North Central Accountable Community of Health

Governing Board Annual Meeting
1:00 PM–3:30 PM, December 2, 2019

Location	**Call-in Details**
Confluence Technology Center 285 Technology Center Way #102 Wenatchee, WA 98801	Conference Dial-in Number: (408) 638-0968 or (646) 876-9923 Meeting ID: 429 968 472# Join from PC, Mac, Linux, iOS or Android: https://zoom.us/j/429968472

TIME	AGENDA ITEM	PROPOSED ACTIONS	ATTACHMENTS	PAGE
1:00 PM	Introductions – **Barry Kling** • Board Roll Call • Declaration of Conflicts • Approve Consent Agenda • Public Comment • January Retreat Date	• Approval of Consent Agenda	• Agenda, Acronyms & Decision Funds Flow Chart • Consent Agenda o Minutes o Monthly Financial Report o Board Decision Form - IGT Funds Approval	*1-3* *4-17*
1:05 PM	Executive Director Update – **Linda Parlette**		• Exec Director Report	*18*
1:15 PM	Board Elections – **Barry Kling**	• Elections	• Nomination Slate	*Sep Attach*
1:25 PM	Pathways HUB CCHE Evaluation – **Allen Cheadle**		• Evaluation Report	*19-22*
1:40 PM	Community Based Care Coordination – **Christal Eshelman & Deb Miller**		• Board Information Form – Community-based Care Coordination	*23-26*
2:10 PM	Okanogan CHI – **Peter Morgan, Karen Schimpf, Lauri Jones**		• Board Information Form	*27-37*
2:20 PM	2020 Budget – **John Schapman**	• Approval of 2020 Budget	• Board Decision Form - 2020 Budget Approval • 2020 Budget Spreadsheet	*38-52* *Sep Attach*

Additional Attachments:

- Workgroup Updates
  - Pathways Community HUB ***52-58***
  - Opioid Workgroup ***59-61***
  - WPCC ***62-76***
- Chemical Dependency Professional Apprenticeship Update and Feasibility Study ***77-88***
- Community Partnership for Transition Solutions Update ***89-105***

North Central Accountable Community of Health

A Handy Guide to Acronyms within the Medicaid Transformation Project

ACA: Affordable Care Act

ACH: Accountable Community of Health

ACO: Accountable Care Organization

AI/AN: American Indian/Alaska Native

BAA: Business Associate Agreement

BH: Behavioral Health

BH-ASO: Behavioral Health - Administrative Service Organization

BLS: Basic Life Skills

CBO: Community-Based Organization

CCHE: Center for Community Health and Evaluation

CCMI: Centre for Collaboration Motivation and Innovation

CCS: Care Coordination Systems

CHI: Coalition for Health Improvement

CHW: Community Health Worker

CMS: Centers for Medicare and Medicaid Services

CMT: Collective Medical Technologies

COT: Chronic Opioid Therapy

CP: Change Plans

CPTS: Community Partnership for Transition Solutions

CSSA: Community Specialist Services Agency

DOH: Department of Health

DSRIP: Delivery System Reform Incentive Program

EDie: Emergency Dept. Information Exchange

EMS: Emergency Medical Services

FIMC: Fully Integrated Managed Care

FCS: Foundational Community Supports

HCA: Health Care Authority

HIT/HIE: Health Information Technology / Health Information Exchange

MAT: Medication Assisted Treatment

MCO: Managed Care Organization

MH: Mental Health

MOU: Memorandum of Understanding

MTP: Medicaid Transformation Project(s)

NCACH: North Central Accountable Community of Health

NCECC: North Central Emergency Care Council

OHSU: Oregon Health & Science University

OHWC: Okanogan Healthcare Workforce Collaborative

OTN: Opioid Treatment Network

OUD: Opioid Use Disorder

P4P: Pay for Performance

P4R: Pay for Reporting

PCS: Pathways Community Specialist

PHSKC: Public Health Seattle King County

RFP: Request for Proposals

SDOH: Social Determinants of Health

SSP/SEP: Syringe Services Program / Syringe Exchange Program

SMI: Serious Mental Illness

SUD: Substance Use Disorder

TCDI: Transitional Care and Diversion Interventions

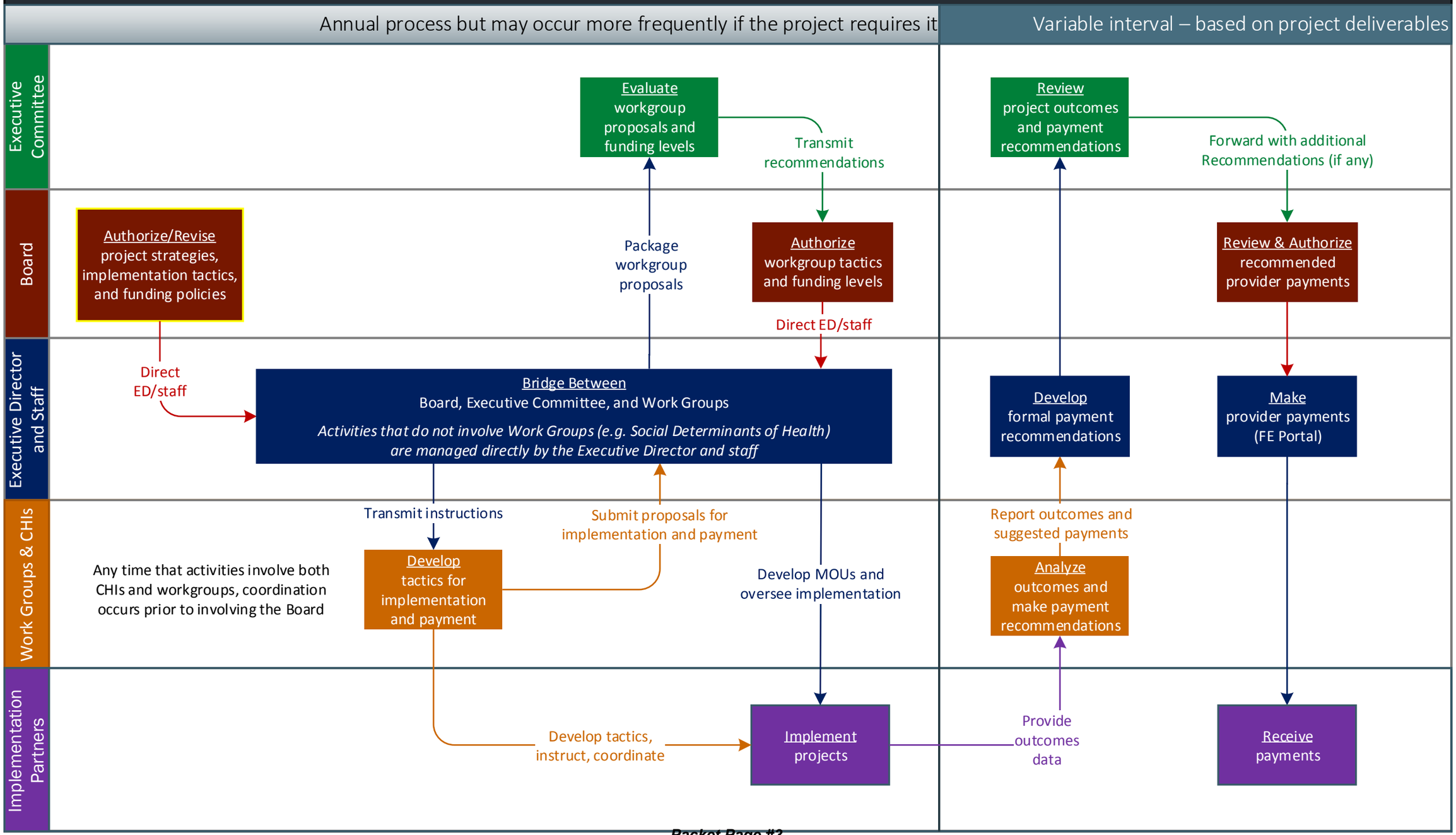
TCM: Transitional Care Management

VBP: Value-Based Payment

WPCC: Whole Person Care Collaborative

Decision Flow for Funding Design and Allocation

[This process is utilized when a budget amendment is requested to the Annual Budget]



Location	Attendees
Confluence Technology Center **285 Technology Center Way #102** **Wenatchee, WA 98801**	**Governing Board Members Present:** Blake Edwards, Rick Hourigan, Doug Wilson, Rosalinda Kibby, David Olson, Carlene Anders, Senator Warnick, Cathy Meuret, Barry Kling, Ken Sterner, Nancy Nash Mendez, Courtney Ward, Molly Morris, Ray Eickmeyer, Brooklyn Holton, Kyle Kellum, Mike Beaver **Governing Board Members Absent:** Scott Graham, Daniel Angell **Public Attendance:** Kate Haugen, Mattie Haugen, Kelsey Gust, Dan Sutton, Jorge Rivera, Paul Hadley, Dwayne Dobbs, Julie Rickard, Penny Quist **NCACH Staff**: Linda Parlette, John Schapman, Caroline Tillier, Wendy Brzezny, Christal Eshelman, Tanya Gleason, Sahara Suval, Mariah Brown, Teresa Davis – Minutes

Agenda Item	Minutes
• Introductions – **Barry Kling** • Review of Agenda & Declaration of Conflicts • Public Comment • Approval of Consent Agenda • Board Expirations	• **Conflicts of Interest:** Brooklyn was part of one of the CHI applications, David disclosed that CVCH is sponsoring one of the CHI applications, Barry disclosed that CDHD is taking a more active role in homelessness, Ken Sterner and Nancy also disclosed that they are also involved in the homelessness sector as well, Carlene disclosed that she is involved in one of the CHI applications. • **Consent Agenda**: Barry reviewed the consent agenda procedure. He noted that some of the staff updates have some budget figures in them and budget items should not be included in staff updates if they will be in the consent agenda in the future. Any motion to approve the consent agenda should exclude those budget figures. • Senator Parlette noted that HCA is no longer considering the Pathways HUB as the Model of Care Coordination more to come in the future as discussions happen. • September Minutes • Monthly Financial Report • Executive Director Report • Workgroup Updates ❖ ***Carlene Anders moved, Doug Wilson seconded the motion to approve the consent agenda (excluding budget figures included in staff updates), motion passed*** • **Public Comment:** None • **Board Member Expirations:** There is a list of Board members and expiration dates in packets. Anyone highlighted in green has a term expiration this December. Please check in with your sectors about serving another term prior to the annual meeting. o David asked if someone from the Board can nominate a Board member to the Executive Committee. Barry said yes via email.
• CHI Update – **Sahara Suval**	**Chelan Douglas CHI** Looking at how to work the 2019 Action Plan that they developed and decide whether to continue working on it and/or reprioritize for 2020. Will be using upcoming meeting to hear CHNA Report and 211 Report **Okanogan CHI** – Discussing that there may be another member that wants to take over the Board seat. Also doing some work around crafting a future vision and mission statement. **Grant County CHI** – Last meeting was hosted in partnership with the Suicide Task Force - discussions are underway to consider how CHI can support Task Force work in future.

	Sahara presented the small projects that the award committee has put forward for funding from the CHI Community Initiatives. Sahara reviewed the scoring process and explained that each of the five top scoring applications' budgets was reduced by 10% to stay within the $100,000 that was allocated to small projects. ❖ **Doug Wilson moved, Senator Warnick seconded the motion to allocate awards for top-scoring project applications based on the recommendation developed by the Award Committee. Abstentions: Carlene Anders & Brooklyn Holton, Motion Passed** Discussion ensued around if some of the projects fit into the work of the NCACH and staff reminded the Board that the application and scoring process that they approved provided protections for this and these projects were the highest scoring applications.
• Tribal Updates – **Molly Morris**	In 2017 we talked about having quarterly tribal updates now we have a group. Molly is giving the Yearly update to the Board today. Molly acknowledged that we are on the land of the Wenatchi Tribe. November is Native American Month. Visit Colvilletribes.com / business governance page / resolutions for more information on the Colville Tribal Council monthly meetings. Molly will try to get this information out quarterly. Molly handed out the culture card, which is a guide on how to approach the tribes. She also talked about how she has been guiding NCACH staff when they have questions on the proper way to communicate with tribal partners.
• Draft 2020 Budget – **NCACH Staff**	**Draft 2020 Budget** – Staff went over the draft 2020 budget. • Any newly introduced item has an information only form. • All line items are considered up to amounts. **Tribal Investments** – Sahara presented on the tribal investments. We are accountable to HCA for reporting on our partnership with Colville Confederated Tribes. We are working with the leadership of the CCT and have built into the 2020 budget of an up to amount of $500,000. David asked how we came up with that amount: They have identified CDP Apprenticeship, human resource management, capacity building training needs, goals around population health management data, they also submitted a LOI through the CHI Community Initiatives Funding of $300,000. See the Board information form for more information. Barry asked if this is a workgroup. Sahara clarified that this is not a "workgroup" per say, it is more of a staff group with the addition of Molly. Christal noted that our main contact with the tribes has been Allison Ball and Carmella Alexis. This month Christal has done two Train the Trainer Narcan trainings. She has had some conversations about the CDP Apprenticeship program and they are very interested in this program but their barrier is that they do not currently have any CPD's to serve as the supervisors. Caroline talked about a need to access to data: they have partners across 5 counties that are serving their membership. There was enough interest in collaborating with partners including WPCC partners that this meeting is going to continue. All of the other ACH's have a tribal investment and/or a percentage allocated toward tribal investments. **Community Info Exchange**– An ecosystem comprised of multi-disciplinary network partners that use a shared language, a resource database, and technology platform to deliver enhanced community care planning. • Funding a Community Information Exchange (CIE) Workgroup *Goal: create and implement a sustainable process and interconnected network of clinical systems and community-based providers of SDOH* • Funding for Consulting and Technical Assistance Contract - Looking for approval of up-to $50,000 for: ▪ Support with CIE workgroup creation and partnership building

- Blueprints and work plan for community engagement and process development
- Comprehensive landscape assessment of systems and their relationships to tech vendors (past, current, potential)

Potential Timeline:
Dec 2019- Feb 2020—Workgroup Creation
Request funding for CIE Workgroup creation and recruitment strategies; set initial monthly meeting schedule; create Workgroup Charter with input from community members and ACH staff
Feb-Dec 2020—Building Year and Sustainability Planning
Recruitment of workgroup members in four-county region; select consultant for blueprint creation of CIE through 2021/2022; full landscape assessment of systems and their relationship to preferred tech vendors provider buy-in and marketing of workgroup intent; sustainability planning
2021—Full Scale Implementation
Integration of previously siloed EHR systems with preferred vendor(s) to include funding necessary API building activities; technical assistance; payments to preferred vendor(s) for met scope of work deliverables.
2022 and Beyond—Handoff
TBD depending on scope of NCACH post-MTP funding. Will need to create processes to maintain and fund TA needs and/or select new backbone organization to act as the administrator of TA or vendor contracts.

Health Equity Innovation: Regional fund to support health equity innovation in TRANSPORTATION and HOUSING *Goal: to support intentional health equity efforts (ex. policy development, outreach, translation, etc.)*

- $450,000 allocated in 2020
- Open to all partners and sectors
- Could support the infrastructure-building needed for potential future NCACH capital investments.
- Potential to establish an multi-year or annual fund in years 2021 and 2022

Benefits
- Touches diagnosis points as identified by the board
- Adds a necessary building block for SDOH focus.
- Ability to help address local disparities in communities that will continue to exist in SDOH if HE is not intentionally built.
- Financially engaging communities currently addressing health equity to bolster efforts
- Addressing HE with specified funding will improve the health of all people in communities

Capacity Building Rapid Cycle Fund

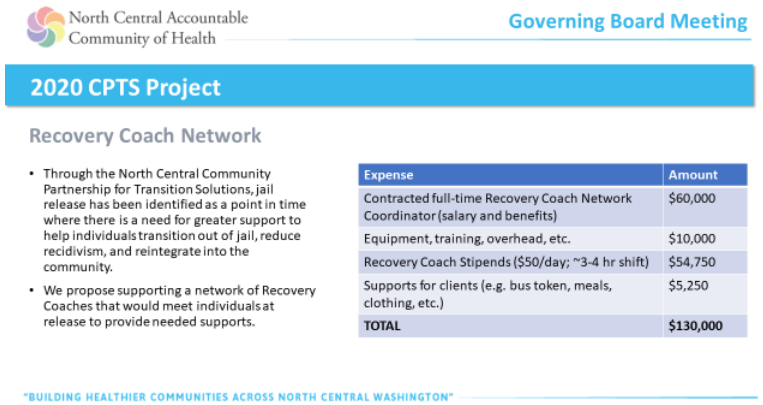
Goal: The creation of a formal partnership between NCACH and partnering agencies/entities

- Creates a synergistic relationship, bolstering NCW as a region of excellence around topics identified by the community.
- Focus on specific needs of CBOs in whatever format is most meaningful to them
- Partnering with entities means we do not reinvent the wheel, but combine efforts to achieve two-fold results:
- Bolster an existing entity, driving the community to them through jointly-offered trainings
- Lessen administrative staff time, while providing a need as identified to create healthy, thriving organizations

CPTS Project
- This builds on efforts we invested in 2019.
- Opportunity to leverage recently trained recovery coaches.

- Directly supports objectives associated with three of our six selected Medicaid Transformation Projects:
  - Transitional Care Project
  - Diversion Interventions Project
  - Opioid Project
- Also aligns with workforce development

North Central CPTS formed on August 30th 2018. Purpose of the North Central CPTS is to bring together various stakeholders who are committed to working together to support successful transitions and better coordinate services for people reentering communities after incarceration. Had a strategic planning process. Key need identified was support for individuals just released from custody before 5 AM. Developed an idea for a recovery coach network to help the work through the access. This would involve a coordinator position and support with that. This aligns with the TCDI and some of the homelessness metrics.



Discussion:

- Overall Budget: Barry noted that there are some things that we need to approve in December for operations: We may need to make some choices and wait on a few items if we are not ready to approve right now.
- David suggested that we schedule another meeting to give this due process
- Ray said he feels pretty good about the work that staff did on this process

Tribal Investment:

- Courtney noted that we need to make that we are not duplicating funding efforts to the tribes. (staff will follow up with BHT to clarify what they funded the CCT for).
- Barry said he feels that it is a little disrespectful without working out the amount with the Tribes.
- Brooklyn noted that is what the "*" process is for. We have a reporting requirement, we can't keep giving lip service, we need to support staff.

TCDI:

- Barry asked if this is new work or a continuation of previous work. John said it is the same work as last year. It is up to the Board how they want to proceed with marking items with asterisks. Barry noted that he believes the items on the Hospital Project & Community

	Para medicine should have an "*" **Opioid Workgroup:** ▪ School Based Prevention – is a continuation of an RFP, right now the awardees are assessing the needs. The amount allocated for 2020 is for the RFP awardees to implement projects. **CIE:** ▪ Blake does not think that we should be the trailblazers in this space. ▪ Rick - concern that this is a project that we can't take on, there are big entities that have not been able to tackle this. ▪ David - Are we assuming that if we go through this timeline that there would be significant funding needed to move forward. Yes, it would be a significant investment. This is something that we really need to look at before we even approve $50,000 for the workgroup. ▪ Courtney said it this was explored prior to the BHO dissolving. ▪ Rick noted that if there is even one extra step providers probably will not use it. We need to let the state take this on. ▪ Brooklyn would be interested in seeing what the SDOH system could be improved upon. **Health Equity Innovation Fund:** ▪ Barry thinks it is premature to allocating this. ▪ Courtney there are providers whose job it is to do the items that are listed in this. We need to fully evaluate what currently exists and look into enhancing those. We need to really look into the sustainability aspect. ▪ Brooklyn would like to see how it could be partner with the CHI Initiative Funding (make those items--health equity, transportation, and housing higher scoring). **Capacity Building & CPTS:** ***No time to review, talked of possibly scheduling an extra meeting or mid-month call to discuss further – no decision made on when and if to schedule.***
• Summary of October Board Retreat – **John Schapman**	John summarized where we are at so far in strategic planning and sustainability: See packet for full presentation **5 Criteria** To make a meaningful impact on the social determinants of health and health equity To promote sustainable change, rather than fleeting investments To connect partners and encourage information sharing To strengthen the engagement of marginalized groups To be developed into a region wide agenda **Candidate Strategies** The Board has developed 7 candidate strategies constructed in 3 parts Diagnosis, Distinct Advantage & Policy Barry noted that the Candidate Strategy 1 was incorrect - affordable housing was not the point. Homelessness needs to be the point ▪ Candidate Strategy 1: Housing ▪ Candidate Strategy 2: Respite Housing ▪ Candidate Strategy 3: Transportation ▪ Candidate Strategy 4: Community Based Care Coordination Expansion ▪ Candidate Strategy 5: Community Information Exchange

	▪ Candidate Strategy 6: Leverage Funding for SDOH Work ▪ Candidate Strategy 7: Addressing Adverse Childhood Experiences Proposed Actions: Board members and staff should be encouraged to submit additional candidate strategies using that format. **<u>Next steps – Workgroup development</u>** The Board agreed to create a workgroup and charge it with evaluating candidate strategies, drafting documents, etc. The Board did not have time to determine how the workgroup should be constituted or what its specific charges should be. • Select members for the Strategy Workgroup o Or multiple workgroups if that method is adopted • Give the workgroup a charge, including o An overall deadline (if any) o A schedule for reporting to the Board o Guidelines for developing business cases, evaluating evidence, etc. o Rules for assessment, deliberation, and voting
• Staff Updates	• Approval of Opioid Prescriber Coaching ❖ Motion to allocate **up to** $44,000 to contract with Physician & Healthcare Consulting to provide education, outreach, and coaching to high-volume opioid prescribers to help them identify issues contributing to their prescribing habits and get their prescribing practices more normalized relative to their peers. ***Not approved*** Discussion: Rick said until we have more data he is not comfortable approving this. Dr. Rickard responded that providers can have group training. From the data we saw even if a third of the prescribers change their practice, we still have a problem. There can still be some coaching that could be corrected by one on one coaching. Rick is skeptical that some of these physicians will want coaching. Julie noted that currently half of her cliental come to her voluntarily the other half are mandated. Barry would like to see some success info from the mandated Dr.'s. Doug noted that he feels a moral obligation to address this problem. Cathy noted that we need to hammer out the metrics and data – would like to Rick recommended a different type of contract payment. He sent an example to Barry, Doug and David. He will send that to John as well. ∗ ***Board agreed that the $44,000 left in the 2019 Opioid budget can carry over to 2020, so there is no rush to approve this motion until we get updated data.*** • Approval of Revision to WPCC Stage 2 Funding Framework ❖ ***Carlene Anders moved, Nancy Nash Mendez seconded the motioned to adjust the variable portion of funding so that each organization participating in a learning activity lasting about 1 quarter (2-4 months) is compensated $10,000 per team, and each organization***

	participating in a year-long learning activity is compensated $10,000 per quarter per team, provided they meet participation requirements. Motion passed. David asked if there is anything else changed – nothing else has changed, he also asked that MOU's be clearer in the future around deliverables. • Approval of Data Support Contract Increase ❖ ***David Olson moved, Doug Wilson seconded the motion to increase the 2019 budgeted amount for the PHSKC contract by $16,000 (from $24,000 to $40,000) to cover data analytic services through the end of 2019 and comply with the Board's budget deviation policy. Motion passed*** Brooklyn noted that we should have a discussion with all contractors to invoice in a timely manner.

NCACH Funding & Expense Summary Sheet

	CDHD ACCOUNT			FINANCIAL EXECUTOR FUNDS		
Funding Source	**SIM/Design/Misc Funds Received**	**SIM/Design/Misc Funds Expended**	**SIM/Design/Misc Funds Remaining**	**NCACH Funds @ FE**	**FE Funds Expended**	**FE Funds Remaining**
SIM Funding*	**$ 115,329**	**$ 115,329**	$ -			
Transformation Project Funding						
Original Contract K2296 - Demonstration Phase 1	$ 1,000,000					
Original Contract K2296 - Demonstration Phase 2	$ 5,000,000					
Transfer from FE Portal	$ 226,961					
Interest Earned on Demo Funds	$ 198,486					
Transformation Total	**$ 6,425,447**	**$ 2,536,289**	**$ 3,889,158**			
Workshop Registration Fees/Misc. Revenue*	**$ 15,370**	**$ 13,720**	**$ 1,650**			
			$ -			
Financial Executor Funding						
Project Incentive Funds				$ 13,863,063	$ 5,876,527	$ 7,986,536
Integration Funds				$ 5,781,980	$ 58,422	$ 5,723,558
Bonus Funds				$ 1,455,842		$ 1,455,842
Value Based Payment (VBP) Incentives				$ 300,000		$ 300,000
DY1 Shared Domain 1 Funds**				$ 4,350,278	$ 4,350,278	$ -
Totals	**$ 6,556,146**	**$ 2,665,338**	**$ 3,890,808**	**$ 25,751,163**	**$ 10,285,227**	**$ 15,465,936**

**A portion of funds in this category were collected when CDHD held the SIM Contract*

***Automatically paid out through FE Portal from Health Care Authority and therefore not reflected on Financial Executor budget spreadsheet*

2019 NCACH Budget: Monthly Summary

CDHD Account Expenses

Fiscal Year: Jan 1, 2019 - Dec 31, 2019

Budget Line Item	Total Budgeted	Oct-19	Totals YTD	% Expended YTD to Budget
Salary & Benefits	**$ 983,205**	$ 75,807	$ 768,404	78%
Supplies				
Office	**$ 9,420**	$ 83	$ 3,133	33%
Drugs and Medicines	**$ 15,100**		$ 9,594	64%
Furniture < $500	**$ 2,400**		$ 1,554	65%
Books, References, & Videos	**$ -**		$ 551	
Software	**$ 3,000**		$ 681	23%
Computer Hardware	**$ 6,000**		$ 3,487	58%
Services				
Legal Services	**$ 8,400**		$ 877	10%
Computer	**$ 16,140**		$ 4	0%
^Misc. & Contracts	**$ 27,500**		$ 5,000	18%
Mileage	**$ 81,760**	$ 3,489	$ 17,922	22%
Professional Travel and Training	**$ 16,800**	$ 600	$ 5,803	35%
^Conference - Program Meals/Lodging	**$ 38,250**	$ 2,129	$ 11,019	29%
Other (Train/Plane/Boat/Parking)	**$ 10,200**	$ 31	$ 5,025	49%
Advertising - Newspapers	**$ 3,800**		$ -	0%
Advertising - Other	**$ 7,900**	$ 514	$ 11,489	145%
Insurance	**$ 5,700**		$ 5,702	100%
Printing - Office	**$ 7,900**		$ 3,050	39%
^Printing - Copier	**$ 12,200**	$ 843	$ 7,724	63%
Dues and Memberships	**$ 3,300**		$ 3,028	92%
Subscriptions	**$ 658**	$ 704	$ 1,614	245%
^Other Expenditures	**$ 139,349**	$ 22,373	$ 106,560	76%
CDHD Hosting Fee 15%	**$ 212,322**	$ 15,986	$ 145,833	69%
Grand total	**$ 1,611,305**	**$ 122,560**	**$ 1,118,056**	69%
			% of Fiscal Year	83%

FE Portal Account Expenses

Fiscal Year: Jan 1, 2019 - Dec 31, 2019

Budget Line Item	Total Budgeted	Oct-19	Totals YTD	% Expended YTD to Budget
Operations				
^ OHSU	**$ 100,000**	$4,213	$81,965	82%
Program Evaluation (TBD)	**$ 60,000**		$0	0%
Program Evaluation (Pathways Hub)	**$ 60,000**		$0	0%
^ Public Health Seattle King County(Data)	**$ 40,000**	$19,779	$23,994	60%
Xpio	**$ 20,000**		$350	2%
Feldsman Tucker Leifer Fidell LLP	**$ 40,000**		$7,500	19%
** Asset Mapping (TBD)*	**$ 52,800**		$0	0%
^ Workforce Development	**$ 48,125**	$2,213	$8,877	18%
Communications and Outreach				
Training (TBD)	**$ 10,000**		$0	0%
Lead Agencies (CHIs)	**$ 150,000**	$20,167	$122,886	82%
** CHI Partner Payments*	**$ 450,000**		$0	0%
Whole Person Care Collaborative				
^ Comagine Health (Qualis Health)	**$ 215,710**	$3,262	$53,725	25%
Shift Results	**$ 53,820**	$348	$37,246	69%
CCMI - Advising	**$ 186,000**		$56,000	30%
Learning Activities	**$ 246,640**		$151,174	61%
CSI - portal & TA	**$ 75,992**	$3,899	$19,822	26%
Learning Community - fixed	**$ 1,080,000**		$810,000	75%
Learning Community - variable	**$ 2,080,000**	$180,000	$250,000	12%
Pathways Hub				
Community Choice - Hub Lead Agency	**$ 1,426,612**	$69,257	$467,797	33%
Transitional Care and Diversion Intervention				
Confluence Health (TCM Trainer)	**$ 55,000**		$0	0%
Add Hospital Contractor Payment (TBD)	**$ 20,000**		$0	0%
EMS Contractor Payments(NCECC)	**$ 60,000**		$22,042	37%
TCDI Hospital Partner Funds	**$ 234,626**		$233,763	100%
EMS Partners Payments	**$ 240,000**		$113,500	47%
Emerging Initiatives Approval (CCOW)	**$ 20,000**		$0	0%
** Other TCDI Initiatives*	**$ 370,000**		$0	0%
Opioid Project				
Rapid Cycle Applications	**$ 100,000**		$59,599	60%
Public Awareness Contract	**$ 30,000**		$2,100	7%
^ School Based Prevention Contracts	**$ 60,000**		$60,000	100%
*^ * Other Opioid Initiatives (TBD)*	**$ 35,000**		$0	0%
Grand total	**$ 7,620,325**	**$303,137**	**$2,582,340**	**34%**
			% of Fiscal Year	83%

Total Budget	**$ 9,231,630**	**$ 425,697**	**$ 3,700,395**	**40%**

"*" asterisks - This means a line item will need to go back to the Board in 2019 for further approval prior to any funds being expended.

"^" Budget Amendment Occurred in 2019

Budget Amendments - 2019

Date	Amendment
01.07.19	Motion to approve an increase of $116,425 to the current 2019 budget amount allocated to the Qualis Health Contract to include contracting for HIT technical assistance, This will bring the total budgeted amount for the Qualis Health contract to a maximum (up to) amount of $215,710 in 2019.
03.04.19	Motion to approve $13,500 to allocate for a contracted vendor to support Executive Director coordination and support between the nine ACHs in 2019.
05.06.19	Approval of the adjusted Opioid Project Budget as presented at the Board meeting.
7.3.2019	Motion to increase the 2019 budgeted amount for the OHSU contract by $28,000 (from $72,000 to $100,000) to support current initiatives through the end of 2019.
7.3.2019	Motion to increase the 2019 budgeted amount for workforce development by $7,125 (from $41,000 to $48,125) to support current initiatives through the end of 2019.
11.04.2019	Motion to increase the 2019 budgeted amount for the PHSKC contract by $16,000 (from $24,000 to $40,000) to cover data analytic services through the end of 2019 and comply with the Board's budget deviation policy.

Board Decision Form

TOPIC: Payments to "Shared Domain 1 Partners" as part of Washington State Intergovernmental Transfer payment mechanism

PURPOSE: Approve distribution of North Central Accountable Communities of Health Shared Domain 1 Incentive funding (December 2019)

BOARD ACTION:

☐ Information Only

☑ Board Motion to approve/disapprove

BACKGROUND:

Summary of IGT Strategy:

- The Centers for Medicaid and Medicare Services (CMS) approved 2 funding sources for the Transformation project: Designated State Health Programs (DSHP) and Intergovernmental Transfers (IGT). NCACH approved the current IGT strategy funding concept and is approving anther payment to IGT contributors and their partners.

Background on Distribution of Shared Domain 1 Investment Funds:

- Part of the IGT arrangement is that our region will approve money twice a year to IGT contributors and their partners.
- The approved $1,461,587 will flow through the Financial Executor in an account held for NCACH funding designated for Shared Domain 1 Investments.
- The Governing Board will approve release of these dollars in December 2019 which will be distributed to Shared Domain 1 Partners based on the following process:
    - Dollars will go into the account under the Shared Domain 1 Investment category from HCA
    - Once those dollars go into the account under the Shared Domain 1 Investment category, the pre-approval of the Governing Board will cause the Financial Executor to automatically release those dollars to the Share Domain 1 partners
- Board approval allows release of dollars from the Shared Domain 1 Investment category (Dollars in the NCACH Project Incentives, FIMC, VBP, and High Performance Pool categories will not be affected)
- If the release of dollars to Shared Domain 1 Partners is not approved, this will affect the Project Incentive Funds associated with the IGT strategy that is going to NCACH
- NCACH, IGT contributors, and HCA continue to work together on a plan to address Shared Domain 1 initiatives that is a mutually beneficial for all parties.

PROPOSAL:

Motion to approve the payment of $1,461,587 to partnering providers as allocated under the NCACH column of the Shared Domain 1 Investments worksheet to be distributed when the funding is placed in the NCACH account under the Shared Domain 1 Investment Category held by the Financial Executor.

IMPACT/OPPORTUNITY (fiscal and programmatic):

Intergovernmental Transfer payments is one way that the Washington State Medicaid Transformation Project is funded. Approval of these payments ensures that this process stays on track. If an ACH does not approve their portion of the payment, then all ACHs will see a decrease in total available funds available through the Medicaid Transformation Project.

TIMELINE:

- December 2nd, 2019: NCACH Board approves payment to partnering providers
- December 2019: Shared Domain 1 incentives are distributed to partners in the Financial Executor portal.

Submitted By: John Schapman
Submitted Date: 12.02.19

Attachments:

- Consolidated Partnering Provider Achievement Report

Consolidated Partnering Provider Achievement Report - Demonstration Year 3 (January-June 2019)

ACH Name	Better Health Together	Cascade Pacific Action Alliance	Greater Columbia	HealthierHere	North Central	North Sound	Olympic Community of Health	Pierce County	SWACH	All ACHs
Shared Domain 1 Incentives	$3,215,491	$2,923,175	$4,092,444	$6,430,982	$1,461,587	$4,384,761	$1,169,269	$3,507,809	$2,046,222	**$29,231,740**

Partnering Provider	Provider Name in FE Portal	Earned Funds	Earned Funds	Earned Funds	Earned Funds	Earned Funds	Earned Funds	Earned Funds	Earned Funds	Earned Funds	Total Earned Funds
EVERGREEN HEALTHCARE	King County Public Hospital District 2	$282,963	$257,239	$360,135	$565,926	$128,620	$385,859	$102,896	$308,687	$180,068	$2,572,393
VALLEY MEDICAL CENTER	Public Hospital District No 1 of King County	$282,963	$257,239	$360,135	$565,926	$128,620	$385,859	$102,896	$308,687	$180,068	$2,572,393
ASSOCIATION OF WA PUBLIC HOSPITAL DISTRICTS	ASSOCIATION OF WA PUBLIC HOSPITAL DISTRICTS	$26,055	$23,687	$33,161	$52,111	$11,844	$35,530	$9,475	$28,424	$16,581	$236,868
SKAGIT REGIONAL HEALTH	PHD 1 DBA SKAGIT VALLEY HOSPITAL	$8,584	$7,804	$10,925	$17,168	$3,902	$11,705	$3,121	$9,364	$5,462	$78,035
OLYMPIC MEDICAL CENTER	Clallam County Pub Hosp Dist 2	$4,888	$4,443	$6,220	$9,775	$2,222	$6,665	$1,777	$5,332	$3,110	$44,432
WHIDBEYHEALTH- GENERAL HOSPITAL	WHIDBEY GENERAL HOSPITAL	$2,803	$2,548	$3,568	$5,606	$1,274	$3,823	$1,019	$3,059	$1,784	$25,484
GRAYS HARBOR COMMUNITY HOSPITAL	GRAYS HARBOR COMMUNITY HOSPITAL	$217	$197	$276	$434	$99	$296	$79	$237	$138	$1,973
JEFFERSON HEALTHCARE- GENERAL HC	JEFFERSON GENERAL HOSPITAL	$2,719	$2,471	$3,459	$5,436	$1,235	$3,706	$988	$2,965	$1,730	$24,709
ISLAND HOSPITAL	Island Hospital	$2,642	$2,402	$3,363	$5,285	$1,201	$3,603	$961	$2,883	$1,681	$24,021
MASON GENERAL HOSPITAL	Public Hospital district No 1 of Mason County	$2,595	$2,360	$3,304	$5,190	$1,180	$3,540	$944	$2,832	$1,652	$23,597
SAMARITAN HEALTHCARE- HOSPITAL	Samaritan Healthcare	$2,160	$1,963	$2,750	$4,320	$982	$2,946	$786	$2,357	$1,375	$19,639
KITTITAS VALLEY HEALTHCARE- COMMUNITY HOSPITAL	Kittitas County Public Hospital District No 1	$1,990	$1,809	$2,532	$3,979	$904	$2,713	$723	$2,171	$1,266	$18,087
PULLMAN REGIONAL HOSPITAL	Public Hospital District No 1-A of Whitman County	$1,782	$1,621	$2,269	$3,565	$810	$2,431	$648	$1,944	$1,134	$16,204
PROSSER MEMORIAL HEALTH- HOSPITAL	Prosser Public Hospital District of Benton County	$1,374	$1,249	$1,749	$2,749	$625	$1,874	$500	$1,499	$875	$12,494
SNOQUALMIE VALLEY HOSPITAL	King County Public Hospital District No 4	$1,039	$945	$1,323	$2,079	$472	$1,417	$378	$1,134	$661	$9,448
SUMMIT PACIFIC- MEDICAL CENTER	Grays Harbor County Public Hospital No 1	$875	$795	$1,114	$1,750	$398	$1,193	$318	$954	$557	$7,954
COULEE MEDICAL CENTER	Douglas Grant Lincoln and Okanogan Counties Public Hospital Dist 6	$848	$771	$1,079	$1,697	$385	$1,156	$308	$925	$540	$7,709
NEWPORT HOSPITAL & HS- COMMUNITY HOSPITAL	NEWPORT COMMUNITY HOSPITAL	$1,220	$1,109	$1,552	$2,439	$554	$1,663	$444	$1,331	$776	$11,088
MID VALLEY HOSPITAL	Okanogan County Public Hospital District No 3	$976	$888	$1,243	$1,953	$443	$1,331	$355	$1,065	$621	$8,875
WHITMAN HOSPITAL AND MC	WHITMAN HOSPITAL and MEDICAL CENTER	$819	$744	$1,042	$1,637	$372	$1,116	$298	$893	$520	$7,441
FORKS COMMUNITY HOSPITAL	Clallam County Hospital District 1	$813	$739	$1,034	$1,626	$369	$1,108	$296	$887	$517	$7,389
LAKE CHELAN COMMUNITY HOSPITAL	Chelan County Public Hospital District 2	$797	$724	$1,015	$1,593	$362	$1,086	$290	$869	$507	$7,243
ARBOR HEALTH (MORTON)	Lewis County Hospital District No 1	$801	$728	$1,020	$1,603	$364	$1,094	$291	$874	$510	$7,285
OCEAN BEACH HOSPITAL & CLINICS	Public Hospital District 3 of Pacific County	$755	$686	$960	$1,509	$343	$1,029	$275	$823	$480	$6,860
LINCOLN HOSPITAL	LINCOLN HOSPITAL	$760	$691	$968	$1,521	$346	$1,037	$276	$829	$484	$6,912
KLICKITAT VALLEY HEALTH	KLICKITAT VALLEY HEALTH	$725	$659	$923	$1,451	$330	$989	$264	$790	$462	$6,593
NORTH VALLEY HOSPITAL	Okanogan Public Hospital District 4	$694	$632	$884	$1,389	$316	$947	$252	$757	$442	$6,313
WILLAPA HARBOR HOSPITAL	WILLAPA HARBOR HOSPITAL 1	$677	$615	$861	$1,354	$308	$923	$246	$738	$431	$6,153
SKYLINE HOSPITAL	Public Hospital District No 2 of Klickitat County	$687	$625	$874	$1,374	$312	$937	$250	$750	$437	$6,246
DAYTON GENERAL-COLUMBIA COUNTY HS	Columbia County Public Hospital District 1	$550	$501	$701	$1,102	$250	$752	$201	$601	$351	$5,009
COLUMBIA BASIN HOSPITAL	Grant County Public Hospital District No 3 dba Columbia Basin Hospital	$558	$506	$708	$1,113	$253	$759	$202	$607	$354	$5,060
CASCADE MEDICAL CENTER	Chelan County Public Hospital District No. 1 dba Cascade Medical Center	$626	$569	$797	$1,252	$284	$853	$228	$683	$398	$5,690
OTHELLO COMMUNITY HOSPITAL	OTHELLO COMMUNITY HOSPITAL	$569	$517	$724	$1,137	$259	$776	$207	$621	$362	$5,172
THREE RIVERS HOSPITAL	Three Rivers Hospital	$693	$630	$882	$1,386	$315	$945	$252	$756	$441	$6,300
VERDANT HEALTH COMMISSION	Public Hospital District No 2 Snohomish County	$329	$299	$418	$657	$149	$448	$120	$359	$209	$2,988
FERRY COUNTY MEMORIAL HOSPITAL	FERRY COUNTY MEMORIAL HOSPITAL 1	$470	$429	$599	$941	$214	$641	$171	$513	$299	$4,277
ODESSA MEMORIAL HEALTHCARE CENTER- HOSPITAL	Lincoln County Public Hospital District 1	$491	$447	$625	$983	$223	$670	$178	$536	$313	$4,466
EAST ADAMS RURAL HEALTHCARE- HOSPITAL	EAST ADAMS RURAL HOSPITAL 1	$464	$422	$590	$928	$211	$633	$169	$506	$295	$4,218
QUINCY VALLEY MEDICAL CENTER	Grant County Public Hospital District 2	$598	$543	$762	$1,197	$272	$816	$218	$653	$381	$5,440
GARFIELD COUNTY- MEMORIAL HOSPITAL	Garfield County Hospital District Pomeroy Medical Clinic	$504	$458	$641	$1,007	$229	$686	$182	$549	$320	$4,576
MCKAY HEALTHCARE & REHAB	GRANT COUNTY McKay Rehab	$365	$331	$464	$729	$166	$497	$133	$398	$231	$3,314
PH UNITED GENERAL- SKAGIT CO. PHD#304	SKAGIT CO PHD United General	$55	$50	$70	$110	$25	$75	$20	$60	$35	$500
PH PEACE ISLAND MEDICAL CENTER- SAN JUAN PHD#1 (EMS)	SAN JUAN PHD Peace Island	$55	$50	$70	$110	$25	$75	$20	$60	$35	$500
FRANKLIN COUNTY PHD#1	Franklin County Public Hospital District 1	$55	$50	$70	$110	$25	$75	$20	$60	$35	$500
KITTITAS VALLEY HEALTHCARE-EMS PHD#2	KITTITAS COUNTY PHD 2	$55	$50	$70	$110	$25	$75	$20	$60	$35	$500
LOPEZ ISLAND HOSPITAL DISTRICT- CLINIC	SAN JUAN PHD Lopez	$55	$50	$70	$110	$25	$75	$20	$60	$35	$500
ORCAS ISLAND HEALTHCARE DIST	SAN JUAN COUNTY PUBLIC HOSPITAL DISTRICT 3	$55	$50	$70	$110	$25	$75	$20	$60	$35	$500
POINT ROBERTS CLINIC	POINT ROBERTS CLINIC	$55	$50	$70	$110	$25	$75	$20	$60	$35	$500
GRANT CO PHD#7	GRANT COUNTY PHD 7	$55	$50	$70	$110	$25	$75	$20	$60	$35	$500
DOUGLAS CO PHD#2	DOUGLAS CO PHD 2	$55	$50	$70	$110	$25	$75	$20	$60	$35	$500
GRANT CO PHD#5 MATTAWA COMMUNITY MEDICAL CLINIC	GRANT COUNTY PHD 5	$55	$50	$70	$110	$25	$75	$20	$60	$35	$500
SKAMANIA COUNTY PHD #1- EMS	SKAMANIA COUNTY PHD	$55	$50	$70	$110	$25	$75	$20	$60	$35	$500
STILLY VALLEY HEALTH	PUBLIC HOSPITAL DISTRICT 3 SNOHOMISH COUNTY WA	$55	$50	$70	$110	$25	$75	$20	$60	$35	$500
UNIVERSITY OF WASHINGTON	University of Washington	$2,572,393	$2,338,540	$3,273,955	$5,144,785	$1,169,270	$3,507,809	$935,414	$2,806,247	$1,636,979	$23,385,392
Shared Domain 1 Incentives Total		$3,215,491	$2,923,175	$4,092,444	$6,430,982	$1,461,587	$4,384,761	$1,169,269	$3,507,809	$2,046,222	$29,231,740

Final incentive amounts are contingent upon all nine ACHs providing final approval for their portion of the shared domain 1 incentives and full IGT contribution.

Executive Director's Report – December 2019

As we enter a time of giving and gratitude with family, I wanted to take a moment to honor the legacy of one of NCACH's champions and dear partner, Eric Skansgaard.

(Eric Skansgaard (L), at an NCACH event in April 2018. Photo – NCACH)

Eric passed unexpectedly on November 8, 2019, and his loss came as a shock to us all. He was dedicated and steadfast in his resolve to improve access to behavioral health care and crisis services for the North Central region. We were lucky to have Eric step into a leadership role for our organization as the chair of NCACH's Transitional Care and Diversion Interventions (TCDI) Workgroup for the past two years.

Eric had such a strong personality and presence – which he used to fiercely advocate for those in crisis across the region. His leadership created important partnerships that advanced NCACH's work, including a pilot project for EMS responders to transport patients in crisis to Parkside, and engagement with law enforcement and first responders.

As the TCDI Workgroup Chair, Eric always made sure that crisis response and mental health care were at the forefront of our conversations. He constantly challenged our healthcare system to better serve those who were often underserved – and to embrace mental health care as a tenant of whole person health. He was always willing to listen or lend advice, something that will be missed terribly by many in our community.

One of Eric's lasting contributions to the region endures in the work he did with the *Trueblood* grant, which provided funding and support to get people in crisis access to services that they needed, and diverted them away from incarceration. Eric's work touched thousands of people in the region, whether or not they knew it. Our region is stronger because of him.

For those who are interested in supporting Eric's family, a GoFundMe account has been set up to benefit his family during their time of grief.

Our hearts are with you.

In remembrance,

Linda Evans Parlette, Executive Director

NCACH Pathways Community HUB – Assessment, Recommendations

Center for Community Health and Evaluation

November 1, 2019

Background

North Central Accountable Community of Health (NCACH) is implementing the Pathways Community HUB (HUB) care coordination model as part of their Medicaid Transformation Project work. An initial pilot is being conducted in Moses Lake and enrollment is lagging behind expectations. NCACH engaged the Center for Community Health and Evaluation (CCHE) to conduct stakeholder interviews to help identify ways of increasing enrollment and improving overall program implementation.

CCHE interviewed a range of stakeholders, including HUB staff from Action Health Partners (AHP), Community Specialist Services Agency (CSSA) leadership, Pathways Community Specialists (PCSs), Managed Care Organizations (MCOs), and leadership from Samaritan Hospital in Moses Lake. CCHE also reviewed relevant documents, including the initial HUB RFP, contract templates, audit instruments, meeting minutes & presentations.

This report summarizes the results of the interviews and other data gathering and makes recommendations. Sections include:

- Brief overview of the HUB model
- Desired state for community care coordination
- Assessment of the current state, challenges to reaching the desired state, and recommendations

Pathways Community HUB model

The HUB is managed by a coordinating organization designed to support a sustainable community-based care coordination system, that includes a network of CSSAs and PCSs (who function as Community Health Workers (CHWs))[1]. The core of the program consists of 20 Pathways that range from social determinants (e.g., housing, education, employment) to more medically focused (e.g., medication management, immunizations, finding a medical home). Each Pathway includes a series of steps and desired outcomes, that patients are coached through by the PCS.

In NCACH, the HUB target population is frequent emergency department (ED) users – 3 or more visits in the past 12 months. An initial pilot of the program began in October 2018 in Moses Lake (Grant County), with the Samaritan ED as the referral source and a single zip code (98837) as the initial geographic area. The Grant County geography was expanded in July 2019 to include additional zip codes. An expansion into Chelan-Douglas counties is scheduled for the fourth quarter of 2019. More details on the Moses Lake pilot are provided below.

NCACH is committed to financially supporting the HUB through the initial planning and implementation phases in order for it to become a viable and sustainable program. Funding for the selected HUB lead agency–Action Health Partners-is being provided to build its capacity to:

- identify, recruit, and support a network of CSSAs
- create referral networks to bring patients into the HUB
- coordinate training and provide ongoing support for PCSs to support patients through Pathways
- administer the program, including the outcome-based payment system

[1] Nationally, the Pathways Community HUB model often is described as a network of care coordination agencies (CCAs) and their community care coordinators (CCCs, aka Community Health Workers). The North Central region uses the terms Community Specialist Services Agency (CSSA) and Pathways Community Specialists (PCSs) to distinguish these entities and roles from other care coordination or care management efforts in the region.

Elements of a successful HUB

The long term goal is to build and sustain the full evidence-based HUB model, including a HUB coordinating agency and CSSAs paid through the HUB outcome-based reimbursement system. Based on conversations and reading HUB documents, the elements that need to be in place for a sustainable and effective HUB are:

- Referral networks capable of providing CSSAs/PCSs with adequate caseloads, along with a workflow and supporting communications and IT infrastructure that facilitates inputting patient information into the CCS data system[2]
- Trained and supported PCSs capable of leading patients to Pathways completion at HUB standards. The training for new PCSs must be efficient and provide them with the skills to recruit, retain, and lead patients through Pathways. The support provided will include structured training, informal training and mentoring, and providing real-time answers to questions that arise in day-to-day operations
- Communication networks that ensure that all organizations that touch a patient are able to communicate with each other about relevant aspects of the patient's care
- A well-functioning HUB agency that provides overall coordination for the system and can respond to challenges that arise in the ongoing HUB operation, as well as creatively identifying new opportunities for collaboration and referral
- Information technology (IT) infrastructure that can facilitate transfer of information about patient interventions and outcomes. This should include providing information *from* the HUB to patient medical and administrative homes (e.g., Primary care providers (PCPs) and MCOs); and may include providing information and referrals *to* the HUB via electronic (as opposed to paper/fax) methods.
- Funding sources to support the HUB system, including the PCSs and HUB/CSSA administrative costs. Payment mechanisms may include the standard HUB model of paying for Outcome Based Units[3]

Current state, successes and challenges

Current state. The Pathways Community HUB model has been in operation since October 2018 in Moses Lake. Partners involved in the pilot implementation include:

- Action Health Partners – HUB (the central HUB agency administering/managing model)
- Grant Integrated Services – CSSA employing one PCS
- Moses Lake Community Health Center – CSSA employing one PCS
- Rural Resources – CSSA employing one PCS, currently on leave of absence
- Samaritan Healthcare – referral partner

Given the selected target population, the HUB currently relies on a referral system where Samaritan generates a list of patients with 3+ visits to the ED, determines whether they are on Medicaid, gives them information about the program, and then sends the list to the HUB. The HUB enters the list into the Care Coordination System (CCS) that houses the HUB data and assigns them to one of three CSSAs. The PCSs at each CSSA then do cold calling of patients on their list to recruit them into the program.

[2] Care Coordination Systems LLC provides the licensing for the Pathways HUB connect software platform that supports the Pathways HUB model, also known as the Care Coordination System. .

[3] Completed Pathways are assigned values known as Outcome Based Units (OBUs). Different Pathways have different OBUs based on the difficulty and impact of completing the Pathway; e.g., housing may have higher OBUs than assistance with utility bills, since housing is more challenging and represents a more significant well-being improvement for clients.

Enrollment results to date (as of June 30, 2019) are:

- A total of ~350 HUB eligible patients have been identified
- ~50 patients have been enrolled (15% of those eligible) – with caseloads ranging from 6 to 25 across the four PCSs

All of the PCSs have been through the Pathways training, including two one-week didactic sessions, with a six-month practicum in between the two sessions. Clients are being served and Pathways completed. A total of 266 Pathways had been initiated for current and past enrollees through June 30, 2019 and 51 (19%) of these have been completed. Leading Pathways initiated include social services referrals (32% of all Pathways), education (22%), medical referral (12%), and tobacco cessation (7%). Most of the completed Pathways have been for education (33 completed or 65% of all completed pathways).

Successes and challenges. The positives with respect to the six required HUB elements outlined above are:

- Trained PCSs housed at agencies that are well-suited to the CSSA role. The CSSAs have successfully recruited PCSs from a diversity of backgrounds, including some that fit the profile of a peer lay health worker with a high-school education
- Potential future funders with a relatively positive view of the HUB model, particularly the structure it provides to the care coordination process, who are interested in exploring the sustainability of the HUB and are in active conversations with AHP about potential funding models

Challenges to date include:

- Small caseloads, despite a considerable amount of cold-calling by the PCSs. An ED is a challenging environment for recruiting patients into a care management program such as the HUB. Patients are often stressed and focused on their visit and not receptive to information being provided by ED staff about a new program. The caseloads to date fall well short of the estimates from the Pathways Community HUB Institute (PCHI) of 40-50 per PCS needed to sustain a HUB - based on an estimated total OBU payment of $1700-1800 per client and current PCS salaries
- Referral process – Samaritan ED has been a committed referral partner, developing workflows and encouraging their staff to recruit people into the program. Despite these efforts there has been a lack of recognition of the Pathways HUB by potential HUB recruits when they are called by the PCSs
- Administrative challenges– There have been delays in some administrative tasks (e.g., contracts, MOUs) as a result of staff turnover and the substantial data-entry burden with the current referral system. The HUB is required to hand enter hundreds of referral records into the CCS system, and then the PCSs need to contact potential clients from the list repeatedly to determine interest and recruit
- Expensive, ineffective training – Training costs have been $4,000 per PCS and the training was not viewed as valuable by the PCSs interviewed. Particular weaknesses were in training around Community Health Worker skills and providing workflows for PCS activities
- Imperfect communication among the different elements of the HUB. For example, regular channels are not available for the MCOs, health systems, and other patient medical homes to find out whether their patients are enrolled in the HUB and, if so, the Pathways that they are working on or have completed. And the HUB is unable to complete soft handoffs to the MCOs when it identifies a Health Homes client who has been referred to the HUB or one that is enrolled in the HUB who becomes Health Homes eligible
- Inadequate IT infrastructure – The HUB CCS data system is not currently able to serve as an effective IT platform to facilitate communication and information exchange. It can not send and receive information from health care systems, providers and MCOs

Recommendations

The following are recommendations, in order of priority, for improving HUB performance:

1. Recruit other referral partners. Federally Qualified Health Centers (FQHCs) and Rural Health Centers are good candidates for referral partners: they have a high proportion of Medicaid patients who can benefit from the HUB model and they may have access to Collective Medical to verify that they meet the 3+ ED visit criteria. AHP is currently in conversations with Moses Lake Community Health Center to add being a referral source to their current role as a CSSA.

Using clinics as referral partners has the added advantage of addressing some of the structural challenges with the HUB noted above - communication, referrals, and a well-functioning IT infrastructure. For example, an FQHC or Rural Health Center can serve as both a referral partner and a CSSA. They can search their own patient records for candidate referrals (using their access to Collective Medical to confirm eligibility), work with their own providers to confirm potential candidates, and have preliminary conversations with patients before sending them to the HUB. The HUB can then assign the FQHC patients to their own PCSs which makes communication between the HUB/PCS and health care providers much simpler and potentially more effective.

It may be advantageous for MCOs to be involved in the new clinic-based referral process, especially in the pilot phase where value of the HUB to potential payors is being determined. MCOs can generate lists of patients that meet the 3+ ED visit criteria (and perhaps other criteria, including cost of care). These lists can be sent to the clinic referral partners and used as a starting point for recruitment.

2. Pursue other enrollment strategies. Other strategies to promote recruitment into the HUB include:

- Provide better marketing and program materials to sell the value of the program to referral partners and clients – including videos and PowerPoints.
- Implement texting and emailing (vs. phone calls) as a contact option for recruiting patients.

3. Improve the PCS training and support system.

- Approach the Washington State Department of Health (DOH) and ask them to add a module to their CHW training that is specific to the PCS/pathways. This would be more cost-effective than the current CCS training and would provide standardization across HUBs from different ACH regions
- Reach out to other ACHs and the PCHI to see if there are existing online or other modules that can be used to onboard a PCS
- Work with CCS to write up work flows for each position (e.g., PCS, supervisor) so there is a guide for each aspect of the process and each staff person knows their responsibilities.
- Provide better 1-1 support from the HUB to the PCSs; that support has been limited/inadequate to date partly due to HUB capacity issues

4. Take steps to improve the IT infrastructure. A sustainable HUB will require bi-directional communication among organizations through their IT platforms. Specific things to focus on include:

1. Create a connection from the HUB to clinics and health systems so that Pathways information can be transmitted efficiently into EHRs
2. Identify ways of sending MCOs patient lists from the HUB so they can track cost, utilization and clinical outcomes for those patients Work to document the value of HUB services using key MCO cost and health outcome metrics

North Central Accountable Community of Health

Board Information Form

TOPIC: Community-based Care Coordination

PURPOSE: Prepare Governing Board, Action Health Partners, and NCACH staff for the Governing Board and/or a Committee of the Board to have in-depth informed discussions about the future of Community-based Care Coordination in the North Central ACH region over the next 2-3 months.

BOARD ACTION:

- ☑ Information Only
- ☐ Board Motion to approve/disapprove

BACKGROUND:

NCACH selected Community-based Care Coordination as part of their Medicaid Transformation Project (MTP) portfolio, and the Health Care Authority (HCA) designated the Pathways Community HUB as the only evidence-based model to select from. NCACH has been implementing this model through a contracted lead agency (Action Health Partners.)

Health Care Authority Position Statement

Recently, the HCA released a position statement to all ACHs to provide guidance on where they stand with respect to payment and sustainability planning for the Pathways Community HUB model (the position statement is attached). Given the clarification that "HCA is reinforcing Health Homes as HCA's community-based care coordination program for high-risk Medicaid beneficiaries", they provided 3 distinct potential directions ACHs could take:

A. Continue Pathways to serve a unique target population
B. Discontinue Pathways but maintain certain functions/components
C. Discontinue Pathways and identify other support/investment opportunities

All three of these options would require close collaboration and consultation with Managed Care Organizations (MCOs).

The HCA also clarified the following:

- HCA is not requiring or asking ACHs to discontinue Pathways
- MCOs are ultimately responsible for needs identification, care coordination and management of managed care beneficiaries
- HCA is not restricting MCOs from paying for or engaging in innovative care coordination partnerships or models, including Pathways
- HCA recognizes Pathways evaluation and return on investment will take time, and the position HCA is taking is not based on preliminary evaluation results

- Earnable funds associated with project 2b should not be impacted if an ACH discontinues Pathways, as long as rationale is clear and an appropriate alternative strategy and focus is defined.
- ACHs who pivot away from their current 2b Pathways work plans should complete a modification request seeking HCA approval.

In light of this change, HCA shared a draft Care Coordination Action Plan outlining their Medicaid Transformation priorities around care coordination:

A. Optimize Health Home enrollment/engagement and program capacity
    a. Patient identification, activation and notification
    b. Assignment of responsibility, management, and coordination between entities and across programs
B. Establish a common Health Home platform between Health Home Lead Entities and across Health Home Lead Entities and providers
C. Agree to community information exchange (CIE) future state and lead coordinated effort.

ACH Executive Directors, MCO representatives, and HCA leaders have been meeting monthly since August to clarify HCA's direction and vision for care coordination, and to understand its impact on Pathways Community HUB implementation.

<u>NCACH Pathways Community HUB Progress and Challenges to Date</u>

The Pathways Community HUB has experienced many successes and challenges during implementation. Below is a brief (not exhaustive) list of both.

Successes

- Pathways HUB launched on time on October 1, 2018 in Moses Lake
- Contracted CSSA organizations with staffing
- Use of the CCS IT platform and monthly reports
- Buy-in from necessary partners (referral partners, CSSAs, social service agencies)

Challenges

- Lower than expected enrollment and caseloads
- Lead agency turnover and understaffing
- Communication barriers between different elements of HUB
- Referral process slow to include primary care referrals
- Limited Pathways Community Specialists and expansion due to lack of training opportunities
- Challenges with IT infrastructure

IMPACT/OPPORTUNITY (fiscal and programmatic):
The NCACH Governing Board allocated $5 million to the Community-based Care Coordination project over the course of the MTP. To-date, has contracted for $1,094,500 in the development and implementation of the Pathways Community HUB care coordination model. Through this work, Action Health Partners has hired staff and established multi-year contracts with IT providers at the direction of the Governing Board.

We are near the end of year 3 of the Medicaid Transformation Project and Year 1 of Pathways Community HUB Operations. Given where things stand, it is important for NCACH staff, the Governing Board, and the HUB lead agency to weigh successes and challenges to evaluate the future of Pathways Community HUB in the North Central region and to ensure we are using resources efficiently to improve care coordination services and patient health.

TIMELINE:
The information above provides the rationale to commit to funding for the first six months of 2020 and why it is important to discuss the future of Community-based Care Coordination in the context of the Medicaid Transformation. Below is a tentative timeline to accomplish these goals.
December 2019: Commit to funding for the first 6 months of 2019
January 2020: Board Retreat Discussion
February: If needed, continued discussions during Board meeting, retreat, or other communication
March or April: Clarify North Central ACH's vision and direction for Community-based Care Coordination and decide whether to release or reallocate funding for July-December 2020.

Submitted Date: 12/02/2019
Staff Sponsor: Christal Eshelman

Washington State Health Care Authority

HCA's Position on ACH Implementation of the Pathways Community-Based Care Coordination Model

The purpose of this document is to clearly articulate HCA's position on ACH implementation of the Pathways Community-Based Care Coordination model, including related payment and sustainability planning.

HCA remains supportive of community-based care coordination, delivered by a wide array of staff/disciplines, to ensure access and continuity across the continuum of care. That being said, it is important to account for two important factors:

- Health Homes has a proven track record and ROI, and HCA is reinforcing Health Homes as HCA's community-based care coordination program for high-risk Medicaid beneficiaries.
- MCOs are responsible for a broad spectrum of care coordination activities for Medicaid managed care covered lives, including appropriate identification, access and enrollment into the Health Homes program.

HCA understands model-agnostic functions (e.g., CHWs, information exchange, and access to data) will benefit from ongoing discussion and HCA engagement. That being said, HCA will not entertain ongoing conversations regarding an HCA directive to fund Pathways. ACHs are expected to engage directly with local and regional partners, including MCOs, to establish the unique value that Pathways or other programs provide and to develop appropriate financing strategies.

Regardless of the course an ACH takes, and recognizing several ACHs are not implementing Pathways, HCA encourages ACHs to consider foundational care coordination needs that could be supported by the ACH and/or Initiative 1 resources. ACHs have flexibility surrounding the future of Pathways implementation efforts. Examples are provided below for consideration.

A. **Continue Pathways to serve a unique target population**: Identify other rising risk populations that may benefit from Pathways care coordination initiatives that aren't duplicative of existing Medicaid programs or MCO-led care coordination initiatives, and leverage and test Pathway's ROI with those populations to demonstrate potential sustainable interventions.

B. **Discontinue Pathways but maintain certain functions/components**: Identify opportunities to leverage functions and infrastructure (e.g., CHWs, HIT, centralized administration) to collaborate with MCOs and support beneficiary identification and access to care coordination programs, including Health Homes, and other community resources.

C. **Discontinue Pathways and identify other support/investment opportunities**. Pivot to a different investment and support strategy that fills identified care coordination gaps, in consultation with MCOs and HCA.

October 4, 2019

North Central Accountable Community of Health

Board Information Form

TOPIC: *Okanogan County Coalition for Health Improvement*

PURPOSE: *To update the NCACH Governing Board on the work of the Okanogan County CHI has completed on Coalition sustainability and mission beyond the MTP*

BOARD ACTION:

☑ Information Only

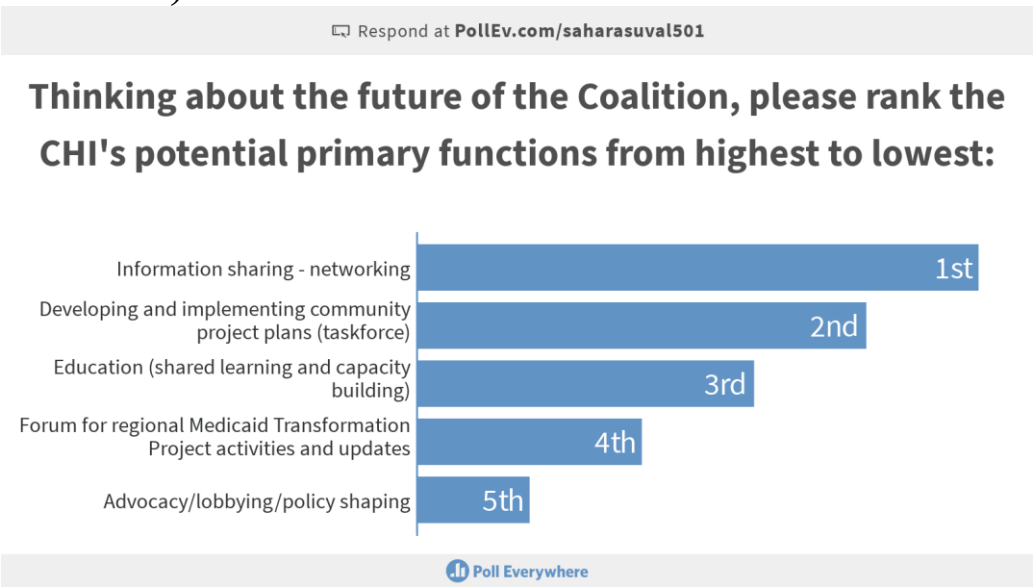
☐ Board Motion to approve/disapprove

BACKGROUND:

The Okanogan County CHI Leadership Council (Peter Morgan, Karen Schimpf, Lauri Jones, Orlando Gonzales, Mike Beaver, and Molly Morris) have recently polled Okanogan County Coalition members about their priorities and goals for the CHI as it looks at the future.

At the September 2019 meeting, Okanogan County CHI members were asked to identify the primary goals of the Coalition, what they would like the primary function of the group to be, and next steps to move the Coalition closer to their identified goals.

(Figure below shows some of the results from the 09/26/2019 Okanogan CHI Meeting Live Poll Exercise)



In response to Coalition feedback, Okanogan County CHI's Leadership Council has been working to develop a revised mission and vision statement and review potential structural changes the Coalition may need to make to achieve its future goals.

Revisions to Mission Statement and Okanogan CHI Values:

Please see attached version of Okanogan CHI Charter document with proposed updates.

The Leadership Council has also identified questions they would like to discuss with the Governing Board including:

1. The CHI is part of the NCACH Governance Structure through NCACH's Bylaws. What authority does the Okanogan County CHI have to develop our own mission and work? Are we required to update the CHI Charter to make these changes?
2. What will be the role of NCACH after the Medicaid Transformation Project (MTP), and what guidance can the NCACH Governing Board give about the role of the CHIs in the post-MTP period?
3. What authority does the Okanogan County CHI have to explore the following elements to guide future governance of the CHI?
    - *Vision*
    - *Purpose*
    - *Governance and management structure*
    - *Legal structure (501c3 or other?)*
    - *Key activities and responsibilities*
4. If allowed to update the mission statement, will the Okanogan County CHI have to rewrite its entire charter?
5. The Okanogan County Coalition for Health Improvement is interested in electing two individuals to share the CHI position on the Governing Board. Would this be possible and what discussions would need to happen to explore this further?

RECOMMENDATION:

For the Governing Board to provide direction on what the Okanogan County Coalition for Health Improvement needs to do to comply as an NCACH CHI while they develop plans for sustainability beyond the MTP.

Submitted By:	Okanogan County Coalition for Health Improvement
Submitted Date:	11/22/2019
Staff Sponsor:	Sahara Suval

North Central Accountable Community of Health

North Central Accountable Community of Health
Okanogan County Coalition for Health Improvement Charter
2019 - 2020

Background

On January 9th, 2017 the Washington State Health Care Authority (HCA) signed an 1115 Waiver, now known as the Medicaid Transformation Project. The goal of the Transformation is to improve care, increase efficiency, reduce costs and integrate physical and behavioral health into Medicaid contracting. To align clinical aspects of behavioral and physical health with payment integration, HCA developed the Medicaid Transformation Project Toolkit to provide tools, resources and guidance for these efforts.

As the North Central Accountable Community of Health (NCACH) began planning for regional health improvement projects under this 5-year contract initiative, they relied on input from local stakeholder groups, the Coalitions for Health Improvement.

The Coalitions for Health Improvement (CHI) were formed in 2014 in each of the public health jurisdictions (Chelan-Douglas, Okanogan, and Grant) to engage a wide variety of provider partners and stakeholders in the work of the NCACH. CHIs originally provided input regarding the formation of an ACH in this region, and the development of the NCACH Leadership Group. They were utilized to distribute information about design grants and upcoming State Innovation Model Transformation efforts. In 2016, the NCACH was officially formed as a standalone organization, and entered the Design Phase of the Medicaid Transformation, including the formation of a Governing Board. In April 2017, the NCACH Governing Board determined that the CHIs should be NCACH's primary means for community-level input and representation in NCACH's work. In July 2017, a voting seat for each CHI was established by the Governing Board which ensures that each Coalition is represented on the Board. In 2018, NCACH formally contracted with three hosting organizations and provided them with operational funding to organize and facilitate each Coalition.

In December 2018, the NCACH Governing Board moved to allocate funding for the three Coalitions for Health Improvement to direct towards regional and local-level health and wellness initiatives across the North Central region with oversight by the NCACH Governing Board.

Charge

~~The mission of the **Okanogan** Coalition for Health Improvement ("Coalition") is to foster authentic community engagement, create an ongoing pathway for gathering input from diverse groups of community members, and identify local projects that could support the~~

North Central Accountable Community of Health

~~overall goals of the Medicaid Transformation Project. Coalition members will advise the Governing Board on issues directly related to NCACH's mission and activities, including needs assessments and local health data; community health improvement plans and priorities; health improvement initiatives; project planning and selection; and delivery system transformation. Input from each Coalition, from the voting member on the NCACH Governing Board and through other means, will be utilized in the decision making process of the Governing Board, and any decision and direction approved by the Governing Board will be shared with the Coalition from the Coalition Governing Board Member.~~

The mission of the Okanogan County Coalition for Health Improvement is to improve the health of the people of Okanogan County by:

1) Fostering authentic community engagement by presenting opportunities for networking and supporting collaboration among diverse community groups in Okanogan County.
2) Identifying and implementing community health improvement projects that support the goals of NCACH and the specific needs and priorities of the Okanogan CHI.
3) Advising and guiding the work of NCACH through membership on its board and promoting communication and coordination of efforts between NCACH and Okanogan CHI.

Okanogan County Coalition for Health Improvement Values:

- Community
- Commitment
- Diversity
- Collaboration
- Communication

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Composition

The **Okanogan** Coalition for Health Improvement is open to anyone living or working in **Okanogan County** and is interested in building a healthier North Central Washington**.** All members of the community are welcome to attend Coalition meetings, however, voting privileges are limited to Coalition membership. Membership from the following sectors is encouraged but not limited to:

- Medical Provider Organizations (Behavioral Healthcare Providers, Medical Clinics, Hospitals, and other health providers)
- Local Health Jurisdictions
- Managed Care Organizations
- Medicaid Beneficiaries
- Community Based Organizations
- Community members

- Community partners such as transportation, housing, employment services, education, criminal justice, and financial assistance
- Tribal members and providers serving tribal populations

Anyone interested in attending or becoming a member of the Coalition should contact **[Coalition Contact].** Members will need to meet the minimum qualifications outlined below and sign the membership agreement form. There is no term limit for membership in the coalition. A voting member of the Coalition is defined as an individual who has signed the CHI membership form and attended at least 50% of Coalition meetings in a rolling calendar year. ***Not meeting the minimum requirements for membership could result in the loss of membership status for the Coalition Member.***

Each Coalition has a representative seat as a voting member of the NCACH Governing Board for a term of three years. To support the efforts of each Coalition and its Governing Board member, each Coalition is led by a leadership committee, who comprise the Coalitions for Health Improvement Leadership Council.

The Coalitions for Health Improvement Leadership Council consists of locally selected CHI members who have signed both a CHI membership agreement and a "CHI Leadership Council Membership Agreement." Leadership Council members are committed to facilitating and coordinating their local Coalition's efforts and goals, and ensure that county-level priorities are not lost in regionalization efforts. The CHI Leadership Council meets on a bi-monthly basis.

Meetings

The Coalition for Health Improvement will meet no less than on a bi-monthly basis (6 times annually), but may meet more frequently as needed. All meetings will have an option to participate via teleconference for those unable to attend in person. The Coalition Chair and contracted support staff will develop the agenda. Notes for all meetings will be sent to NCACH staff within 2 weeks of each meeting. All meeting materials (agendas, notes, presentations, etc.) will be posted by contracted support staff on the NCACH website (https://ncach.org) under the **Okanogan** Coalition for Health Improvement page.

Key Responsibilities

1. Form a local leadership group who is responsible for planning meetings, agendas, and relevant material for Coalition meetings.

2. Actively educate community partners about the work of the NCACH and let them know how members can engage in NCACH projects.

3. Convene a broad base of on-the-ground stakeholders and community partners to gather data and input on needs assessments and local health data; community health improvement plans and priorities; health improvement initiatives; project planning and selection; and delivery system transformation that the Governing Board can incorporate in their decision making process.

4. As directed by the Governing Board, create workgroups to assist in the implementation of Demonstration project initiatives.

5. Conduct open public meetings and upload all documents to the NCACH website within two weeks of each meeting.

Authority

The Coalition for Health Improvement will serve in an advisory capacity to the Governing Board by providing local input on the direction of Medicaid Transformation activities and regional projects, as well as for any local or regional initiatives that the Coalition wishes to endorse for Medicaid Transformation Funding under the 2019 CHI Community Initiatives funding See "Funding for Work" section to learn more.

The Coalition will have one voting Board Member on the NCACH Governing Board that is proposed by the Coalition and approved by the NCACH Governing Board. The leadership group of the Coalition will take nominations for Coalition Board Member from its members. At a regularly scheduled meeting of the Coalition, members will elect a Board Member by simple majority vote.

Funding for Work

The North Central Accountable Community of Health will provide funding for the work of the Coalition through a contract held by an organization residing within the Local Health Jurisdiction of the Coalition. This funding and the deliverables that are required will be set forth in the contract between the Governing Board and the contracted organization.

In December 2018, the NCACH Governing Board moved to allocate funding for the three Coalitions for Health Improvement to direct towards regional and local-level health and

wellness initiatives across the North Central region with oversight by the NCACH Governing Board.

The three Coalitions are tasked with forming one advisory group ("Advisory Group") with diverse representation from each Coalition (Chelan-Douglas, Grant, Okanogan) to design a community investment process in 2019, including – the development of eligibility requirements, funding applications, project selection criteria, and evaluation process for regional projects. Once the developed process is approved by the NCACH Governing Board, community partners will be invited to apply for funding to support regional projects. *To learn more about the role of the Advisory Group, please see "2019 CHI Community Initiatives Funding Advisory Group Charter."*

Procedural Policies

Conflicts

No one may profit financially from membership in the Coalition by sales or solicitation at meetings or workshops. Participants will disclose any actual or potential conflicts of interest to the membership or other designee.

Decision Making

Coalition business shall be conducted based on the philosophy of mutual respect. Coalition recommendations to the Governing Board will be voted on by voting members of the Coalition by simple majority rules. Coalition members attending the meeting either in person or by teleconference will be entitled to one vote.

Coalition Membership

1. Coalition Members agree to regularly attend scheduled meetings and actively participate in the work of the Coalition. Minimum requirement is defined as attending at least 50% of rolling calendar year meetings.
2. Coalition Members will sign a Membership Agreement (attachment A)

North Central Accountable Community of Health

North Central Accountable Community of Health Coalition for Health Improvement Charter
(Attachment A)

Membership Agreement Page

I acknowledge by my signature of this membership agreement that I have read, understood, and agreed to follow the guidelines and policies outlined in the North Central Accountable Community of Health Coalition for Health Improvement Charter.

I understand that continued membership in the Coalition is contingent on following the minimum requirements of membership that are outlined in the Charter. Not meeting the minimum requirements for membership could result in the loss of my membership status in the Coalition.

North Central Accountable Community of Health

Dated: _____ Signed: _____

Print Name: _____

Title: _____

North Central Accountable Community of Health
Coalition for Health Improvement Charter
Leadership Council Member Agreement 2019 - 2020
(Attachment B)

Purpose
To support the efforts of each Coalition and its Governing Board member, each Coalition is led by a local leadership group. The three Coalition's respective committees are called the Coalitions for Health Improvement Leadership Council.

The Coalitions for Health Improvement Leadership Council consists of locally selected CHI members who have signed a membership agreement and are committed to facilitating and coordinating their local Coalition's efforts and goals through the Charge as outlined below.

Charge
The Coalition for Health Improvement Leadership Council will serve in an advisory capacity to the NCACH Governing Board by providing local input on the direction of Medicaid Transformation activities and regional projects on behalf of the three Coalitions.

North Central Accountable Community of Health

Locally, the Okanogan County CHI leadership group is tasked with:

- Developing meeting agendas and strategic direction for the Okanogan County Coalition
- Design and facilitate meeting activities as needed
- Help develop and recommend processes associated with Coalition meeting objectives and Coalition/regional goals
- Assist in identifying, recruiting, and educating community partners about the Coalition and encouraging membership
- Provide input on NCACH activities as they relate to the Okanogan County Coalition goals and objectives
- Work collaboratively with the other Coalition's leadership groups to identify shared goals, priorities, and community resources
- Oversee the election process to appoint the Okanogan County Coalition voting Board Member as needed
- Representing Okanogan County Coalition's county-level priorities and needs to ensure they are not lost in regionalization

Each Coalition will have one voting Board Member on the NCACH Governing Board that is proposed by their respective Coalition and accepted by the NCACH Governing Board. The leadership committee of each respective Coalition will take nominations for the Coalition Board Member from its members. At a regularly scheduled meeting of the Coalition, members will elect a Board Member by simple majority vote.

If the Coalition does not meet the key responsibilities as outlined in this charter, the Coalition Leadership commits to meet with Governing Board members on a regular basis to address identified issues. The Coalition recognizes that oversight of the Coalition's work is the responsibility of the Governing Board.

Membership Roles and Responsibilities

- Attend at least 75% of regular meetings of the Okanogan County Coalition and actively participate in the work of the Coalition
- Attend at least 50% of regular meetings of the Okanogan County Coalition leadership group and bi-monthly CHI Leadership Council calls convened by NCACH
- Sign a Coalition Membership Agreement (Attachment A)
- Sign a Coalition Leadership Council Agreement (Attachment B)

Membership Agreement Page

North Central Accountable Community of Health

I acknowledge by my signature of this membership agreement that I have read, understood, and agreed to follow the guidelines and policies outlined in the North Central Accountable Community of Health Coalition for Health Improvement Leadership Council Agreement.

I understand that continued membership in the Coalition is contingent on following the minimum requirements of membership that are outlined in the Charter. Not meeting the minimum requirements for membership could result in the loss of my membership status in the Coalition.

Dated: _____ Signed: _____

Print Name: _____

Title: _____

North Central Accountable Community of Health

Board Decision Form

TOPIC: *2020 NCACH Budget Package*
PURPOSE: *Approve the 2020 NCACH Budget.*
BOARD ACTION: ☐ Information Only ☑ Board Motion to approve/disapprove
BACKGROUND: In September, NCACH staff worked to develop detailed budgets outlining expenses for each workgroup and non-workgroup operations, shared the process with the Governing Board, approved budgets within their workgroups and met with the Board Treasurer Brooklyn Holton to develop the budget outline for the Board. The initial draft of the 2020 budget was presented to the Executive committee on October 25th and to the Governing Board on November 5th. Based on feedback provided from the Board, NCACH Executive crafted a 2020 Budget Package recommendation for the Governing Board to approve. The recommended budget with an overview of changes are attached.
PROPOSAL: Motion to approve the 2020 annual budget for fiscal year January 1st to December 31st, 2020 as outlined in the attached budget spreadsheet totaling $7,897,054.
IMPACT/OPPORTUNITY (fiscal and programmatic): Will allow NCACH to adopt an operational Budget in 2020 and engage partners in contracting when the budget is approved.

Submitted By:	NCACH Executive/Finance Committee
Submitted Date:	12/02/2019
Staff Sponsor:	John Schapman

Changes to the NCACH Budget presented at the Nov 4th Gov. Board Meeting:

NCACH Executive/Finance Committee met on Friday November 15th and recommended the following changes to the 2020 budget.

As a reminder, the NCACH budget utilizes an Asterisk for budget line items that require further Governing Board discussion and action before funds are committed.

Asterisk "*" the following items:

- **CHI Partner Payments (2020):** This is to allow the initial 2019 round of CHI partner payment funding to be completed and have staff evaluate the process of fund distribution from the first round of funding. After evaluating the process, staff will provide recommendations to the Board on process adjustments or discontinuation prior to having the Board approve additional funding.
- **Community Information Exchange Workgroup:** At the November meeting, Board members felt like there was more discussion that needed to occur on this topic. The Board understands this is a scope of work that should receive additional evaluation, but are cautious proceeding forward.
- **Community Partnerships for Transition Solutions (Recovery Coach Network):** The Board has not had the opportunity review the details behind this budget request and it will be brought to the Board at a future meeting.

Remove the following items from the 2020 Budget:

These are budget items that Board member still need additional discussion to determine if it is an area of focus they want to invest funding. The Board needs to discuss these items and provide direction to staff on next steps for each item. Next steps will be determined in quarter 1 of 2020.

- **Health Equity Innovation Fund**
- **Capacity Building Rapid Cycle Applications**
- **NCACH Future Operations Funding (Reserves)**

Action Health Partners – Hub Lead Agency:

The committee knows that additional evaluation needs to be done in quarter 1 of 2020 to determine if any adjustments need to be made to the Community Based Care Coordination project including how we proceed forward with the Pathways Hub. Due to this information the Finance Committee is recommending the following:

- **Approve Pathways Hub lead agency funding for January – June 2020**
- **Asterisk "*" Pathways Hub lead agency funding for July – December 2020**

Discussion at December 2nd Board Meeting to Finalize

Executive Committee members wanted a status update on the below projects at the December 2nd Board meeting prior to determine if more information is needed to proceed forward with funding in 2020. Executive committee members recommend Board members review the information forms attached to the decision package to prepare for discussion at the December 2nd Governing Board meeting and choose to approve or asterisk "*" budget line items below based on the information provided.

- **TCDI Hospital Partner Work**
- **EMS Partner Work**
- **Opioid Prescriber Coaching Pilot**

North Central Accountable Community of Health

2020 Budget Board Decision Form Attachment

TCDI – Hospital Project Update

Purpose

To provide an overview of 2019 Hospital Project outcomes and recommendations for 2020 in order to justify allocation of funding to the hospital portion of the overall TCDI project in the 2020 Budget

2019 Funding

NCACH Governing Board approved up to $759,000 for the Hospital portion of the TCDI Project in 2019. The following eight Hospital partners participated and were allocated up to $71,000 each through an application process:

- Columbia Basin Hospital
- Confluence Health (TCM Trainer)
- Coulee Medical Center
- Lake Chelan Community Hospital
- Mid-Valley Hospital
- North Valley Hospital
- Samaritan Healthcare
- Three Rivers Hospital

Project Focus Areas

- **Transitional Care Management (7 hospitals)**
  - Transitional Care Nurse follow up within 48 hours of inpatient discharge
- **ER is for Emergencies Seven Best Practices focus areas (5 hospitals):**
  - Developed workflow to connect patients to outpatient services
  - Educate patients on accessing appropriate care for non-emergent issues
  - Integration of Emergency Department Information Exchange (EDie system) into Electronic Medical Record and workflow development to fully utilize this system
- **Transitions of Care with Community Partners (5 hospitals):** Examples include,
  - Each participating hospital identified a unique transitions of care initiative to implement I partnership with a non-clinical partner. Examples include:
    - Behavioral health referral between Coulee Medical Center and Colville Confederated Tribes
    - Partnership with Columbia Basin Hospital and People 4 People to transport patients to specialty care in Moses Lake
    - Workflow development for LCCH and North Valley Hospital acute care patients to transition to local outpatient clinical providers for follow up care.

To support Hospital partners in these focus areas, NCACH provided training in Transitional Care Management, Quality Improvement, Billing and Coding, and the Emergency Department Information

Additional information available at http://www.mydocvault.us/diversion-interventions-and-transitional-care-workgroup.html

Exchange system (EDie). Partners were also required to submit quarterly reports, participate in shared learnings, and attend individual meetings with NCACH staff.

Impact

1. Transitional Care and ED Diversion policies and procedures completed in six hospitals by the end of 2019. *Impact: Workflows are embedded in care delivery system.*
2. Increased partner collaboration. *Impact: Best practices shared saving time and resources.*
3. Online and onsite EDie training and technical assistance from Collective Medical Technology. *Impact: Improved data entry by ED providers and increased continuity of care between Emergency Departments and outpatient providers utilizing Collective Medical Platform.*
4. Agreements and workflows developed between agencies. Examples include Coulee Medical Center's partnership with Grant Integrated Services for behavioral health patients and North Valley Hospital's partnership with Confluence Health for inpatient discharges. *Impact: Improved continuity of care between Emergency Departments and primary care and behavioral health providers.*

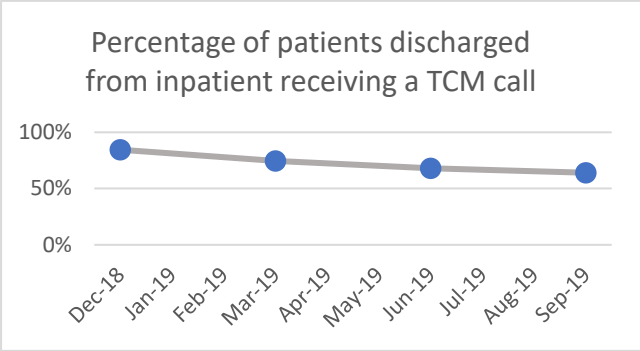
Data Collection

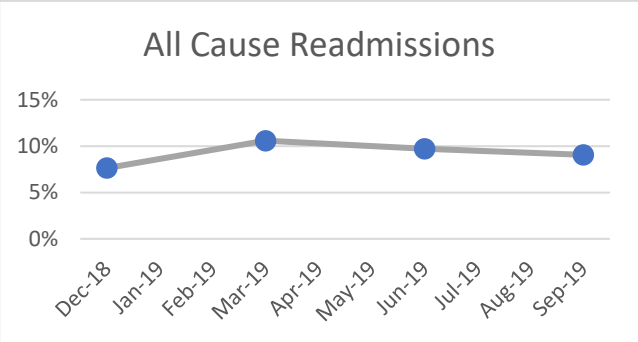
Hospital partners are collecting seven standard data points (4 TCM and 3 ED Diversion):

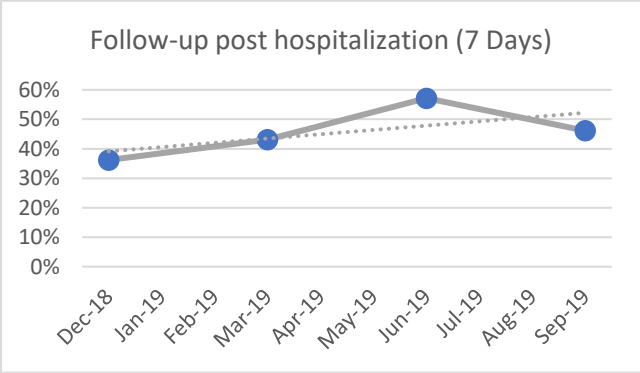
1. Percentage of patients discharged from inpatient receiving a TCM call
2. All cause readmission
3. Follow-up post hospitalization (7 days)
4. Follow-up post hospitalization (30 days)
5. 3+ ED visits in a rolling calendar year
6. Follow up from ED (7 days)
7. Follow up from ED (30 days)

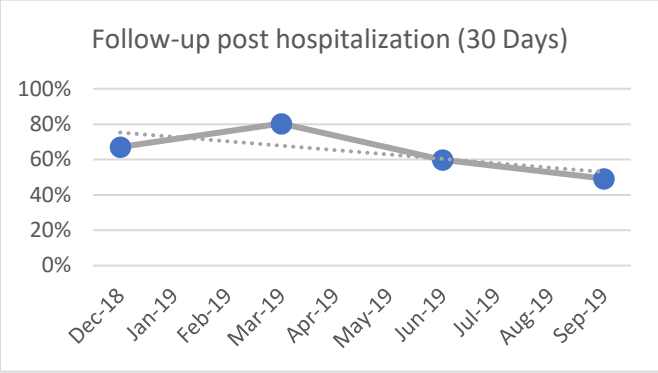
Partners have rigorously engaged in PDSA cycles to improve data collection on these metrics making it difficult to compare from quarter to quarter in 2019. It is also understood that there is seasonal variability to these metrics. It will be more appropriate to evaluate improvement efforts when 2-3 years of data have been collected. In 2019, there was a lot of focus on quality improvement (4-week training) and standardization of metrics.

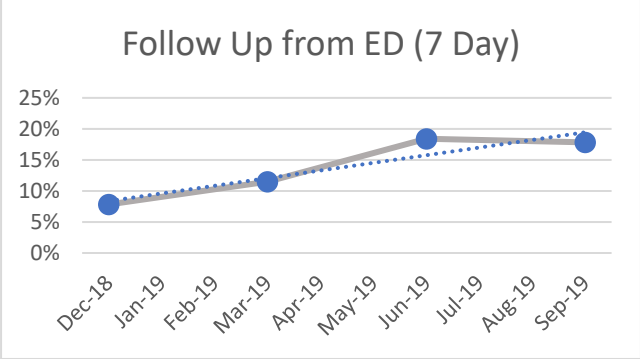
Additional information available at http://www.mydocvault.us/diversion-interventions-and-transitional-care-workgroup.html

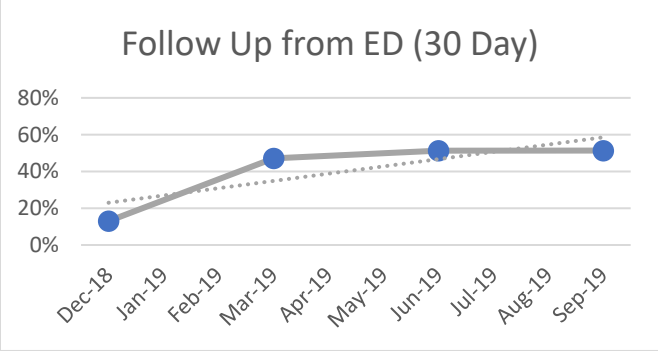


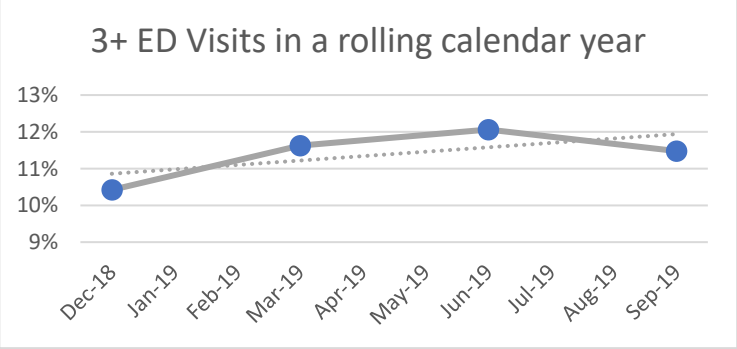












Additional information available at http://www.mydocvault.us/diversion-interventions-and-transitional-care-workgroup.html

North Central Accountable Community of Health

2020 Recommendations

Based on the mid-year reports submitted by partners, partner meetings, evaluation of quarterly reports, and evaluation with the TCDI workgroup, the following objectives and associated deliverables were approved by the Transitional Care and Diversion Intervention Workgroup on September 26, 2019.

Objective 1: Continue and expand ED Diversion and Transitional Care Management processes within each organization.

Objective 1 Deliverables:

1. Application extension to provide a current status update to project implementation, successes and barriers they are currently experiences, and how partners will expand their work.
2. Provide quarterly data reports that outline progress on quality metrics.
3. Semi-Annual reports on project status, challenges, and successes.
4. Identify barriers in implementation and participate in technical assistance opportunities provided by NCACH to overcome identified barriers.

Objective 2: Create regional workflows between primary care, behavioral health, and acute care (inpatient and Emergency Department) to improve transitions between providers.

Objective 2 Deliverables:

1. Connect with additional external partners
2. Participated in NCACH hosted regional Transitions of Care Planning meetings. Meetings will focus on workflow development for patients transitioning from acute care to primary care, behavioral health, and other partners where appropriate.

Objective 3: Develop clinical-community linkages for providers specific to their regional need (e.g. partnerships with transportation and/or housing agencies).

Objective 3 Deliverables:

1. Project plan to connect partners who are transitioning from acute care to local community based organization in the area.
2. Participate in technical assistance opportunities provided by NCACH

Based on the above objectives and deliverables, the TCDI workgroup recommends that NCACH offer funding to the eight hospital partners that participated in 2019 to continue expanding and improving their current TCDI efforts. Each partner would be eligible to receive up to $65,000 based on the following:

Partner Payment Type	Funding Amount
Transitional Care Management	$25,000
ED Diversion	$25,000
Clinical-Community Linkages	$15,000
Total (Each)	**$65,000**
Total Project (8 Organizations)	*$520,000*

Additional information available at http://www.mydocvault.us/diversion-interventions-and-transitional-care-workgroup.html

Payments would be distributed after submission of reports as follows:

Report Completion	Payment Date	Amount
Application Extension	February 2020	$208,000 *$26,000/organization; 40% of funding*
Quarter 2 Semi-Annual Report	August 2020	$156,000 *$19,500/organization; 30% of funding*
Quarter 4 Semi-Annual Report	February 2021	$156,000 *$19,500/organization; 30% of funding*

Additional information available at http://www.mydocvault.us/diversion-interventions-and-transitional-care-workgroup.html

North Central Accountable Community of Health

2020 Budget Board Decision Form Attachment

TCDI – EMS Project

Purpose

To provide an overview of 2019 EMS project outcomes and recommendations for 2020 in order to justify allocation of funding to the EMS portion of the overall TCDI project in the 2020 Budget.

2019 Funding and Objectives

NCACH approved $244,000 for 10 EMS agencies to complete the following objectives:

- Develop a "treat a referral" program: connect non-emergent patients to services in order to reduce ambulance transports and Emergency Department visits.
- Develop a program for alternative transport options to Parkside
- Improve clinical documentation and reporting functions using Washington Emergency Medical Service Information System (WEMSIS)

Each EMS Agency chose a specific area of focus as part of their "Treat and Referral" section of the project. Each agency's focus is shown below:

Agency	Treat and Referral Project Overview
Aero Methow Rescue Services	Adopted an agency Treat and Referral protocol that allowed EMTs to evaluate and connect non-emergent patients to primary care or other follow up services
Ballard	Implemented a Stay Active and Independent for Life (SAIL) fall prevention program. Ballard identified and referred patients to the program who routinely call Ballard for EMS services and did not receive transport
Cascade Medical Center (CMC)	Worked with CMC acute care to identify patients that benefit from post discharge follow up and provide those patients with follow up home visits with an EMS professional.
Douglas Okanagan County Fire District	Create wrap around services for fall risk patients that frequently use EMS services to reduce both non-transport and transport calls. Partnerships were created with Life Alert, Adult and Aging services, and senior centers.
Lake Chelan Community Hospital (LCCH)	Identify high utilizers of the LCCH and refer them to the LCCH Community paramedicine program for post discharge follow up with a Community Health Worker trained EMS professional
Lifeline	Partner with primary care providers and local health systems to identify high utilizers of 911 services and the Emergency Department. Partners created referral workflows to divert patients from 911 services and ensure they connect with appropriate care.
Moses Lake Fire Department	Adopted a Treat and Referral protocol within the agency that allowed EMTs to evaluate and connect high utilizers of the Emergency Department and 911 services to non-acute services (e.g. primary care, mental health, and community based organizations).
Protection-1 LCC	Partner with local hospital(s) (initially Quincy Valley Medical Center) to (1) identify high utilizers of ED that are non-emergent and refer them to lower acuity services, and (2) identify patients post discharge from inpatient or Emergency Department care that could benefit from an in-home follow-up visit from EMS.
Waterville EMS	Partner with Ballard Ambulance in the implementation of SAIL fall prevention program and refer non-emergent patients to the program who frequently use EMS services.

Additional information available at http://www.mydocvault.us/diversion-interventions-and-transitional-care-workgroup.html

Key Impacts on Patient Care and Workflow

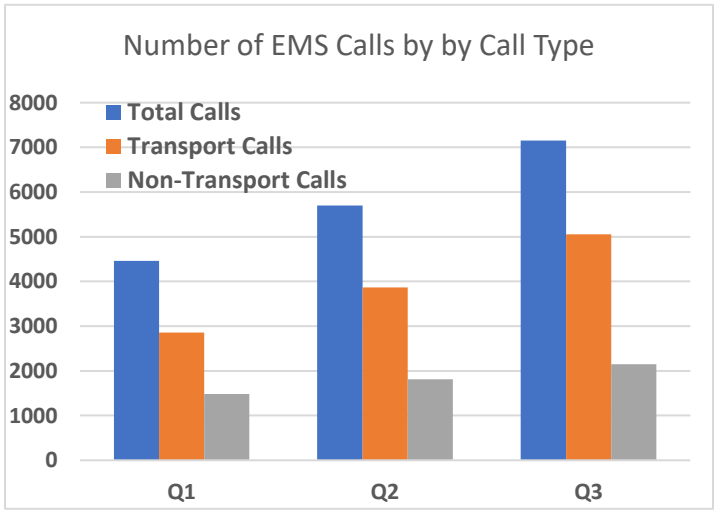
1. 65 EMS professionals attended Certified Ambulance Documentation Training and implemented these best practices at their agency. *Impact: Decrease time spent on documentation and improve rate of reimbursement due to improved accuracy.*
2. EMS agencies collectively designed a protocol for transport to Parkside. The protocol was ultimately deemed not beneficial for patients or agencies and not adopted. *Impact: Partners tested a collective protocol across region and evaluated effectiveness of workflow.*
3. Treat and referral policies and procedures have been adopted or are in the process of being adopted by 7 agencies. *Impact: Emergency Department visits avoided.*
4. EMS agencies have completed follow up care after inpatient discharged and billed for services under their program. *Impact: Reduces the potential for readmission and increases patient satisfaction.*
5. Community Paramedicine Program discussions have taken place across the region. Impact: 5 out of 10 agencies are *now interested in implementing Community Paramedicine Program.*

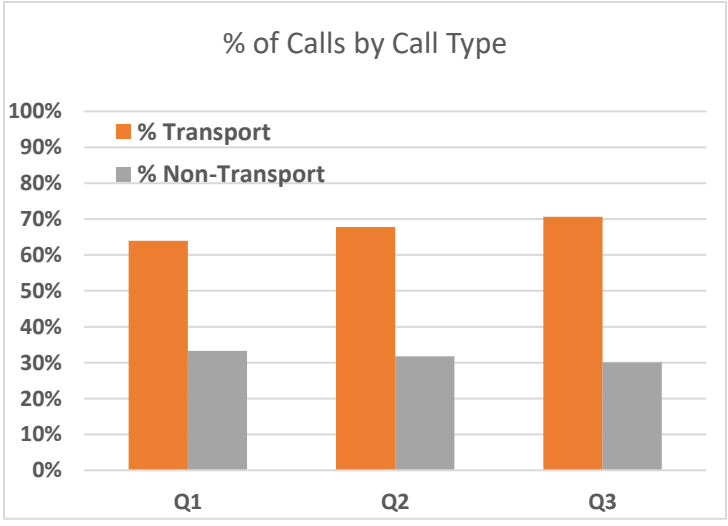
Data Collection

EMS partners are collecting three standard data points:

1. Number of total 911 calls
2. Number of transport calls
3. Number of non-transport calls

Partners have rigorously engaged in PDSA cycles to improve data collection on these metrics making it difficult to compare from quarter to quarter in 2019. It is also understood that there is seasonal variability to these metrics. It will be more appropriate to evaluate improvement efforts in when 2-3 years of data have been collected. In 2019, there was a lot of focus on helping partners in basic data collection and developing "Unified measures" in order to be able to compare metrics across organizations.





Additional information available at http://www.mydocvault.us/diversion-interventions-and-transitional-care-workgroup.html

North Central Accountable Community of Health

2020 Recommendations

Based on evaluation of the quarter 2 reports EMS data collected and partner meetings with EMS agencies, the following objectives and associated deliverables were recommended by the Transitional Care and Diversion Intervention Workgroup on September 26, 2019.

EMS Agencies Scope of Work

Objective 1: Expansion and sustainability planning of Treat and Referral programs.

Objective 1 Deliverables:

1. Updated 2020 project plan outlining how agency will grow and move toward sustainability in current treat and referral programs
2. Quarterly status update providing a summary of current progress and plans for next quarter.
3. Participation in shared learning activities between EMS providers in region (Attend a minimum of 2 quarterly EMS partner meetings and present project work)

Objective 2: Support partners in complying with SSB 5380 which requires all EMS agencies to report to WEMSIS in 2020 through improved documentation and reporting into WEMSIS

Objective 2 Deliverables:

1. Identify staff to participate in new online Certified Ambulance Documentation Training Course (if available) or, if necessary, identify another on site course.
2. Participate in NCACH coordinated DOH training programs to ensure compliance with SB 5380.

NCECC Scope of Work

NCECC will continue to support EMS agencies in accomplishing the above objectives in a project management capacity with the following deliverables.

Objective 1: Project monitoring of Treat and Referral program expansion

1. Monitor and report on expansion of Treat and Referral programs.
2. Collect quarterly reports, evaluate progress, and provide feedback to partners on areas of improvement.
3. Coordinate and provide documentation of quarterly EMS partner meetings.

Objective 2: Organize EMS Partner trainings including

1. Provide technical assistance (through contractors and/or subject matter experts) for identified key challenges twice in 2020 to EMS partners (e.g. WEMSIS Training, Motivational Interviewing, Quality Improvement, Certified Ambulance Documentation, etc.)

Additional information available at http://www.mydocvault.us/diversion-interventions-and-transitional-care-workgroup.html

EMS Partner Payments

Payments will be made quarterly for 25% of the total amount. Agencies must submit a completed quarterly report to be eligible for payment. The funding and payment cycles for all EMS partners (including NCECC) is provided below.

Organization	Q1	Q2	Q3	Q4	Total
NCECC	$5,000	$5,000	$5,000	$5,000	$20,000
Ballard	$8,750	$8,750	$8,750	$8,750	$35,000
Lifeline	$8,750	$8,750	$8,750	$8,750	$35,000
Moses Lake Fire	$8,750	$8,750	$8,750	$8,750	$35,000
LCCH EMS	$5,000	$5,000	$5,000	$5,000	$20,000
Cascade Medical Center	$5,000	$5,000	$5,000	$5,000	$20,000
Protection 1 Ambulance	$5,000	$5,000	$5,000	$5,000	$20,000
Aero Methow EMS	$3,750	$3,750	$3,750	$3,750	$15,000
DOCFD 15 - Brewster EMS	$3,750	$3,750	$3,750	$3,750	$15,000
Waterville Ambulance	$3,750	$3,750	$3,750	$3,750	$15,000
Total	**$57,500**	**$57,500**	**$57,500**	**$57,500**	**$230,000**

Specific Examples of 2019 EMS Project Work

Aero Methow Rescue Services (Funding Amount: $15,000)

2019 Project Success: Organization adopted a treat and referral protocol at organization:

1. **Outcome:** Decreased transport of patients to Emergency Department. Examples include:
    a. Provided onsite assessment of child's cold symptoms to help caregiver determine if Emergency Department visit is needed.
    b. Developed a protocol with local primary care provider, EMS Medical Program Director, and EMS staff to teach patient to properly clean their catheter. Prior to protocol, patient went to the ED via ambulance in pain when he had catheter issues. The protocol saved multiple ambulance rides and ED visits.
2. **Process:**
    a. Organization adopted Treat and Referral protocol.
    b. Trained staff on protocol and potential scenarios.
    c. Evaluated each case on best way to proceed forward with new protocol.

Lake Chelan Community Hospital (Funding Amount: $20,000)

2019 Project Success: Follow up home visiting Program after discharge from Hospital and ED

1. **Outcome:** Decreased readmission and Emergency Department Visits by following up with patient in home.
2. **Process:**
    a. Patients discharged from acute care are referred to the LCCH Paramedicine Program
    b. Community Health Worker trained EMS professionals go onsite to patient homes for follow up post discharge and identify care needs of the patient.
    c. EMS staff members were trained as Community Health Workers and are currently in the process of receiving Mental Health First Aid training.
    d. After visit, the EMS professional bills the insurer under care coordination codes associated with Community Health Worker outreach.

Additional information available at http://www.mydocvault.us/diversion-interventions-and-transitional-care-workgroup.html

North Central Accountable Community of Health

2020 Budget Board Decision Form Attachment

Opioid Project – Opioid Prescriber Coaching and Education

Purpose

Allocate funding to opioid prescribing coaching and education in the 2020 Budget.

Background

Within the Board approved 2019 Opioid Project Budget, there was $33,000 of unallocated funding reserved for unexpected initiatives. In addition to the unallocated funding, the Opioid Project is currently $10,826 under budget.

Through discussion during the August Opioid Workgroup meeting, a need was identified to provide high opioid prescribers with one-on-one technical assistance to reduce their prescribing to within recommended guidelines. Based on the discussion, Physician & Healthcare Consulting (Dr. Julie Rickard) submitted a proposal for this work.

To determine if there was a true need for this work, NCACH staff requested opioid prescriber data from the Health Care Authority (for the measurement period April 2019 – September 2019). Based on this data, the NCACH region includes:

- 20 prescribers who have 3 or more patients with >90 Morphine milligram equivalents/day.
- 22 prescribers who have 3 or more opioid naïve patients 20 years and younger who received more than a 3 day supply.
- 55 prescribers who have 3 or more opioid naïve patients 21 years+ who received more than a 7 day supply.
- There are 86 unique prescribers who fall into one or more of the categories above.

Staff consulted with two subject matter experts (Dr. Rick Hourigan, Governing Board Member and Dr. Malcolm Butler, Opioid Workgroup Chair) who reviewed the list and recommended 16 prescribers to be included in an initial pilot of this project (note: pain specialists, oncologists and out of region providers were excluded; dentists were included). Targeted small group education for certain provider types was recommended rather than one-on-one coaching, and this could also potentially be included in the contract with Physician & Healthcare Consulting.

Impact/Opportunity

In May, NCACH organized a conference for dentists which included best practices around opioid prescribing. To date, however, NCACH has not provided targeted technical assistance directly addressing opioid prescribing. Ensuring that providers are following prescribing guidelines would

support efforts of our Whole Person Care Collaborative and Transitional Care and Diversion Interventions Workgroup partners.

Through targeted technical assistance and education, we have an opportunity to positively impact prescribing practices for providers who fall outside of prescribing guidelines. Because not all prescribers may be willing to accept coaching, sensitive outreach will be critical. Working through existing contacts at provider organizations involved in WPCC and TCDI work will be important.

To promote use of funds on education and coaching (and not just outreach), the contract will be structured to incentivize time spent on coaching. The contract will be an up to amount rather than a predetermined amount. If there is limited engagement by prescribers, the funds will not be fully utilized. In addition, NCACH staff will meet with the consultant on a monthly basis to review outreach attempts, coaching engagement, and coaching completion. NCACH staff will evaluate progress and engagement during these meetings and will ultimately terminate the contract if prescribers are not engaging in the coaching. Upon contract execution, the contractor, in consultation with subject matter experts and NCACH staff, will develop metrics to track success, including:

- Prescriber engagement in coaching
- Coaching completion
- Improved prescribing patterns (e.g. number of prescriptions and patients above certain prescribing thresholds based on Medicaid claims data)

Budget Implications

The 2020 Budget includes a line item of $28,000 for Opioid Prescribing Coaching and Education. This represents unspent funds from 2019 that would carry over into 2020 to support this work.

Upon approval by the Board, NCACH staff will negotiate rates with the contractor for the pilot phase of this initiative, to include:

1. Coaching up to 16 prescribers for up to 3 hours each
2. Up to 10 targeted educational presentations to small prescriber groups

The pilot phase will not exceed $28,000. The Board will receive updates on the engagement and success of this initiative. If deemed successful, NCACH staff may bring a request to the Board to expand upon the pilot, which would require Board action to move forward.

Timeline

Given the sensitive nature of this work, it may take time to build relationships with high prescribers and get them to be open to coaching. While it is difficult to predict, it is estimated

that the coaching will be completed in ~6 months with additional follow-up on prescribing patterns for those who received technical assistance in order to gauge success.

- December: Contract development and execution
- January: Launch initiative
- January – June: Outreach, education, and coaching provided; targeted small group education; monthly meetings with consultant and NCACH staff.
- July – December: Tracking and reporting prescribing patterns of those that received coaching.

Recommendations

The Opioid Workgroup and NCACH staff (WPCC Manager, TCDI Project Manager, and Opioid Project Manager) recommend supporting the allocation of funding for education, outreach, and coaching targeted towards high opioid prescribers.

NCACH Project Workgroup Update

Pathways Community HUB

December 2019

Key Updates-October/November Activities

- Blue Orange IT HIPPA management consulting calls began in October. This is a contracted service agreement Action Health Partners (AHP) entered into as required for Pathways Community HUB implementation. Quarterly P.O.E.M. (Plan, Organize, Execute, Monitor) coaching calls are scheduled quarterly over the next year. ACP has hired a temporary, part-time IT Technical Project Coordinator to work directly with Care Coordination Network Director and Blue Orange Team.
- AHP Care Coordination Network team participated in numerous non-traditional health partner outreach events in October and November. These non-traditional health partners include, but are not limited to school district outreach; *Pay It Forward* faith-based social service delivery event; homeless services community planning meetings; *Blue Zones Project* Wenatchee community event;
- Care Coordination Network Director has been participating in regular statewide HUB partner meetings. SWACH has hosted a collaboration portal for statewide HUB partners to share best practices and other shared learning documents. This *grassroots* teaming with other statewide HUBs is invaluable to the AHP work.
- AHP Executive Director has been participating in statewide HCA Care Coordination action planning meetings with NCACH Executive staff. Continued participation in these meetings throughout the process is important to the regional work moving forward.
- AHP Executive Director and Care Coordination Network management staff joined the NCACH staff at the Healthier Washington Learning Symposium in October.
- MCO Funder meetings continued in October and November. Forward progress is being made.
- AHP staff submitted two grant applications for supplemental project funding.

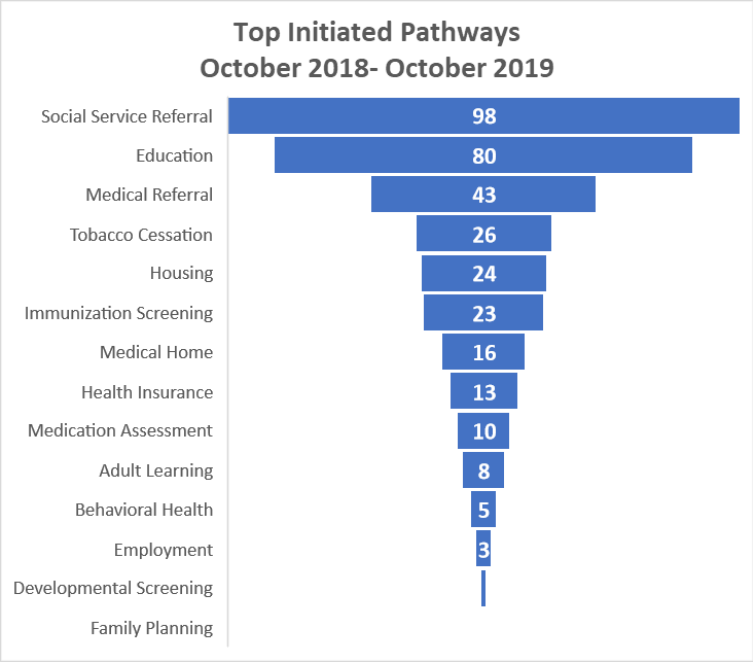
- Final evaluation report received from CCHE. See attached AHP response/actions regarding final recommendations.

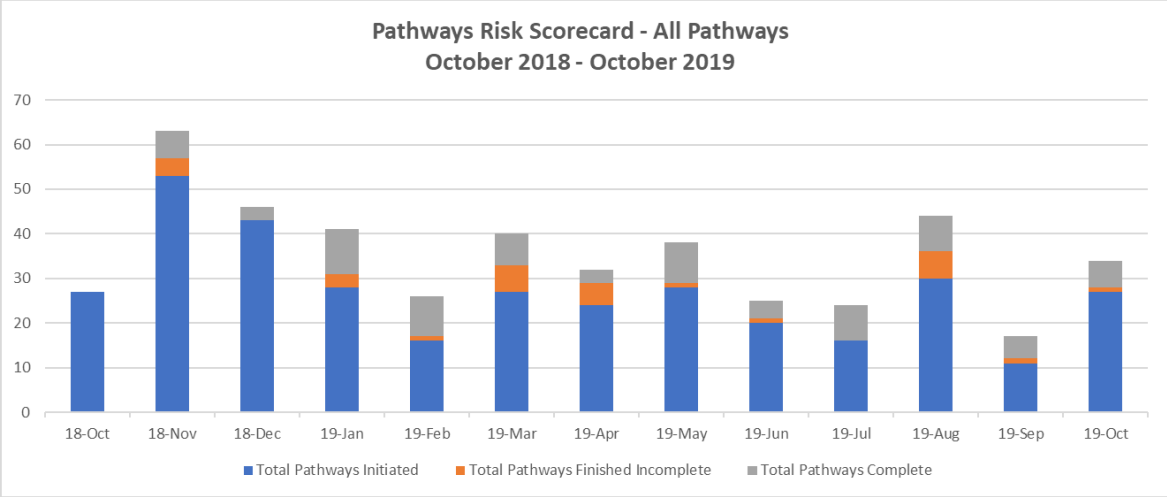
Program Metrics-Data

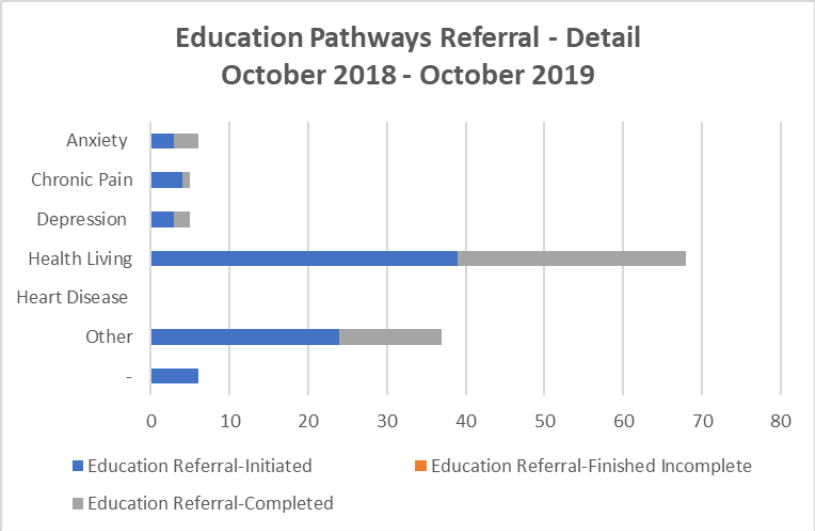
Client Caseload - 10/1/2018-10/31/2019			
Total Client Caseload			
Client Type	**Assigned***	**Enrolled****	**Enrollment Rate**
Adult	266	40	15%
Pediatric	8	4	50%
Pregnant	0	0	0%
Senior	22	1	5%
Total	296	45	15%
Current Client Caseload by PCS			
PCS	**Total Clients Assigned**	**Total Clients Enrolled**	**Total Enrollment Percentage**
1	138	28	20%
2	118	15	13%
4	40	2	5%

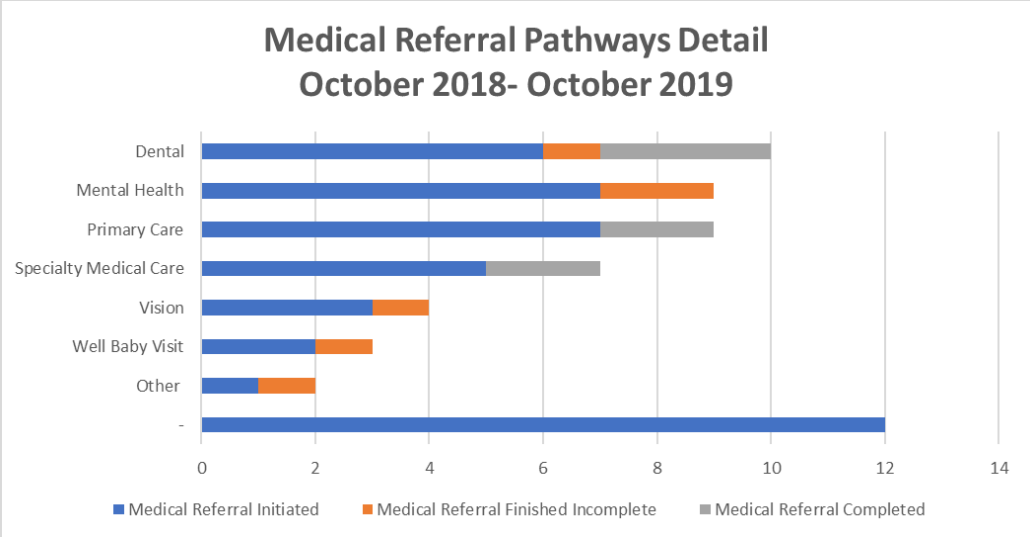
Pathways Report by PCS - 10/1/2018-10/31/2019				
PCS	**Pathways Initiated**	**Pathways Finished Incomplete**	**Pathways Completed**	**Total Completed Pathways Percentage**
1	19	0	1	**5%**
2	12	1	5	**42%**
4	0	0	0	**0%**

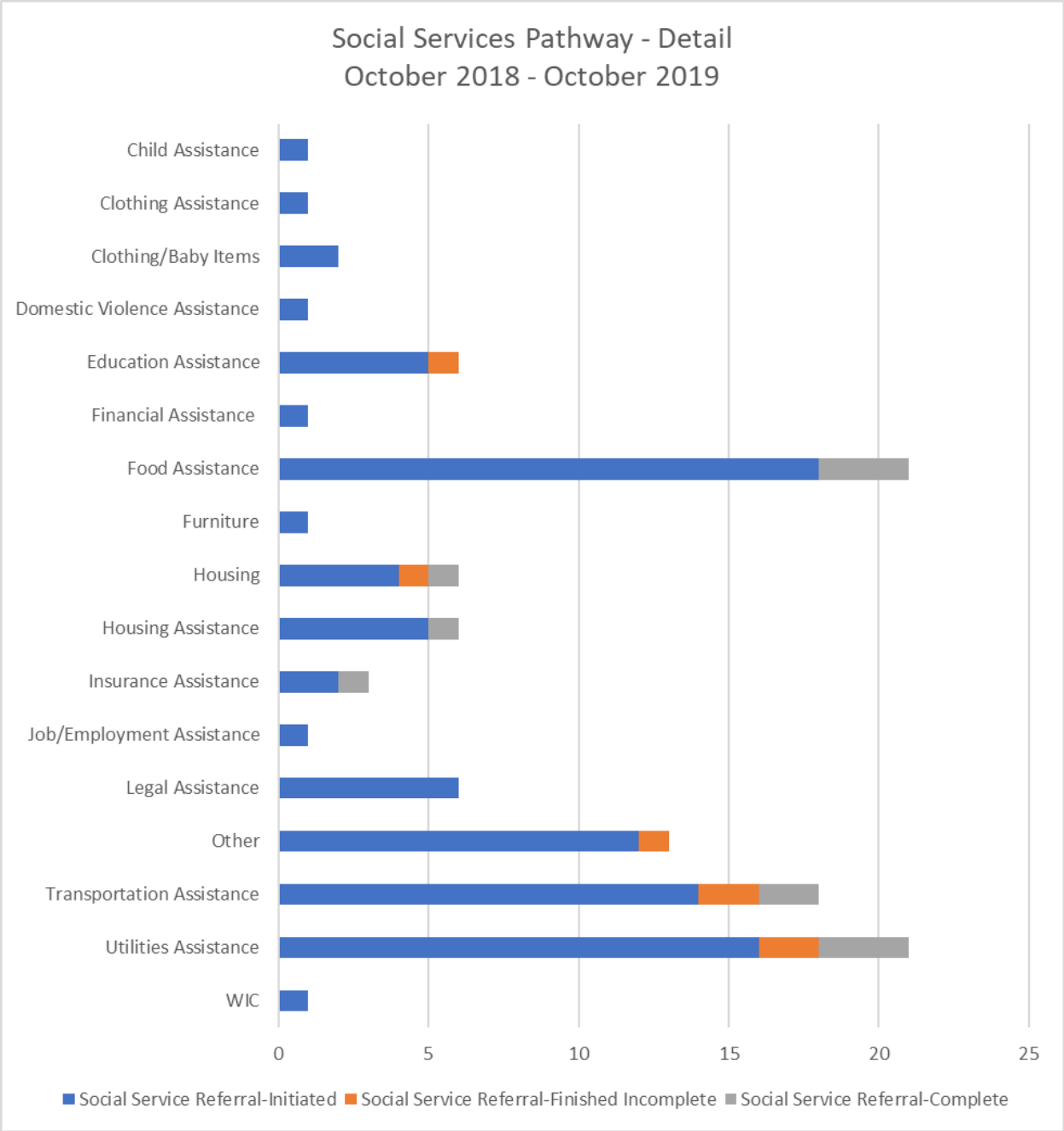
Client Tools - 10/1/2018-10/31/2019		
Client Tools by PCS		
PCS	**PAM**	**PHQ-9**
1	23	28
2	15	14
4	0	1
Total Client Tools	**38**	**43**


Top Initiated Pathways
October 2018- October 2019
Social Service Referral
Education
Medical Referral
Tobacco Cessation
Housing
Immunization Screening
Medical Home
Health Insurance
Medication Assessment
Adult Learning
Behavioral Health
Employment
Developmental Screening
Family Planning
98
80
43
26
24
23
16
13
10
8
5
3


Pathways Risk Scorecard - All Pathways
October 2018 - October 2019
70
60
50
40
30
20
10
0
18-Oct
18-Nov
18-Dec
19-Jan
19-Feb
19-Mar
19-Apr
19-May
19-Jun
19-Jul
19-Aug
19-Sep
19-Oct
Total Pathways Initiated
Total Pathways Finished Incomplete
Total Pathways Complete


Education Pathways Referral - Detail
October 2018 - October 2019
Anxiety
Chronic Pain
Depression
Health Living
Heart Disease
Other
-
0
10
20
30
40
50
60
70
80
Education Referral-Initiated
Education Referral-Finished Incomplete
Education Referral-Completed


Medical Referral Pathways Detail
October 2018- October 2019
Dental
Mental Health
Primary Care
Specialty Medical Care
Vision
Well Baby Visit
Other
-
0
2
4
6
8
10
12
14
Medical Referral Initiated
Medical Referral Finished Incomplete
Medical Referral Completed


Social Services Pathway - Detail
October 2018 - October 2019
Child Assistance
Clothing Assistance
Clothing/Baby Items
Domestic Violence Assistance
Education Assistance
Financial Assistance
Food Assistance
Furniture
Housing
Housing Assistance
Insurance Assistance
Job/Employment Assistance
Legal Assistance
Other
Transportation Assistance
Utilities Assistance
WIC
0
5
10
15
20
25
Social Service Referral-Initiated
Social Service Referral-Finished Incomplete
Social Service Referral-Complete

Upcoming Meetings

12-11-2019	HUB Advisory Board Meeting
TBD	PCS/Supervisor Meeting

North Central Accountable Community of Health

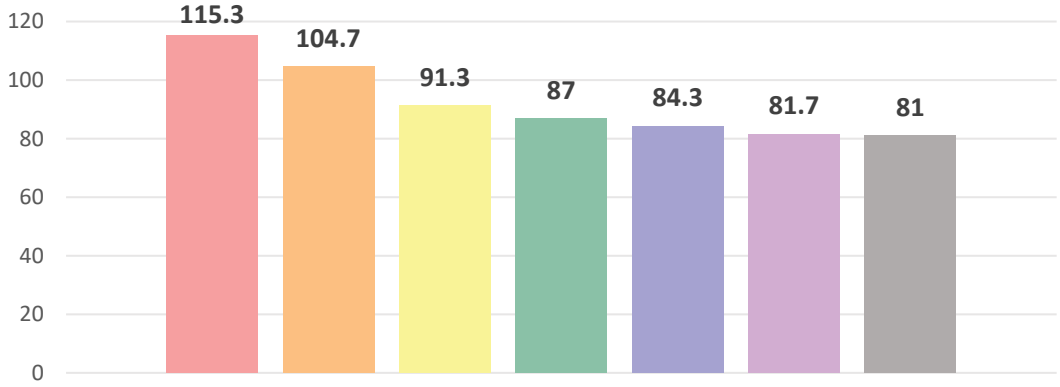
NCACH Project Workgroup Update

Regional Opioid Stakeholders Workgroup

December 2019

Key Updates

- **Rapid Cycle Opioid Awards:** There were seven applicants for this round of Rapid Cycle Opioid Award funding. The scores were as follows:



Some proposals included items that could or should be funded through other mechanisms including funding for Narcan distribution and Whole Person Care Collaborative. Taking this into account, the Opioid Workgroup made the following recommendation for funding for the January 2020 – December 2020 Rapid Cycle Opioid Award Funding:

Organization	Project	Amount Awarded – 2020 Rapid Cycle funds	Amount Awarded – 2019 Narcan funds	Total Amount Awarded
Catholic Charities	Jail Opioid Intervention Service	$10,000		$10,000
Chelan-Douglas Community Action Council	Direct Service AmeriCorps Member Focusing on Opioid Outreach & Education	$5,000		$5,000

Coulee Medical Center	Take Home Naloxone Project	$5,000	$5,000*	$10,000
Grant County Health District	Syringe Service Program Continuation/ Expansion	$10,000		$10,000
Oroville CARES	Slaying the Dragon (transportation and childcare services for those with OUD; meeting basic needs of children of parents with OUD)	$8,450		$8,450
Room One	Interactive, Web-based Methow Valley Resource Guide	$10,000		$10,000
Samaritan Healthcare	Narcan Take Home and Proper Storage and Disposal of Opioids	$2,500	$2,500	$5,000
Total Awarded		**$50,950**	**$7,500**	**$58,450**

* $1000 of this funding is from 2020 Narcan Distribution funds

- **Stories of Recovery:** NCACH has contracted for the production of six short professional quality videos. These videos will highlight local stories of hope and recovery. Two videos have been completed, see below.

Victor Estrada

https://vimeo.com/370436539

Joseph Hunter

https://vimeo.com/368136020

- **MAT Waiver Training:** NCACH is partnering with the Washington State Department of Health to provide a MAT Waiver Training in Wenatchee in early February.
  Register Here: https://mat_waiver_training.eventbrite.com
- **Opioid Awareness and Marketing Campaign:** Two screenings of the documentary Written Off are taking place.
  - Moses Lake: November 21 at 6PM (https://www.cityofml.com/CivicAlerts.aspx?AID=795)
  - Omak: December 2 at 5PM (https://www.facebook.com/events/550390955720948/)

  In 2019, Grant County Health District was the awardee for the Opioid Awareness and Marketing Campaign. Due to staffing turnover and change in scope, NCACH staff feel it is appropriate to

reissue an RFP for this project in 2020. The RFP will be issued in December with the intent for the contract to begin March 2020.

- **Narcan Training:** This year, $5,000 was available to each of Chelan/Douglas, Grant, Okanogan County, and the Colville Confederated Tribes for Narcan Distribution. NCACH opened an application allowing for agencies to apply for funding for up to 10 boxes of Narcan per application. The application was minimally used with ~$10,000 of funding remaining. In November, the Opioid Workgroup received and endorsed a request from the Okanogan County Opioid Treatment Network (OTN) for the remaining 2019 Okanogan County Narcan funds ($4,000). The OTN is mounting a response to a recent opioid overdose by distributing ~130 Narcan kits to at-risk individuals (intensive outpatient clients, homeless, transitional housing residents etc.)

Upcoming Meetings and Events

December 2nd	*Written Off* Documentary Screening in Omak
December 19th	Opioid Steering Committee Meeting
January 16th	Opioid Steering Committee Meeting
February 7th	MAT Waiver Training
February 21st	Opioid Quarterly Workgroup Meeting
May 15th	Opioid Quarterly Workgroup Meeting
August 21st	Opioid Quarterly Workgroup Meeting
November 21st	Opioid Quarterly Workgroup Meeting

North Central Accountable Community of Health

NCACH Project Workgroup Update

Whole Person Care Collaborative
November 2019

Key Updates

Learning Activities Update

- The year-long Population Health LAN began on November 12th. We have 10 organizations and 13 clinical teams participating. Currently in the process of setting up systems to track 5 measures as cohort – diabetes (2), depression (2) and patient experience. We are working with all three of our MCOs to get provider level data sent to each individual clinic.

General Updates

- 2020 Change Plans were submitted November 1st. We received 16 of 17. The 17th will be submitting a change plan during the write back period that ends December 6th. Change plans were scored by 4 NCACH staff members and results returned to organizations on November 15. Seven of the 16 change plans received scored high enough for full funding. The other 10 organizations are working with their Practice Facilitators to increase their score for full funding.
- At the November WPCC meeting participants engaged in a discussion on how to maximize the value of the WPCC monthly meeting. The meeting leaned toward improvements that can be made. An attendee wanted to hear more of what is working well and the successes we have experienced. The conversation will continue to ensure that the meetings are tailored to the needs of the collaborative and that members find value in them.
- December WPCC meeting – cancelled
- Attached is the Quarter 3 WPCC Improvement Process Summary for your review. Please contact me if you have any questions regarding this summary. wendy.brzezny@cdhd.wa.gov

For more information on the WPCC Meetings, please visit https://ncach.org/wpcc/ where you will find, minutes, presentation slides and the recorded meeting.

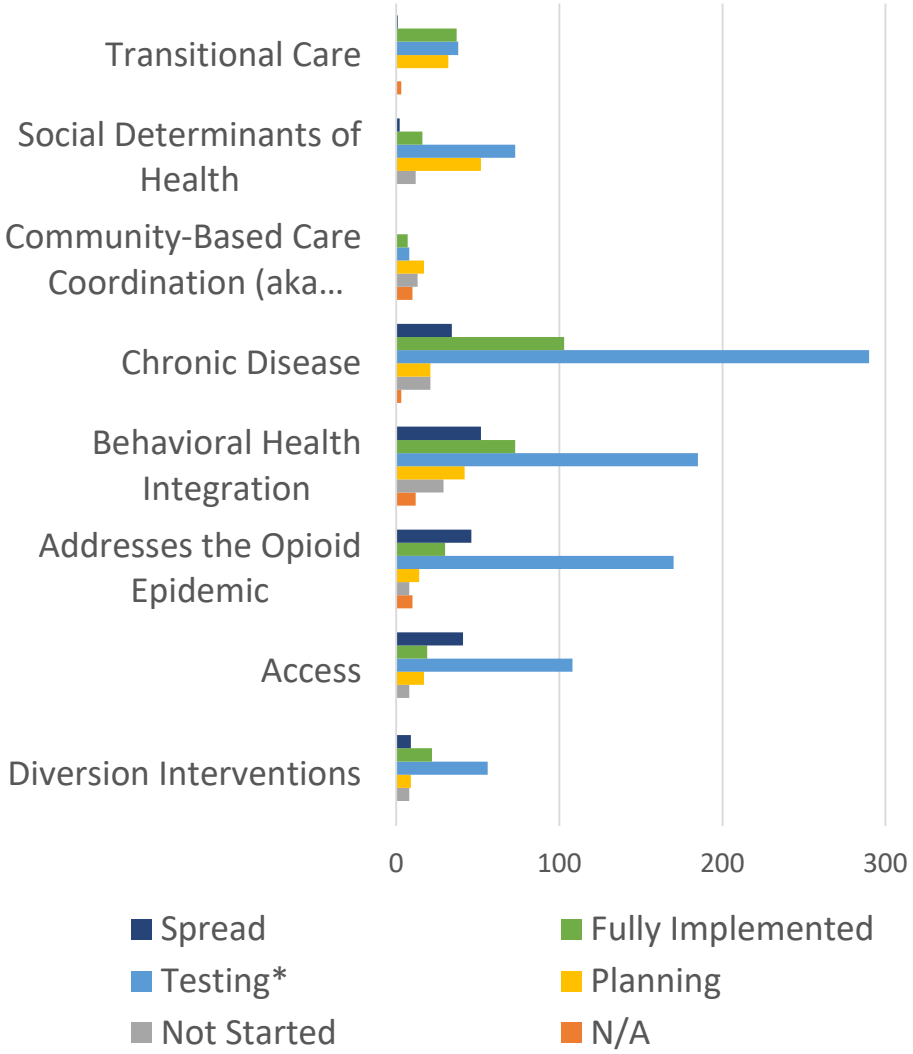
North Central Accountable Community of Health

WPCC Improvement Progress Summary

2019 Q3

Where are we focusing our efforts?

Considerable testing is continuing. All change plan topics showing increases in ideas fully implemented and spreading over Q2.



*testing combines statuses testing, limited implementation, and fully implemented but with gaps

North Central Accountable Community of Health

Early Improvement Data

- The median number of measures organizations selected to remains at 20
- More common measures shared across organizations
- Data presented in run charts on portal dashboard

North Central Accountable Community of Health

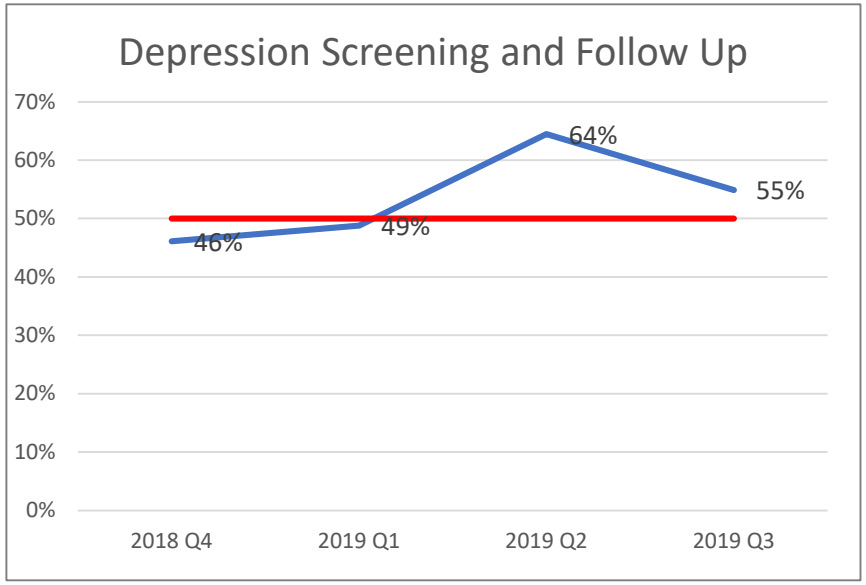
Common measures

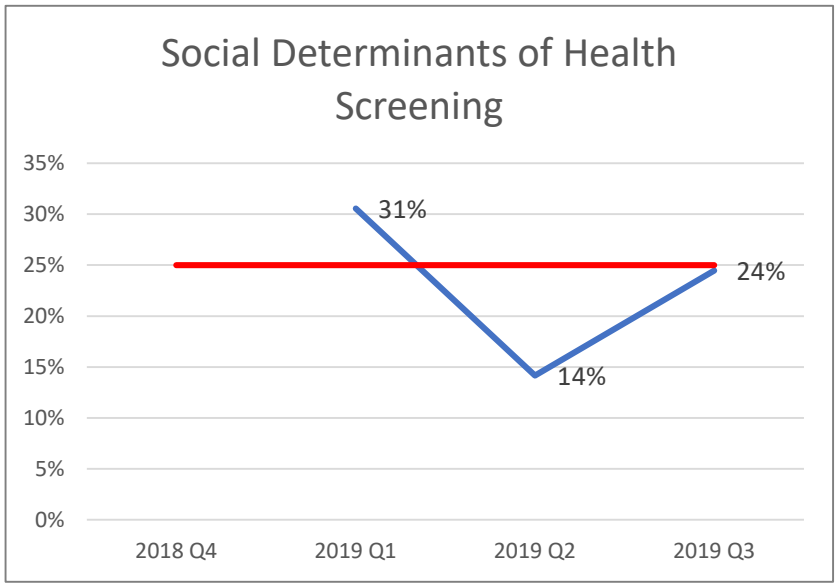
Measure	2019 Q3 Teams
Depression screen and follow-up	15
SDOH Screening %	13
Pathways Referrals	11
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	11
SDOH Referred	10
Pathways Provider Training	10
MAT Patients	10
MAT Provider Capacity	10
Providers Trained on Opioid Prescribing Guidelines	9
Pathways Provider Education	9
3rd Next Available Appointment	8
Follow-up After Hospitalization for MI: 7 day	7

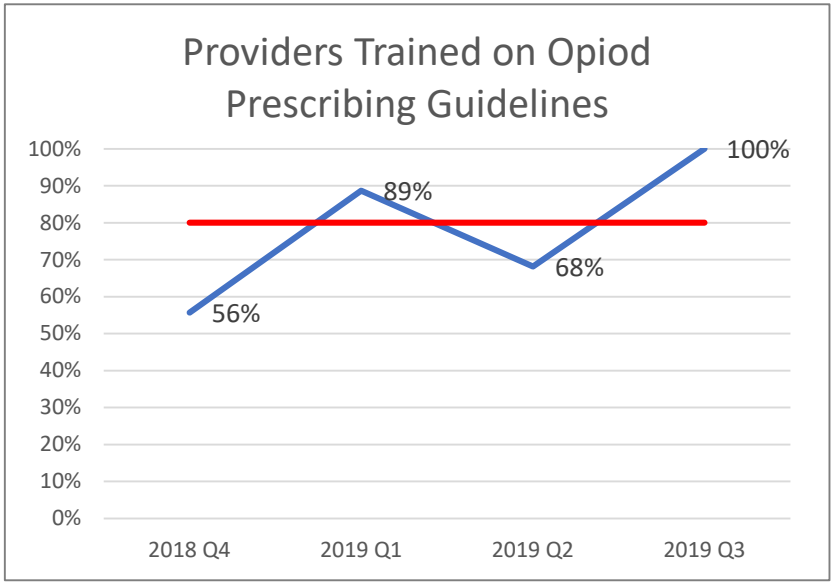
Note about Interpreting QI Data

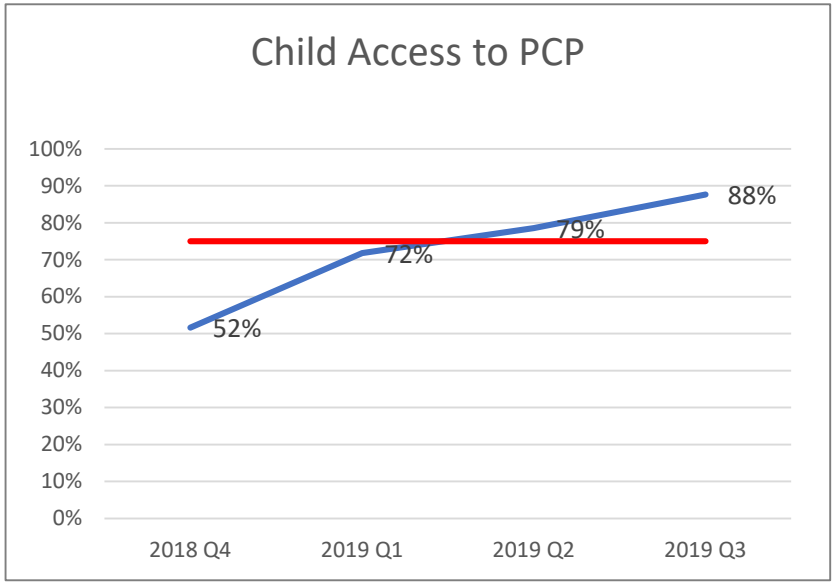
- The purpose of improvement data is for learning and improvement
- Improvement data is understood to be imperfect; all that is needed is just enough, good enough data to drive learning and improvement
- Data over time is essential to understand variation in the system (run charts)

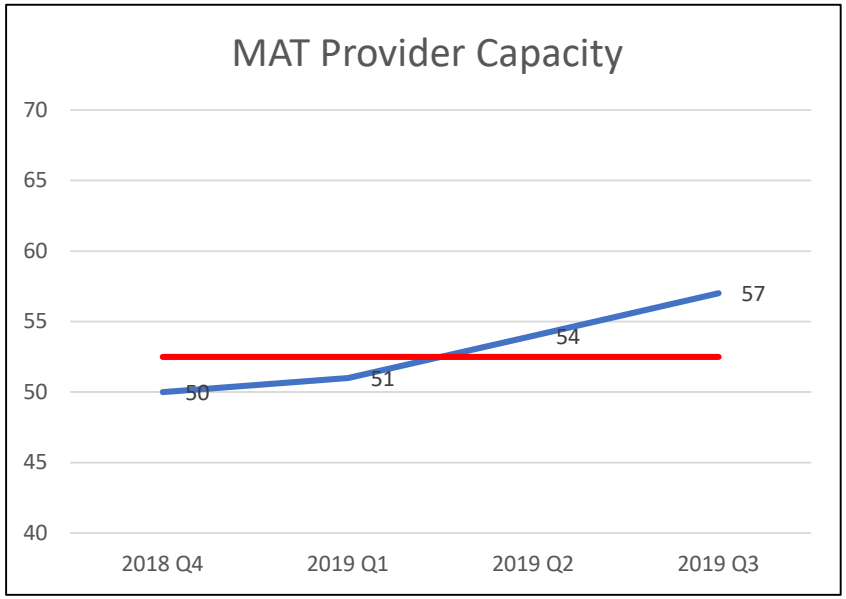
North Central Accountable Community of Health

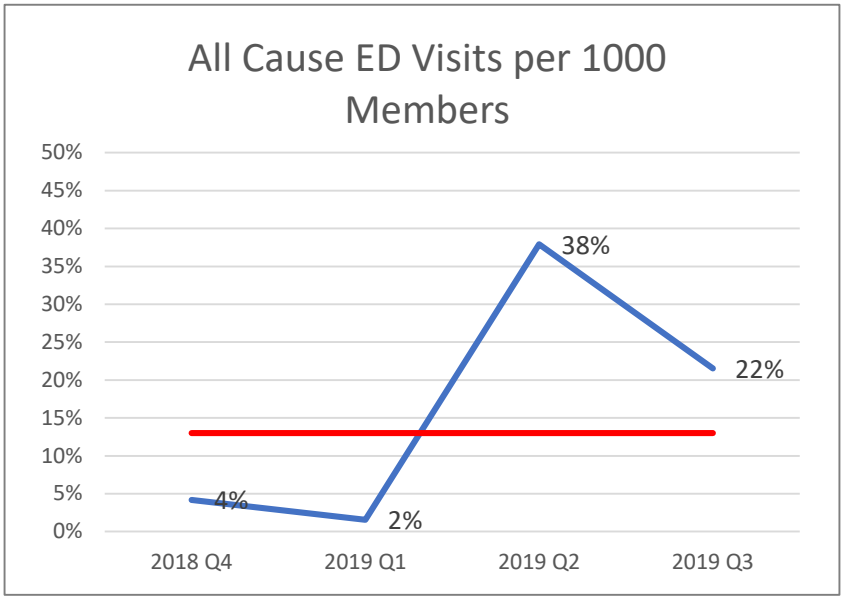

Depression Screening and Follow Up
70%
60%
50%
40%
30%
20%
10%
0%
46%
49%
64%
55%
2018 Q4
2019 Q1
2019 Q2
2019 Q3

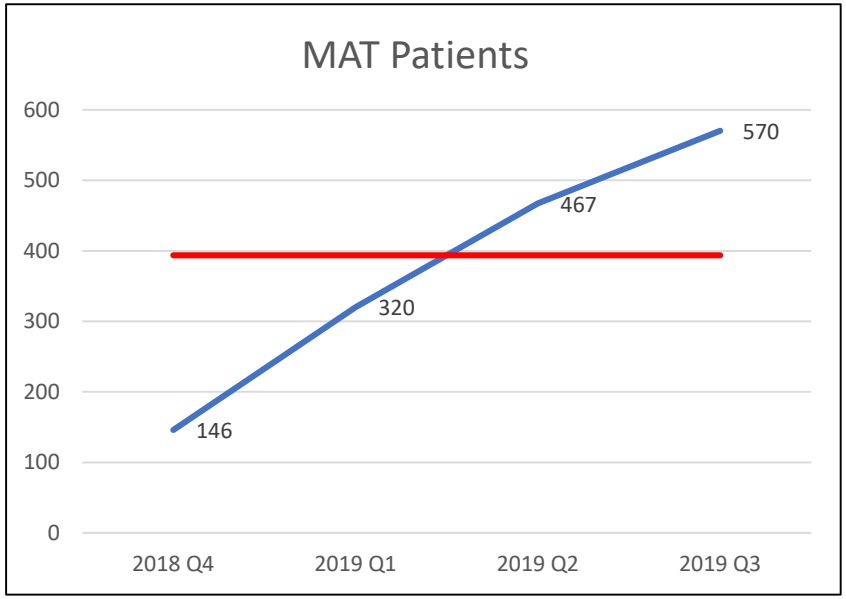

Social Determinants of Health Screening
35%
30%
25%
20%
15%
10%
5%
0%
31%
14%
24%
2018 Q4
2019 Q1
2019 Q2
2019 Q3

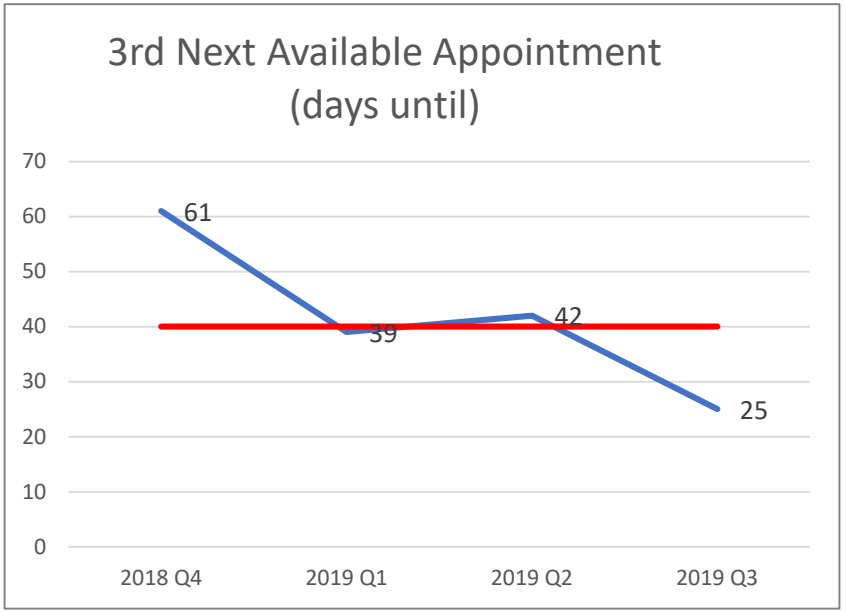

Providers Trained on Opiod Prescribing Guidelines
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
56%
89%
68%
100%
2018 Q4
2019 Q1
2019 Q2
2019 Q3


Child Access to PCP
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
52%
72%
79%
88%
2018 Q4
2019 Q1
2019 Q2
2019 Q3


MAT Provider Capacity
70
65
60
55
50
45
40
50
51
54
57
2018 Q4
2019 Q1
2019 Q2
2019 Q3


All Cause ED Visits per 1000 Members
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
4%
2%
38%
22%
2018 Q4
2019 Q1
2019 Q2
2019 Q3


MAT Patients
600
500
400
300
200
100
0
146
320
467
570
2018 Q4
2019 Q1
2019 Q2
2019 Q3


3rd Next Available Appointment (days until)
70
60
50
40
30
20
10
0
61
39
42
25
2018 Q4
2019 Q1
2019 Q2
2019 Q3

Key Themes

1. Continued forward movement with improvement
2. Increasing testing of new ideas
3. More innovative solutions
4. More solutions fully implemented
5. More solutions being spread
6. Improved care for patients
7. Using data to drive change

North Central Accountable Community of Health

1. Moving forward with improvement

- "We are moving forward with both successful Empanelment and Team Based Care. The staff and providers who were involved with the Team Based Care LAN are excited about moving forward, and have already implemented many of the tools that were presented." Family Health Centers
- "We have hit our stride with our internal incentive program. This includes chronic care measures and beyond. We have great provider buy in to this program and we have seen it really drive results throughout the last year." Columbia Basin Health Association
- "At this point we have successfully created a system that ensures each client has an assigned pcp. In many cases, we find that a client has recently moved into the area, and they actually DO have a pcp but they don't know their name. We are able to communicate that information and get our EPSDT's sent off successfully to the pcp to inform them of the BH dx." Children's Home Society
- "We have had two big successes - Our partnered primary care clinic and our patient registry. Team leaders have had the most impact for both of these. Finding staff with the heart and talent for this work is essential." Catholic Charities
- "A growing part of our business is providing screening for children who are believed to be on the autism spectrum. We have been working to standardize our workflow and provide the support the parents and patient need. We also have provided a document to our referral partners helping them to understand the Autism diagnosis process and the state's requirements to get a diagnosis from a center of excellence. This is a chronic condition that is impacting several children in our community, we are excited to have the opportunity to help these families, get answers and assistance." Parkview Medical Group

2. Continued testing of new ideas

- "Currently, group visits are offered for diabetic and chronic pain patients. They have been well-received by our patients and Primary Care Providers fully support this program. We plan to expand these group types to include sleep groups and other." Cascade Medical Center
- "We continue to expand testing on-line scheduling with multiple providers allowing patients to schedule their own appointments." Columbia Valley Community Health
- "We are continuing to make small changes to our scheduling model and are currently beginning to test a new process to make access more compatible with a true "walk-in" model. There is a lot more "team" effort surrounding this change plan and we have adopted a strategy to remain in communication regarding test results weekly." Okanogan Behavioral Healthcare

3. Innovative solutions

- “Tessa Timmons, Behavioral Health Service Line Director worked with primary care providers to "gamify" screening patients for depression using the PHQ-9. In essence she created a competition between departments to see which could increase their screening rate the most. The result was a significant increase in the rate of depression screening in the departments involved, which put Confluence Health as an organization above the 50% mark. This will be spread across more departments in the coming months and effort are being made to ensure the gains are maintained.” Confluence Health
- “Implementation of an on-line PDSA style Escalation form that was created by Dr. Smith has been a big win. This allows all providers and staff to quickly submit either "Inspiration" or "Aggravation" topics for our Quality Committee to address (or to direct to the proper person) for review and action. This has been used for process improvement with our Athena workflow development and for clinical work flow in general.” Family Health Centers
- “We have increased our same-day access schedule to support the ongoing needs of our community.” Grant Integrated Services

4. Improved care for patients

- "Optimize available visits has had the most impact on our team and our patients. Walk in is now closed and same day access has been implemented. The scheduling templates and visit lengths have been standardized to allow convenient scheduling across care teams." Lake Chelan Community Hospital

- "Our Psychiatric ARNP is HERE! She officially starts on 10/14/19 and we are so incredibly excited to introduce integrated BH into our organization. By putting our strategy our goal of integrated BH on paper (change plan), it made the goal seem more achievable, versus keeping it on our wish list." Mid Valley Hospital

- "In addition to scheduling sibling visits and referring clients to transportation resources, we are also providing bus tokens for clients and their caregiver to commute to their appointment." Children's Home Society
- "We are most proud of being in the beginning stages of starting a collaborative care practice in our primary care clinic which should allow us to impact a greater number of patients by increasing access to behavior health services." Coulee Medical Center

5. Using data to drive change

- “Staff continues to improve with data gathering, screening, and treatment/referrals for our patients. We continue to see our numbers grow in areas such as CCM and patients are being more open to understanding all the whys of all of the changes we have implemented.” Columbia Basin Family Medicine
- “We worked hard to refine our diabetes care. We did some work to our Diabetes Lab results letters and increased the number of patients enrolled in nurse care management. Our Medical Director also began Medical Team Collaboration meetings - where he meets with two providers and their staff to discuss updated Diabetes care protocols and also show some new features we had built into the diabetes visit template for providers. Our data walls (monthly updated printouts of our clinical measures) are always helpful in providers and their teams moving the measures.” Moses Lake Community Health Center
- “Report NCACH activity at Quality Council, Safety and Quality, and Board on Quarterly basis: We do have an NCACH report, and its information is transferred to the Scorecard, and then showed to the Senior Leadership on monthly/quarterly basis” Samaritan Healthcare

Challenges experienced

- Turnover of leadership
- Organizational culture of teams and between teams and leadership
- Staffing, turnover, capacity to do new/different work
- Getting the right data (e.g., lack of HIE, accurate coding, legislative barriers)
- EMR functionality, completeness, and transitions
- Reimbursement for VBC lags behind work being done to provide it
- Using QI methodology

North Central Accountable Community of Health

NCACH Project Update

Chemical Dependency Professional Apprenticeship

December 2019

Key Updates

- In July 2019, NCACH engaged RtR Workforce Solutions to support development of a Chemical Dependency Professional (CDP) apprenticeship.
- There are five phases in the agreed upon work (1) Project onboarding, research, and feasibility study, (2) Steering committee engagement and establishment, (3) Program development and design, (4) Program implementation, and (5) Program evaluation.
- Phase one is complete and the feasibility study has come back favorable (final feasibility study report attached). The CDP apprenticeship concept was deemed to meet all five of the feasibility criteria including need, labor market and projections, apprenticeship model viability, administration, and education partner.
- NCACH is formally partnering closely with The Washington Association for Community Health (The Association) in the development and launch of this apprenticeship (MOU discussions are underway). Additionally, The Association will be the administrative organization for the apprenticeship.
- NCACH and The Association are in the process of having conversations with Wenatchee Valley College to be the education partner which would provide the curriculum and be the credit awarding institution.

Attachments

1. CDP Apprenticeship Feasibility Report

North Central Accountable Community of Health

CDP APPRENTICESHIP FEASIBILITY REPORT

Introduction

In the Medicaid Transformation Project Toolkit,[1] four items out of six identified a shortage of substance use disorder (SUD) providers as a crucial capacity issue in Washington State. "Identifying critical workforce gaps in the substance use treatment system and develop[ing] initiatives to attract and retain skilled professionals in the field" was stated as important to the regional workforce and training plan, (reference Appendix A).

This study has been commissioned to determine the feasibility of a CDP Apprenticeship model that would potentially address access and capacity issues for alcohol and drug treatment in the North Central Accountable Community of Health (NCACH) region.

In this analysis, we propose the following criteria for determining feasibility for this project:

	Feasibility Criteria	Yes	No
1)	Need (accessibility and capacity)		
2)	Labor Market and Projections		
3)	Apprenticeship Model Viability		
4)	Administration (anchor organization)		
5)	Education Partner		

Determining the Need

Introduction

In 2018, the NCACH board approved a workforce strategy to develop a Chemical Dependency Professional (CDP) Apprenticeship to effectively address the SUD priorities expressed by community members. The primary factors influencing the adoption of this strategy were articulated by those in the region. Those factors were 1) access to mental health/behavioral health services, 2) increasing substance use disorder issues, and 3) capacity.

As part of the part of the 2016 North Central Community Health Needs Assessment[2], community members responded to a survey, (Table 1, below), in which they shared concerns and priorities about quality of life and quality health care in the region. Respondents clearly stated the need for better access to drug and alcohol treatment resources. Responses also indicated that mental health and substance use disorder are primary issues related to "health problems" and "unhealthy behaviors" affecting the community. Taken together, these responses greatly underscore *access* as a key component of addressing substance use disorder in the region.

	Community Voice Survey - Key Questions and Responses
1	**What do you think are the three most important factors that will improve the quality of life in your community?** 1. Improved access to mental health care 2. Healthy economy 3. Good jobs
2	**What do you think are the three most important "health problems" that impact your community?** 1. Mental health problems 2. Overweight/obesity 3. Access to health care
3	**What do you think are the three most important "unhealthy behaviors" seen in your community?** 1. Drug abuse 2. Alcohol abuse 3. Poor eating habits

Table 1

[1] NCACH Project Toolkit: https://www.hca.wa.gov/assets/program/project-toolkit-approved.pdf
[2] NCACH Project Plan: https://www.hca.wa.gov/assets/program/ncach-project-plan-final.pdf

Access and Capacity

A fundamental component of access is the issue of *capacity*. In terms of labor analysis, in a simplistic sense, capacity is essentially a supply and demand equation. It refers to the *supply* of workers in relation to the *demand* for people to perform a set of skills and/or tasks. At issue in the NCACH region and elsewhere are the number of qualified CDPs available in the area's talent pool in relation to the number of individuals needing treatment. When examining supply in terms of any position, there are a number of elements examined. One must look at 1) a specified area or region, 2) current unemployment (within the area or region), 3) the education/training and experience necessary to meet the requirements of a position, 4) the education/training available to develop the knowledge and skills for the position, and 5) economic and labor market projections.

Access (in this scenario) refers not only to the overall availability of services, but also to how easy it is for individuals in need of specific services to obtain them, and how appropriate the services are for an individual or group. An example would be when someone whose primary language is not English needs medical or dental care. They may find a care provider, but if the doctor or dentist and her/his staff speak only English, adequate care to that patient (or others who do not speak English) may be compromised. In a broader sense, if there are no caregivers who speak the prevalent language(s) within a particular service area, a reasonable conclusion would be that care in that region is not going to be *accessible* to those for whom English is not their primary language. So, looking at accessibility as it relates to labor market capacity must examine 1) overall availability, 2) ease of access, and 3) appropriateness of readily available skillsets.

Prevalence of Need

In determining the need for substance use disorder (SUD) treatment services within the NCACH region, we looked at several factors. State drug overdose data from 2016 through 2018 shows a statewide trend toward a decrease in all drug overdoses. However, in the NCACH four-county region, the trendline is static, overall. In terms of scale, while the NCACH numbers are not large, in comparison to statewide data, these numbers are representative of the NCACH population percentage. According the Washington State Office of Financial Management, the total population in the NCACH region as of April 1st, 2019 is 262,710 compared with a total state population of 7,546,410, making the four counties represent 3.5% of the state's population.[3] In contrast, the region represents nearly 18% of the total land mass of the state, with three out of four NCACH counties ranked in the top four.[4]

In terms of drug overdoses, NCACH's death rate for all drugs is statistically comparable to our population percentage. This indicates that we have no greater or lesser rate of overdose than in the state, overall. Psychostimulants represent the highest rate of overdoses in the region at 3.2%. This also is representative of the rural and economic challenges in our region.

NCACH Overdoses – Percentage of Statewide Total[5]

All Drugs	All Opioids	Heroin	Prescription opioids (non fentanyl)	Psycho-stimulants	Synthetic opioids (not methadone)
2.6%	2.2%	1.8%	2.8%	3.2%	1.6%

[3] WA State Population Data: https://www.ofm.wa.gov/sites/default/files/public/dataresearch/pop/april1/ofm_april1_population_final.pdf.
[4] County Land Mass Data: http://www.usa.com/rank/washington-state--land-area--county-rank.htm.
[5] Washington Dept. of Health Opioid Overdose Dashboard: https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/OpioidACHOverdoseDashboard.

Recent issues with the opioid epidemic and related drug behaviors have become a problem in Washington State and throughout the U.S. In addition, alcohol use disorders have seen a drastic increase over the past ten years, according to a JAMA Psychiatry study.[6]

Looking at the criminal justice impact in the NCACH region, while there is wide variation among counties, there has been a net 7.7% increase in adult drug offense arrests between 2012 and 2018.[7]

This makes a strong case for CDPs in general, and for treatment attendants in corrections facilities, more specifically. These trends are not unique as national incarceration rates for drug-related offenses have steadily risen since the 1990s as a result of zero tolerance drug policies. To mitigate the overwhelming increase in those serving jail sentences for drug offenses, many counties throughout the country have adopted drug court, or drug diversion, programs. This underscores the need for CDPs working adjunct to the criminal justice system.

Proposed Strategy

Therefore, as a workforce strategy to address these issues and priorities, NCACH has proposed the development of a Chemical Dependency Professional (CDP) Apprenticeship Program. To frame the need, we will start with a current employment snapshot for this position in Washington State.

Washington State, May 2018

Occupation (SOC code)	Employ-ment[(1)]	Hourly mean wage	Annual mean wage[(2)]	Employ-ment per 1,000 jobs
Substance abuse, behavioral disorder, and mental health counselors (211018)	8350	$23.28	$48,430.00	2.563

An Innovative Approach

The apprenticeship strategy offers a multi-pronged approach to addressing SUD issues via an innovative, experiential, on-the-job training model. The apprenticeship model has been utilized in training artisans for centuries, and formal experiential and on-the-job models have been effectively used to train tradespeople in the U.S. and abroad for over a century. The CDP apprenticeship approach is innovative because 1) the apprenticeship model has not been used in more "white collar" professions, and 2) currently, there are only two other drug and alcohol counselor apprenticeship programs in the U.S.[8] However, over the past several decades, European countries have expanded the apprenticeship approach to training non-trades-related workers with good results. In the U.S., historically low unemployment for the past several years has provided added incentive for employers to explore the merits of an apprenticeship approach for training people for non-trades-related careers.

[6] JAMA Psychiatry Article Abstract: https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2647075; References JAMA research: https://www.therecoveryvillage.com/alcohol-abuse/news/increase-nationwide/#gref

[7] WA County Criminal Justice Data, Office of Financial Management: https://sac.ofm.wa.gov/washington-state-county-criminal-justice-data-book-1990-2018.

[8] Rutgers receives $1.3 million endorsement for drug apprenticeship program | The Daily Targum; Nation's First Certified Alcohol and Drug Counselor Apprenticeship Program will Expand - New Jersey Business Magazine; New England & Rhode Island Licensed Alcohol and Drug Counselor Apprenticeship Standards: https://hcapinc.org/files/library/LADC-Standards.pdf.

Recently in Washington State, two of the first non-trades-related apprenticeships were developed and implemented by the Washington Association for Community Health, (The Association, formerly, Washington Association of Community and Migrant Health Centers), in collaboration with South Seattle College. The Medical Assistant and Dental Assistant Apprenticeships were developed to meet acute workforce needs at The Association member healthcare providers throughout the state. The Medical Assistant Apprenticeship has been very successful in training individuals for this extremely in-demand position in healthcare. A year ago, the educational partnership changed from South Seattle College to Wenatchee Valley College and from all reports, this has been a very viable partnership.

In the case of a CDP apprenticeship in the North Central region, the goal is not only to increase the overall talent pool but to *grow more CDPs regionally* in partnership with employers, colleges, and other organizations. It is important to reiterate that the CDP shortage is not only statewide, but is, in fact, nation-wide. So, rather than recruiting or "importing" trained CDPs from other communities – a strategy that represents significant challenges due to statewide shortages for this position -- a community-based talent pool for CDPs could be developed. This is in line with proactive talent pipeline development strategies.

A talent pipeline can be defined as "… a ready pool of potential candidates who are qualified and prepared to step up and fill relevant key roles within the organization as soon as they fall vacant".[9] These strategies are only as good as ensuing pipeline development efforts. With retention and turnover of CDPs contributing to overall high turnover for employers, one foundational idea with this model is that apprentices from the community would be more likely to stay with an employer who has invested in training and paying them while they complete their coursework. If successful, this strategy could potentially increase hiring from the community while reducing turnover. The goal would be for the capacity for SUD services in the region to increase which would then improve overall access to these needed services.

Chemical Dependency Professional (CDP) Education

Wenatchee Valley College offers the only CDP program in the region, with a satellite campus in Omak. This is a two-year (90 credit), full-time, in-class program. To complete 90 credits generally takes two years. Additionally, to obtain a CDP certification requires a 2500-hour internship which takes a year and a half for most students working full-time at their internships. The number of internship hours varies based on the degree of the individual – an Associate of Arts degree requires 2500 hours with higher level degree-holders requiring 1500 hours.[10] Cumulatively, this is a three-plus year commitment before a student would be able to work in a bona fide SUD services position. It is conceivable that a person could complete classwork and internship hours concurrently, but according to program administrators at Wenatchee Valley College, most students complete coursework prior to doing internships.

The intensity of managing a full-time class load and a full-time job unrelated to one's course of study is difficult for anyone. Add to that having to travel long distances to class and it is not a formula for academic or career success. Not being able to work while in school often presents an economic hardship and a barrier for students in the region who have no choice but to work.

[9] Definition of Talent Pool: https://www.hrtechnologist.com/articles/digital-transformation/what-is-talent-pipeline/.
[10] Revised Code of Washington Substance Use Counselor Training Requirements: https://app.leg.wa.gov/RCW/default.aspx?cite=18.205.090.

To address this, the apprenticeship model would offer the Wenatchee Valley College CDP curriculum online via a portal managed by WACH. Because of WACH's statewide membership, students could be located anywhere in the state. While our focus is on students in the four NCACH counties, we are unable to guarantee a minimum number of students for a class. A partnership with WACH would allow enrollment to meet the minimum necessary for WVC because students throughout the state could register for the online classes. This would mitigate the issue of scale for the college while still making the classes easily accessible to those students in our region (and other regions with limited access to CDP programs) who live in more rural or remote communities. The online option therefore addresses the need for access throughout North Central's geographic, economic, and ethnically diversity region.

A paid training job directly related to a student's field of study would enhance their academic learning, making coursework less burdensome. Additionally, intern hours would be earned concurrently with academic credit, reducing the need to do an internship *after* completing 90 credits. Also, state approved apprenticeships are available for a 50% tuition reduction at colleges. With this foundation, it sets students up for less educational debt or economic hardship than might otherwise be the case.

The advantages of this model are apparent for someone starting out in their new career: a) the time frame for obtaining certification is reduced by a full year which b) makes them ready for full-time, regular employment much faster. Instead of not being able to work in a full CDP capacity until three and a half years elapses, a CDP apprentice would potentially be able to work as a certified CDP counselor after two years. The economic benefits of such a program (at the individual and community levels) are clear, but the potential to address access and capacity in mental and behavioral health care are equally as important.

Labor Market Information

Introduction

The following section will serve as a brief orientation to labor market terms found in the data presented. To start with, an overview of terms might be useful.

- BLS - Bureau of Labor Statistics (BLS) is a federal government arm of the Department of Labor.
- ESD - Washington State Employment Security Department is the state version of BLS. WAESD provides data to BLS.
- NAICS - The North American Industry Classification System is the standard used by Federal statistical agencies in classifying business establishments for the purpose of collecting, analyzing, and publishing statistical data related to the U.S. business economy, (https://www.census.gov/eos/www/naics/).
- SOC Codes - The Standard Occupational Classification (SOC) system is a federal statistical standard used by federal agencies to classify workers into occupational categories for the purpose of collecting, calculating, or disseminating data. All workers are classified into one of 867 detailed occupations according to their occupational definition, (https://www.bls.gov/soc/).
- OCC Codes – this term is interchangeable with SOC code. (For more information about the SOC classification system, go to https://www.bls.gov/soc/socguide.htm. This offers an explanation of how the codes are laid out).

In this analysis of CDP jobs, we looked at current data and projections. Most of our data was pulled from BLS and WA ESD. Additional sources came from these same (or other state's) employment and labor data, all of which is

based on these classification systems. Throughout this section, occupation name groupings will appear with the associated classification numbers. Employers are required to classify employees according to this system when they file quarterly unemployment taxes. Keep in mind that position classifications may or may not relate to a particular industry. The industry designation is separate. For example, in this analysis, we looked at the occupations across several industry classifications which are identified by NAICS codes. With that, let's jump in.

The primary SOC code we examined was 21-1018: substance abuse, behavior disorder, and mental health counselor. According to projection data, these positions are increasingly difficult to fill nationally, at the state level, and in the North Central Region. According to the U.S. Bureau of Labor Statistics (BLS), nationally, SUD employment is anticipated to grow 22 percent from 2018 to 2028. This is a 10% faster rate than for counselors, social workers, and other community and social service workers, and a *17% higher rate than for all other occupations in the U.S. economy*.[11]

National Projections

Employment projections data for substance abuse, behavioral disorder, and mental health counselors, 2018-28

Occupational Title	SOC Code	Employment, 2018	Projected Employment, 2028	Change, 2018-28		Employment by Industry
				Percent	Numeric	
SOURCE: U.S. Bureau of Labor Statistics, Employment Projections program						
Substance abuse, behavioral disorder, and mental health counselors	21-1018	304,500	373,100	22%	68,500	Get data

In Washington State, long-term projections through 2028 indicate an over 20% increase in employment for substance abuse and behavioral disorder counselor positions.[12] In addition, protective service workers, which increasingly include corrections treatment personnel, (many of which require CDPs), are projected to grow 19%.[13] Much of this is due to the proliferation and efficacy of deferral programs (a.k.a. "drug court") for alcohol and drug offenses.

For a more current snapshot of open positions, we looked at active job postings (as of Sept 10th, 2019) for "Chemical Dependency Counselor", "Substance Use Disorder Counselor", and "CDP":

	Indeed.com
United States:	1985
Washington:	292
NCACH Openings:	**6**

[11] US Bureau of Labor Statistics, Employment Projections Program: https://www.bls.gov/ooh/community-and-social-service/substance-abuse-behavioral-disorder-and-mental-health-counselors.htm#tab-6

[12] Washington State Employment Projections: https://projectionscentral.com/Projections/LongTerm

[13] Washington State Employment Projections: https://projectionscentral.com/Projections/LongTerm

In our region there are eleven employers with CDP positions. Five are in Wenatchee, one is in Chelan, two are in Okanogan, one is in Omak, one is in Moses Lake, and one is in Nespelem. Of those, five are community behavioral health organizations, one is a county hospital, one is a nonprofit organization, three are private, and one is a county corrections center.

While at first glance, the regional numbers may not seem significant, taken in context with unanimous feedback from local employers regarding the difficulty in recruiting and retaining CDPs for open positions, this is significant. In fact, an employer in Wenatchee has had an open CDP position listed on its website for 6 months, since April 2019. Another employer in Okanagan County has had a CDP position posted continuously for over a year. This points not only to the difficulty of recruiting CDPs for open positions, but also to the difficulty of retaining employees in CDP positions. This is true all over the state and the country, not just in the North Central Region.

Regardless, the long-range occupational outlook for these positions is clear:

Washington State
Long Term Projections **2016 - 2026**

SOC Code	Occupation Name	Base Year	Base Nbr Employed	Proj. Year	Projected Nbr Employed	Nbr Change	% Change	Avg Annual Openings
21-1023	Mental Health and Substance Abuse Social Workers	2016	2430	2026	2930	500	20.6%	320
21-1092	Probation Officers and Correctional Treatment Specialists	2016	2280	2026	2440	160	7%	210
21-1011	Substance Abuse and Behavioral Disorder Counselors	2016	2220	2026	2670	450	20.3%	300

https://projectionscentral.com/Projections/LongTerm

There are several reasons posited for these projected trends, but two of the main reasons are a) the increase in opioid addiction and related offenses and b) the efforts of municipalities and counties to divert drug-related jail sentences to addiction treatment.[14] Relatively speaking, Washington State has fared somewhat better than other states in the opioid crisis, with urban centers on the west side of the state experiencing a majority of opioid-related deaths. In the rural east side of the state, there is a proportional degree of methamphetamine and alcohol-related issues.[15] Also, historically low unemployment has had an effect.

Pay for CDPs

Non-metropolitan Eastern Washington is the *fifth highest paying non-metropolitan area for SUD positions in the nation.*[16] In fact, comparing Eastern and Western Washington non-metropolitan average hourly pay for substance abuse-related job categories shows a full $1.15 per hour higher pay in Eastern Washington than in Western Washington.[17] Reasons for this are not apparent but given the relative level of poverty in rural communities one might surmise that it has to do with geographic density and easier access to metro areas. These metro areas offer

[14] Addiction Centers, Treatment Barriers: https://americanaddictioncenters.org/rehab-guide/treatment-barriers.
[15] Washington Dept. of Health Opioid Overdose Dashboard: https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/OpioidACHOverdoseDashboard.
[16] Office of Employment Statistics, BLS: https://www.bls.gov/oes/current/oessrcma.htm
[17] Office of Employment Statistics, BLS, Metro and Non-Metro Wage and Employment Data: https://www.bls.gov/oes/current/oes_5300007.htm.

many more college CDP programs. In fact, there are three times as many CDP programs throughout Western Washington as there are in Eastern Washington. This presents access to a 300% larger talent pool for open positions making pay one factor used to attract someone to a position in a rural community on the east side of the state. While not true for all rural communities in Western Washington, the closer a community is to the Greater Seattle and Tacoma metropolitan areas, the higher the cost of living. This, then, would not account for higher wages in non-metro areas on the east side of the state.

WASHINGTON NONMETROPOLITAN JOBS AND WAGE DATA[18] **May 2018**

Eastern Washington Nonmetropolitan Area

SOC CODE	OCC TITLE	TOTAL EMPL		HOURLY MEAN	ANNUAL MEAN
21-1018	Substance Abuse, Behavioral Disorder, and Mental Health Counselors	140		$27.41	$57,020.00
21-1023	Mental Health and Substance Abuse Social Workers	40		$23.62	$49,120.00
21-1092	Probation Officers and Correctional Treatment Specialists	50		$27.61	$57,420.00
	TOTAL:	**230**	**AVG:**	$26.21	$54,520.00

Western Washington Nonmetropolitan Area

OCC CODE	OCC TITLE	TOTAL EMPL		HOURLY MEAN	ANNUAL MEAN
21-1018	Substance Abuse, Behavioral Disorder, and Mental Health Counselors	400		$25.25	$52,530.00
21-1023	Mental Health and Substance Abuse Social Workers	100		$22.15	$46,060.00
21-1092	Probation Officers and Correctional Treatment Specialists	230		$27.77	$57,760.00
	TOTAL:	**730**	**AVG:**	$25.06	$52,116.67

Employer and Stakeholder Meetings

During the week of July 23rd-26th, Christal Eshelman, NCACH Project Manager, and Linda Rider, Workforce Consultant, met with agencies involved in treating substance use disorders throughout the NCACH region. Our

[18] Office of Employment Statistics, BLS, Metro and Non-Metro Wage and Employment Data: https://www.bls.gov/oes/current/oes_5300007.htm

goals were to introduce the Workforce Consultant to potential CDP Apprenticeship stakeholders, to gauge interest and need, and to solicit feedback and concerns regarding such a program model.

We met with seven agencies directly involved in SUD services.

- Columbia Valley Community Health (CVCH) - Blake Edwards, Director of Behavioral Health Services
- Grant Integrated Services (GrIS) - Gail Godwin, Director of Integrated Services, Noemi Garcia, CDP Supervisor, Dell Anderson, Incoming Clinical Director
- Wenatchee Valley College (WVC) - Jenny Capello, Dean of Allied Health and Beverly Warman, Director of Chemical Dependency Studies
- The Center for Alcohol and Drug Treatment - Loretta Stover, Executive Director
- Amerigroup - Courtney Ward, Business Improvement Consultant
- Okanogan Behavioral Health Center (OBHC) - Lisa Apple, Interim CEO, Jessica Blake, Human Resources Manager, and Dan Boyle, Supervisor of SUD Services
- Family Health Centers - Jesus Hernandez, CEO, and Brad Hankins, VP of HR and Risk Management.
- On September 17th, we also met with Carmella Alexis, Deputy Director of Human Services staff at Colville Confederated Tribes.

Concerns and Feedback

Responses from agency representatives was enthusiastic and positive. All expressed a degree of difficulty recruiting and hiring CDPs for openings at their agencies.

Several concerns expressed were:

- Budget concerns for hiring CDP/Ts – Medicaid reimbursements for SUD/CD services will not be obtainable until an apprentice has their Trainee (a.k.a. "T") designation. This requires a four-hour HIV/AIDS online course and successfully passing a background check. Then, once they have worked 50 hours with their supervisor, CDP/Ts are then authorized to meet one-on-one with clients at which time their client-facing work hours become reimbursable at the full rate. While having a trainee's hours be reimbursable, this is only one part of the budgetary concerns for behavioral health organizations. Most are constantly trying to figure out how to stretch budget dollars to meet existing mental and behavioral health needs. So, the question will still be one of how those organizations can justify the time and expense of investing in a trainee while they are gaining the knowledge and experience to operate at full CDP capacity.
- Workload and Service Capacity – The state requires SUD/CD supervisors to reduce their own caseloads by 25% for each apprentice, intern, or trainee. Therefore, it creates an urgency for CDP/Ts to take on client-facing duties (or a "caseload") prior to being fully prepared or, in some cases, appropriate. Most stakeholders felt that for a "green" trainee to take on clients prior to some basic addiction/treatment and counseling theory (at minimum), was not necessarily advisable. This would leave SUD/CD services teams to absorb any displaced workload.
- Understanding Theory and Practice – In addition to the HIV/AIDS training and background check required by the state for the CDP/T designation, several SUD/CD administrators recommended that, prior to working unsupervised with clients, CDP apprentices take CDS 100 – Survey of Chemical Dependency (WVC) and CDS 103 – Foundations of SUD Counseling prior to working unsupervised with clients. Once again, this idea creates a tension between the need for students to be paid throughout their training, the

need for SUD/CD organizations to not have unprepared or inappropriate individuals working with vulnerable clients, and the need for employers not to be paying limited dollars for apprentices who are not likely to pan out.

- Apprentices in Recovery – We have received ancillary feedback that those in recovery from addiction have the greatest potential to make effective CD/SUD counselors because those who have not personally addressed addiction themselves often have difficulty relating to and/or building rapport and credibility with clients. This presents a "Catch-22" because a number of those interested in CDP counseling careers are early in their recovery. It was stated that this has the potential to create treatment efficacy issues since those in early recovery may not yet be appropriate for working with clients in treatment.
- Additional concerns: 1) how to provide adequate supervision with rural CDP/Ts or apprentices, 2) how best to keep apprentices engaged and provide them with ongoing support while they are in school and training, and 3) how to provide salary to attract individuals to open rural positions.

Conclusions

There is no doubt that community stakeholders in mental health and recovery throughout the north central region believe there is a need for more, and better, access to CDPs. State data indicate that the need for CDPs is expected to grow by 20%. While job projections for this occupation in the north central region do not show significantly large numbers, compared to a) smaller rural populations in Douglas, Chelan, Grant, and Okanagan Counties and b) to the needed access to SUD services, an investment in a solution for training CDPs in the region is well-founded. Also, since north central employers pay well for CDPs compared to other non-metro areas in the country, these well-paying jobs for those interested in, and well-suited for, this rewarding profession would be a solid health care workforce investment in the region.

Budget issues for employers will continue to present a challenge to being able to staff enough CDPs to meet the need. The question of how to pay for enough treatment professionals overall -- trainees, apprentices, or full CDPs -- will remain. Nonetheless, it is clear the need is there and that the current supply of candidates for jobs is not going to meet this need. Even higher pay has not been enough to attract the candidates needed for open positions, especially in more rural areas. The CDP Apprenticeship model proposed here not only offers a new way to meet the need, it makes it much more likely that north central residents will be the ones benefitting from this opportunity. For NCACH to invest in an apprenticeship model for the SUD/CD counseling profession is at the cutting-edge nationally and has the potential to be a state-wide best practice for meeting a crucial workforce and community need.

Returning to the criteria proposed for determining this project's feasibility, it seems clear that this program is not only feasible but is strongly recommended. Therefore, it is our recommendation that we proceed to the next phases of the project development.

	Feasibility Criteria	Yes	Notes
1)	Need (accessibility and capacity)	X	The need is clearly articulated for NCACH region, as well as statewide and nationally
2)	Labor Market and Projections	X	Shows strong occupational outlook
3)	Apprenticeship Model Viability	X	Overwhelming support from employers
4)	Administration (anchor organization)	X	WA Assoc. for Community Health has signed on
5)	Education Partner	X	Wenatchee Valley College is on board

APPENDIX

A. **From NCACH Project Plan, p. 14**

"Workforce capacity is a significant challenge for the region. Three of the four counties in the region are designated as Medically Underserved Areas (Douglas, Grant, and Okanogan). The entire region is designated as a geographic Health Professional Shortage Area (HPSA) for primary care, mental health, and dental care[43]. Large areas of the region also have population based HPSA designations for migrant workers, low-income individuals, and Native Americans. Health care employers have experienced difficulty in filling vacancies for positions for registered nurses, clinical social workers, and mental health counselors[44]. Based on population/primary care provider ratios, workforce shortages are most prevalent in Grant and Okanogan Counties. The Medicaid Demonstration projects provide a crucial opportunity for NCACH partners to address workforce capacity issues, through regional collaboration and planning to implement strategies such as telehealth to build workforce capacity. Access to behavioral health care is another challenge. There are no designated psychiatric inpatient beds in the region, despite the fact that mental and behavioral health diagnoses are among the top reasons for hospitalization. The region's rates of mental health treatment penetration (45.5%) and substance use disorder treatment penetration (22.2%) are below the state average for these indicators (42.9% and 26.7%, respectively)[45]. This suggests that there are Medicaid members with treatment needs who may not have adequate access to care."

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[43] WA State Department of Health, Health Professional Shortage Areas: https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/RuralHealth/DataandOtherResources/HealthProfessionalShortageAreas

[44] Washington State Health Workforce Sentinel Network: http://www.wtb.wa.gov/HealthSentinel/findings.asp

[45] HCA AIM, ACH Toolkit Historical Data file.

North Central Accountable Community of Health

NCACH Project Update

Community Partnership for Transition Solutions

December 2019

Background

- The North Central Community Partnership for Transition Solutions (CPTS) was formed in August 2018 with the purpose of bringing together various stakeholders who are committed to working together to support individuals to successfully transition out of incarceration and back into the community.

Strategic Planning

- Over the summer, the local Chelan-Douglas CPTS engaged in a strategic planning process facilitated by NCACH staff, Caroline Tillier. This process led to the development of an Action Plan with six action items:
    1. Reintegration roadmap
    2. Recovery Coach Network
    3. Legal Financial Obligation (LFO) mitigation
    4. Free transportation options
    5. Select free phone calls from Chelan County Jail
    6. Reintegration Programming in Jails
- In October, each action item was assigned a lead and a support team. Partners were very engaged in this process and will be working to address each of the Action Items over the next year.

Attachments

1. Chelan-Douglas CPTS Strategic Planning Summary (summary of the strategic planning process and identified opportunity areas)
2. Chelan-Douglas CPTS Action Plan (living document with identified action items, leads, and support teams)

Attachment 1

Chelan-Douglas CPTS
Strategic Planning Summary

Background

On July 22nd and August 26th 2019, a subset of participants from the Chelan Douglas Community Partnerships for Transition Solutions (CPTS) met to identify existing resources and gaps for people reintegrating into their communities after a period of incarceration. A list of participants is included in ***Appendix A***.

The objective of these meetings was to propose a draft action plan to the broader group outlining ideas and strategies that could be collectively advanced by the group to support successful transitions. In other words, the ultimate questions the planning was designed to answer is: "What barriers could CPTS work on. What specifically could CPTS do?" An overarching principle for this group is to advance solutions that work for *anyone* being released from incarceration.

Assets

Existing services and resources were mapped out on a rough timeline, based on when these services might be available to an individual experiencing incarceration (starting from the point of arrest/incarceration, at release, or post-release). Participants were asked to be specific about the following:

- Name of the program/resource
- Who provides the program/resource (including service capacity)
- Who is eligible (including restrictions)
- How people hear about the program/resource
- When the program/resource is realistically available to individuals

A summary of this resource inventory is included as ***Appendix B***. This inventory reflects what participants in the room were aware of and should only be considered a starting point.

Recommendation: Consult with individuals who have experienced transitions from incarceration to truth-test this inventory and ensure the group did not overlook critical information.

Gaps

In discussing existing programs, the group identified the following gaps in programs/resources:

During Incarceration

- Evaluations and treatment for SUD/MH treatment

    - Note that Loretta Stover from the Center for Alcohol and Drug Treatment is looking into an idea of offering drug and alcohol assessments in the jails.
- Peer specialists and mentors who can meet with people in jails
- Jail programming
    - WorkSource and partners are pursuing ideas for offering jail programming. This is a work in progress and Ashley Olson can provide updates.
    - North Central Regional Library (NCRL) is exploring a partnership with jails to help people relieve old library debt and obtain library cards prior to release.
    - Need input from those with direct experience to build out recommendations and priorities.

5am Release

- Recovery Coach / Peer specialist
- Transportation
- Clothes

Post-Release

- Transportation
- Housing, including emergency housing and more beds for Oxford Houses
    - Need a housing inventory that outlines eligibility barriers related to convictions, income, mental health needs and status, SUD needs and status.
- Legal Financial Obligations (LFO) Remittance

Action Plan Ideas

The group brainstormed a draft action plan to address some of the gaps outlined above (***Appendix C***). This plan will be shared at the next Chelan-Douglas CPTS meeting to test assumptions, get input and buy-in, and help with prioritization. **Note that many of the action items focus on the 5am release, as this time period reflects many gaps and needs.**

Recommendation: As the group refines this action plan, participants suggested inviting representatives from ABHS /Parkside, the Community Housing Network, and the transportation sector to future CPTS meetings.

Recommendation: For each action item, identify a "sponsor" (point person) who will be responsible for moving the action forward while resolving any barriers and questions. The sponsor should identify and recruit any needed partners, outline action steps, and those responsible for completing those tasks. Based on this mini work plan, the sponsor can provide progress updates at CPTS meetings.

Unresolved Questions

The following questions surfaced during our planning sessions. **CPTS should identify a champion "detective" who can research and bring answers back to the CPTS group.**

- Need to confirm whether the Emogene Women's Shelter 24 hour services would allow for 5am release support, and what that might look like. How do we ensure that a housing specialist can help coordinate this pre-release so individuals know where to go upon release?
- Does Parkside (ABHS) offer any housing options? Are there restrictions around using beds for other purposes (is it really just for MH and SUD treatment)?
- Do the Catholic Charities housing apartments under construction (due to open January 2020) involve any eligibility restrictions? Need to ask Shawn Delancy at Catholic Charities to confirm whether this is truly a low barrier resource.
- The YMCA opens its doors for exercise machines/showers at 5:15am. Could we explore a partnership with the YMCA to provide a landing space from 5-8am? How might this work? Need to ask Dorry Foster.
- Could chaplain services offer transportation vouchers?

Strategic Planning Participants

1. Kathy Blauman
2. Michelle Bolyard
3. Bev Cabrera
4. Leslie Carlson
5. Christal Eshelman
6. Victor Estrada
7. Jeni Latimer
8. Karen Lynch
9. Alyssa Martinez
10. Deb Miller
11. Ashley Olson
12. Lisa Owens
13. Sunshine Poliquin
14. Caroline Tillier (facilitator)

Organization Name	Program Name	Description	Program Capacity	Eligible Population	How do people hear about it?	Arrest/Incarcerated	6 mo. Pre	3 mo. Pre	1 mo. Pre	5am release	3 mo.	6 mo.	9 mo.	12 mo.	15	18	21	24	+
Chelan County Superior Court	Drug Court	Diversion meant to minimize incarceration and promote treatment.	Serves 9-10 individuals at a time	Those charged with a drug-related felony, with no more than $2,500 in LFOs	Brochures in county jail, defense attorney, The Center/Prosecutor/Judge	Up to 2 years from enrollment													
Catholic Charities	Jail Reentry Program	Provide case management services in jails and assist in transitioning to services outside of jail (until connected to services).	No limits on caseload.	Must have Axis I mental health diagnosis	Typically jail staff refer to program, word of mouth														
DSHS		Child support assistance		Anyone owing child support	Jeni														
Catholic Charities	Diversion Mobile Crisis Intervention crisis outreach (trueblood program)	Case management, including housing, wrap around services		Anyone with law enforcement contact who's in crisis (MH), no serious charge	Referred by diversion, law enforcement														
Chelan County Superior Court	Community Recovery Program		Only serves 8 at a time	Male over 18, facing homelessness upon release from incarceration	Self-referral, DOC prisons, family														
Department of Corrections (DOC)	Release Readiness Program			Those incarcerated in DOC facilities															
Washington Health Exchange	Medicaid insurance enrollment	Enrollment in health insurance		Anyone eligibile for Medicaid	At any medical/behavioral health clinic/office and in jails, brochures, word of mouth														
Worksource	Federal Bonding	Insurance bond for at-risk employee from $5-25K for the first 6 mo. Of employment		Employers who hire individuals who have been released/incarcerated (employer must find them "risky")	Website, brochure, word of mouth, job hunter workshops at Worksource														
Worksource	Work Opportunity Tax Credit	Tax credit to employers who hire individuals in various categories		Employers who hire individuals who have been released/convicted within the last 1 year from date of hire	Info targeting businesses, including website, brochure, accountant, job seekers at wroksource														
Amerigroup (through local providers like Catholic Charities)	Foundational Community Supports (FCS)	Housing and employment case management services		Those with complex needs (MH, SUD, long-term care), with 2+ incarcerations in last 12 months															
Worksource	Job Hunter Workshops	Job search/skills and abilities, applications, resume/CV, interviews	Max 15 per workshop	Everyone	Flyer, staff referral, Worksource Calendar, outreach presentations														
Worksource and DSHS	Strategies for Success	Classes on life/job skills each week (work concepts, communication, community engagement, personal strengths)	Max 15 per class	Open to all people willing to participate	Brochures, word of mouth, referrals from Worksource/DSHS														
Action Health Partners (through local providers)	Community Care Coordination - Health Homes	Provides care coordination of medical, behavioral health, long-term services and other community supports for eligible Medicaid clients (who also receive Medicare) at no cost to the client		Medicaid, 1+ chronic illness (including BH), high utilizer of healthcare services (PRISM score > 1.5)	Get letter from state when originally become eligible, or from care coordinator														

Organization Name	Program Name	Description	Program Capacity	Eligible Population	How do people hear about it?	Arrest/Incarcerated	6 mo. Pre	3 mo. Pre	1 mo. Pre	5am release	3 mo.	6 mo.	9 mo.	12 mo.	15	18	21	24	+
Action Health Partners (through local providers)	Community Care Coordination - Pathways Community HUB	Provides community-based care coordination to Medicaid and Medicaid-eligible clients through data-driven model		Medicaid (or eligible), 3+ ED visits in past 12 months	Brochure														
HopeSource		Housing stabilization support services for veterans and families (emergency housing, first & last months rent, security deposit, $1500 for household items)		Veterans with 1 day of active duty who are homeless or at-risk of becoming homeless	Brochures, referrals, word of mouth														
Oxford House	Oxford House Chapter 16	Structured and supported housing with peers in recovery	7 women, 33 men	Must be clean & sober	Panels in treatment centers, word of mouth, jail referral, DOC														
DSHS		Foods stamps, free phone, ID voucher		Can't be incarcerated, no more warrants, but open to anyone who's income eligible	Flyers handed out in the jail														
Action Health Partners	SHIBA Program	Is Medicare suspended, can advise about their coverage?		Anyone available for SHIBA	Brochures that could be provided														
Federal Communications Commission	Lifeline	Federal program providing free mobile phones and monthly services to people with limited incomes.	One smart phone per household (data and minutes), or one contract for internet service	Income requirements (SNAP, Medicaid, SSI, Section 8, Veterans Benefits, tribal programs)	Brochure														
YWCA	Emergency Shelter	Case management services, 24 hour services, can hold a bed	Can stay up to 90 days. 10 beds total (can hold beds by month)	Just for women. Exclusions: registered sex offenders and crimes against persons (murder, assaults, violent and strike crimes). Open to those released from prison or jail but must be clean & sober.	Referral from jail/prison staff, case managers, etc														

Action #1: Develop a concise booklet outlining a reintegration roadmap of critical resources that can help individuals focus on immediate post-release needs.

Goal: Improve the way information is shared and distributed with individuals transitioning from incarceration to promote successful transitions.

Assumptions

Many rack cards, brochures and pamphlets exist for various programs. Every program/case manager has their own resource list. This means that distribution of materials is ad-hoc and inconsistent. There are also comprehensive reentry guides (Appleseed) but these may be too overwhelming (unusable) for individuals facing an overwhelming transition back to the community.

Developing a concise booklet focused on immediate release needs will consolidate and streamline critical resources in one place to help individuals navigate their transition and get back on their feet in the community. This booklet will align with some of the major reentry topics outlined in the Appleseed guide but will be more user-friendly. It will also offer a consistent and comprehensive resource that a variety of partners can distribute to individuals transitioning back to the community. Jail staff can include the booklets in release bags to ensure that all individuals released from incarceration get the information.

Potential Resources

- NCACH staff can do an initial lift to design and format the draft booklet using basic software that can be easily edited (to ensure that anyone with basic word processing software can upkeep of this resource)
- William Bilderback from the Women's Resource Center may be able to help with the booklet, according to Bev and Jeni
- Jeni volunteered to update the resource once it is developed
- Oliver Crane (City of Wenatchee) may also be able to help keep up to date

Barriers

A challenge of any booklet or resource is identifying owners that are accountable for keeping the resource up to date (sustainability). This is something the sponsor(s) of this action item should address.

Target for Resource Availability AT RELEASE

Action #2: Train and support recovery coaches to serve as a 5am release resource.

Goal: Improve peer support at release and post-release to promote successful transitions for individuals transitioning from incarceration.

Assumptions

North Central Accountable Community of Health recently partnered with the Central Washington Recovery Coalition to offer a new training opportunity in North Central Washington. The Recovery Coach Academy is a 30-hour intensive training academy focused on providing individuals with the skills needed to guide, mentor and support anyone who would like to enter into or sustain long-term recovery from an addiction to alcohol or other drugs. Recovery coaches typically have personal and professional experience with mental health, addiction, and recovery and service work is huge for recovery coaches.

Since a majority of people experiencing incarceration have struggled with mental health and/or addiction issues, recovery coaches could assist with release and post-release. For example, they might agree to volunteer one day a month to be on call at 5am at the local jail to help people with release. They could be trained to walk through the booklet with individuals leaving incarceration.

Note that this resource would be similar to the *Reentry Corps* which was formed in the Seattle area to assist with transitions. These advocates consist of former Justice Involved consumers and family members who are committed to "paying it forward" to help others make a successful transition and reintegration into their community.

Potential Resources

- Reintegration roadmap booklet (once developed), which could be used by recovery coaches as a check-list of immediate needs to assist with
- North Central Accountable Community is supporting Recovery Coach trainings and may be able to assist financially during a pilot phase
- Central Washington Recovery Coalition
- Reentry Corps (could consult with them)

Barriers

A decentralized network of peer support may need the support of an organization (administrative backbone) to access updated resources and continued training/support. This is something the sponsor(s) of this action item should address.

Target for Resource Availability AT RELEASE

Action #3: Increase awareness about Legal Financial Obligation (LFO) remittance resources.

Goal: Remove financial barriers to successful reintegration into the community through Annual Remittance Day event.

Assumptions

Many people who transition back to their community after a period of incarceration face significant employment and financial challenges. Their inability to pay fines, fees, and restitution imposed by the courts puts them into debt, and only contributes to their already existing financial challenges.

Legal advocates are working on reforming the LFO system in Washington State, and individuals may need assistance to fully understand and navigate their options.

Potential Resources

- Judith Lurie from Northwest Justice Project about offering regional trainings

Target for Resource Availability POST RELEASE

Action# 4: Increase access to free transportation options upon release.

Goal: Ensure that individuals can travel to a stable landing place upon release.

Assumptions

Many individuals need transportation upon release, and being released at 5am makes it especially hard to rely on family/friends or case managers that typically start work at 8am. The jails do not have funding to offer free bus passes. Employers, however, are able to access discounts through agreements with Link Transit.

CPTS could explore solutions and share a plan/recommendations with jail staff to make transportation tokens/passes more systematically available upon release.

Potential Resources

- Link Transit

Target for Resource Availability AT RELEASE

Action #5: Remove barriers to making phone calls from jails.

Goal: Promote pre-release planning so individuals and their case managers can line up resources (e.g. rides, getting on priority lists, coordinated entry line, etc.) prior to release.

Assumptions

Individuals who are incarcerated have trouble placing calls from jail (e.g. calls are not free, calls are limited, can only be made at specific times, etc.) Adding to these barriers is the fact that collect calling to cell phones is limited, and collect calls to programs can't go through if a live person doesn't pick (e.g. if there is an answering system). Individuals can place calls to programs, families, and friends that have signed up for pre-paid accounts from third-party vendors. Per minute rates, however, are often much higher than normal, which can be cost prohibitive for families and friends. Note that the jail has the ability to make calls to certain phone numbers for free, as they have done for Catholic Charities Jail Services Program.

Potential Resources

- Jeni agreed to explore (champion)
- Community housing network hotline
- Crisis Line
- YWCA

Target for Resource Availability PRE RELEASE

Action #6: Advocate for more housing options for people with criminal justice and behavioral health challenges.

Goal: Expand housing options for individuals when they are released from incarceration to prevent homelessness and/or dependence on people that may hinder their reintegration and recovery.

Assumptions

Certain groups are working to increase housing options in our region, including low barrier shelters. While CPTS might not have the expertise or resources to come up with specific housing solutions, the group can elevate and advocate for the unique needs of individuals who are seeking stable housing after being released from incarceration, including those that need assistance with long-term recovery efforts.

Potential Resources

- Chelan-Douglas Homeless Task Force
- Oxford House

Target for Resource Availability AT RELEASE

Action: Reintegration Roadmap

CPTS Action Team

Lead: Jeni Latimer (*the lead is responsible for moving the work forward and delegating tasks)*

Support: Tanya Gleason, Sunshine Poliquin, Lisa Owens, Bev Cabrera

Timeline Target

At Release

could also be used for pre-release planning

Goal: Improve the way information is shared and distributed with individuals transitioning from incarceration to promote successful transitions.

Assumptions

Many rack cards, brochures and pamphlets exist for various programs. Every program/case manager has their own resource list. This means that distribution of materials is ad-hoc and inconsistent. There are also comprehensive reentry guides (Appleseed) but these may be too overwhelming (unusable) for individuals facing an overwhelming transition back to the community.

Developing a concise booklet outlining a reintegration roadmap of steps to take (and the suggested order to take them in) will consolidate and streamline critical resources in one place to help individuals navigate their *immediate* transition and get back on their feet in the community. This booklet may align with some of the major reentry topics outlined in the Appleseed guide but will be more user-friendly. Where possible, existing resources/templates will be used so we don't reinvent the wheel, but the content will be tailored to the region.

This booklet can become a consistent resource that a variety of partners can distribute to individuals transitioning back to the community. Jail staff can include the booklets in release bags to ensure that all individuals released from incarceration get the information.

Potential Resources

- NCACH staff can do an initial lift to design and format the draft booklet/roadmap using basic software that can be easily edited (to ensure that anyone with basic word processing software can upkeep of this resource)
- William Bilderback from the Women's Resource Center may be able to help with the booklet, according to Bev and Jeni
- Jeni volunteered to update the resource once it is developed
- Oliver Crane (City of Wenatchee) may also be able to help keep up to date

Barriers

A challenge of any booklet or resource is identifying owners that are accountable for keeping the resource up to date (sustainability). This is something the lead of this action item should address.

Action: Recovery Coach Network

Timeline Target

At Release

could also assist post-release with longer-term needs

CPTS Action Team

Lead: Christal Eshelman *(the lead is responsible for moving the action forward and delegating tasks)*

Support: Deb Miller, Karen Lynch

Goal: Improve peer support at release and post-release to promote successful transitions for individuals transitioning from incarceration.

Assumptions

North Central Accountable Community of Health recently partnered with the Central Washington Recovery Coalition to sponsor a Recovery Coach Academy. This 30-hour intensive training academy focused on providing individuals with the skills needed to guide, mentor and support anyone who would like to enter into or sustain long-term recovery from an addiction to alcohol or other drugs. Recovery coaches typically have personal and professional experience with mental health, addiction, and recovery and service work is huge for recovery coaches.

Since a majority of people experiencing incarceration have struggled with mental health and/or addiction issues, recovery coaches could assist with release and post-release. For example, they might agree to volunteer one day a month to be on call at 5am at the local jail to help people with release. They could be trained to walk through the roadmap with individuals leaving incarceration, which is important since there is no one-stop-shop in our region to help people upon their release. Note that this resource would be similar to the *Reentry Corps* which was formed in the Seattle area to assist with transitions. These advocates consist of former Justice Involved consumers and family members who are committed to "paying it forward" to help others make a successful transition and reintegration into their community.

Potential Resources

- Reintegration roadmap booklet (once developed), which could be used by recovery coaches as a check-list of immediate needs to assist with
- NCACH is supporting Recovery Coach trainings and may be able to assist financially during a pilot phase
- Central Washington Recovery Coalition
- YMCA (potentially willing to make space available until 8am – Deb Miller on point)
- Reentry Corps (could consult with them)
- Wenatchee Valley College (work study placements for criminal justice students -- 1-2 year placements up to 19 hours/week – could increase capacity)
- OIC of Washington (paid internships up to 240 hours could increase capacity)

Barriers

A decentralized network of peer support may need the support of an organization (administrative backbone) to access updated resources and continued training/support. This is something the lead of this action item should address.

Action: Legal Financial Obligation (LFO) Mitigation

CPTS Action Team

Lead: Judith Lurie *(the lead is responsible for moving the action forward and delegating tasks)*

Support: Ashley Olson, Sunshine Poliquin, Lisa Owens

Timeline Target

Post Release

Goal: Remove financial barriers to successful reintegration into the community through Annual Reconsideration Day event.

Assumptions

Many people who transition back to their community after a period of incarceration face significant employment and financial challenges. Their inability to pay fines, fees, and restitution imposed by the courts puts them into debt, and only contributes to their already existing financial challenges.

Legal advocates are working on reforming the LFO system in Washington State, and individuals may need assistance to fully understand and navigate their options.

Potential Resources

- Judith Lurie from Northwest Justice Project was interested in offering regional trainings

Action: Free Transportation Options

CPTS Action Team

Lead: Tanya Gleason *(the lead is responsible for moving the action forward and delegating tasks)*

Support: Sunshine Poliquin

Timeline Target

Post Release

for longer-term transportation needs

Goal: Ensure that individuals can travel to a stable landing place upon release and navigate service needs post-release without being impeded by transportation barriers.

Assumptions

Many individuals need transportation upon release, and being released at 5am makes it especially hard to rely on family/friends or case managers that typically start work at 8am. The jails have access to free bus passes at release (through the chaplain services), but they do not have the resources to make free monthly passes available.

Longer term options like monthly passes, however, are not systematically available. Some programs offer monthly bus passes, and some employers are able to access discounts through agreements with Link Transit. While Link Transit is not able to give away bus tokens or passes by law, they might consider simplified fares based on community interest and advocacy.

CPTS could explore solutions and share a plan and recommendations with jail staff to make transportation passes more systematically available upon release.

Potential Resources

- Serve Wenatchee, Community Action, OIC, and Catholic Charities provide access to monthly bus passes
    - Clarify whether bus passes are only available to those engaged in their programming
- Link Transit
    - CPTS members can attend Board meetings to be squeaky wheels about this need (every 3rd Tuesday of the month from 3-5pm)
    - Can set up free travel trainings
- Rotary (sponsorship program opportunity)

Action: Phone Calls from Chelan County Jail

CPTS Action Team

Lead: Jeni Latimer *(the lead is responsible for moving the action forward and delegating tasks)*

Support: Jail colleagues

Timeline Target

Pre Release

Goal: Promote pre-release planning so individuals and their case managers can line up resources (e.g. rides, getting on priority lists, coordinated entry line, etc.) prior to release.

Assumptions

Individuals who are incarcerated have trouble placing calls from jail (e.g. calls are not free, calls are limited, can only be made at specific times, etc.) Adding to these barriers is the fact that collect calling to cell phones is limited, and collect calls to programs can't go through if a live person doesn't pick (e.g. if there is an answering system). Typically, individuals can place calls to programs, families, and friends that have signed up for pre-paid accounts from third-party vendors. Per minute rates, however, are often much higher than normal, which can be cost prohibitive for families and friends.

In our community, the jail has the ability to make calls to certain phone numbers free, as they have done for Catholic Charities Jail Services Program. Local jail staff have graciously agreed to add certain numbers to the list, allowing individuals to make calls to a broader array of organizations or programs while incarcerated.

CPTS should identify priority numbers since jail staff have limited capacity to add and maintain numbers on this list. Ideally, these numbers would align with the key resources in the reintegration roadmap (focusing on priority issues that should be addressed immediately upon release.)

Potential Resources

- Coordinated Entry hotline can be accessed up to 14 days prior to release (this is a Department of Commerce program managed by Catholic Charities in our region)
- Community housing network hotline
- Crisis Line
- YWCA (could hold a bed for housing, if housing immediately upon release is going to be an issue)

Action: Reintegration Programming in Jails

CPTS Action Team

Lead: Ashley Olson *(the lead is responsible for moving the action forward and delegating tasks)*

Support: Christal Eshelman, Lisa Owens, Jeni Latimer

Timeline Target

Pre Release

Goal: Provide reentry program pre-release to make share resources and make connections to service providers.

Assumptions

The Chelan County Jail has agreed to partner on a 3-day (12 hour) reintegration programming project that will take place once per month. The program will include the following:

- Day 1: Addressing Basic Needs
- Day 2: Personal and Professional Development
- Day 3: Empowerment: Employment, Education, Training

This opportunity to engage participants in planning for their release is also a great time to let them know about recovery coaches and refer those interested to a Recovery Coach for peer support upon release. Some of this would have to be worked out once the network is up and running, but the network coordinator may want to be involved in this action item to make sure those connections happen.

Potential Resources

- DSHS services and program
- Division of Child Support
- North Central Accountable Community of Health Narcan Training
- Columbia Valley Community Health
- Planned Parenthood
- SAGE
- WorkSource
- Wenatchee Valley College
- SkillSource