tool (CHAT)</td>
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<td><strong>LIB CHURCH</strong></td>
<td>Food pantry, laundry love, youth group.</td>
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<td><strong>ALL SAINTS EPISCOPAL CHURCH</strong></td>
<td>Native American Ministries, babies in need, recovery group hosting, winter hospitality overflow shelter.</td>
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<td><strong>AMITY EMERGENCY FOOD BANK</strong></td>
<td>North Clark County rural area food bank.</td>
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<td><strong>ANGELS OF GOD</strong></td>
<td>Food pantry served by Memorial Lutheran Church.</td>
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<td><strong>ARC OF SOUTHWEST WASHINGTON</strong></td>
<td>Supports special needs and vulnerable populations, support independent living and financial management.</td>
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<td><strong>AREA AGENCY ON AGING AND DISABILITIES OF SOUTHWEST WASHINGTON</strong></td>
<td>State agency serving Medicaid/Medicare clients and guardians/foster parents.</td>
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<td><strong>AUTISM EMPOWERMENT</strong></td>
<td>Autism support group and autism spectrum support group.</td>
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<tr>
<td><strong>BATTLE GROUND ADVENTIST COMMUNITY SERVICES</strong></td>
<td>Food and clothing pantry serving North Clark County zip codes.</td>
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<td><strong>BIRTHRIGHT OF VANCOUVER USA</strong></td>
<td>Family planning support and info on parenting classes, career development, community programs, and adoption.</td>
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<td><strong>BOYS AND GIRLS CLUB OF SOUTHWEST WASHINGTON</strong></td>
<td>Sports, arts, academics programs, and after school care.</td>
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<td><strong>CAMAS FRIENDS CHURCH</strong></td>
<td>Winter hospitality overflow, laundry love, car camping, food pantry, summer meals program.</td>
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<tr>
<td><strong>CATHOLIC COMMUNITY SERVICES OF WESTERN WASHINGTON</strong></td>
<td>Shelter and houseless services, housing, child, youth and family services, specialized services, mh, addiction recovery, disabilities.</td>
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<tr>
<td><strong>CEM-CARING SERVICES</strong></td>
<td>Adult homeless, adult day care, referrals, community partnerships.</td>
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<tr>
<td><strong>CHILDREN'S CENTER</strong></td>
<td>Mental health program, child sexual abuse treatment program, cowpings program.</td>
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<td><strong>CHILDREN'S HOME SOCIETY OF WASHINGTON</strong></td>
<td>Children and family counseling, family support, adoption and secure families, early learning.</td>
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<tr>
<td><strong>CHRIST'S PRODUCE</strong></td>
<td>Produce from (local) area farms.</td>
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<tr>
<td><strong>CLARK COUNTY ADVENTIST COMMUNITY SERVICES</strong></td>
<td>Food and clothing bank.</td>
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<tr>
<td><strong>CLARK COUNTY FOOD BANK</strong></td>
<td>Food bank with commodities.</td>
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<tr>
<td><strong>CLARK COUNTY PUBLIC HEALTH</strong></td>
<td>Community health services, fee and learning services.</td>
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<tr>
<td><strong>CLARK COUNTY SHERIFF'S OFFICE</strong></td>
<td>Emergency responders, Process servers.</td>
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<td><strong>CLARK COUNTY VETERANS ASSISTANCE CENTER</strong></td>
<td>Veterans assistance funds, disability claims assistance, survivor benefits assistance.</td>
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<td><strong>CLARK COUNTY VOLUNTEER LAWYERS PROGRAM</strong></td>
<td>Bankruptcy, dependency, domestic violence, early parenthood, elder law, family law, financial forensics, general law.</td>
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<tr>
<td><strong>CLARK PUBLIC UTILITIES</strong></td>
<td>Offers scholarships to subsidize your electric bill.</td>
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<tr>
<td><strong>CLARK REGIONAL EMERGENCY SERVICES AGENCY</strong></td>
<td>Provides alerts to emergency situations. Dispatch, technology and emergency management services.</td>
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<tr>
<td><strong>COLUMBIA NON-PROFIT HOUSING</strong></td>
<td>Affordable housing gigs in Clark and Cowlitz County to special needs and vulnerable populations.</td>
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<td><strong>COLUMBIA RIVER MENTAL HEALTH SERVICES</strong></td>
<td>Adult outpatient services, children and family services, drug and alcohol services, community services.</td>
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<td><strong>COLUMBIA TREATMENT SERVICES</strong></td>
<td>Recovery programs, spanish services, recovery coaching, deferred prosecution.</td>
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<tr>
<td><strong>COMMUNITY FOUNDATION FOR SOUTHWEST WASHINGTON</strong></td>
<td>Community grants, scholarships, Impact funds.</td>
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<td><strong>COMMUNITY HOUSING RESOURCES CENTER</strong></td>
<td>Homeless education, credit restoration settlement, foreclosure prevention counseling.</td>
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<td><strong>COMMUNITY MEDICATION SERVICES</strong></td>
<td>Medication services and community and workplace learning.</td>
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<td><strong>COMMUNITY SERVICES NORTHWEST</strong></td>
<td>Mental health, addiction, housing, and SSI/SSDI application assistance.</td>
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<td><strong>CONSUMER VOICES ARE BALE</strong></td>
<td>Behavioral health supportive services, peer support, advocacy, employment.</td>
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<td><strong>COOLING CENTERS CLARK, SKAMANIA, COWLITZ, AND WAHKIAKUM COUNTIES</strong></td>
<td>Contact CRESA for area locations.</td>
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<td><strong>COUNCIL FOR THE HOMELESS</strong></td>
<td>Shelter and housing services and food pantry.</td>
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<td><strong>C-TRAN</strong></td>
<td>Public transportation bus service from Vancouver to Portland, Stevenson and Longview.</td>
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<td><strong>DAYBREAK YOUTH SERVICES</strong></td>
<td>Inpatient and outpatient services to you experiencing substance abuse, addiction, and co-occurring mental health issues.</td>
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<td><strong>DHIN</strong></td>
<td>Food, cash, medical assistance, child support enforcement.</td>
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<td><strong>EAST VANCOUVER COMMUNITY CHURCH</strong></td>
<td>No community services available.</td>
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<td><strong>EDUCATIONAL OPPORTUNITIES FOR CHILDREN AND FAMILIES</strong></td>
<td>Head start, early head start and family support programs.</td>
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<td><strong>ED 122</strong></td>
<td>Serves 32 school districts with an emphasis on operations, expertise, student success, and healthy communities.</td>
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<td><strong>EVERGREEN HABITAT FOR HUMANITY</strong></td>
<td>Home ownership, multi-sggered-income assistance, neighborhood revitalization, home construction.</td>
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<td><strong>EVERGREEN PUBLIC SCHOOLS #114</strong></td>
<td>East Vancouver school district with a family resource coordinator for supportive services.</td>
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<td><strong>FAMILIES IN NEED</strong></td>
<td>Support services for families of alcoholics.</td>
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<td><strong>FAMILIES ON THE OUTSIDE</strong></td>
<td>Prison ministry, family events, support groups, seminars.</td>
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<td><strong>FAMILY SOLUTIONS</strong></td>
<td>Mental health services for youth and their families. Multilingual services. Services medicaid population.</td>
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<td><strong>FISH OF ORCHARD INC</strong></td>
<td>Food bank.</td>
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<td><strong>FISH OF VANCOUVER</strong></td>
<td>Food subsidy program for seniors.</td>
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<td><strong>FREE CLINIC OF SW WASHINGTON</strong></td>
<td>Medical services for the uninsured.</td>
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<td><strong>FRIENDS OF THE CARPET</strong>*</td>
<td>Faith-based non-profit providing assistance to vulnerable community members.</td>
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<td><strong>FRUIT VALLEY FAMILY RESOURCE CENTER</strong></td>
<td>Food bank, transportation assistance, nutrition program, vitamins and clothing.</td>
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<td><strong>FLURRY FRIENDS</strong></td>
<td>No-kil cat rescue.</td>
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<td><strong>GOOD SAMARITAN MINISTRIES</strong></td>
<td>Mental health support groups and counseling.</td>
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<td><strong>GRACELF LIVING ACTIVITY CENTER</strong></td>
<td>Fitness, music, arts, support groups, group discussion, speakers, all denominations, lunch and snacks provided at Grace Lutheran Church.</td>
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<td><strong>HOLIDAY PROGRAMS CLARK COUNTY</strong></td>
<td>Salvation Army, DHHS, PWCA, or contact your child's school.</td>
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<td><strong>HOUGHTON FOUNDATION HOUSTON ELEMENTARY SCHOOL</strong></td>
<td>Lunch buddy program, private counseling for students and parents, family service center.</td>
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<td><strong>HUMAN SERVICES COUNCIL</strong></td>
<td>Transportation assistance for employment and Medicaid/Medicare patient appointments, also a bike-to-work program.</td>
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<tr>
<td><strong>HUMANE SOCIETY FOR SOUTHWEST WASHINGTON</strong></td>
<td>Shelter for houseless dogs, cats, rabbits. Temporary shelter for pets whose owners are temporarily houseless.</td>
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<td><strong>INNOVATIVE SERVICES NW</strong></td>
<td>Pediatric therapy, early childhood services, employment services, supervised visitation.</td>
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<td><strong>INTER FAITH TREASURE HOUSE</strong></td>
<td>Food, clothing, emergency assistance in Washougal.</td>
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<td><strong>INTERIOR REVENUE SERVICE VANCOUVER</strong></td>
<td>Tax, income, social security services.</td>
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<td><strong>JAMIS YOUTH</strong></td>
<td>Services for homeless and runaway youth and teen parents.</td>
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<td><strong>LEANING AVENUES CHILD CARE CENTERS</strong></td>
<td>Children, after school programs, and daycare.</td>
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<td><strong>LEGACY SALMON CREEK HOSPITAL</strong></td>
<td>North Vancouver hospital.</td>
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<td><strong>LEWIS RIVER MOBILE FOOD BANK</strong></td>
<td>Cowlitz County rural area food bank.</td>
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<td><strong>OUNGE CONNECTIONS</strong></td>
<td>Drug treatment residential treatment, behavioral health outpatient treatment, medication assisted treatment.</td>
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<td><strong>ORS HOP FISH CHURCH VANCOUVER</strong></td>
<td>Anger management services, provides hot meals, and emerges overnight shelter in inclement weather.</td>
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<td><strong>LUTHERAN COMMUNITY SERVICES</strong></td>
<td>Behavioral health, family and community support, child welfare services, refugee and immigrant services, senior and disability and crime victim services.</td>
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<td><strong>MAATHA'S PANTRY</strong></td>
<td>Food, clothing, hygiene items to those diagnosed with HIV/AIDS. Closed due to fire.</td>
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<td><strong>MIRACLE PLACE MATERNITY</strong></td>
<td>Medical travel financial support.</td>
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<td><strong>MONTGOMERY PLACE</strong></td>
<td>Housing for single mothers of young children under the age of 5.</td>
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<td><strong>NEIGHBORS HELPING NEIGHBORS</strong></td>
<td>Non-profit food bank in Ridgefield.</td>
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<td><strong>NEW HEIGHTS COMMUNITY FOOD BANK CLARK COUNTY</strong></td>
<td>Serving Battle Ground, Yacolt, Amboy.</td>
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<td><strong>ONE LIFE</strong></td>
<td>Food pantry, provides basic needs houseless population, nutrition education, organic garden.</td>
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<td><strong>GREENHOUSE MINISTRIES</strong></td>
<td>Faith-based shelter for families, chemical dependency support, case management, job training.</td>
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<td><strong>OPTIONS 360 PREGNANCY CLINIC</strong></td>
<td>Pregnancy services.</td>
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<td><strong>PARTNERS IN CAREERS</strong></td>
<td>Youth, veterans, language programs, employment opps.</td>
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<td><strong>PATHWAYS PREGNANCY CLINIC</strong></td>
<td>Camas area faith-based center offering pregnancy test, ultrasound, and options.</td>
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<td><strong>PEACHHEALTH SOUTHWEST MEDICAL CENTER</strong></td>
<td>Centralized located hospital in Vancouver.</td>
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<td><strong>REDGFIELD FAMILY RESOURCE CENTER</strong></td>
<td>Food and clothing to Redgfield families.</td>
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<td><strong>REDGFIELD FARMS MARKET</strong></td>
<td>Outdoor produce market with addtl vendors.</td>
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<td><strong>REDGFIELD NAZEIN CHURCH</strong></td>
<td>Chinese pan support, compassion Redgfield, grief share, marriage counseling.</td>
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<td><strong>REDSOILS COMMUNITY TEEN CENTER</strong></td>
<td>Teen activities in Battle Ground/Bush Prairie area.</td>
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<td><strong>SAINT ANNE'S MANSION</strong></td>
<td>Emergency financial assistance.</td>
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<td><strong>SAINT JOHN'S BAPTIST CHURCH</strong></td>
<td>Combat hunger, seasonal assistance, elderly services, housing vouchers, employment opps, disaster assistance.</td>
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<td><strong>SEA MAR COMMUNITY HEALTH CENTER</strong></td>
<td>Physical and mental health services serving marginalized populations and Medicaid beneficiaries.</td>
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<td><strong>SEVERE WEATHER SW WASHINGTON CLARK, CONNUTZ, SKAMANIA, AND WAHKIAKUM COUNTRIES</strong></td>
<td>Weather alerts and shelter information.</td>
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<td><strong>SHARE INC</strong></td>
<td>Meals and housing services.</td>
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</table>
SOUTHWEST WASHINGTON CENTER OF THE DEAF AND HARD OF HEARING  Advocacy, communication assistance, peer counseling, housing assistance, unique and diverse services.

SPECIAL EVENTS CLARK AND SKAMANIA COUNTIES  Autism Society of SW WA

ST. VINCENT DE PAUL CLARK COUNTY  Employment opps, financial assistance opps.

SUPPORT FOR EARLY LEARNERS AND FAMILIES  Support parents, support literacy, advanced quality improvements in early child education and care.

TELCO CORPORATION  Behavioral health services.

THE VANCOUVER CLINIC  Local area medical clinic franchise

TRINITY LUTHERAN CHURCH  School partnerships, clothing swap, kindly knitters, care to homeless individuals.

TRINITY MISSION CUPBOARD  Food pantry.

TRIPLE POINT YOUTH SERVICES  Serving LGBTQ youth

U NORTHEAST WASHINGTON HEALTH NETWORK  Mental health, cancer, homeless veterans, women veterans, pain management and opioid safety.

UW FARMERS MARKET  Downtown Vancouver outdoor market where vendors accept SNAP benefits.

UW HOUSING AUTHORITY  Vancouver area housing programs with wait lists and possible home ownership programs.

VANCOUVER LIONS CLUB  Provides labor and financial support for local charities, Vision assistance and scholarship funds.

VANCOUVER PUBLIC SCHOOLS  West Vancouver School District with a liaison helping homeless youth.

VANCOUVER TREATMENT SOLUTIONS  Methadone clinic.

VANCOUVER VETERANS OF FOREIGN WARS POST #7144  Provides links to veteran resources.

VANCOUVER WOMEN'S FOUNDATION  Financial support for women in crisis.

WASHINGTON ASSOCIATION OF COMMUNITY AND MIGRANT HEALTH CENTERS  Health equity, workforce development, education and training.

WASHINGTON SCHOOLS FOR THE DEAF  Vancouver area school for deaf youth.

WASHINGTON STATE BOARD FOR COMMUNITY & TECHNICAL COLLEGES  Higher education.

WASHINGTON STATE OSOS VANCOUVER DIVISION OF VOCATIONAL REHABILITATION  Vocational employment rehabilitation.

WASHINGTON STATE HEALTH CARE AUTHORITY  Healthcare reforms, AppleHealth/Medicaid provider, public employee benefits provider.

WASHINGTON STATE SCHOOL FOR THE BLIND  Vancouver area school for blind youth.

WASHINGTON STATE UNIVERSITY VANCOUVER  Extension campus of WSU, higher ed in Vancouver.

WASHOUGAL PUBLIC SCHOOLS  East Clark County K-12

WORKFORCE SOUTHWEST WASHINGTON  Employment assistance, resume building, supplemental services.

YMCAS  Community sports, activities, hobbies, childcare.

YOUNG LAKES MINISTRY TO TEEN MOMS  Faith-based teen peer.

YOUTH COMMUNITY CONNECTIONS  Empowering youth to make healthy choices.

YWCA CLARK COUNTY  Domestic violence, sexual assault, post-foster care, CASA programs/services.

YUKON SCHOOL DISTRICT  Prek through 12th in Boldingon, WA

COLUMBIA CASCADE HOUSING AUTHORITY  Located in The Dalles, OR

COLUMBIA GORGE COMMUNITY COLLEGE  Higher Ed in The Dalles, OR

COLUMBIA GORGE FARMERS MARKET  Home ownership, retail store, accepts donations in The Dalles, OR

GUNNISON SCHOOL DISTRICT  Prek through 12th in Klickitat County

GOLDENDELE FOOD BANK  Food donation in Goldendale, WA

GOLDENDELE LIBRARY  Books, computer lab, email, storytime, recreation, learning.

GORGE ECUMENICAL MINISTRIES  Food bank, emergency pantry services, youth services, art and music, climate action.

GORGE TRANSLINK  Rural provider transportation.

Klickitat County Emergency Medical Center  Emergency medical responders.

Klickitat County Health Department  Immunizations, maternity support and personal health services.

Klickitat County Senior Services  Senior programs enhance autonomy and independence.

Klickitat School District  Primary and secondary school, food services, and transportation.

Klickitat Valley Health  Non-profit care provider operated by public hospital district #1.

LIFELINE  Rural area phone service/device subsidy.

MED SCHOOL DISTRICT  Primary and secondary in Lynd. WA

MED COLUMBIA AND COLUMBIA GORGE HOUSING AUTHORITIES  Low income housing programs in Skamania and Klickitat counties.

MED COLUMBIA MEDICAL CENTER  Hospital services located in The Dalles.

MEDICAL CENTER  Medical Clinics in White Salmon

ONE COMMUNITY HEALTH  Family medicine, pediatrics, dental, outreach, obstetrics in Hood River & The Dalles

ONE COMMUNITY HEALTH - DENTAL  Closed dental services for this region.

OPPORTUNITY CONNECTED SEASONAL WORK  Social service organization in Hood River County, Oregon

PATIENT ASSISTANCE PROGRAM CENTER  Prescription drug assistance.

PLANNED PARENTHOOD COLUMBIA WASHINGTON  Vancouver, Portland, Salem, Bend area family planning services.

PROVIDENCE HOOD RIVER MEMORIAL HOSPITAL BEHAVIORAL HEALTH  Multidisciplinary behavioral health - physical, spiritual, psychological and social.

ROOSEVELT SCHOOL DISTRICT  Roosevelt, WA in Klickitat County

SAFE RIDE WIRELESS  Emergency call phone.

SKAMANIA KUCHTAT COMMUNITY NETWORK  Supporting health, education and safety.

SKYLINE HOSPITAL  Emergency medical services located in White Salmon.

TROUT CREEK SCHOOL DISTRICT  Serves 250 students K-12 in Trout Lake, WA

USDA  Funding opportunities for rural area residents.

WASHINGTON GORGE ACTION PROGRAMS  Rural programs.

WASHINGTON GORGE ACTION PROGRAMS  Food, milk, baby formula for low income women, infants, and children.

WASHINGTON STATE UNIVERSITY LUTCHEAN EXTENSION  Healthcare services.

WHITE SALMON VALLEY COMMUNITY LIBRARY  Books, emedia, technology, continued learning.

WHITE SALMON VALLEY SCHOOL DISTRICT  Serves K-12 in White Salmon.

WHITEHORN SCHOOL DISTRICT  Located in lynd. WA

COLUMBIA CASCADE HOUSING CORPORATION  Offers housing and home repair programs.

COLUMBIA GORGE MEDICAL CENTER  Path-based non-profit offers free pregnancy tests, info, and options.

GORGE GROWN FOOD NETWORK  Building a resilient neighborhood food system with local farmers.

GORGE TRANSLINK  Rural transportation service.

HUMAN SERVICES COUNCIL  Located in Vancouver, but extends transportation services to Skamania County, like to work program, employment transportation, Medicaid/Medicare transportation, veteran services.

ODDIN  Pediatric therapy center.

MED COLUMBIA AND COLUMBIA GORGE HOUSING AUTHORITIES  Rural housing programs.

MED COLUMBIA HOUSING RESOURCE CENTER  Housing programs, voucher, self-sufficiency.

MED COLUMBIA MEDICAL CENTER  Hospital services located in The Dalles.

MED COLUMBIA MEDICAL CENTER  Patient-centered medical services throughout the Gorge.

MEDCOLUMBIA CHILDREN'S COUSCIL, INC  Head Start Program

NORTH BOWINSLE SENIOR CENTER  Lunch and social activities for seniors.

NORTHMOUNT MEDICAL CENTER  Community health care, total family wellness.

ONE COMMUNITY HEALTH AND DENTAL CARE  Medical, dental, behavioral health in The Dalles & Hood River

ONE COMMUNITY HEALTH AND DENTAL CARE  Family medicine, pediatrics, dental, outreach, obstetrics in Hood River & The Dalles

PLAY WORKS GORGE CHILDREN'S THEATRE  Speech pathology.

PROVIDENCE HOOD RIVER MEMORIAL HOSPITAL BEHAVIORAL HEALTH  Multidisciplinary behavioral health - physical, spiritual, psychological and social.

SEA MAR VANCOUVER  Mental Health Services available to Skamania residents.

SKAMANIA COUNTY COMMUNITY HEALTH  Mental health, chemical dependency, immunizations, food safety, developmental disabilities.

SKAMANIA COUNTY COURT OF DOMESTIC VIOLENCE AND SEXUAL ASSAULT  Treatment center, advocacy services, shelter, teen programs.

SKAMANIA COUNTY SENIOR SERVICES  Case management, nutrition, transportation, senior activities.

SKAMANIA COUNTY SHERIFF'S OFFICE  Emergency responders.

SKYLINE HOSPITAL  Emergency medical services located in White Salmon.

STEVENS FARMERS MARKET  Produce, fish, meat, crafts, flowers

UNDERWOOD PARK AND COMMUNITY CENTER  Events venue in Underwood, WA

WASHINGTON GORGE ACTION PROGRAMS  Food bank, nutrition, emergency housing, community youth center, crime victim and domestic violence services, energy assistance.

WASHINGTON STATE UNIVERSITY LUTCHEAN EXTENSION  Higher education.

YOUTH EMPOWERMENT SHELTER (YES)  Youth shelter in Mid-Columbia Valley - The Dalles, OR