North Central Accountable Community of Health

2018 Annual Summit

Friday, April 20, 2018

WELCOME!


BRITISH COLUMBIA
WHATCOM COUNTY
SKAGIT COUNTY
SNOHOMISH COUNTY
KING COUNTY
KITTITAS COUNTY
OKANOGAN COUNTY
OKANOGAN
CHELAN COUNTY
WATERVILLE
DOUGLAS COUNTY
WENATCHEE
EPHRATA
GRANT COUNTY
ADAMS COUNTY
FRANKLIN COUNTY
WASHINGTON STATE

Community Health Workers a Promising Workforce

North Central Accountable Community of Health

2018 Annual Summit

April 20, 2018

Red Lion – Wenatchee, WA

Francisco J. Ronquillo, PA

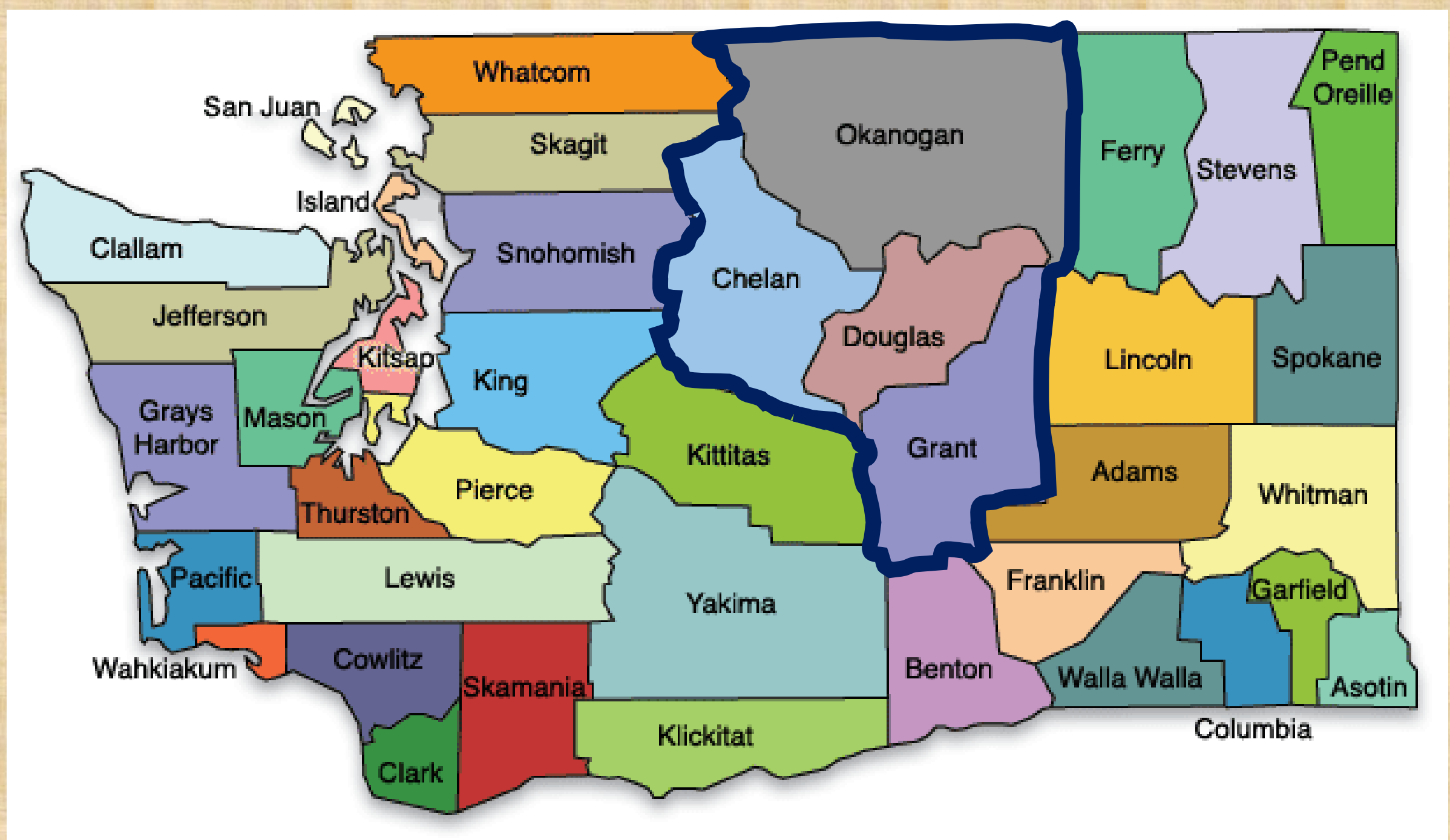
Health Extension Officer

Hispano/Latino Health Specialist

University of New Mexico – Health Sciences Center

Office for Community Health

Albuquerque, New Mexico


Whatcom
San Juan
Skagit
Island
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Jefferson
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Wahkiakum
Cowlitz
Skamania
Clark
Okanogan
Chelan
Douglas
Kittitas
Grant
Yakima
Klickitat
Benton
Ferry
Stevens
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Lincoln
Spokane
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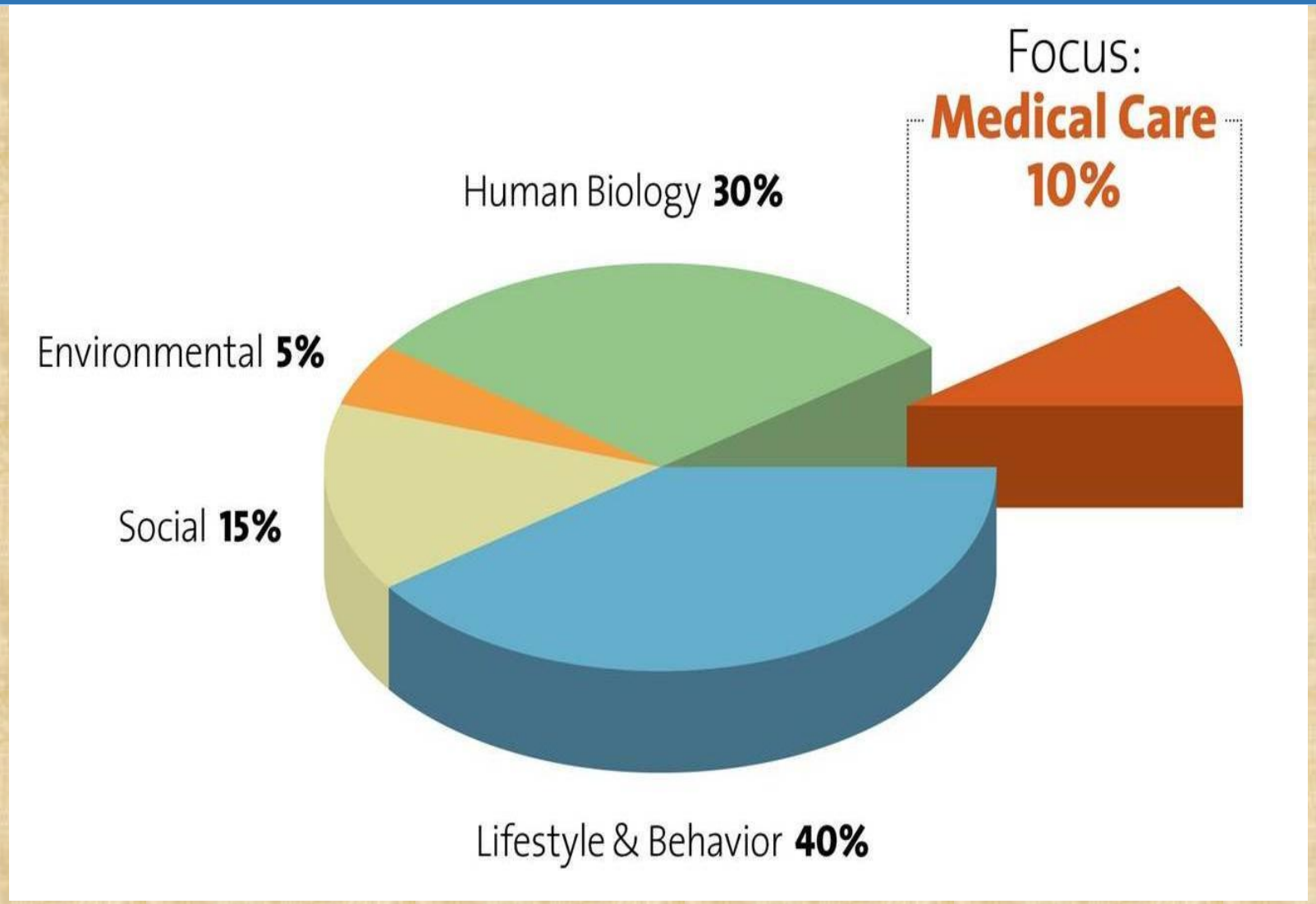
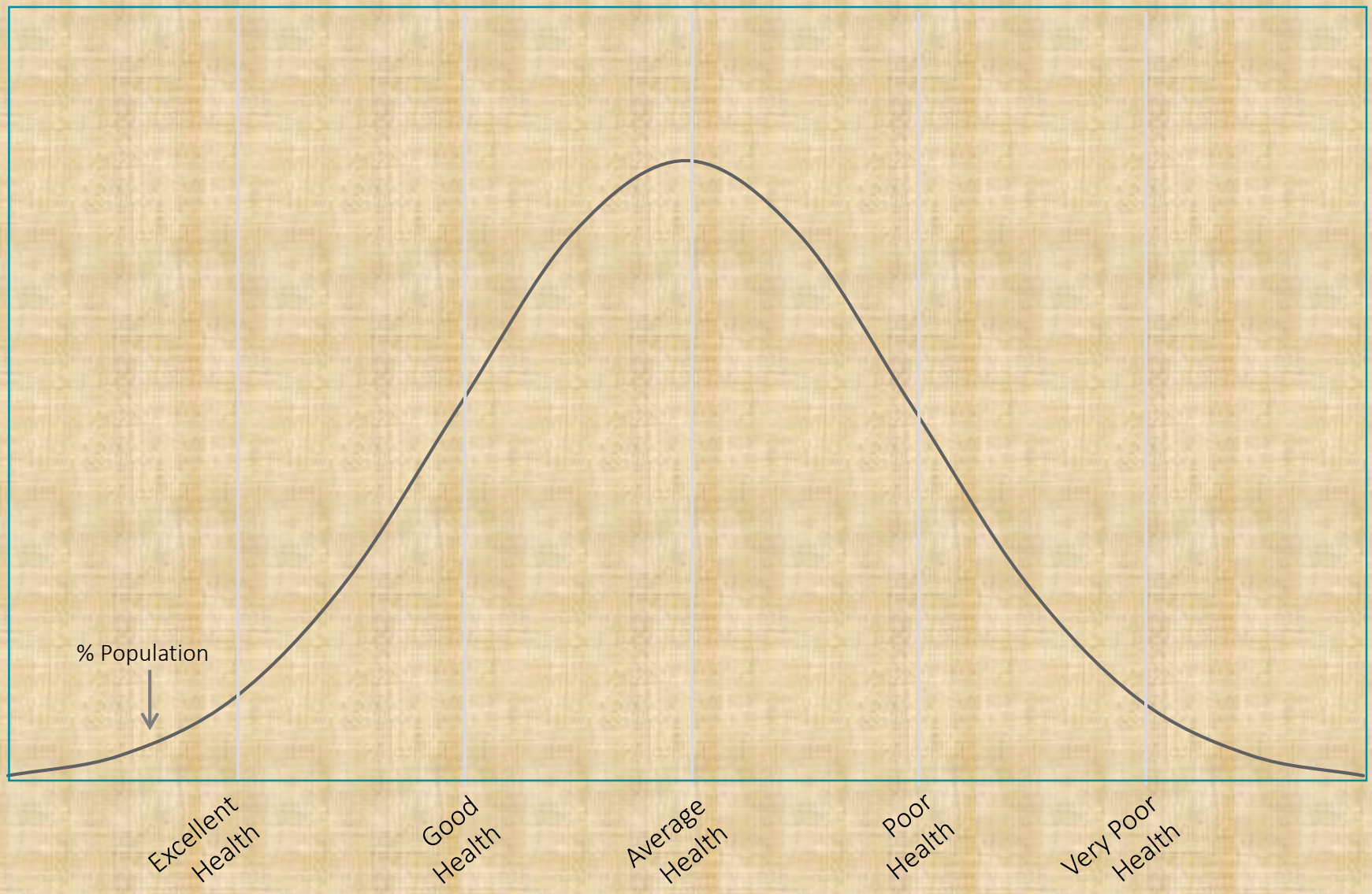
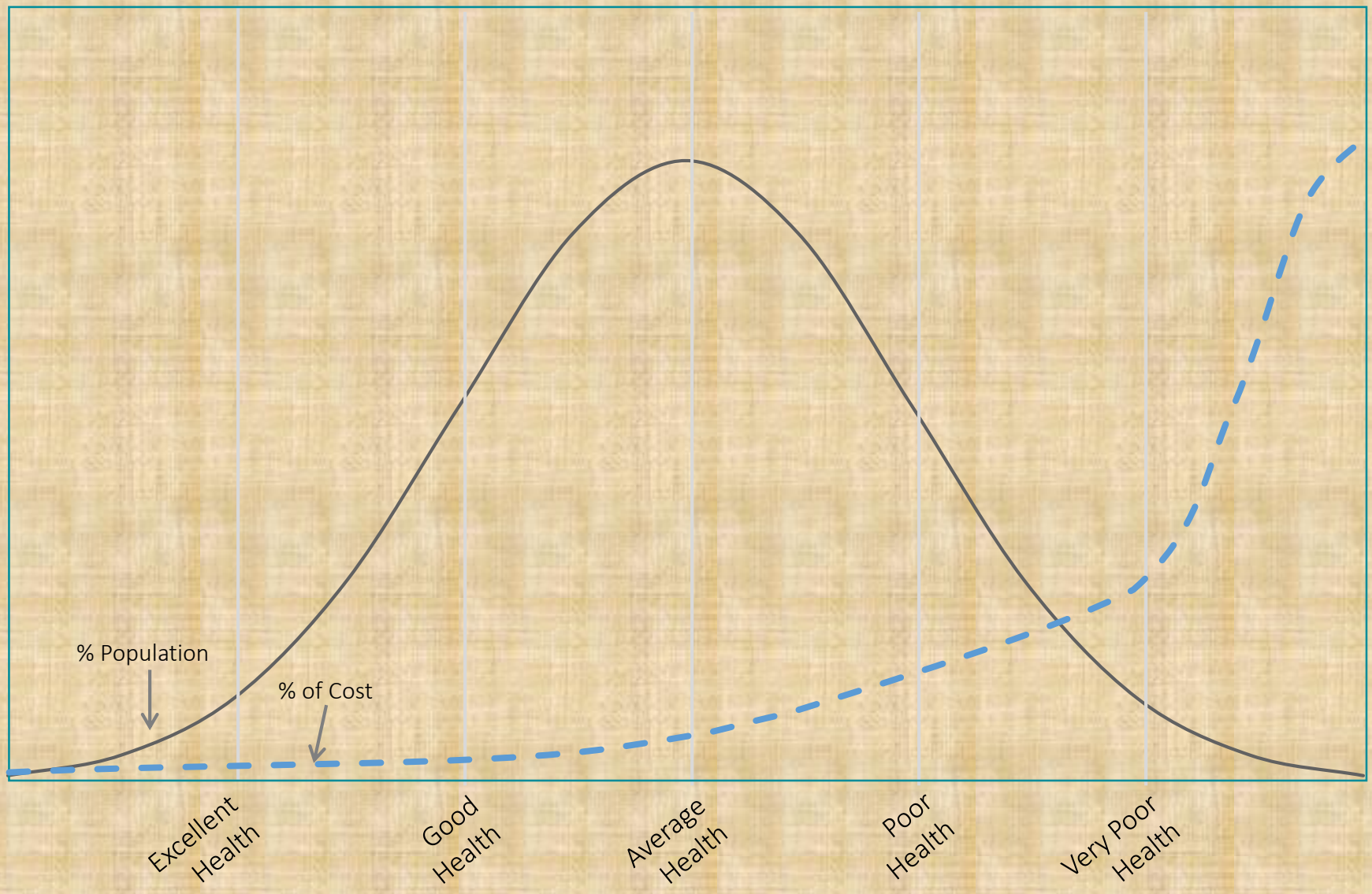
Whitman
Franklin
Garfield
Walla Walla
Asotin
Columbia

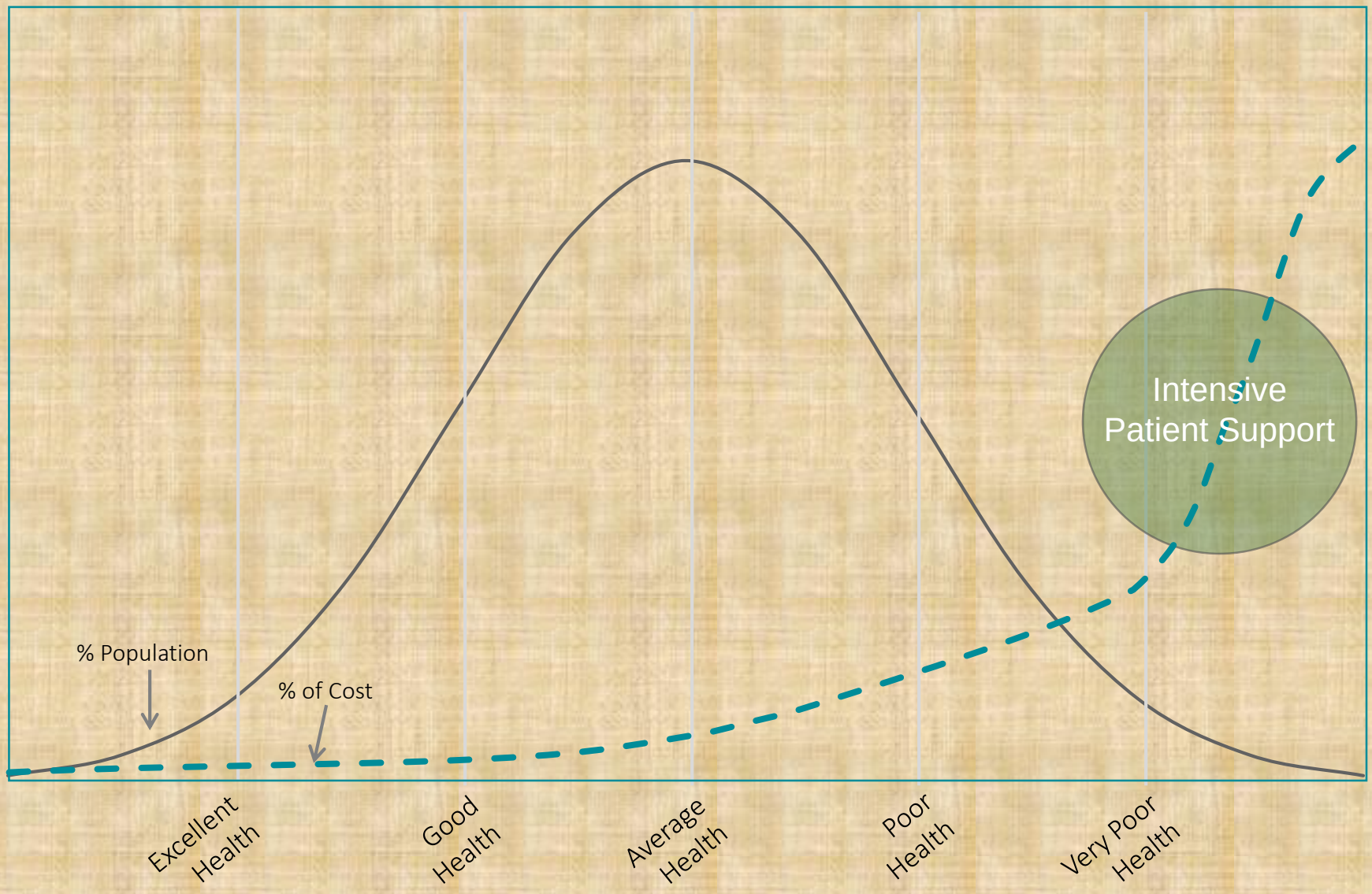
Social Determinants of Health




% Population
Excellent Health
Good Health
Average Health
Poor Health
Very Poor Health

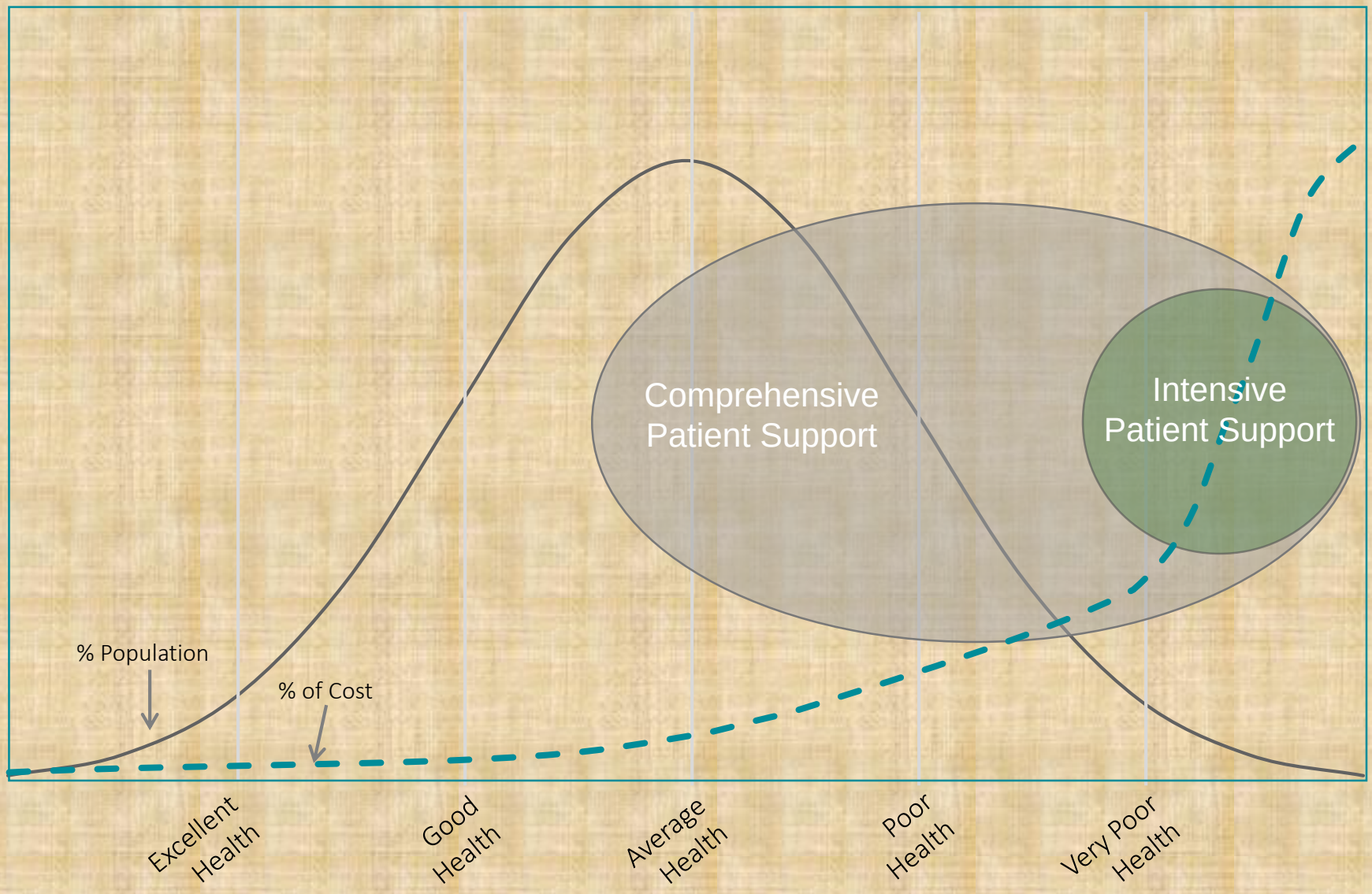

% Population
% of Cost
Excellent Health
Good Health
Average Health
Poor Health
Very Poor Health

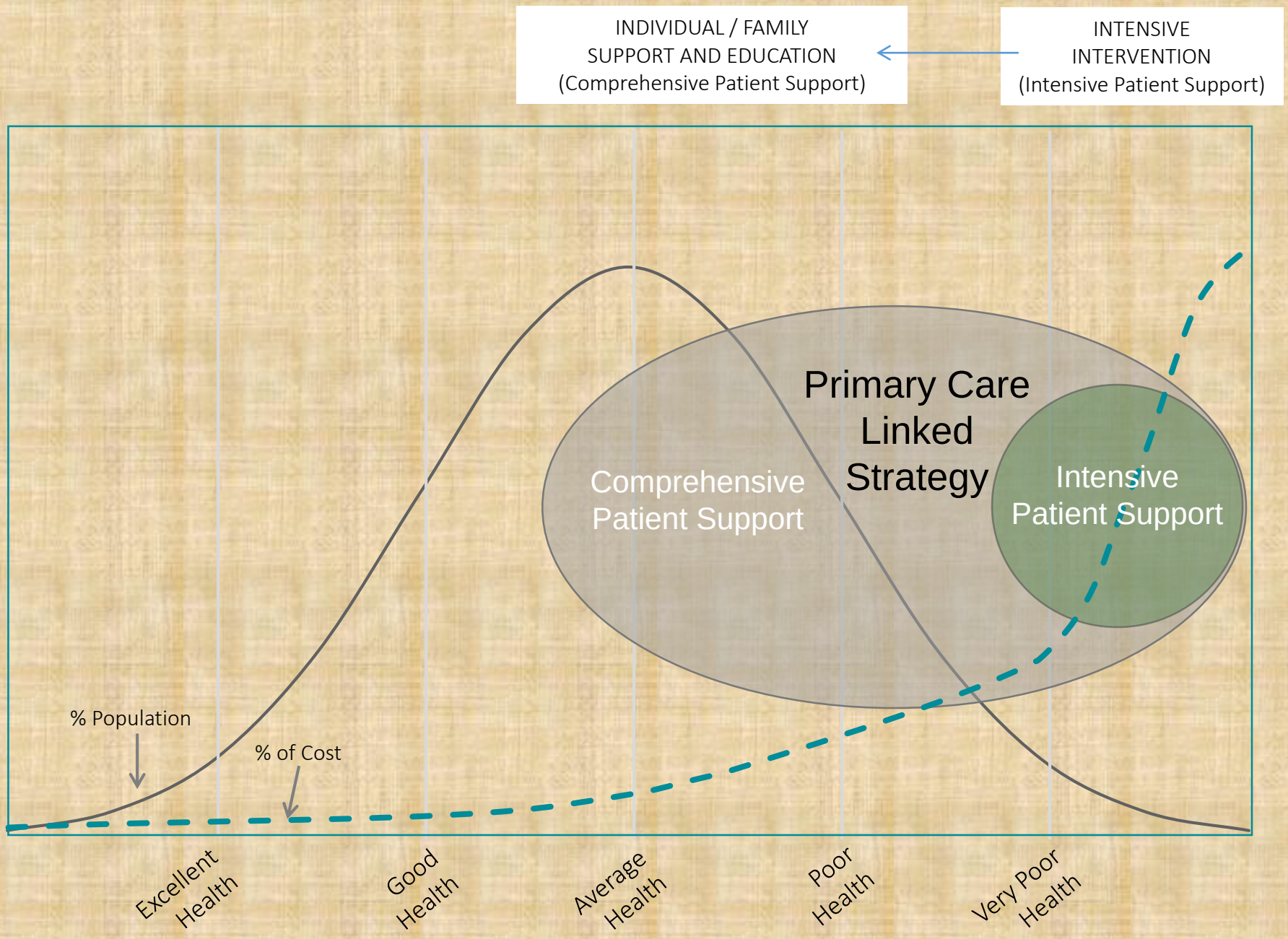
INTENSIVE
INTERVENTION
(Intensive Patient Support)



INDIVIDUAL / FAMILY
SUPPORT AND EDUCATION
(Comprehensive Patient Support)

INTENSIVE
INTERVENTION
(Intensive Patient Support)




INDIVIDUAL / FAMILY
SUPPORT AND EDUCATION
(Comprehensive Patient Support)
INTENSIVE
INTERVENTION
(Intensive Patient Support)
Primary Care
Linked
Strategy
Comprehensive
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Patient Support
% Population
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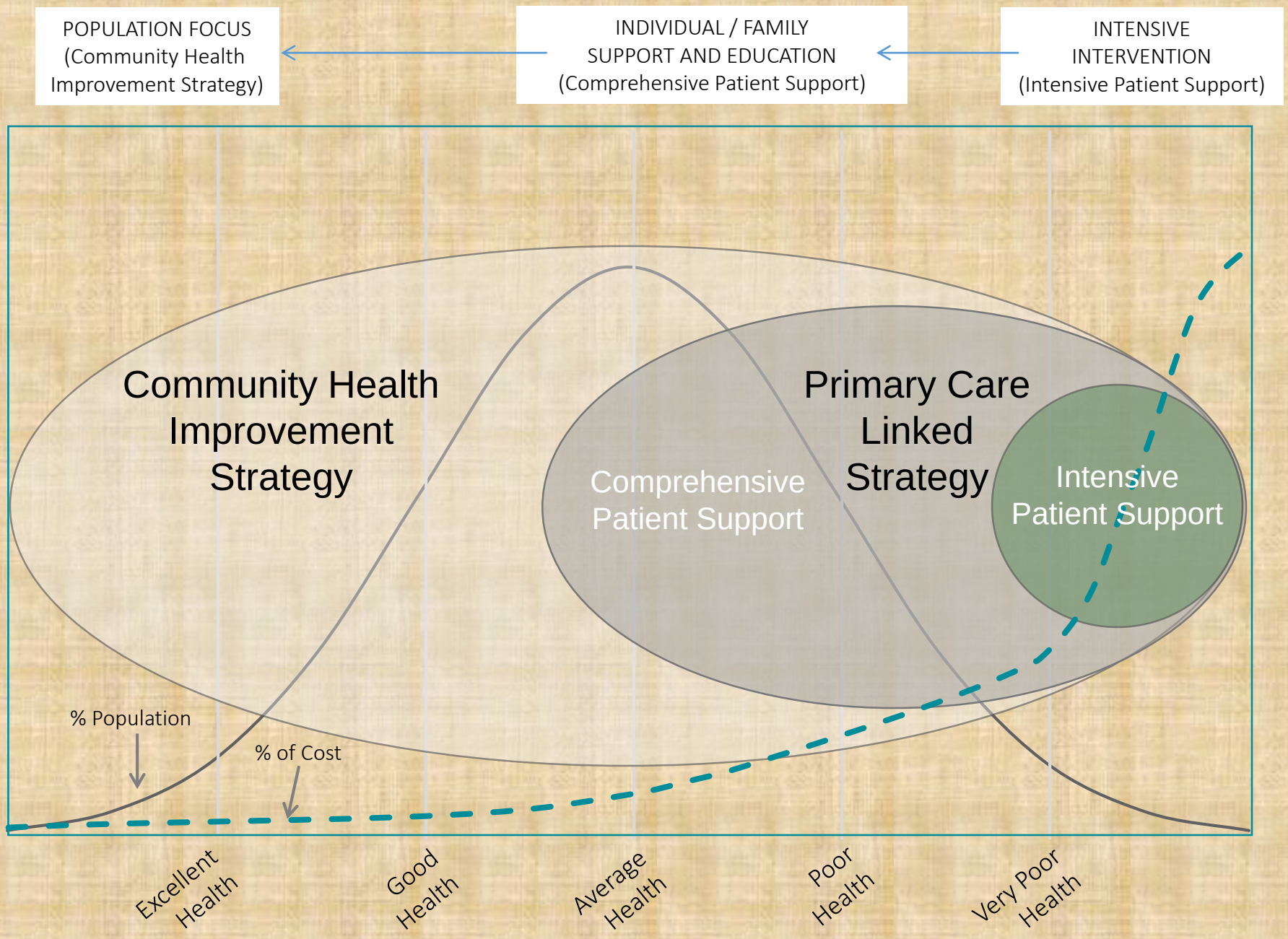
POPULATION FOCUS
(Community Health
Improvement Strategy)
INDIVIDUAL / FAMILY
SUPPORT AND EDUCATION
(Comprehensive Patient Support)
INTENSIVE
INTERVENTION
(Intensive Patient Support)
Community Health
Improvement
Strategy
Primary Care
Linked
Strategy
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Patient Support
% Population
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Excellent
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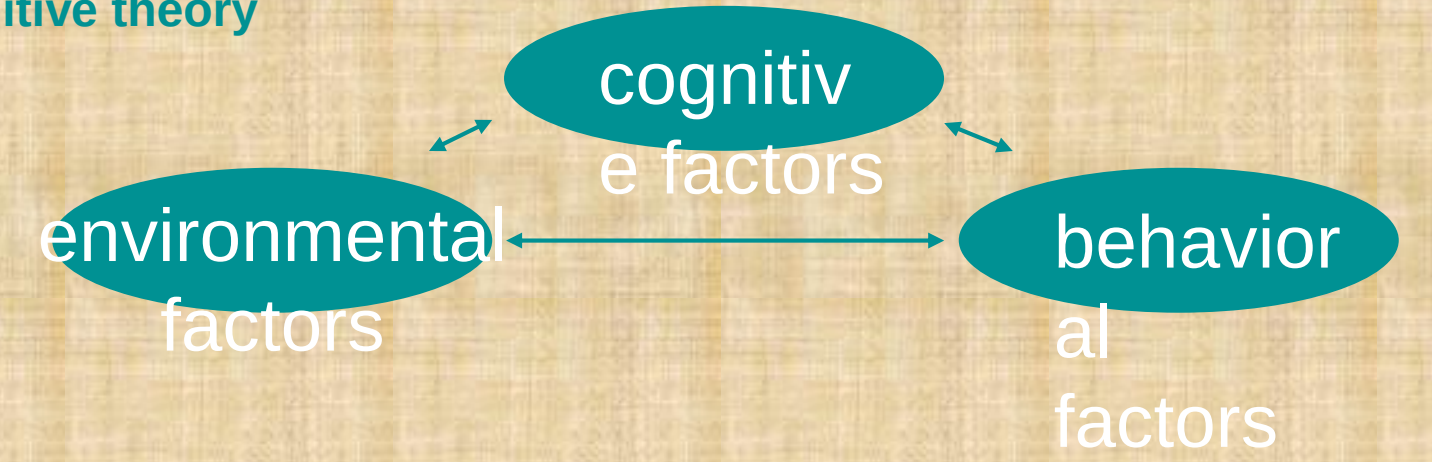
Health

conceptual models/

conceptual models/

social cognitive theory



socio-ecological framework

Who are some of the most influential key players in this process and collective impact approach?

Community Health Workers

Community Health Representatives

A Brief Historical Overview of Community Health Workers

1970s CHWs have been rallying a voice within the American Public Health Association

June 1998 National Community Health Advisor Study that helped identify core roles, competencies, and qualities of CHWs.

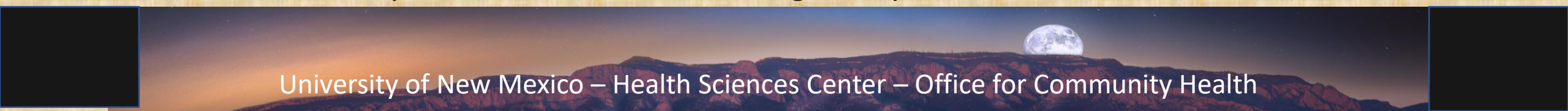
March 2007 HRSA National Workforce Study that provided a comprehensive, national report on the Community Health Worker workforce

2010 Bureau of Labor Statistics assigned an occupational code to CHWs

March 2010 CHWs were cited in three sections of the Patient Protection and Affordable Care Act (PPACA)

July 15, 2013 Centers for Medicare and Medicaid Services(CMS) created a new rule which allows state Medicaid agencies to reimburse for preventive services provided by professionals that may fall outside of a state's clinical licensure system

2014 Community Health Workers Act was signed by the Governor of New Mexico



What is a Community Health Worker/Representative (CHW/R)?

A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the Community Health Worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

What do they do?

- Bridge the gap between cultures and the health care system
- Outreach and community mobilization
- Community/cultural liaison
- Case management and care coordination
- Home-based support
- Health promotion and health coaching
- System navigation to overcome access barriers
- Community-Based Participatory research

A number of states have taken action to support the Community Health Worker profession

15 states and DC have enacted laws addressing Community Health Worker infrastructure, professional identity, workforce development, or financing

6 states have created Community Health Worker advisory boards

8 states have established a Community Health Worker scope of practice

5 states have enacted workforce development laws that create a certification process or require Community Health Workers to be certified

6 states have authorized the creation of standardized curricula

4 states have authorized a certification board for setting education requirements and governance for certification process

7 states have authorized Medicaid reimbursement for some Community Health Worker services

7 states have encourages or required the integration of Community Health Workers into team-based care models

Source: Centers for Disease Control and Prevention, "A Summary of State Community Health Worker Laws"

What are CHW/Rs?

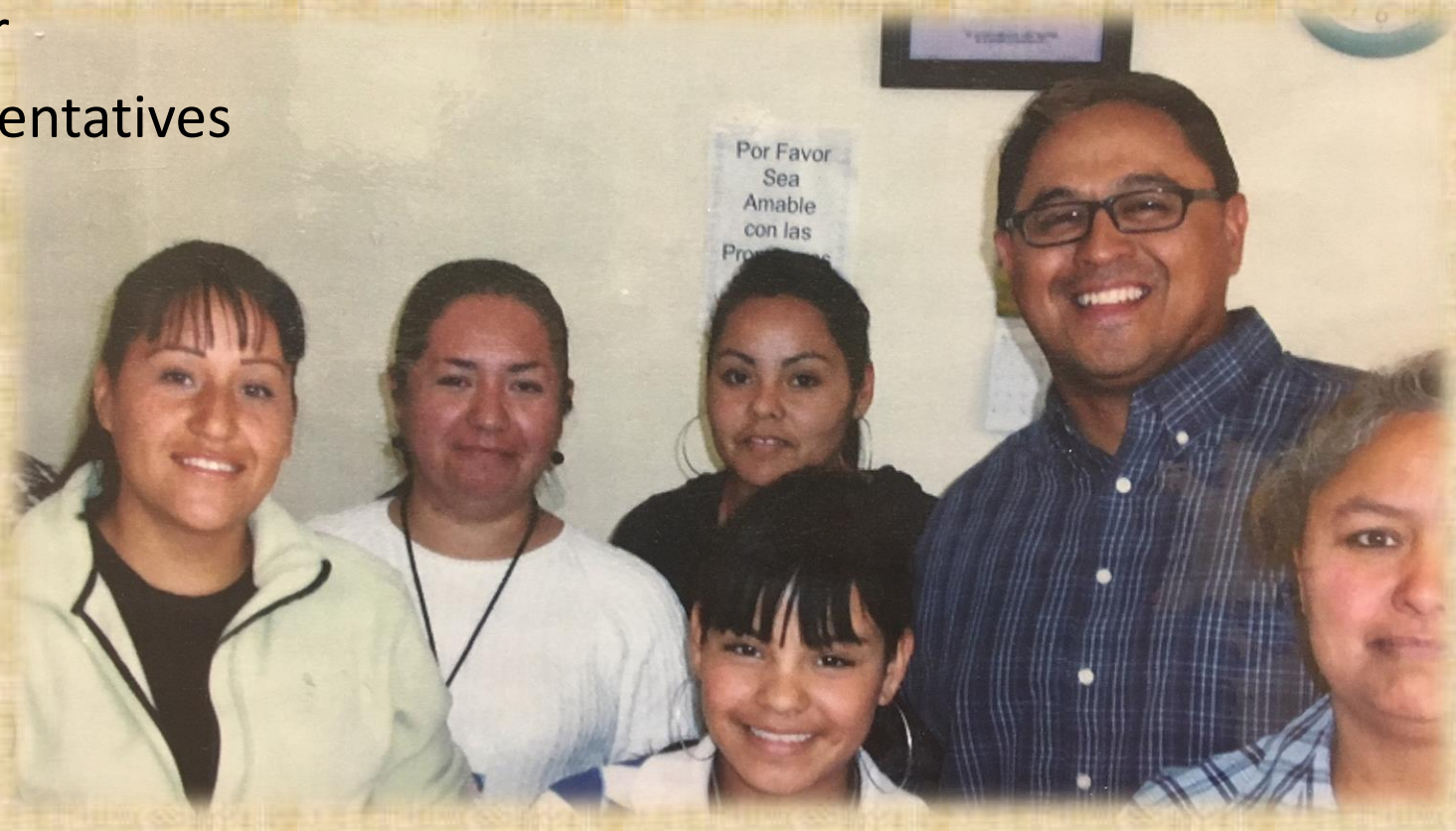
- Trusted members of a community
- Live in the communities they serve
- Look and speak the language of the community
- Credible Leaders
- People connected to community resources
- Agents of change
- Health information disseminators
- Advocates
- Facilitators
- Motivators
- Cultural brokers
- Crucial members of a care team

Their overall goal is mentoring and engaging clients, health care systems, workforces, employers and communities at large to achieve positive outcomes and reach optimal levels of wellness.

Adopted from the CHW Advocacy Toolkit

Different Job Titles

- Community Health Worker
- Community Health Representatives
- Promotores de salud
- Outreach Worker
- Family Resource Worker
- Health Advocate
- Community Advocate
- Doulas
- Peer Health Promoters
- Peer Support Specialist



What do CHWs need to succeed?

- Training and continuing education
- Defined roles and responsibilities
- Close, supportive supervision
- Backup from healthcare professionals
- Career advancement opportunities (A career ladder to retain and promote them)
- Steady, reliable funding
- Public and professional recognition
- Peer support group
- Elevate the profession and integrate them as members of the care team
- Reimbursement for services

Adopted from the CHW Advocacy Toolkit

What is the evidence for CHWs?

As research in this field accelerates, studies are starting to show the impact of CHWs on health outcomes and cost effectiveness. As part of the health care team, CHWs have been show to help…

1) secure access to health care
2) coordinate timely access to primary care, behavioral health, and preventive services
3) help individuals manage chronic conditions.

Adopted from the CHW Advocacy Toolkit

Current & Developing CHW Initiatives

- Accountable Health Communities
- Prevention of Child Abuse and Neglect
- Pathways to a Healthy Bernalillo County
- Re-Entry Resource Center
- Community Health Workers/Representatives & Medical Assistants Academy
- Community Health Specialists Initiative

I-PaCS

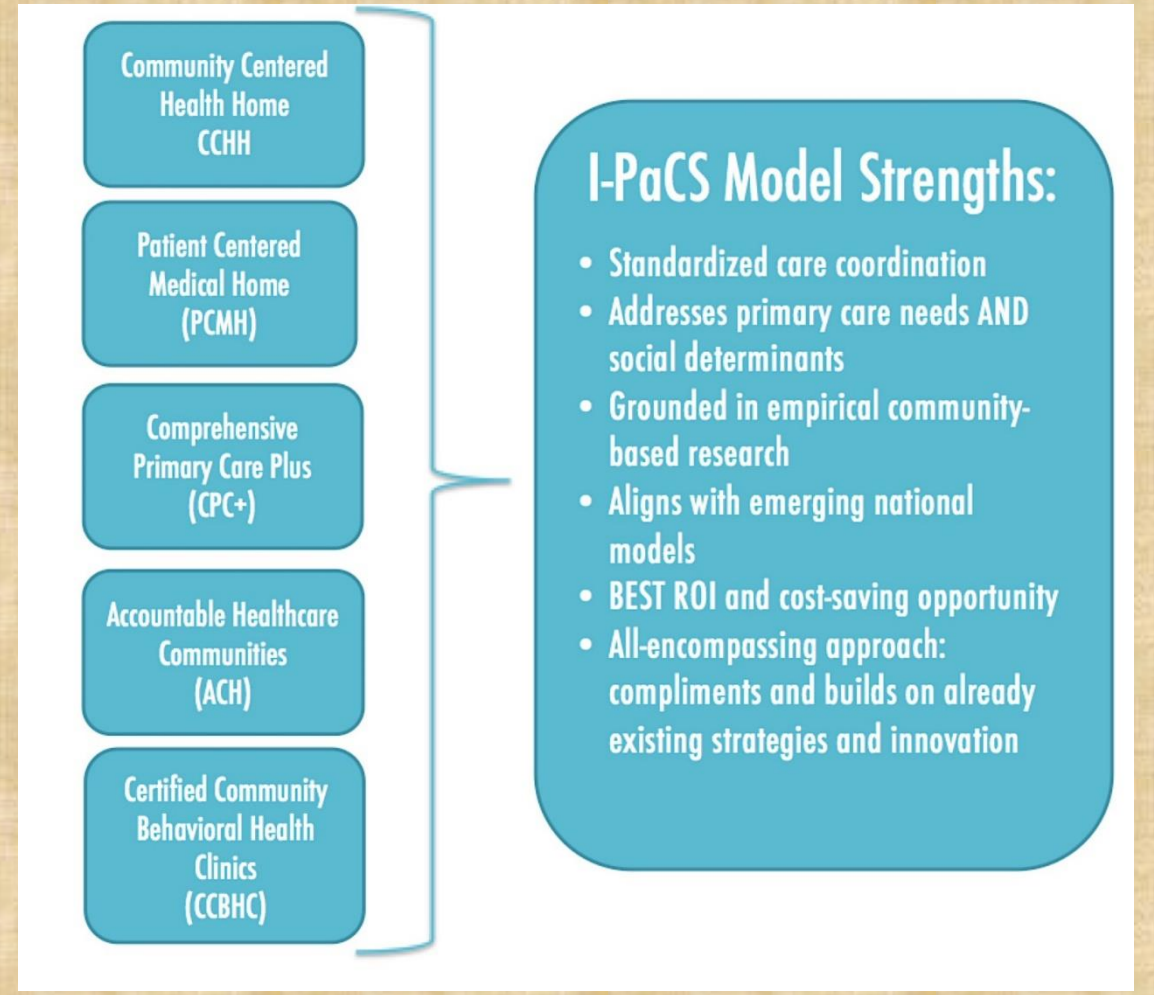
Integrated Primary Care and Community Support

A Population Health Model for Clinics and Communities
to
Improve Health Outcomes & Reduce Healthcare Costs
through the Integration of Community Health Workers

Collaboration

The University of New Mexico Health Sciences Center, Office for Community Health (UNM OCH) will collaborate with the Southwest Center for Health Innovation (SWCHI) and the Human Services Department (HSD)/Medical Assistance Division (MAD) to **further develop, evaluate, and disseminate** the model for integration of Community Health Workers (CHW) into patient care sites and communities to improve population health outcomes and reduce healthcare costs for Medicaid recipients.

Integration, not duplication



MCO members self-select the clinic

Outreach to clinic patients

MCO referral

Members

Members

Members

Community Health Improvement Strategy

Community Organizations

CHW Facilitates Community Efforts

Policy Work

Health Extension (HEROs)

Primary Care Linked Strategy

Screening

CHW Provides Services

Data Collection & Analysis

Data collection and analysis informs population health strategies

Patient Centered Care

Comprehensive Patient Support

Intensive Patient Support

I-PaCS

Integrated Primary Care and Community Support

I-PaCS
Integrated Primary Care and Community Support

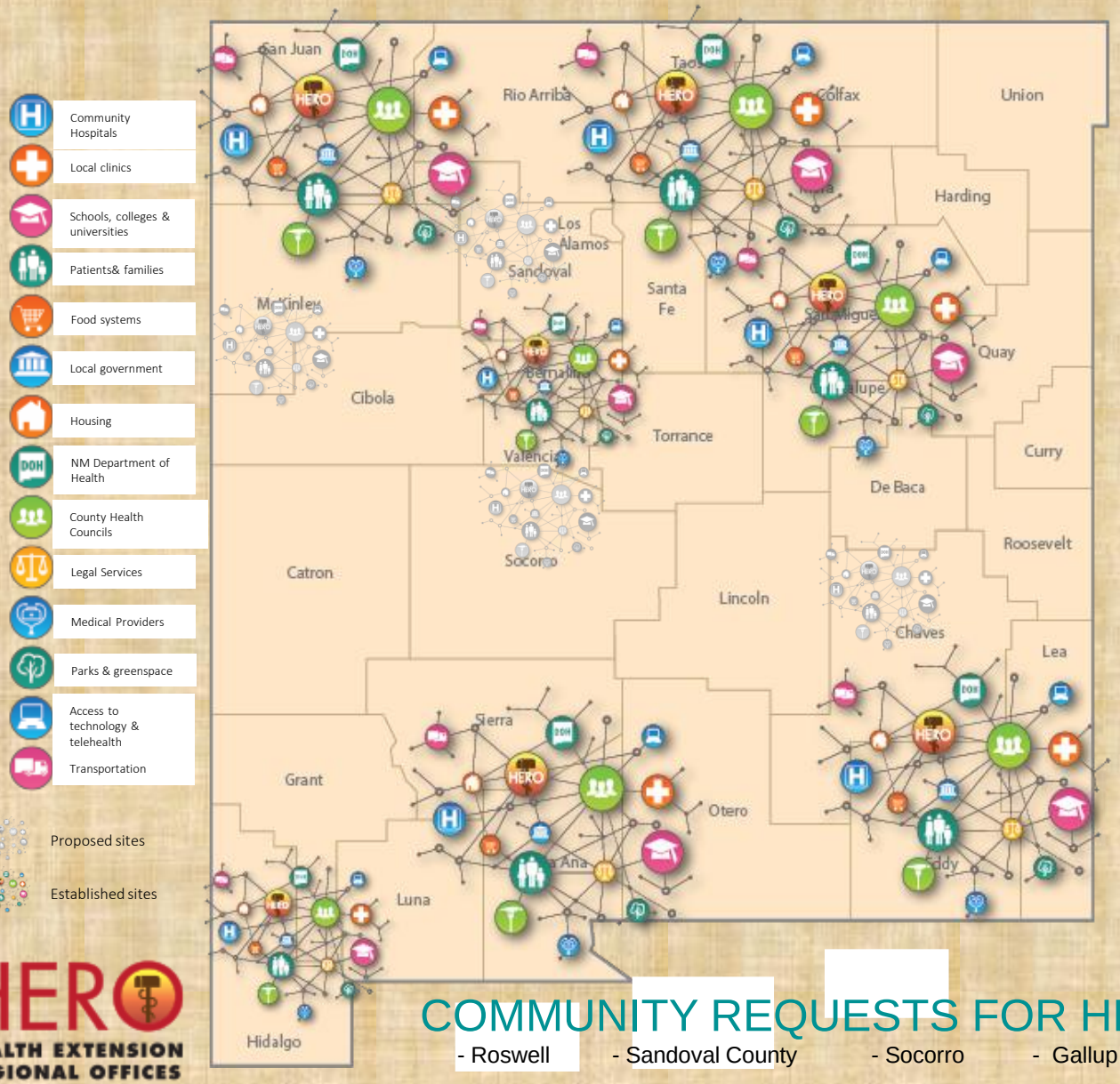
Ecology & Context	Structure	Process		Outcomes		
Rationale	*Evaluation Resources*	*Process Evaluation*	*Reach Evaluation*	*Data Reporting System*	*Medium-term*	*Ultimate impacts*
Patients with adverse socio-economic conditions have worse health outcomes and consume more health service resources	UNMHSC-OCH and SWCHI staff members' experience developing and implementing a pilot program	How was the model implemented? What were challenges and successes?	How many members participated?	CHWs document their work with patients in an internal database that is shared with the OCH Evaluation Team	Number of ER visits and rehospitalizations reduced	Reduced cost
Primary care providers are frustrated by their inability to affect the health of these patients because of the confounding effects of SDH.	UNMHSC-OCH faculty and staff members' experience evaluating similar programs	Do providers believe the model improves care and/or ease of care?	How many SDH were identified?	Clinics provide lists of empaneled patients to MCOs, which provides HRA level assignments to them	Percent increase in primary care utilization	Improved outcomes
No focus on and lack of resources available within the primary care clinic site to address SDH	Buy-in from clinic systems, Medicaid, and MCOs	How were CHWs integrated into clinic operations and how did that process go?	To which external resources were members linked?	HSD and/or MCOs provide cost and utilization data on enrolled patients to OCH Evaluation Team	Number of social needs addressed via CHW referral	Improved patient satisfaction
Members could benefits from CHW services in the primary care clinic setting		How has the model changed the relationship between clinic and community?	With which external organizations or systems were relationships formed?			Improved provider satisfaction
Members could benefit from community health improvement			What policies or procedural changes have resulted from the			Improved health equity

Assumptions

By addressing social determinants of health within the clinic setting, patients with adverse socio-economic conditions will increase their utilization of, and satisfaction with, primary care and demonstrate improved health outcomes; clinic providers will have increased satisfaction; payers will enjoy cost savings; and health equity will improve.

Health Extension (HEROs)

Delivering University of New Mexico Resources to Communities while Building Local Capacity



HEROs strive to inspire local solutions

- Link UNM's clinical service, research and education resources to community-identified needs
- Work with diverse, local stakeholders
- Monitor interventions, track health outcomes
- Promote economic development

HERO
HEALTH EXTENSION REGIONAL OFFICES

COMMUNITY REQUESTS FOR HERO

- Roswell
- Sandoval County
- Socorro
- Gallup

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Re-entry Resource Center

PROGRAM ELEMENTS

-Different pods, genders
- 70% alcohol & substance abuse
-1,500 released monthly
- 70% recidivism rate

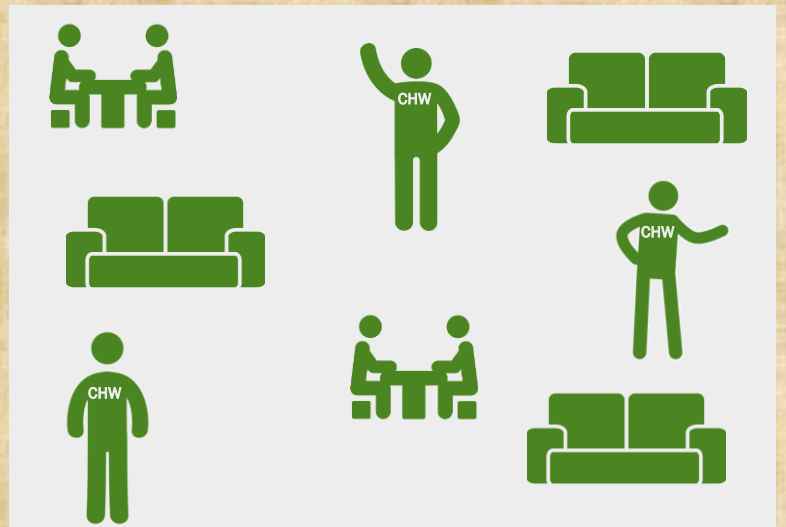
MDC

UNMH Forensic Care Managers & Transition Coordinators Flag high-need cases

Shuttle

12 returning citizens
Runs every 2 hours
Video/materials describing CHW program

Pre-implementation
-Screening tool and referral process based on focus groups of ~100 inmates
- Identifying others working at RRC and solidifying partnerships with MCOs, HSD

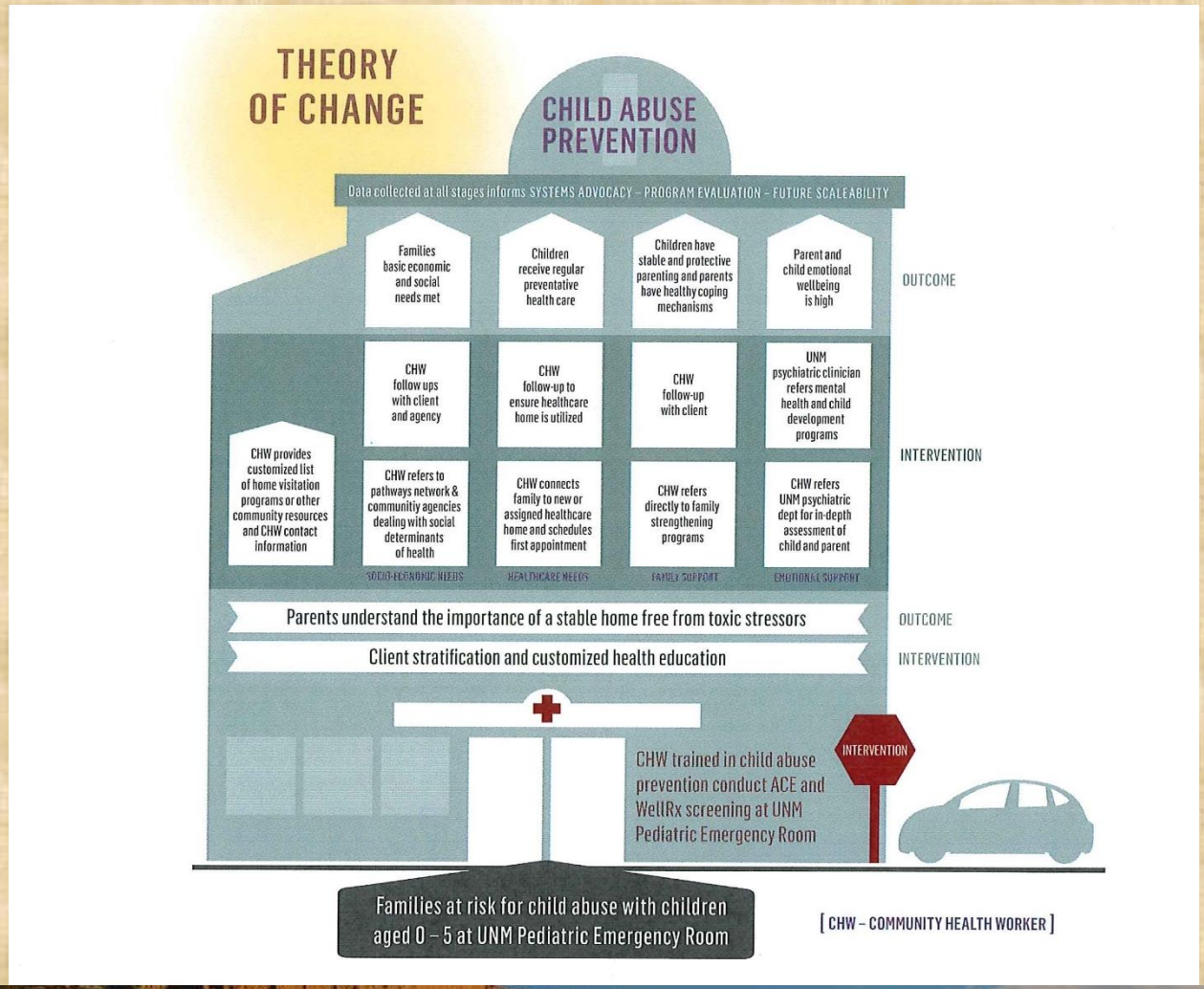


Re-entry Resource Center (RRC)

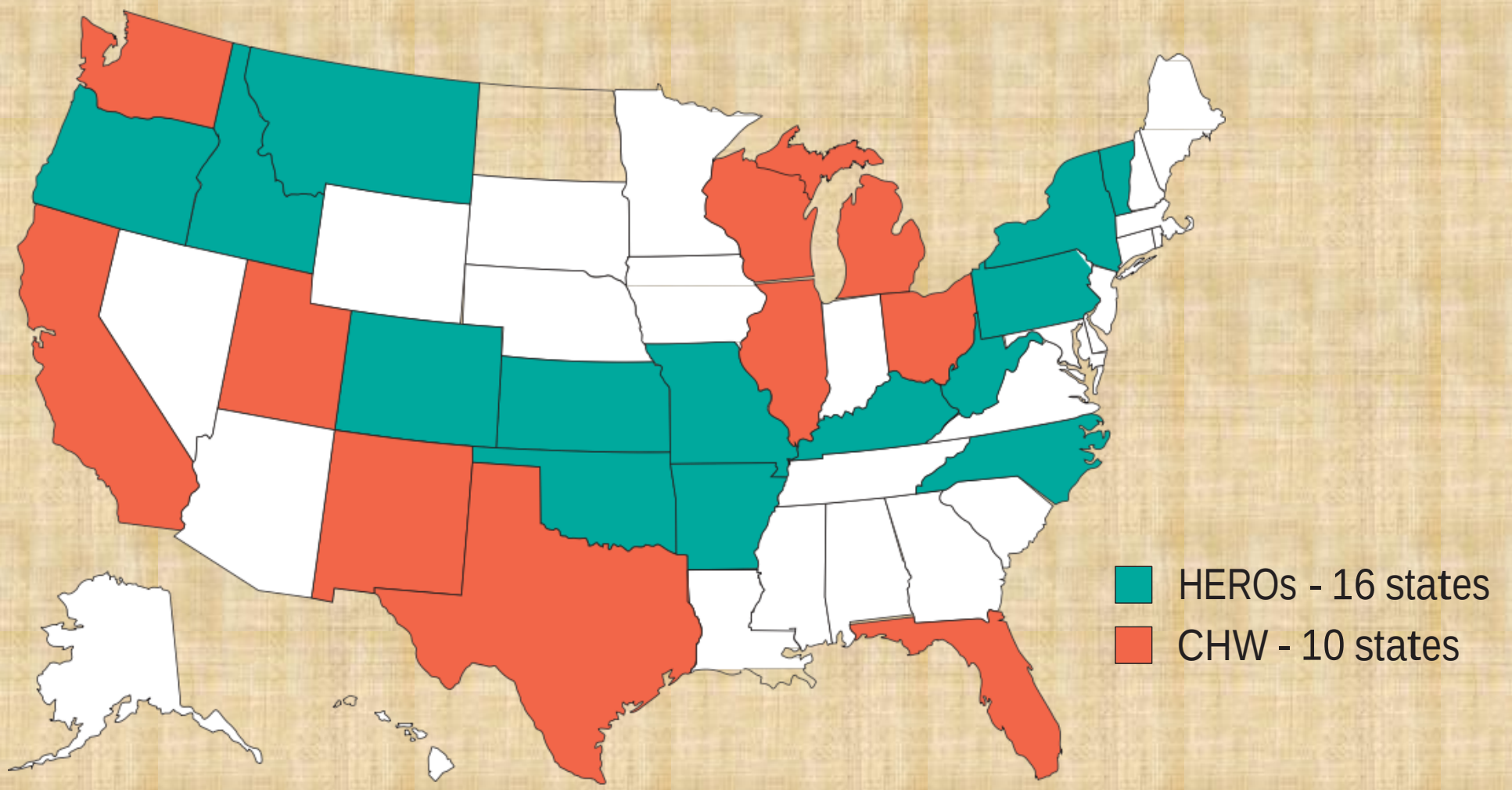
Downtown location: 4th & Roma
Casual, welcoming environment
Screening for social determinants of health & health home
11am-11pm coverage for peak release hours
Specialized CHWs for justice-involved populations

Clinical Services

Pediatric Emergency Department



States Developing HERO or CHW Programs



Online Resources

www.HealthExtensionToolkit.org/ipacs

https://www.youtube.com/watch?v=kEuEnQOrHfw&feature=youtu.be


¡Gracias!
Thank you!

North Central Accountable
Community of Health

Social Determinants of Health

Transportation & Housing Discussion

Social Determinants of Health

What we know

- Only about 20% of *health* is directly tied to *healthcare*
- The other 80% . . .
  - Health behaviors: 30%
  - Social and economic factors: 40%
  - Physical environment: 10%

Social Determinants of Health

Exploring How the ACH Can Help

- Initial focus on clinical transformation
- Limited resources for social determinants – but determined to play a role
- Transportation and housing emerged as points of focus

Social Determinants of Health

- ☑ Facilitated discussions in all four counties →
- ☑ Synthesize results and ideas →
- ☐ Review the results and ideas here →
- ☐ Incorporate input →
- ☐ Formulate recommendations for the NCACH Board

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Facilitated Discussions

Transportation & Housing Experts

April 3

- Chelan & Douglas Counties (Wenatchee)
- Grant County (Moses Lake)

April 4

- Okanogan County (Omak)

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Chelan & Douglas (Wenatchee)

- Maggie Kaminoff – Link Transit
- Shawn Delancy – Catholic Charites
- Steve Maher – Our Valley, Our Future
- Deb Miller – Community Choice
- Alejandra Gonzalez – Children's Home Society of Washington
- Jennifer Latimer – Chelan County
- Alicia McRae – Housing Authority of Chelan County and the City of Wenatchee
- Laurel Turner – Women's Resource Center
- Ken Sterner – Aging and Adult Care of Central Washington
- Brooklyn Holton – City of Wenatchee (individual interview)

Grant (Moses Lake)

- Rosenda Henley – People for People
- Gail Goodwin – Grant Integrated Services
- Sheila Chilson – Moses Lake Community Health Center
- Mary Jo Ybarra-Vega – Quincy Community Health Center
- Theresa Adkinson – Grant County Health District
- Steffanie Bonwell – Housing Authority of Grant County
- Courtney Armstrong – Grant Integrated Services

Okanogan (Omak)

- Nancy Nash-Mendez – Okanogan County Housing Authority
- Shane Barton – Okanogan County Community Action Council
- Deanne Konsack – Okanogan County Transportation and Nutrition
- Elana Mainer – Room One
- Cynthia Button – Aero Methow Rescue
- Molly Morris – Coulee Medical Center
- Adrianne Moore – Room One
- Jennifer Fitzthum – Okanogan County Transportation and Nutrition

Facilitated Discussions

What We Talked About

- Strengths – across the region and in counties
- Misconceptions that our interviewees encounter
- Challenges faced by people
- Challenges faced by organizations
- How the ACH can help – ideas and suggestions

Strengths

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Strengths Across the Region

- Strong sprit of collaboration and pulling together
- Resourcefulness and creative problem solving
- Cooperation among non-traditional partners
- Being small has its advantages
- Recent wins in all four counties – expanding services despite headwinds
- Growing community-wide recognition of the impact that social determinants have on health

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Strengths in Chelan & Douglas

- Coordinated entry system for housing ("no wrong door"), housing-first model
- LINK and LINK-Plus, DART shuttle service, DOT's Apple line and Grape line
- Landlord Liaison program (Women's Resource Center)
- Success in helping high utilizers of the health system
- Mobility Council, Homeless Taskforce, Homeless Steering Committee, Community Housing Network
- Support among elected leaders

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Strengths in Grant

- Public transit system is limited but has been stable and increasing routes and hours
- Reliable paratransit system
- Good connector functions
- Reasonable amount of affordable housing compared to other areas
- Strength in special-needs housing
- Mobile therapy unit

Strengths in Okanogan

- Increasing support from elected officials
- Fires in 2014 brought people together
- Growing recognition of needs related to housing and the connection with health
- County transportation levy passed and implemented (TranGO)
- Youth homelessness is serious, but traction is increasing
- Methow Housing Trust building affordable homes
- Housing authority is progressive and resourceful

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Encountering Misconceptions

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Misconceptions that People Encounter (1 of 2)

- The homeless “are not from here”
- Poverty is not a big problem – or not “our” problem
  - The poor are unemployed – ignoring the working poor
  - The poor are drunk, on drugs, etc.
- Stereotyping of Hispanics
  - The poor and homeless are Hispanic
  - Hispanics are poor and homeless
  - Hispanics are stealing all the resources

Misconceptions that People Encounter (2 of 2)

- Homelessness is a crime / the homeless are criminals
- Chronic stereotyping of certain areas and communities
- Mistaking vacancy rates as evidence of affordability
- Medicaid-brokered transportation is meeting all needs
- Services are more accessible than they actually are
- “Not in my back yard” resistance

Challenges

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Challenges for People (1 of 2)

- Depression and social isolation
- Unavailability of clinicians
- Difficulty of traveling to services and appointments
- Inability to use housing vouchers because no housing is available
- Mentally ill run around in circles
- Rising rents

Challenges for People (2 of 2)

- Unawareness of free/affordable resources
- Difficulty of understanding and navigating complicated requirements, paperwork, etc.
- Lack of access to email/internet and culturally appropriate communications
- Anti-immigrant climate – intimidation and isolation
- Aging population – not enough caregivers
- Insufficient services for youth

Challenges for Organizations

- Decreased funding even as demand increases
- State funding models reflect urban concerns and priorities
- Geographic spread of clients
- Hard to recruit/pay/house workforce and avoid burnout
- Bridging culture gaps can be very difficult
- Reimbursement rates don’t reflect true costs
- Discrepancies between data sources

How The ACH Can Help

5 Suggestions

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How the ACH Could Help: Suggestions (1 of 5)

Help organizations acquire external funding

- Identify high-impact funding opportunities
- Provide support for planning applications, lining up partners, acquiring data, etc.
- Mentor organizations on effective techniques for getting and managing grants

How the ACH Could Help: Suggestions (2 of 5)

Provide Technical Assistance for . . .

- Business practices
- Data and information management
- Workforce (recruitment, retention, professional development)
- Communications and community outreach

How the ACH Could Help: Suggestions (3 of 5)

Convene, Coordinate, Advocate

- Spearhead and coordinate outreach to . . .
  - Business leaders (manufacturers, growers, etc.)
  - State government and local leaders
- Demonstrate how social determinants affect health
- Catalyze problem-solving
  - Coordinate with existing groups and use the Pathways Community Hub as an engine for outreach

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How the ACH Could Help: Suggestions (4 of 5)

Coordinate and Align Information

- Investigate the strengths and weaknesses of current efforts
  - Individual resource guides, WIN211, etc.
- Develop and implement strategies for sustained improvement
- Ensure appropriate modes of delivery

How the ACH Could Help: Suggestions (5 of 5)

Provide Direct Access to Funds

Small rapid-response awards for critical investments

- Aimed at building vital capacity (not just replacing other funding)

Large awards for significant initiatives that bring partners together

- Require sustainability plans

Leverage other funding sources (funds-matching and joint planning)

Your Input

North Central Accountable Community of Health

Find the Pause, Awaken the Presence

Kari Lyons-Price, Meditate Wenatchee

NEAR Leadership

Neuroscience
epigenetics
ACEs
resilience

COMMUNITY
RESILIENCE INITIATIVE

Teresa Posakony, Andrea Medina, & Teri Barila

Emerging Wisdom

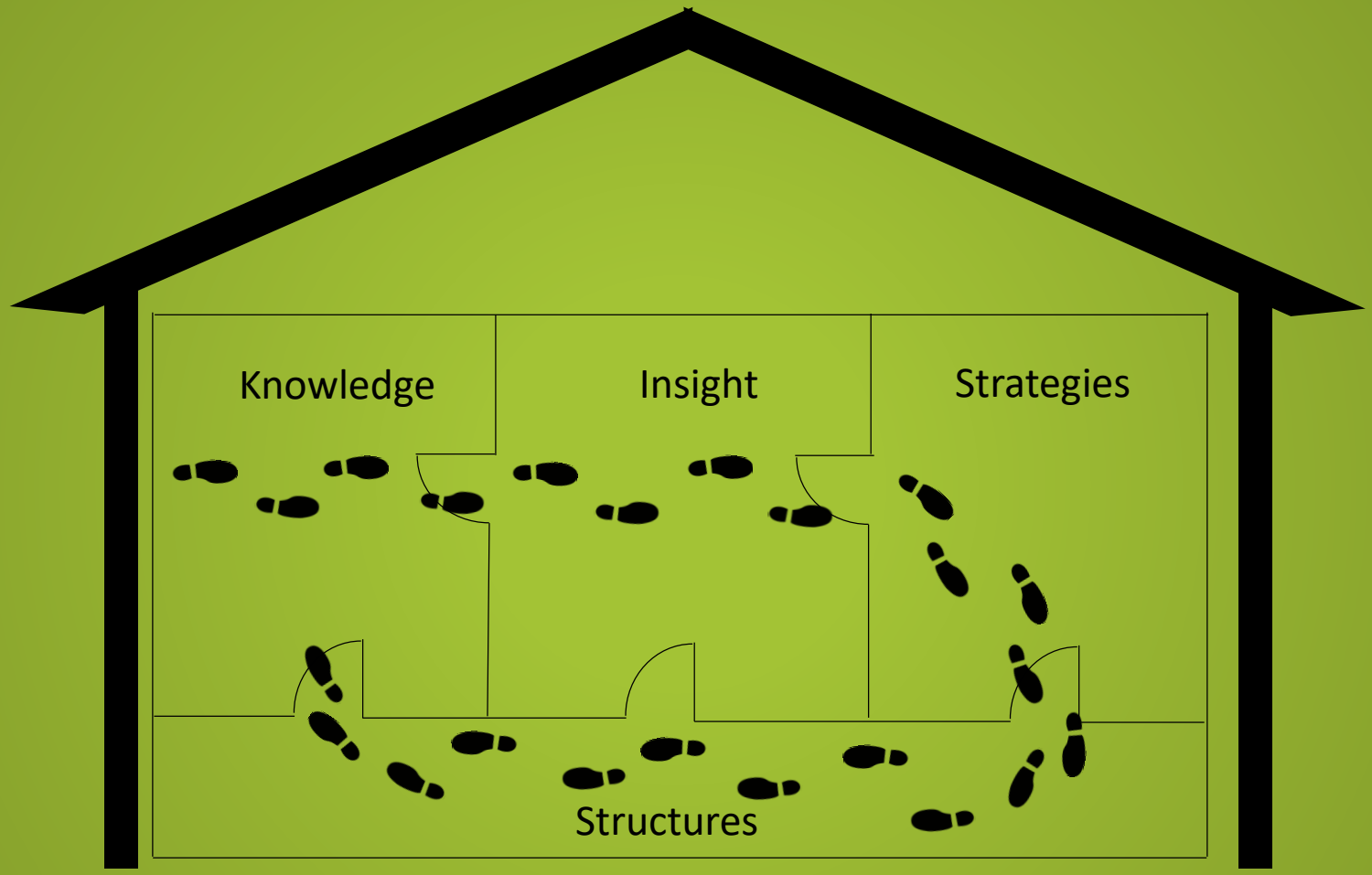
Insight

Insight into your self, others, and your community

- Apply principles of N.E.A.R. into practice
- Understanding ourselves is first step
- Removing prior bias
- Achieve Insight into others

Root Issue = Toxic Stress **Root Strategy=Brain States**

KISS- our framework for community capacity building for Resilience



We need to get kids out of their brainstems!

Step into learning and whole brain intelligence

Neuroscience- structure & function of the nervous system and brain

- Brain, Spinal Cord
- Nervous System
- Connect Us Internally and Externally

COMMUNITY RESILIENCE INITIATIVE

We are shaped by our experiences

Early experiences are built into our bodies.

- Sets the stage to be prepared for life in a ***dangerous*** world—

- Or sets the stage for a ***safe*** and nurturing world

- Patterns of behavior/response established

Know our brain states

Get students out of their brain stem

Executive State
Problem Solving

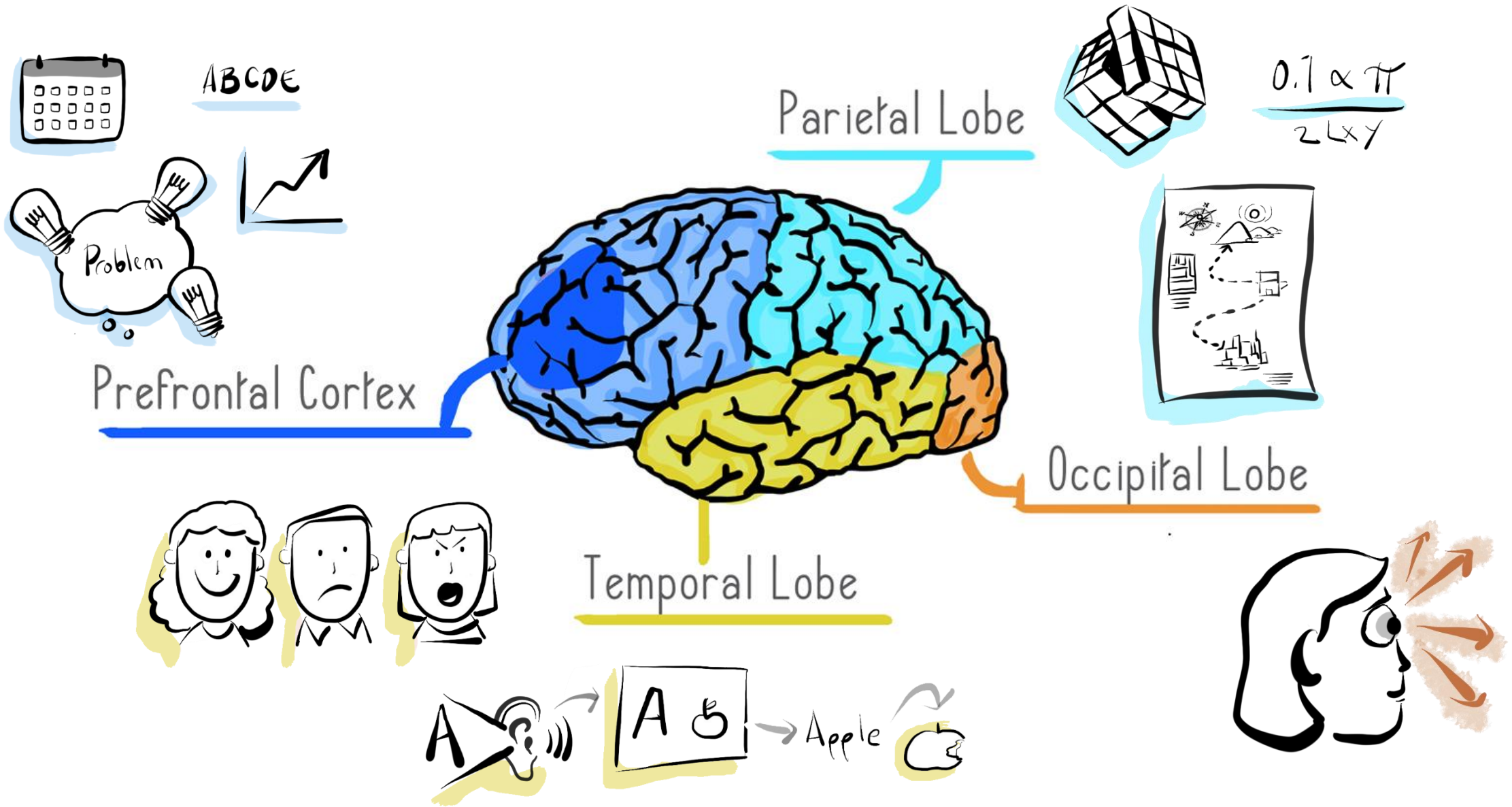
Emotional State
Connection

Survival State
Safety

One strategy for helping child identify emotional state

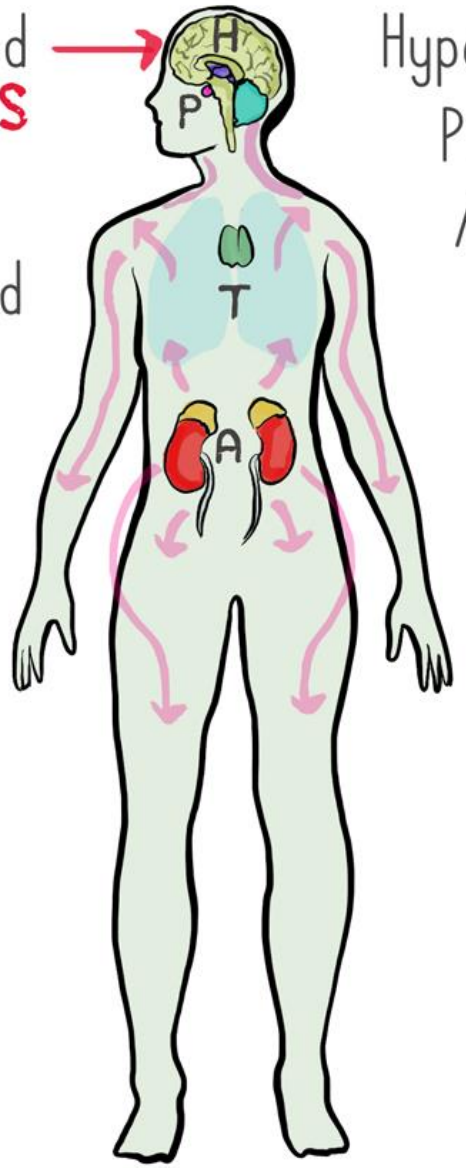
Great for role modeling tool

Learning and the cerebral cortex



Protection/ Stress response

Perceived
STRESS



Hypothalamus

Pituitary

Adrenal

Axis

Thymus gland

Energy moves to the limbs, brain stem & occipital ridge

Sympathetic

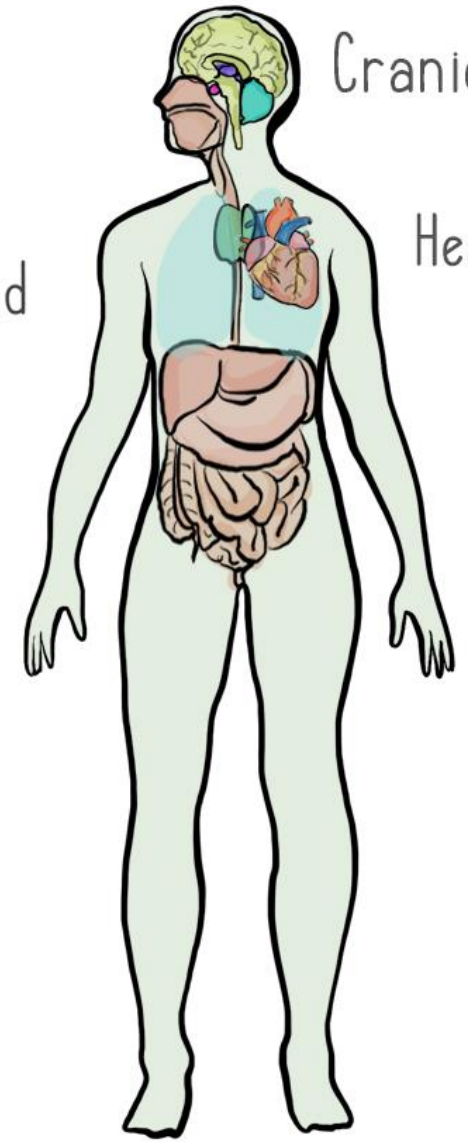
Parasympathetic

Growth and learning / Rest and digest

Craniosacral parasympathetic ganglia

Heart coherence

Thymus gland



Sympathetic

Parasympathetic

Energy moves toward the spine

COMMUNITY RESILIENCE INITIATIVE

New lens helps us understand

Judgment (**fear**) triggers negative response:

- revert to default mode
- "that's the way we do it"
- "he's just manipulating me"
- "he just doesn't work hard enough"

Positive Intent (**love**) creates safety to engage:

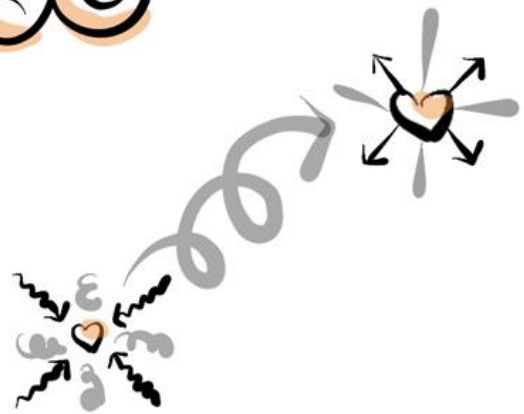
- "it's not about me"
- "I am safe, I am calm, I can do this"
- Recognize lagging or lacking skills, not malintent

Bruce Perry, MD; Michael Meaney, PhD; Heather Forbes, LCSW; William Steele PsyD; Becky Bailey, PhD.

I NOTICE

Body Sensations

Emotions

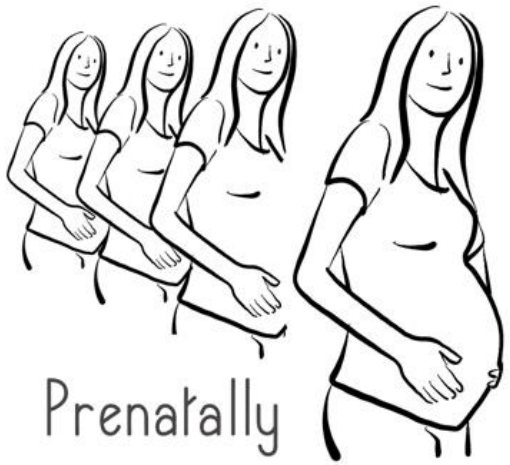


Thoughts

Minding the gap

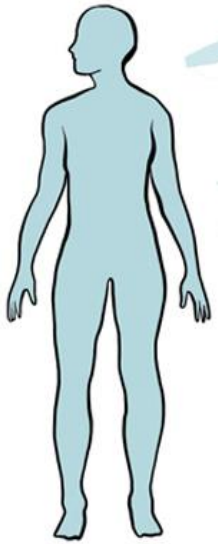
MY NEUROBIOLOGY

Impressions on neurobiology start prenatally



Prenatally

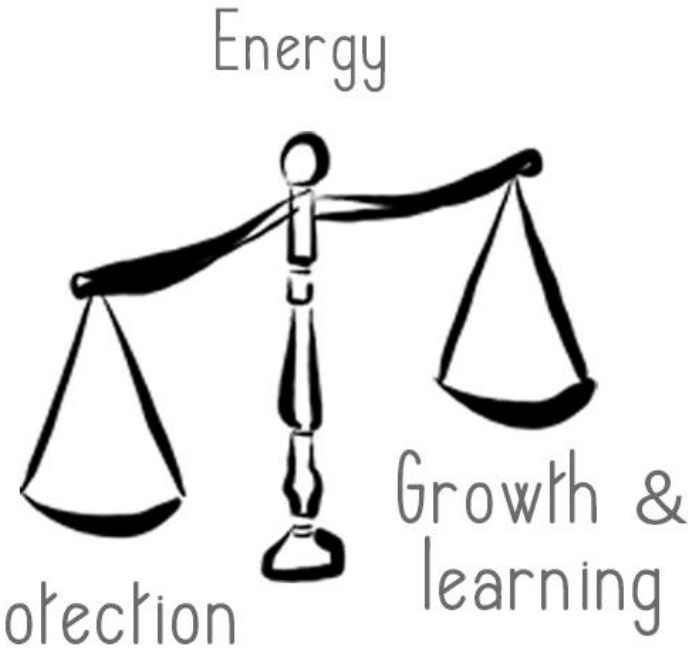
First 1000 days

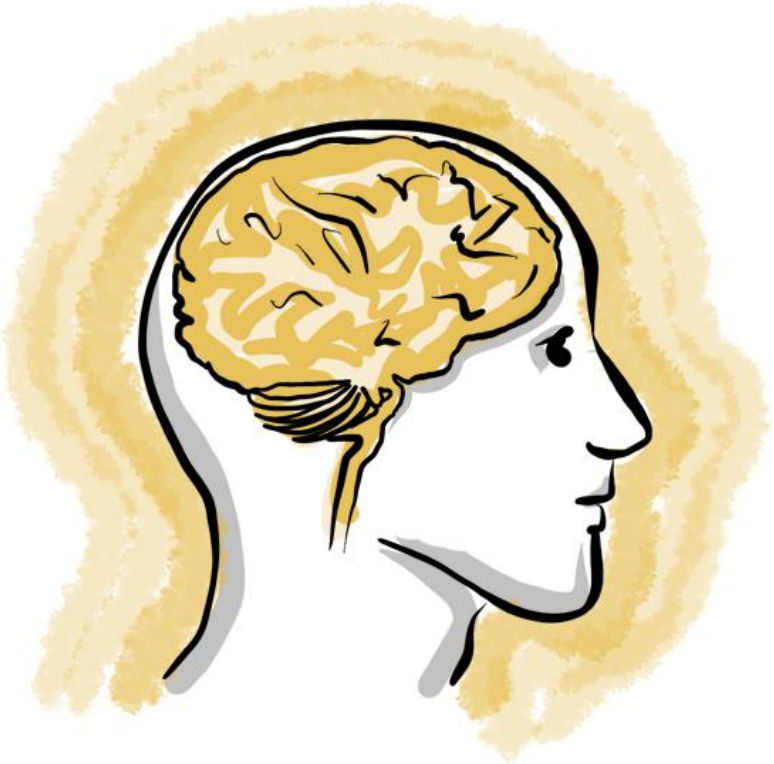


Culture

Tuning to whole brain intelligence

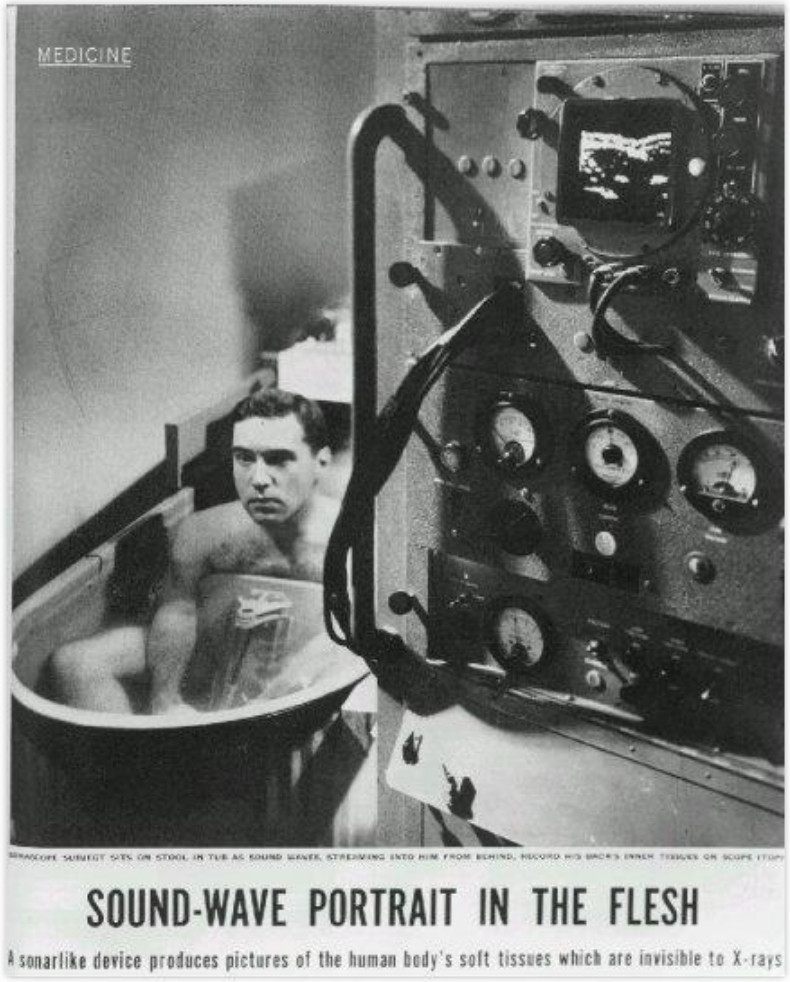
My neurobiology





Whole brain learning/growth

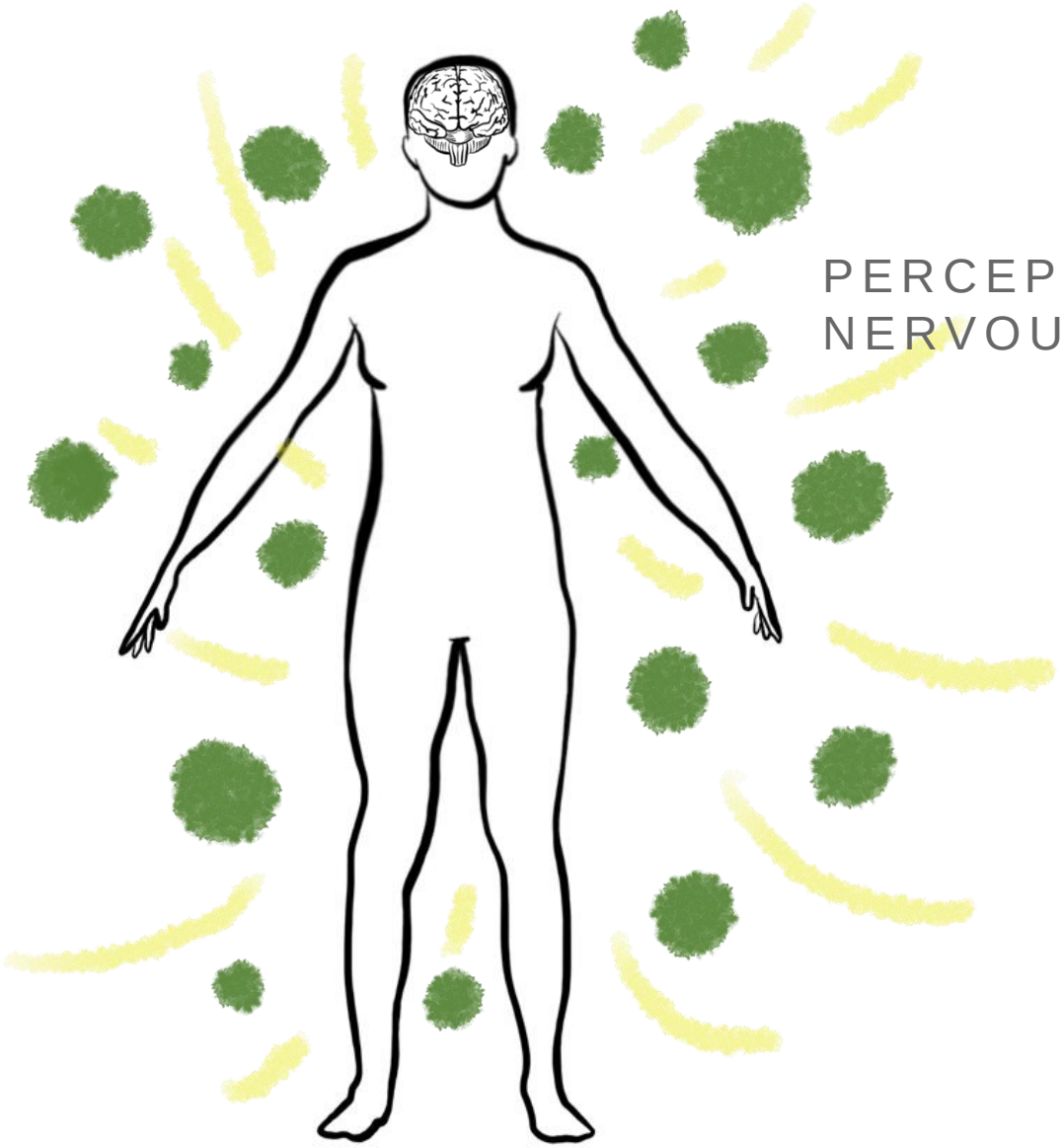
The Sciences of Hope: Epigenetics and Neuroscience



In this image from a 1954 LIFE Magazine article, Jerry Posakony's own kidneys are scanned by his experimental Somascope — an early medical diagnostics innovation. Posakony went on to a long career at PNNL and his pioneering contributions to ultrasonics technology served as the basis for modern ultrasound systems.
Credit: LIFE Magazine

Epi-genetics: above the genes

ENVIRONMENTAL SIGNALS



PERCEPTION THROUGH NERVOUS SYSTEM

Epi-genetics: above the genes

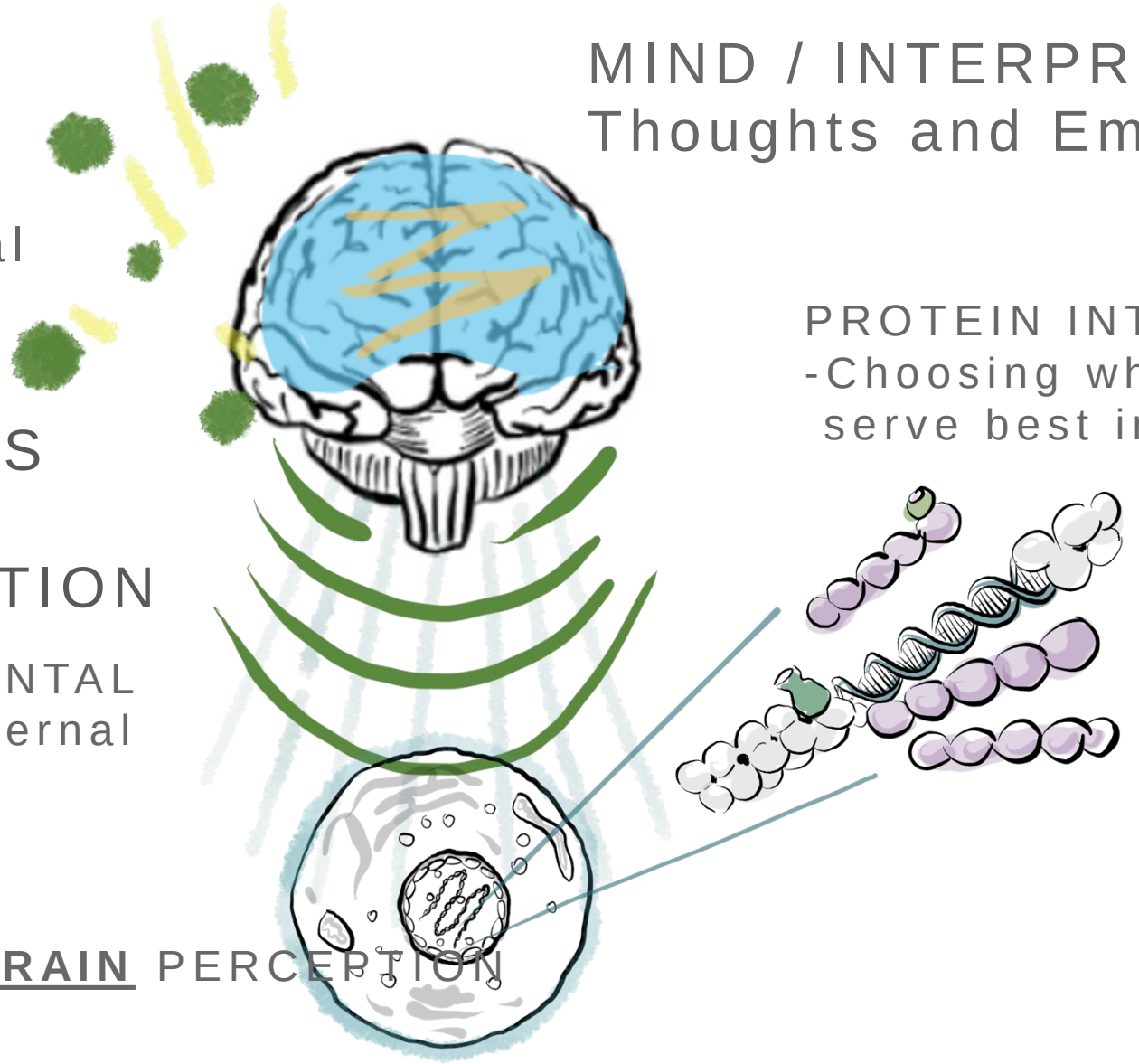
ENVIRONMENTAL
SIGNALS External

MIND / INTERPRETATION
Thoughts and Emotions

PROTEIN INTERPRETATION
-Choosing what Genes in DNA
serve best in this environment-

NERVOUS
SYSTEM
PERCEPTION

ENVIRONMENTAL
SIGNALS Internal

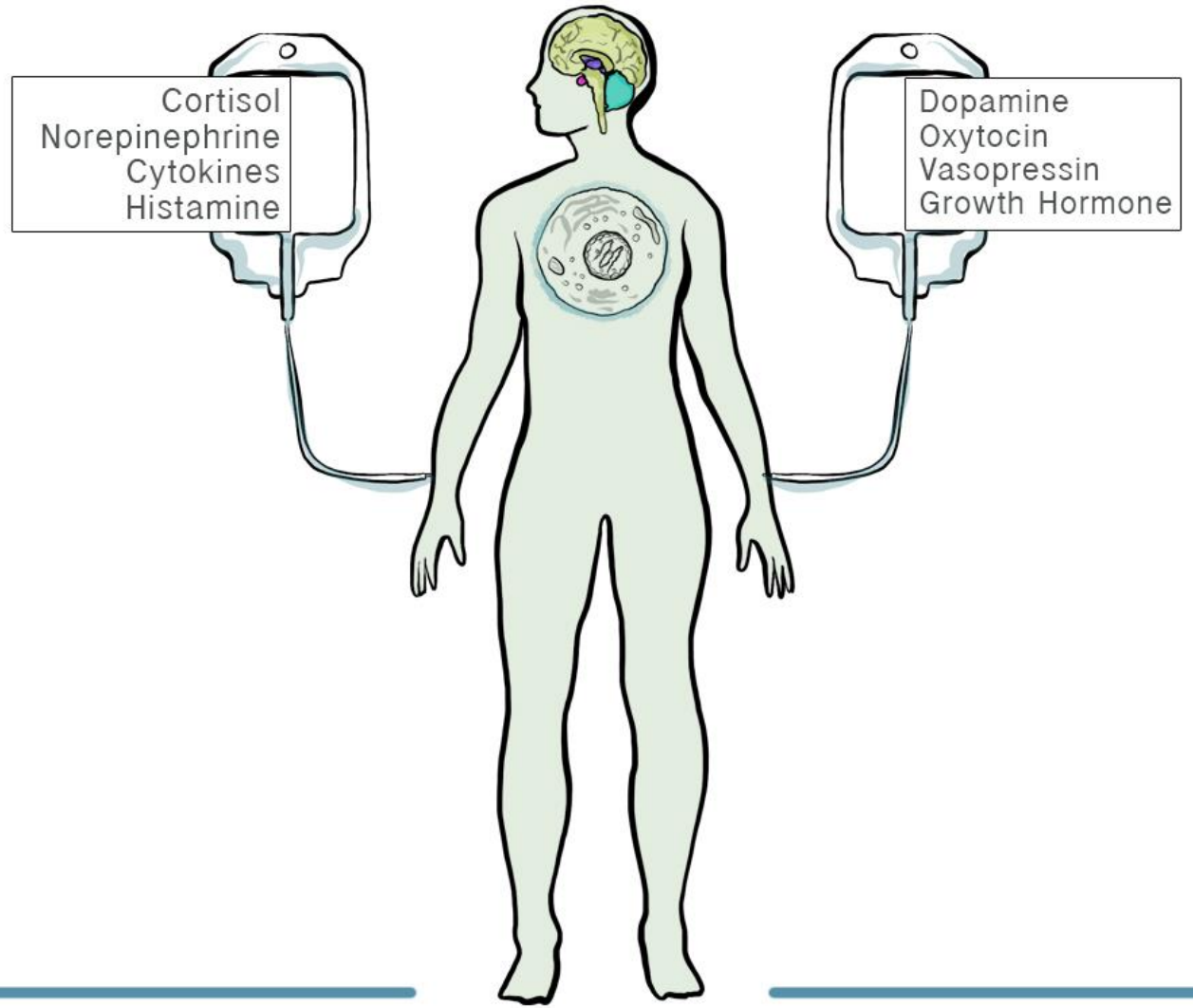


MEM**BRAIN** PERCEPTION

Internal environment changes the signals

FEAR

Cortisol
Norepinephrine
Cytokines
Histamine



Dopamine
Oxytocin
Vasopressin
Growth Hormone

LOVE

Time

Cell- Epigenetics

Time

Now that we know
What do we do? (ACE's)

Adverse Childhood Experience Study and Self Healing Communities

COMMUNITY RESILIENCE INITIATIVE

Adverse Childhood Experiences

THE # 1 CHRONIC HEALTH EPIDEMIC

"ACEs are the main determinates of the health & social well-being of the nation." Felitti

"The impact of ACEs can now only be ignored as a matter of conscious choice."

"With this information comes the responsibility to use it."

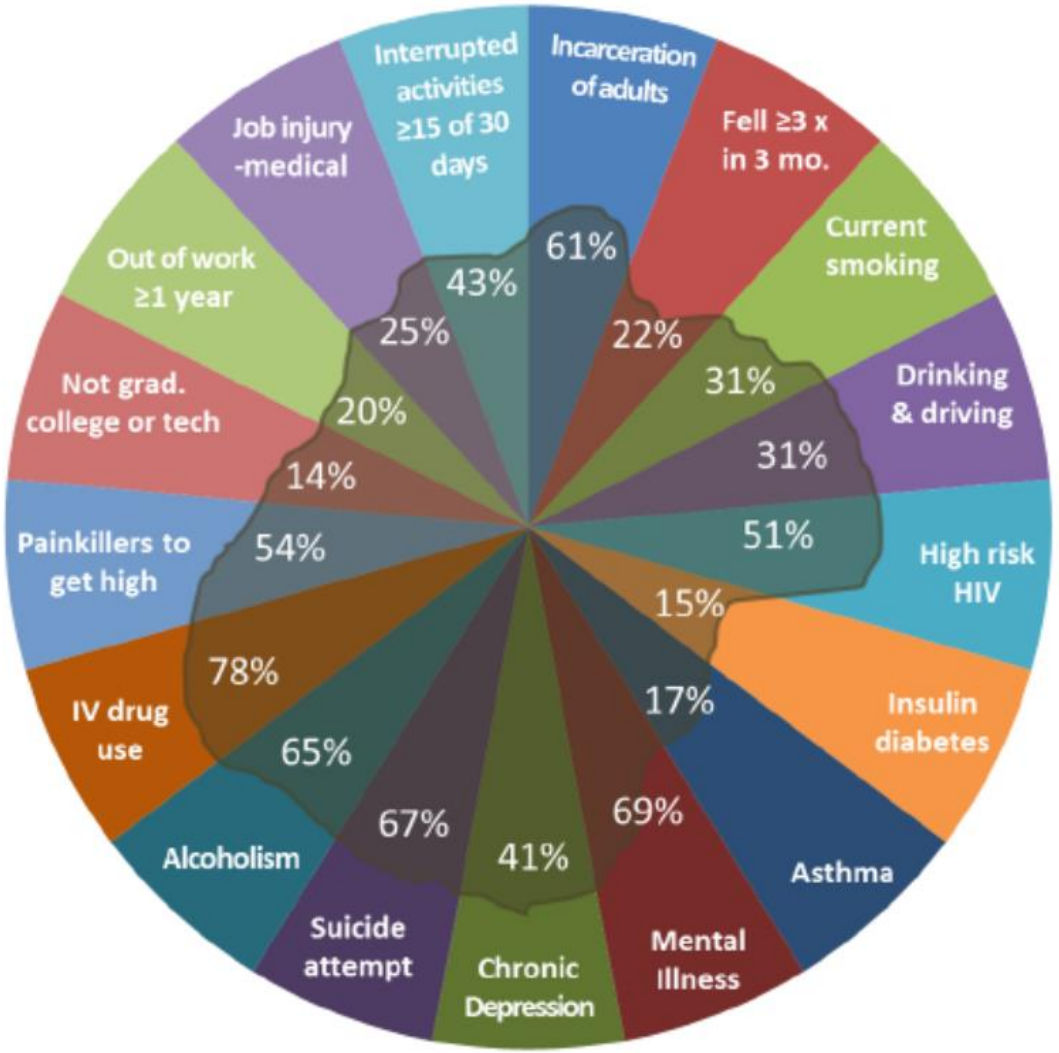
Anda et al 2010

COMMUNITY RESILIENCE INITIATIVE

Root causes

- Poverty
- Community violence
- Power
- Race
- Class inequities
- Privilege

Population Attributable Risk



Major Cost Centers

- Behavioral Health
- Child Welfare
- Corrections
- Economic Assistance
- Health
- Housing & Shelter
- Special Education
- Workforce

Population Attributable Risk (PAR):

Population Attributable Risk means the portion of a disease or condition that is caused by a disease agent. The gray area in the center of this diagram represents the portion of each of these conditions that is attributable to ACEs. As we reduce ACE prevalence from one generation to the next all of these problems will be reduced concurrently.

http://Healthygen.org

Everyone needs to know about ACEs

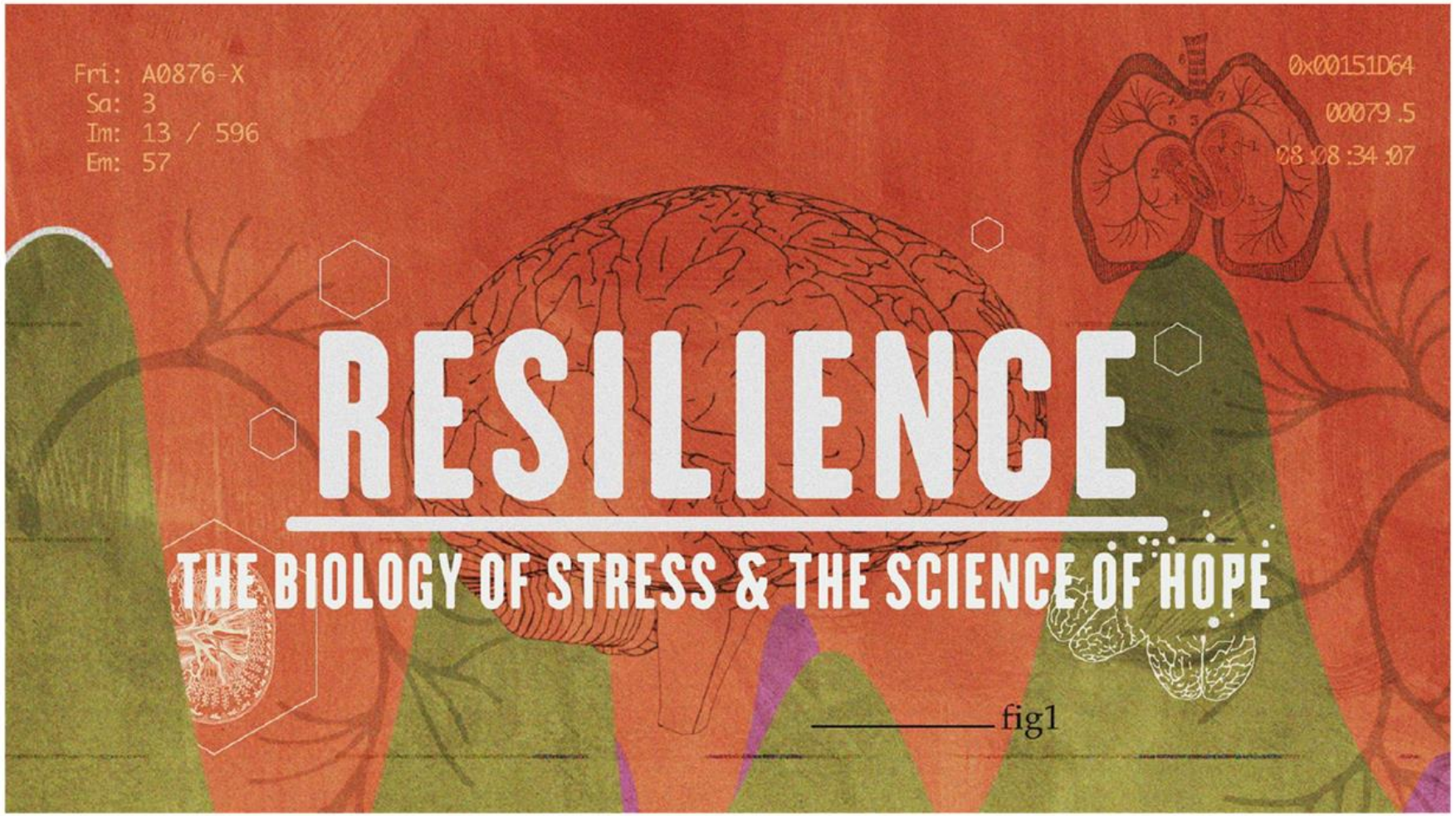


fig1

http://kpjrfilms.co/resilience/

COMMUNITY RESILIENCE INITIATIVE

Not the ACE or ACE Score[1]

- Trauma is buffered by the type of care giver response

High ACE <u>with support</u>
can be less risk than
Low ACE <u>with no support</u>

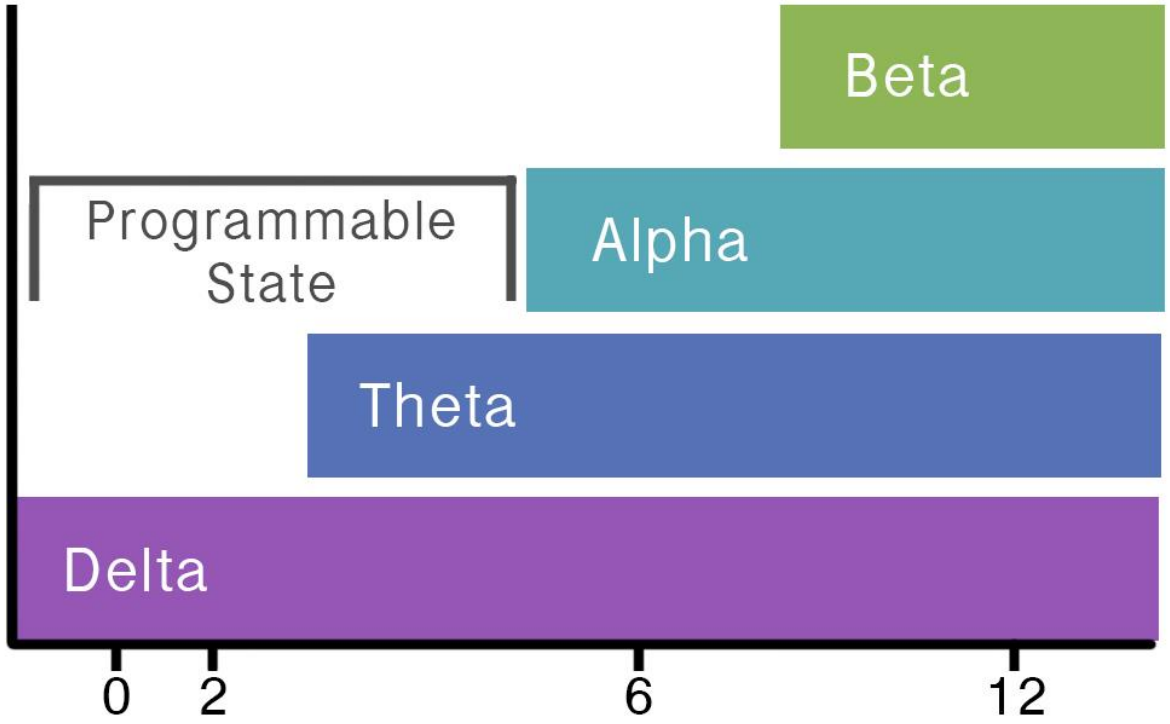
"How has this affected you as an adult?"

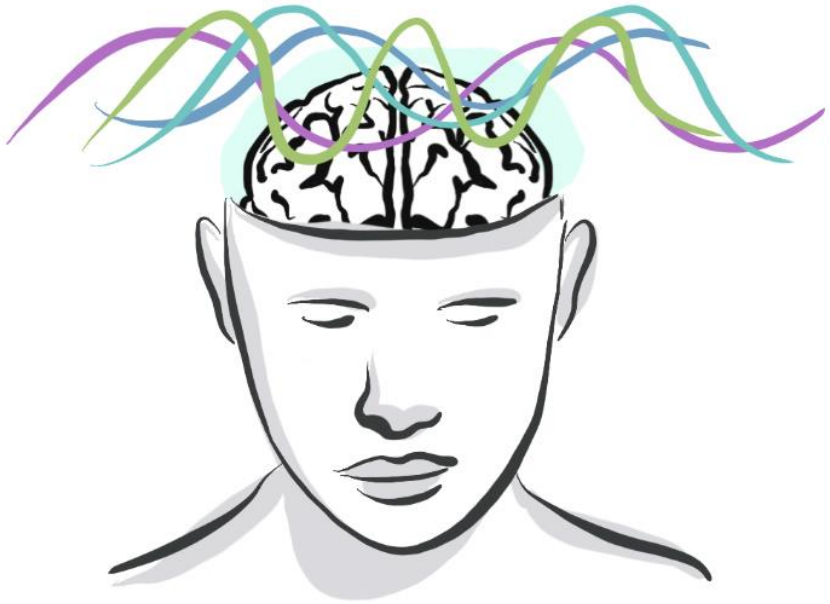
What is your Resilience score?

[1] **Never use as a diagnostic tool**

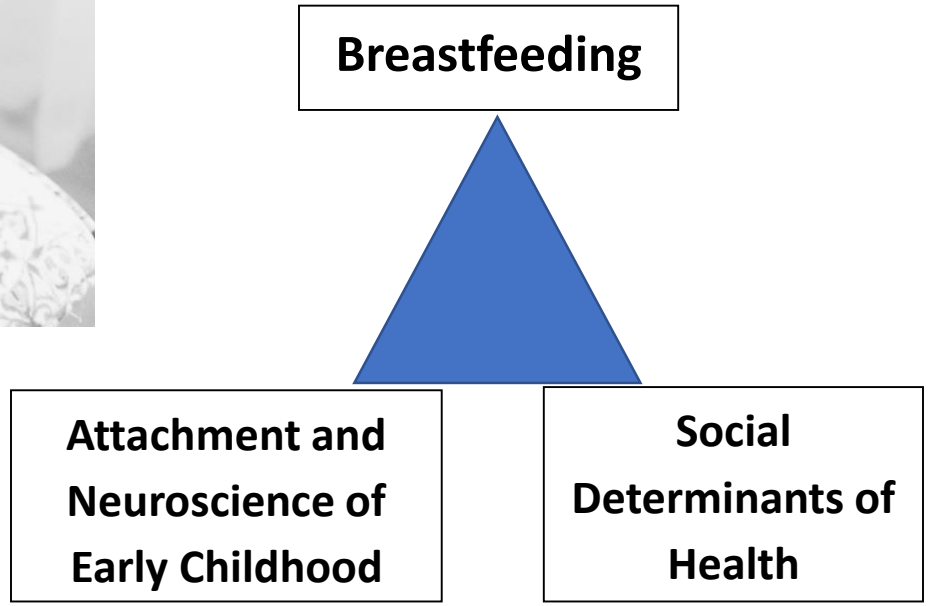
Early Childhood is a Key Opportunity

EGG Activity





Partnering for Breastfeeding for Success Benton-Franklin

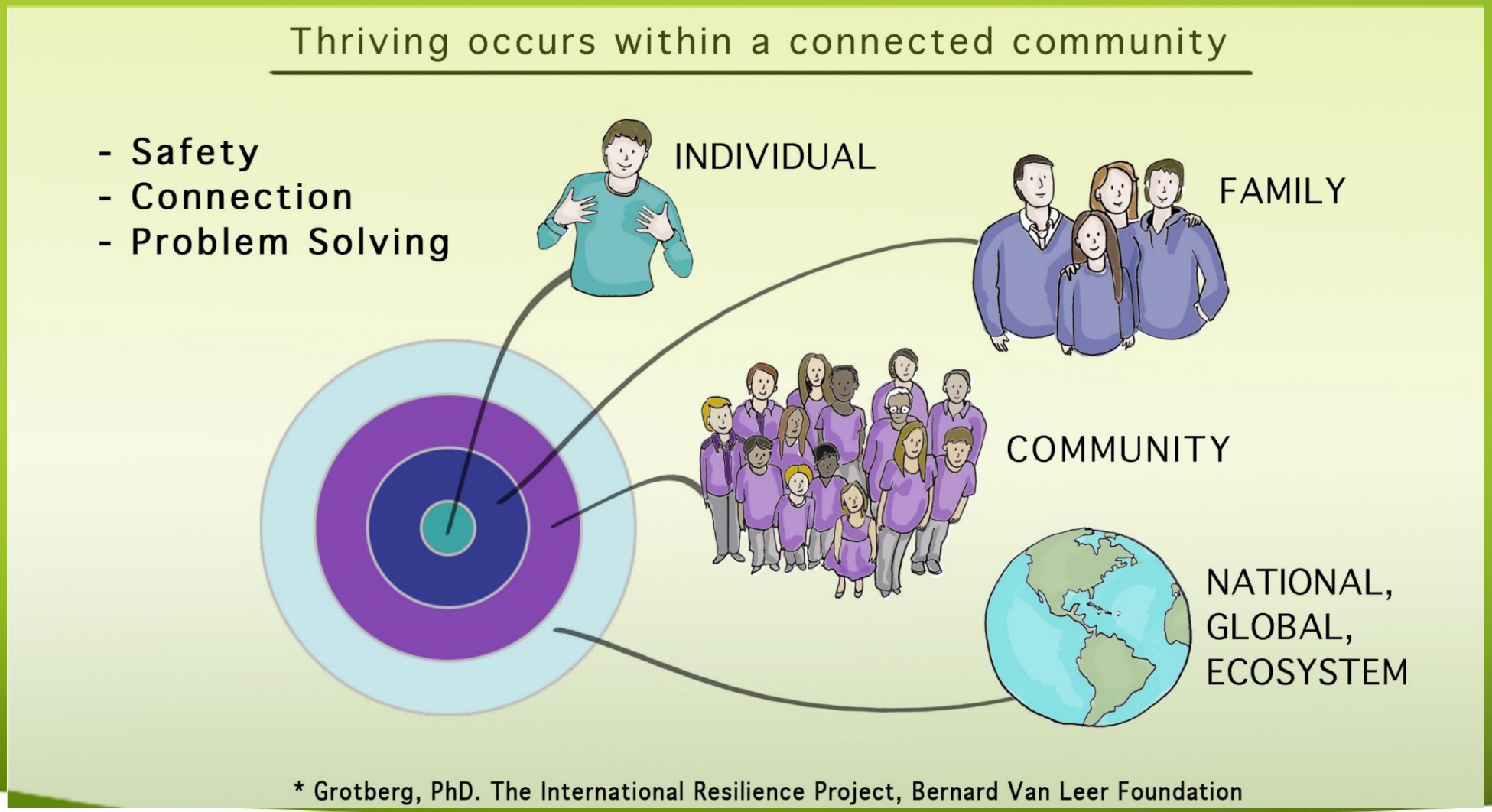


Breastfeeding Friendly Washington – shifting culture

- 9 month two county effort to shift breastfeeding rates and have better outcomes for mama's and babies.
- Build Strong Hospital to Community Partnerships: Develop systems for when Mama's go home and get them support there. (priority)
- Ten steps for Breastfeeding Friendly Hospital certification.
- Develop a network, community of practice and system of influence: including public health, hospitals and clinics, MCOs, community and faith organizations, state.
- Create common messaging, share what's working,
- Move toward Breastfeeding friendly clinics, employers, early learning centers and community education on birth to 5.
- Connect mama's to parenting groups, classes, community

Mirror Neuron’s - our state matters

Resilience is individual, family, community, systems



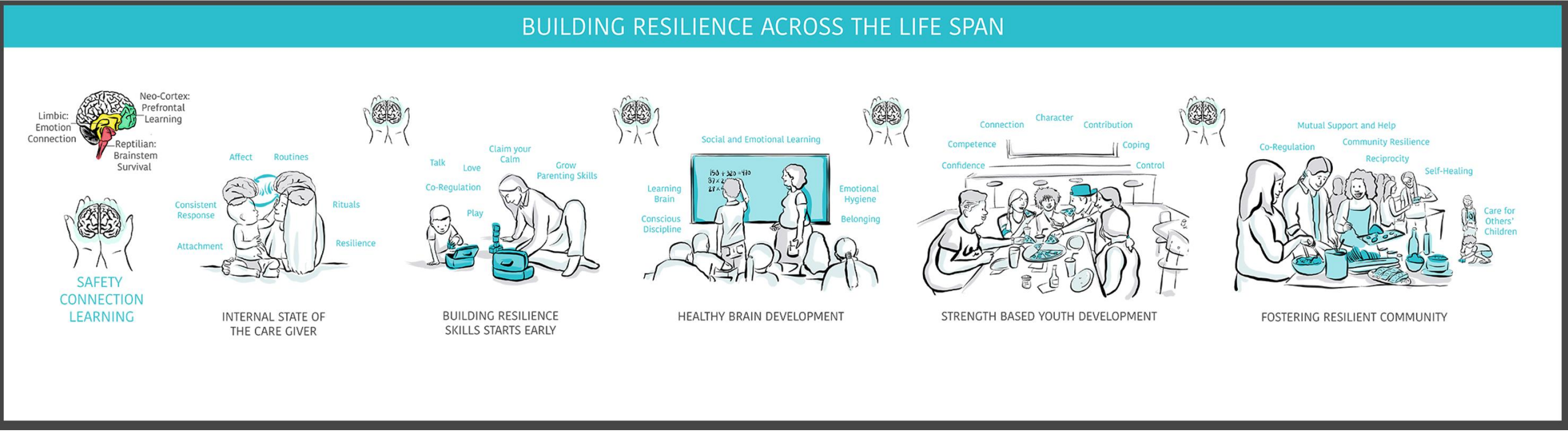
COMMUNITY RESILIENCE INITIATIVE

#1 Recommendation?

The number- and quality- of relationships in a child's life

Rebuilds trust, confidence, sense of security, reconnecting to love through strong social network that surrounds and supports

Bruce Perry MD, PhD



#1 PROTECTIVE FACTOR = RELATIONSHIP

Caring connections to others

Bruce Perry, MD PhD

The number & quality of relationships in a child's life.

The health and social problems we are facing in too many communities are highly complex....Building the community capacity to create a Culture of Health for neighborhoods and families offers us the best hope for addressing the problems in our time.

Self-Healing Communities

Laura Porter
Kimberly Martin, PhD
Robert Anda, MD, MS

North Central Accountable Community of Health

The Rainbow of Health and Whole Person Care

Coalitions for Health Improvement (Chelan-Douglas, Grant, and Okanogan)

Deb Miller, Executive Director, Community Choice
2018 NCACH Summit, Wenatchee, WA

INSPIRE • IMPROVE • INNOVATE
COMMUNITY CHOICE
HEALTH and EDUCATION INSTITUTE

Regional CHI Leadership

Chelan Douglas CHI:

Kris Davis- **Catholic Charities**
Renee Hunter- **TOGETHER! For Youth**
Deb Miller-**Community Choice**
Kelsey Gust -**Community Choice**
Brooklyn Holton-**City of Wenatchee**
Charity Bergman-**United Way**
Rick Escobedo-**North Central E.S.D.**

Grant CHI:

Rosalinda Kibby-**Columbia Basin Hospital**
Gail Goodwin-**Grant Integrated Services**
Sheila Chilson-**Moses Lake Community Health Center**
Amanda Rosales-**Grant Public Health District**
Laina Mitchell-**Grant Public Health District**
Theresa Adkinson-**Grant Public Health District**
Theresa Sullivan-**Samaritan Healthcare**

Okanogan CHI:

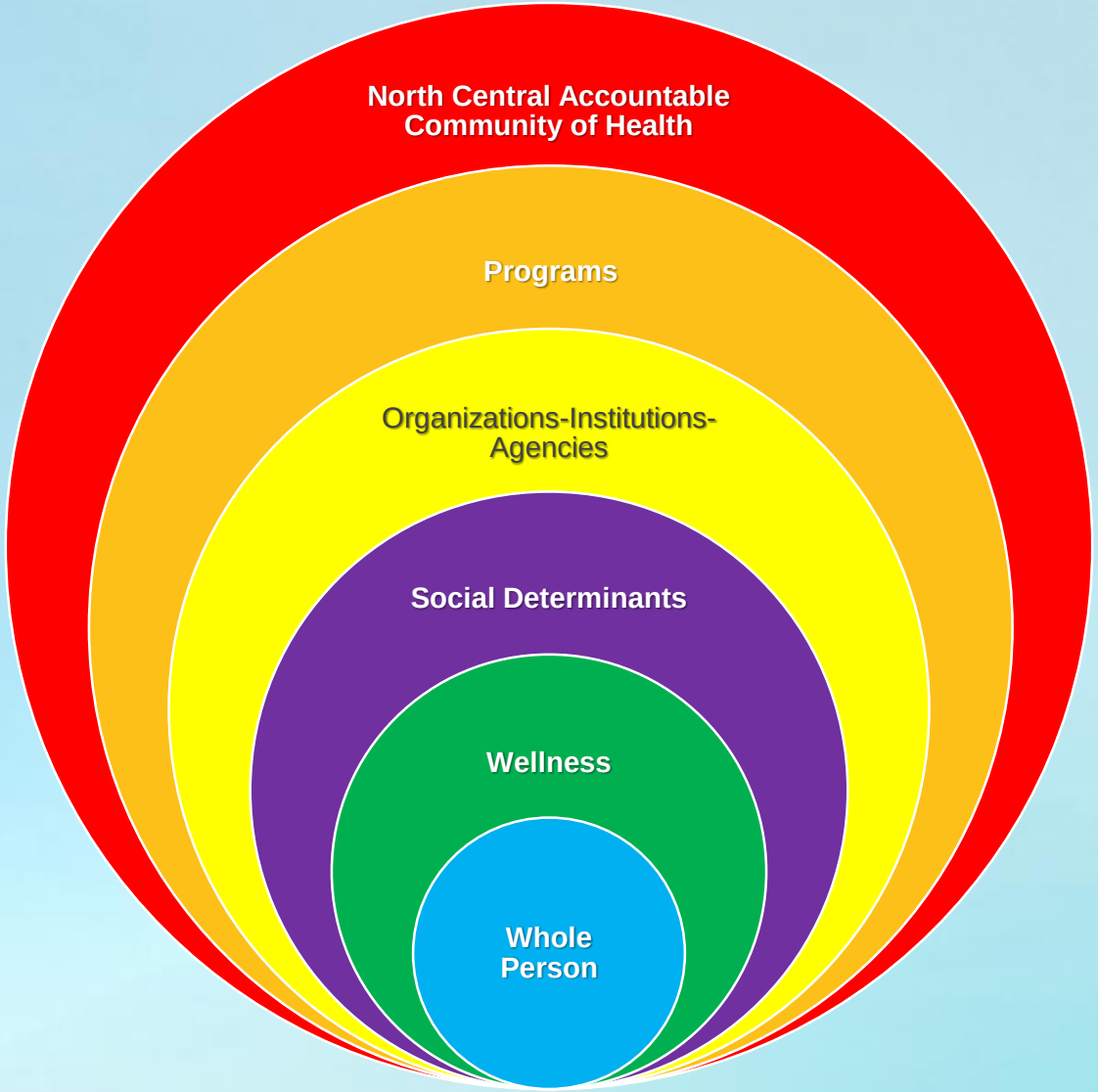
Kelcie Eddy- **Family Health Centers**
Valerie McKenna-**Family Health Centers**
Heather McArthur-**WVC Nursing Student**
Marcia Naillon-**North Valley Hospital**
Karen Schimpf-**North Valley Hospital**
Lauri Jones-**Okanogan Public Health**
Mike Beaver-**Okanogan County Juvenile**

The Perfect Nest

NCACH
Everybody as a partner in community health

PROGRAMS
How each organization serves the individual whole person

ORGANIZATIONS
Provide the boots on the ground ,who deliver the services



Social Determinants
Socio-Economic, Health Behaviors, Clinical Care, Built Environment

Balanced Wellness
Physical-Emotional-Social-Environmental-Financial-Spiritual

Whole Person
The heart of why we are here: to ensure “complete state of physical, mental and social well being.”

Age old silos…

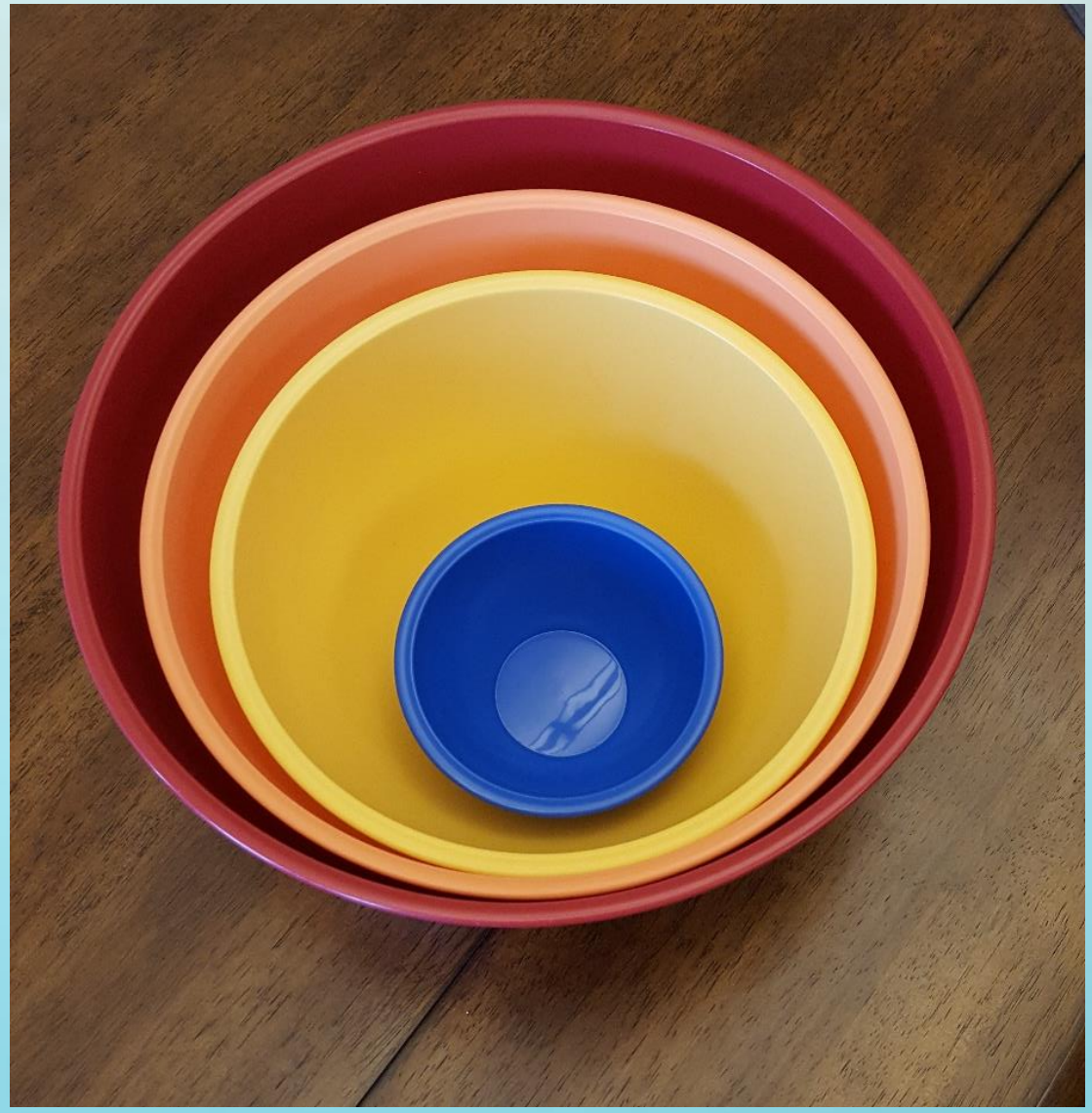
A step in the right direction…

What we don’t want to happen!!!

The Perfect Nest!

What is balanced wellness?

What happens without diverse partners…



Where we are in our journey…

Defining Diverse Partners

The social determinants of health are the circumstances in which people are born, grow up, live, work and age, as well as the systems put in place to deal with illness. These circumstances are, in turn, shaped by a wider set of forces: economics, social policies and politics.

~World Health Organization

Defining Diverse Partners

The social determinants of health are the conditions in the environments in which people are born, live, learn, work, play, worship and age … [that] affect a wide range of health, functioning and quality-of-life outcomes and risks.

~Healthy People 2020, U.S. Dept. of Health and Human Services

Describing the Social Determinants of Health

Describing the Social Determinants of Health

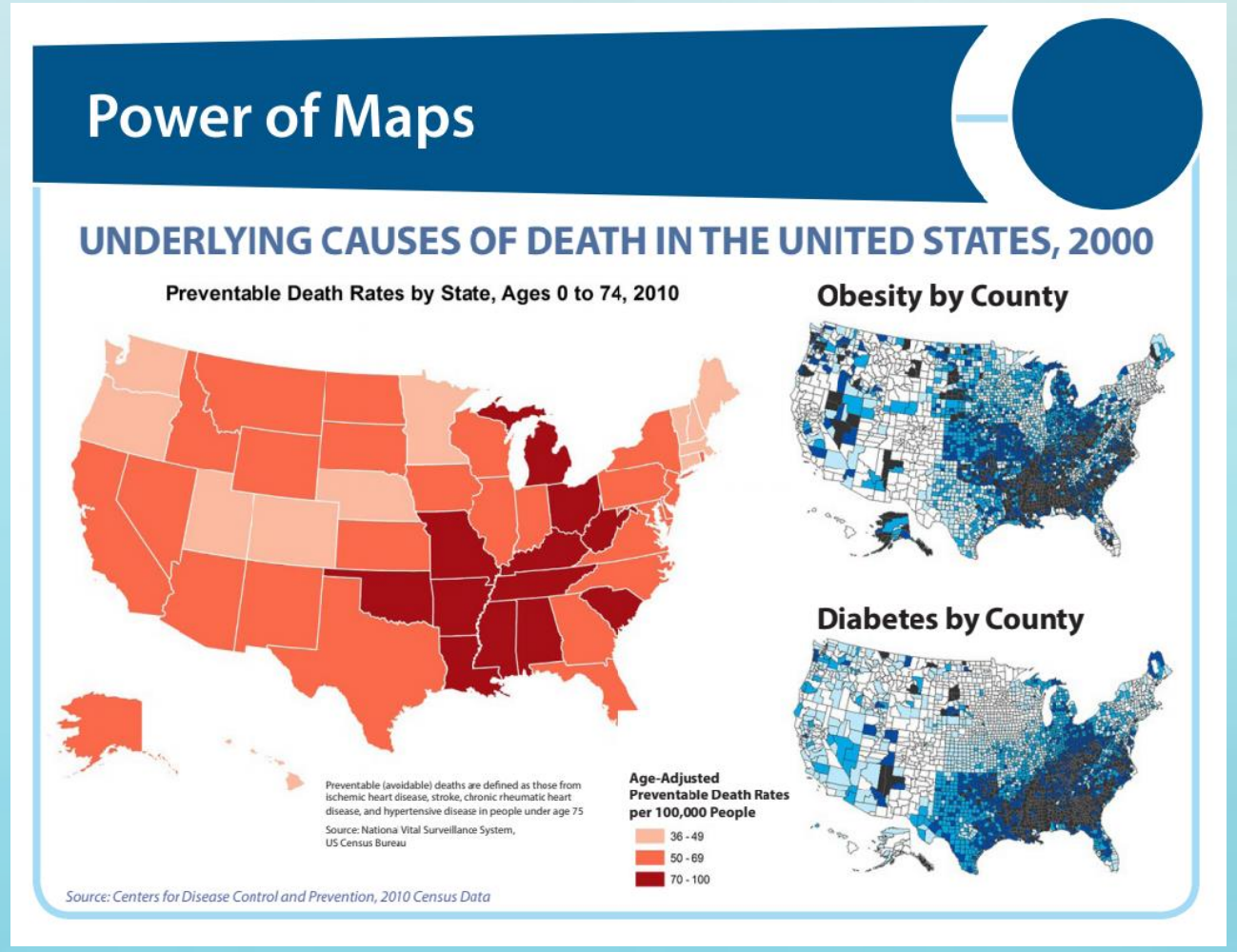
- Which definition or description resonated the most with you? Why?
- Did the same definition or description resonate for everyone? Why or why not?
- Can you think of an example of a personal, social, economic or environmental factor that has impacted a patient/client or family member of yours recently?

Health and Well-Being for All
Meeting-in-a-Box

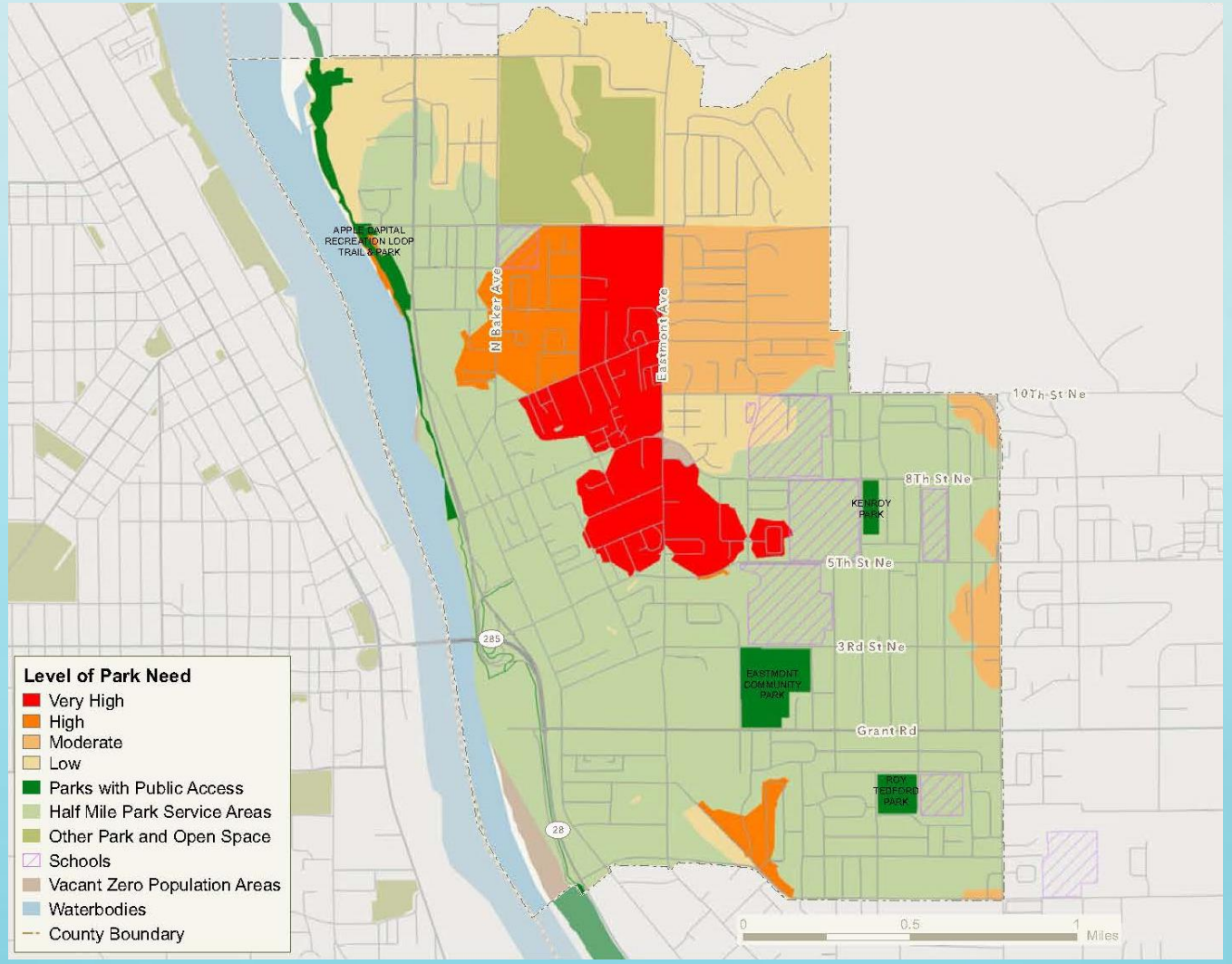
Moving Upstream

Have you had this conversation?

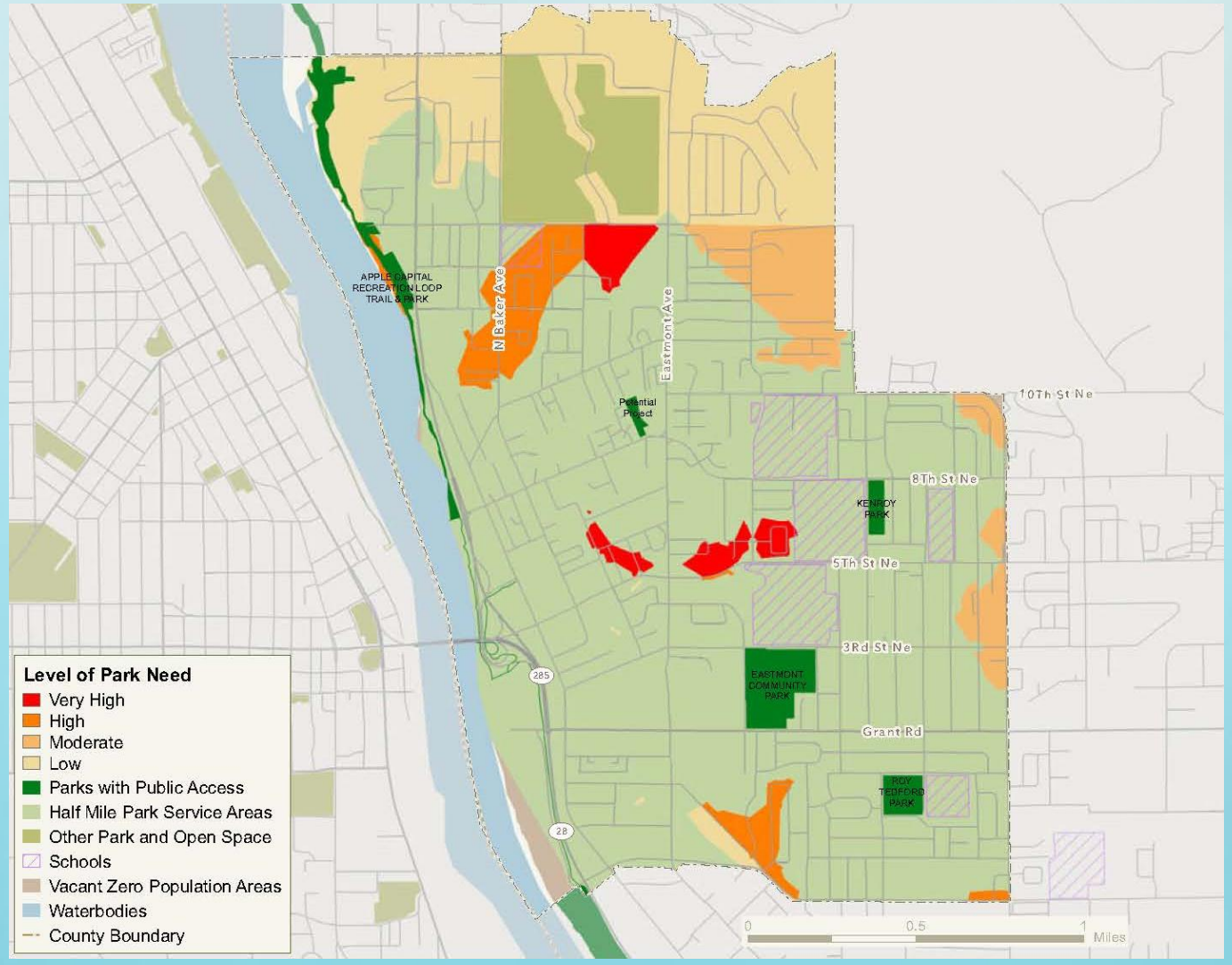
Moving Upstream-The Power of Maps



Moving Upstream-The Power of Maps



Moving Upstream-The Power of Maps



Finding Others Who Care

North Central Accountable
Community of Health

Thank you!

Utilizing the CDC Foundation's *Health and Well-Being for All* Meeting-in-a-Box

NCACH Annual Summit, Wenatchee, WA
April 20, 2018

Bastyr University
Health and Well-Being for All Team

- Heather Carrie, MAS Director, Center for Health Policy Leadership
- Paula Mitchell, MPH candidate 2019, Naturopathic medical student
- Tom Bell, Naturopathic medical student

CDC Foundation's *Health and Wellbeing for All* Meeting-in-a-Box

Components of HWFA Meeting-in-a-Box

- Box with handle to carry contents
- Fabric poster/map, 3' x 5'
- 3 Modules: asthma, gang violence, obesity
  - Dialogue guides for each module
  - A patient story to motivate change
  - Cards to educate and to stimulate discussion
  - Coming together with Others Who Care (role play for gang violence, shorter variation for the other 2)
- All contents brightly colored, appealing
- Modeled after Promedica's Hunger as a Health Issue (produced by same company)

Obesity Module

OBESITY MODULE

The obesity module begins with the story of a single mother, Carmen, and the barriers she faces in addressing her health issues. Dr. Peterson, a young health care provider, wants to help Carmen and patients like her make healthier choices. Participants will discuss the complexity of impacting obesity in a community. They will explore the different viewpoints of community members and how to collaborate to improve the community where Carmen and others live, learn, work, and play.

Tiffany Duncan / Clinic Receptionist

Others Who Care

Profile:

30-year-old black woman, lives in the community with her husband and two children
Struggled with obesity since adolescence
Participates in and has become a champion for the clinic's *Walk with a Doc* program and other community health initiatives

Agenda:

Attain healthy weight for herself and help others too
Become involved in real community level change, like improving the city's sidewalks

Obstacles:

Lack of education/possible perceived lack of professional credibility

Resources:

Community resident/seen as a credible community representative
Affable personality has made her a community connector

Tim Jacobs / Public Health Representative

Others Who Care

Profile:

White man in his mid-twenties
MPH, recently hired by County Health Department

Agenda:

Intervene in the community to break cycle of unhealthy lifestyle choices and preventable diseases, especially involving schoolchildren

Obstacles:

Lack of real-world experience with at-risk communities

Resources:

Aware of funding opportunities and experienced in writing grants
Network of allies in the school district and the county health department
Youthful exuberance

Wade Billups / City Manager

Others Who Care

Profile:

White man, has been the city manager for 25 years
Monitors, reports on and makes recommendations regarding the city budget

Agenda:

Demonstrate Leadership to new boss, develop job security
Interact/get involved in community to understand pressing needs

Obstacles:

A city budget deficit resulting from lower property tax values and higher expenditures for public safety workers

Resources:

Far-reaching professional network
Extensive institutional knowledge of how the city operates

Victoria Nunez / Parks and Recreation Director

Others Who Care

Profile:

Young Latina who grew up in the neighborhood
Spent three years in the military
Has an undergraduate degree in sports management and is passionate for fitness

Agenda:

Initiate new, culturally appropriate fitness programs
Prevent the pending sale of a land tract as commercial real estate and instead have it earmarked for a new park

Obstacles:

Must convince city officials of the merits of building a park instead of leasing land for lucrative fast food outlets

Resources:

Knowledge of the Hispanic community
Personal experience with poor diet and a sedentary lifestyle
Data about the financial advantages of creating a park, such as government subsidies and tax credits

Tien Jiang (T.J.) Xiao / Business Owner

Others Who Care

Profile:

70-year-old Asian owner of Pop's Market, a family business since 1930s

Agenda:

Maintain a successful neighborhood convenience store

Obstacles:

Has lost revenue in the past when attempting to sell fresh fruits and vegetables
Not interested in change

Resources:

Owns a popular and convenient venue, often used by the community for buying groceries

Dr. Julie Carson / Clinic Director

Others Who Care

Profile:

Black woman, physician director of the clinic where Dr. Sylvia Peterson works

Agenda:

Make evidence-based decisions that will benefit the clinic's patients and its financial bottom line

Obstacles:

Does not understand why patients with obesity can't just change their eating habits

Lack of resources to hire extra staff requested for an official obesity program at the clinic

Resources:

Can offer some assistance that is mutually beneficial (such as adding intake questions for patients' electronic health records), as long as cost is minimal

Reverend Isaiah Bishop / Religious Leader

Others Who Care

Profile:

Black Man, pastor of large black congregation in the community
Influential leader with a straightforward no nonsense attitude

Agenda:

Feels he could help make a difference with the right (effective) approach

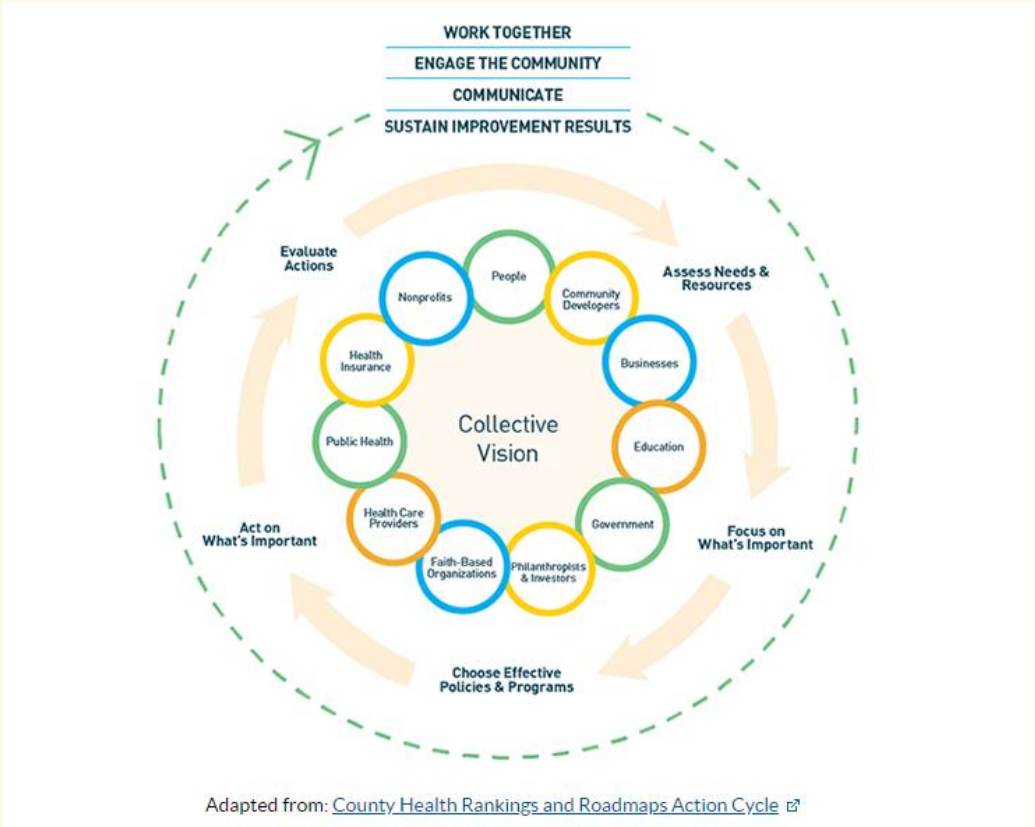
Obstacles:

Prior experience with community-based projects have not always been positive

Resources:

Well-respected by the community
Has influence with many people

Health and Well-Being for All



Adapted from: County Health Rankings and Roadmaps Action Cycle

Collaboration
For
Collective Vision

Thank you!

Update from the Washington State Health Care Authority

Sue Birch, Director, Washington State Health Care Authority

Medicaid Transformation Project Update

Update of North Central Accountable Community of Health Workgroups

North Central Accountable Community of Health

North Central Accountable Community of Health

Healthier Washington - HCA

Healthier WA is a statewide initiative that is focused on achieving system wide change.

Healthier WA focuses on three goals:

1. Building healthier communities
2. Integrating physical and behavioral health to focus on the whole person
3. Improving how we pay for services by rewarding quality over quantity

In 2016, nine Accountable Communities of Health were formed to achieve these goals.

North Central Accountable Community of Health

Five years from now….

Current system

- Fragmented care delivery
- Disjointed care transitions
- Disengaged clients
- Capacity limits
- Impoverishment
- Inconsistent measurement
- Volume-based payment

Transformed System

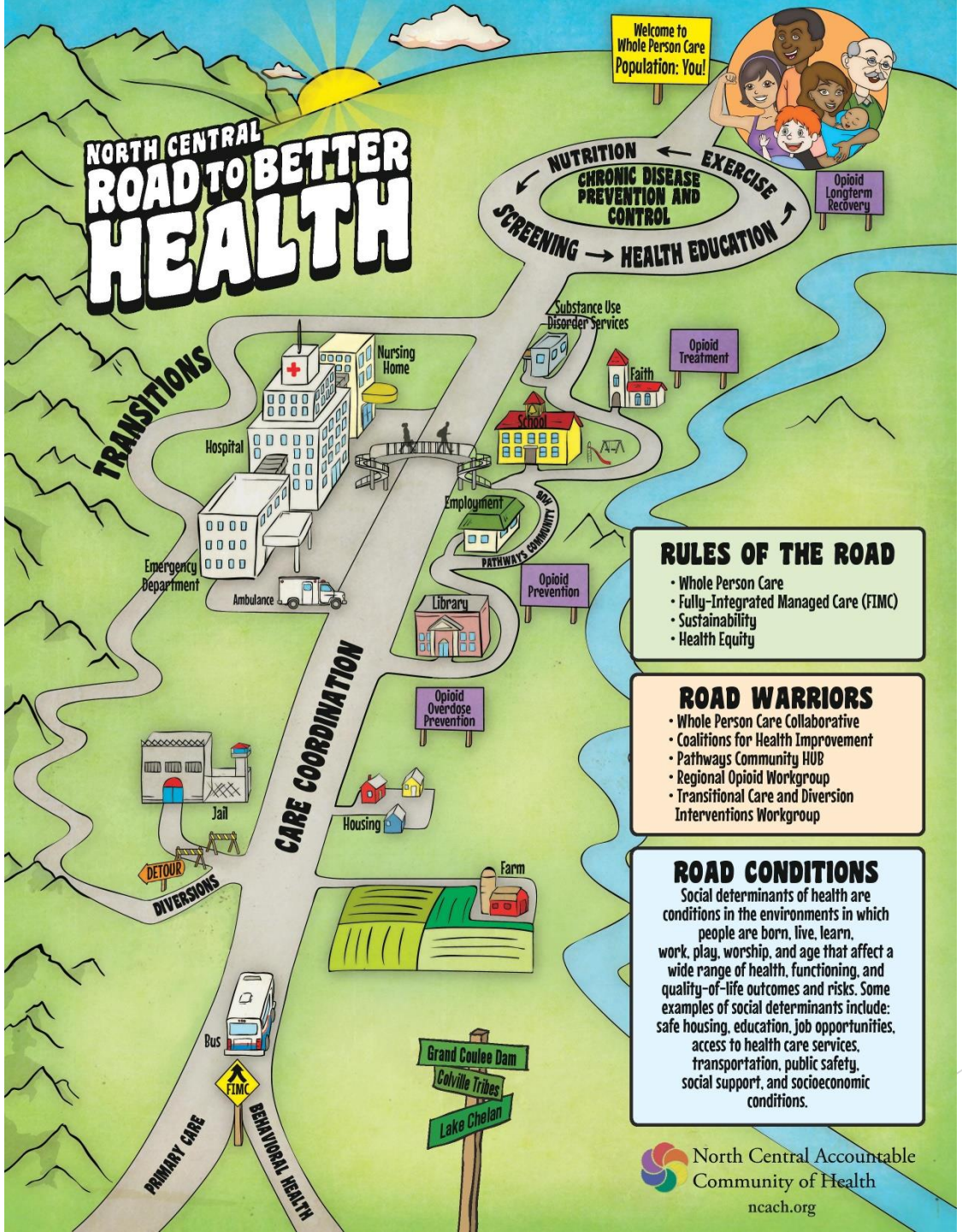
- Integrated, whole-person care
- Coordinated care
- Activated clients
- Access to appropriate services
- Timely supports
- Standardized measurement
- Value-based payment

North Central Accountable Community of Health

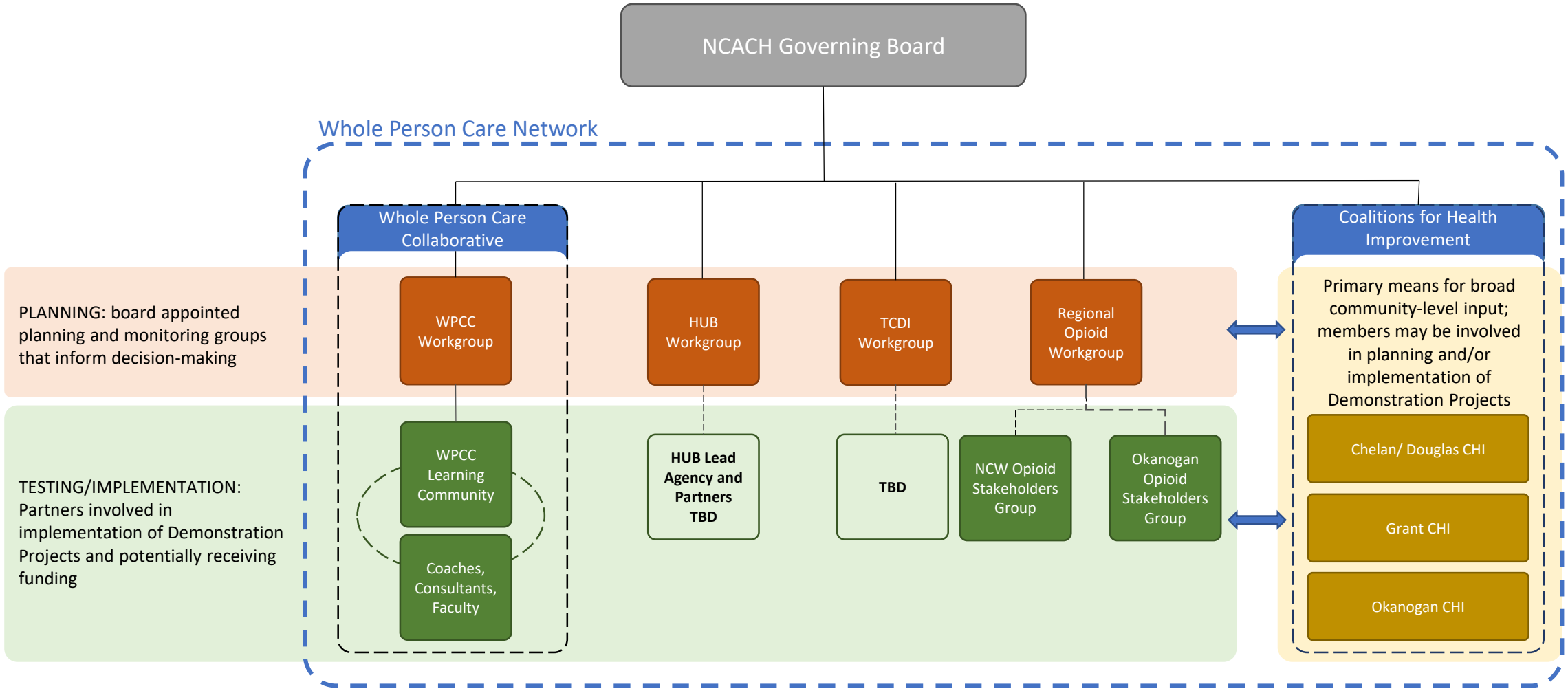
A Regional Approach

- ACHs play a critical role:
  - **Coordinate** and **oversee** regional projects aimed at improving care for Medicaid beneficiaries.
  - **Apply** for transformation projects, and incentive payments, on behalf of partnering providers within the region.
  - **Solicit** community feedback in development of Project Plan applications.
  - **Decide** on distribution of incentive funds to providers for achievement of defined milestones.

North Central Accountable Community of Health



NCACH Structure and Governance
within the Medicaid Transformation



North Central Accountable Community of Health

How did we get here?

2014

State Healthcare Transformation Initiated

- **State Health Care Innovation Plan** (SHCIP) and Round 1 of State Innovation Models (SIM) federal funding
- **Legislation** supports healthcare transformation efforts (E2SHB 2572 and 2SSB 6312)
- **Community forums** organized in our region

2015

- **ACHs** form across WA State
- **CHIs** form in our region
- **Regional health initiatives** begin

SIM Funding Round 2

2016

Collaborative formed

- **NCACH** officially designated
- **Primary Care** organizations invited to participate in a *Whole Person Medical Home Model*
- **WPCC** formed

2017

- Whole Person Care **Summit** at Campbell's!
- NCACH selects **6 Projects**
- Hired 4 more **staff**
- **Certifications** 1 & 2 submitted to HCA
- *Preliminary* project plan applications

Medicaid Transformation – 5 year funding

North Central Accountable Community of Health

Selected Medicaid Transformation Projects & Workgroups

NCACH Workgroups	Projects
Whole Person Care Collaborative (WPCC)	1. Bi-Directional Integration of Physical and Behavioral Health Care 2. Chronic Disease Prevention and Control
Transitional Care and Diversion Interventions (TCDI)	3. Diversion Interventions 4. Transitional Care
Care Coordination (Pathways Community HUB)	5. Community-Based Care Coordination
Regional Opioid Stakeholders	6. Addressing the Opioid Use Public Health Crisis

North Central Accountable Community of Health

Whole Person Care Collaborative

Peter Morgan, NCACH Director of Whole Person Care
Caroline Tillier, NCACH Staff Support

WPCC meetings are open to the public!
Generally 1st Monday of every month 11:00AM – 12:30PM
Find more info at https://ncach.org/wpcc/

When Whole Person Care is Realized…

1. Every patient who wants one, has an engaged care team
2. The care team coordinates the patient's care both within the clinic and wherever the patient is referred for services
3. Patients receive routine reminders about preventive screening and immunizations
4. Patients have online access to their health information to assist in managing their own care.
5. Patients are treated with respect, informed, cared for, and involved in decisions about their care at every step of the way.
6. Patients have access to a responsive care team (e.g. same/next day appointments, phone/email communications, 24/7 nurse advice line)
7. Value based payment systems will adequately compensate organizations who invest in prevention, effective chronic disease management, care coordination, and services that support the triple aim.

WPCC and Medicaid Transformation Projects

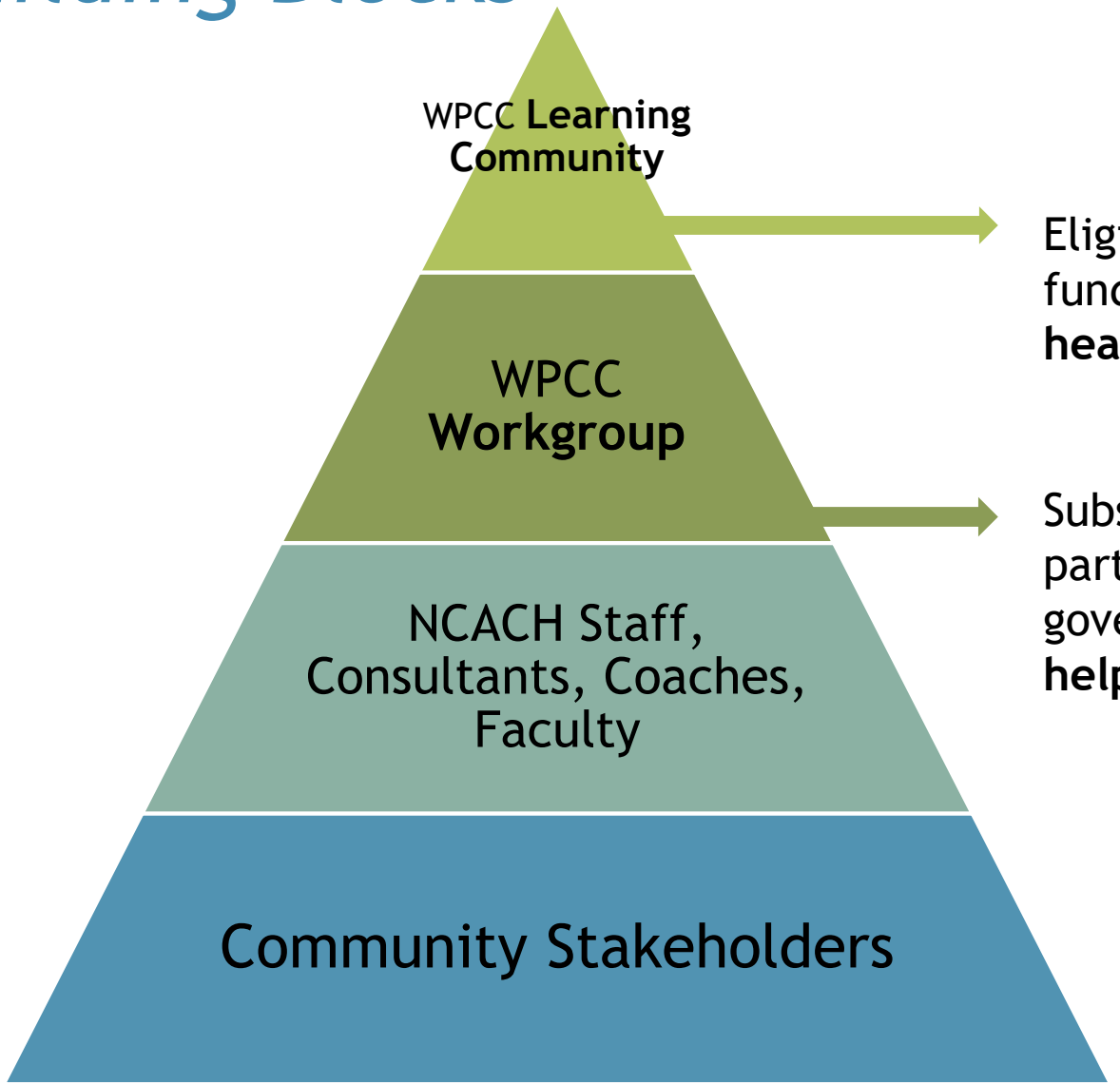
Bi-Directional Integration

- **Objective**: Through a whole-person approach to care, address physical and behavioral health needs in one system through an integrated network of providers.
- **NCACH Target Population**: Medicaid beneficiaries (children and adults) particularly those with or at-risk for behavioral health conditions, including mental illness and/or substance use disorder (SUD).

Chronic Disease Prev. & Control

- **Objective:** Integrate health system and community approaches to improve chronic disease management and control.
- **NCACH Target Population:** Medicaid beneficiaries (children and adults) with chronic conditions, especially diabetes, respiratory issues, heart disease, and depression

Whole Person Care Collaborative
Building Blocks



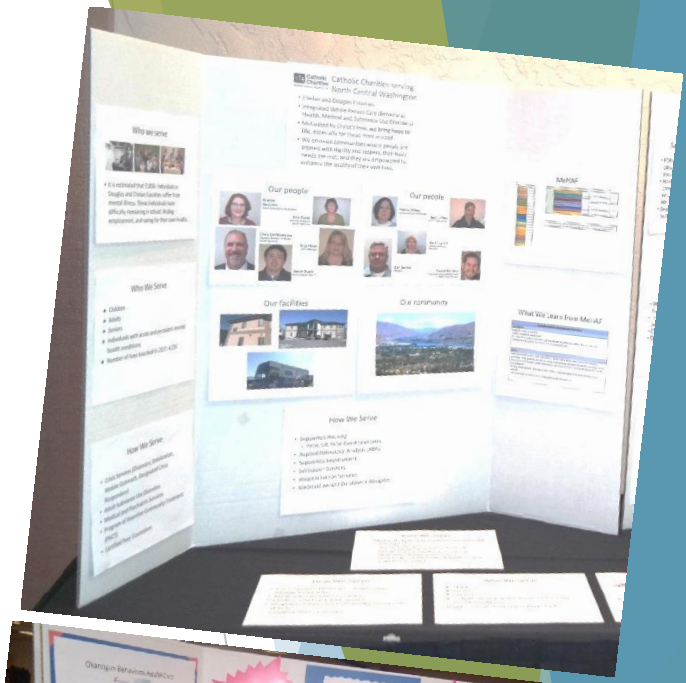
Eligible clinical partners receiving funding to **implement clinical health improvement efforts**

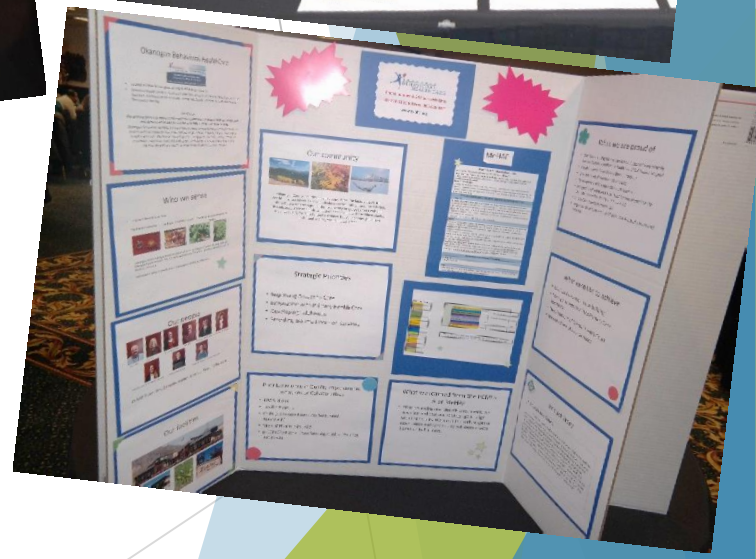
Subset of WPCC participants with targeted governance role - **advise, help plan and monitor**

WPCC Learning Community *Participating Providers*

- Cascade Medical Center
- Catholic Charities
- The Center for Drug and Alcohol Treatment
- Children's Home Society of Washington
- Columbia Basin Health Association
- Columbia Basin Hospital – Family Medicine
- Columbia Valley Community Health
- Confluence Health
- Coulee Medical Center
- Family Health Centers
- Grant Integrated Services
- Lake Chelan Community Hospital & Clinics
- Mid Valley Clinic
- Moses Lake Community Health Center
- Okanogan Behavioral HealthCare
- Parkview Medical Group
- Samaritan Healthcare

Storyboards from Kick-Off





Providers brainstormed ideas for quality improvement

What is the WPCC Learning Community's role in NCACH Projects?

North Central Accountable Community of Health

Coordinator and Funder

NCACH staff and Workgroups are coordinating the planning and implementation of six Medicaid Transformation projects in our region.

1. Bi-Directional Integration
2. Community-Based Care Coordination
3. Transitional Care
4. Diversion Interventions
5. Addressing Opioid Use
6. Chronic Disease Prevention & Control

WPCC Learning Community

Do-ers ("boots on the ground")

Behavioral health and primary care providers in our region are actively implementing clinical health improvement efforts in outpatient settings.

Change Plan

Learning Activities

Faculty/Coaching Support

TA

Funding

$

Our WPCC Learning Community draws on a collaborative framework to support systematic approaches to process improvement while strengthening connections between providers as they share successes and learn from each other. Together, we can get there faster!

Change Plan Topics

Bi-directional integration of Physical and Behavioral Health
Community-Based Care Coordination
Addresses the opioid epidemic
Addresses the social determinants of health
Diversion Interventions
Transitional Care
Chronic Disease Prevention and Control
Improve Access to Care

Performance (P4P) Metrics	2A: Integration	2B: Pathways	2C: Transitional	2D: Diversion	3A: Opioid	3D: Chronic	Total
Outpatient Emergency Department Visits per 1000 Member Months	■	■	■	■	■	■	6
Inpatient Hospital Utilization	■	■	■		■	■	5
Follow-up After Discharge from ED for Mental Health	■	■	■				3
Follow-up After Discharge from ED for Alcohol or Other Drug Dependence	■	■	■				3
Follow-up After Hospitalization for Mental Illness	■	■	■				3
Percent Homeless (Narrow Definition)		■	■	■			3
Plan All-Cause Readmission Rate (30 Days)	■	■	■				3
Substance Use Disorder Treatment Penetration	■	■					2
Mental Health Treatment Penetration (Broad Version)	■	■					2
Child and Adolescents' Access to Primary Care Practitioners	■					■	2
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	■					■	2
Comprehensive Diabetes Care: Hemoglobin A1c Testing	■					■	2
Comprehensive Diabetes Care: Medical Attention for Nephropathy	■					■	2
Medication Management for People with Asthma (5-64 years)	■					■	2
Substance Use Disorder Treatment Penetration (Opioid)					■		1
Antidepressant Medication Management	■						1
Patients on high-dose chronic opioid therapy by varying thresholds					■		1
Patients with concurrent sedatives prescriptions					■		1
Percent Arrested				■			1
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)						■	1

North Central Accountable Community of Health

Transitional Care and Diversion Intervention Workgroup

Eric Skansgaard, Workgroup Chair | Catholic Charities
John Schapman, NCACH Staff Lead

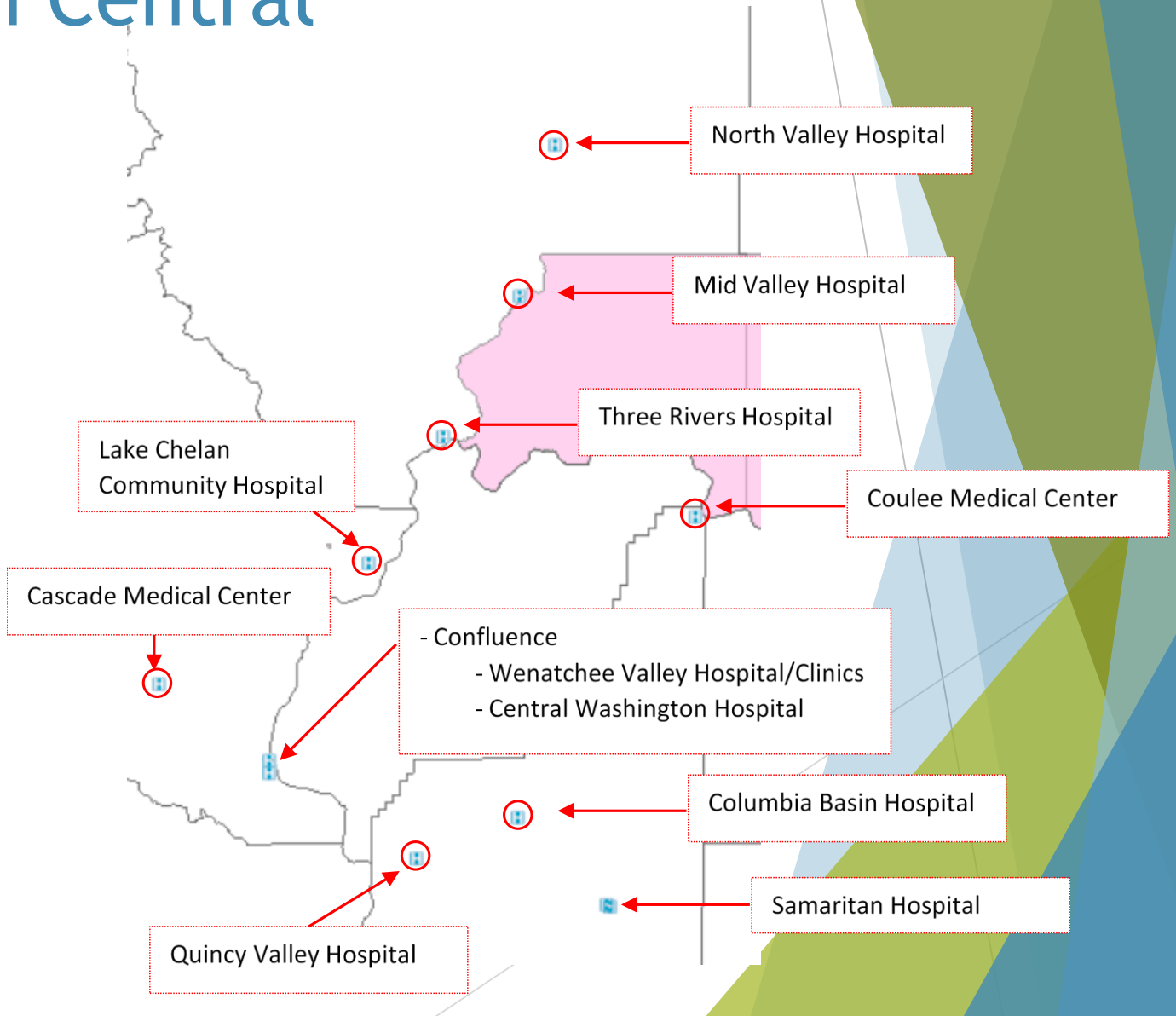
TCDI meetings are open to the public!
Generally 4th Thursday of every month from 10AM – 11:30AM
Find more info at:
https://ncach.org/transitional-care-diversion-interventions/

Transitional Care and Diversion Services

- **Transitional Care:** Improve coordination of services leaving the hospital setting.
- **Diversion Intervention:** Implement strategies to promote more appropriate use of emergency care services

Main Organizations involved in Diversion and Transitions in North Central

- 10 Hospitals in Region
  - 8 Critical Access Hospitals
- 3 Correctional Facilities
- 10 EMS Transport Agencies



Source: Health Services and Resources (HRSA) Map Tool
Critical Access Hospitals circled in red

What would ideal Transitional and Diversion Services Create?

- Individuals will no longer call 911 for non-emergent conditions, because they will be connected to preventative services they need
- Patients discharged from acute care will be connected to community supports and know how to navigate the healthcare system so they do not end up back in acute care
- Healthcare systems will communicate with each other ensuring the appropriate information is shared with all providers to provide the best transition and care for the patient.

North Central Approaches

Transitional Care:

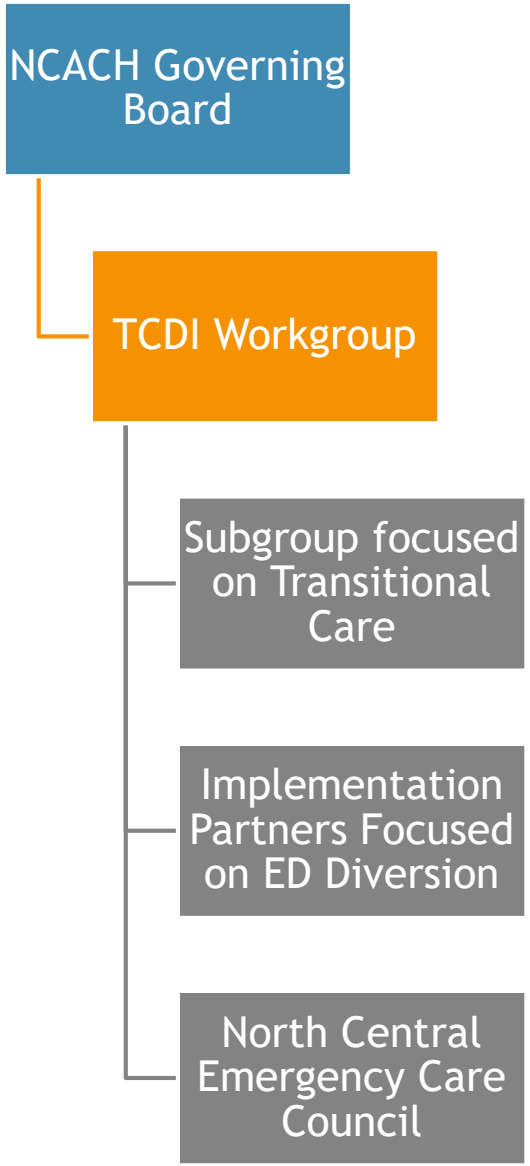
1. Transitional Services for patient's discharged from Hospital
   - Focused on Medicaid beneficiaries discharged from acute care to home or to supportive housing

Diversion Intervention

2. ER Is for Emergencies Seven Best Practices
   - Focused on reducing the number of visits for Medicaid beneficiaries presenting at the Emergency Department for non-acute condition

3. EMS protocols to Divert patients from Emergency Departments
   - Medicaid beneficiaries who access the Emergency Medical Services (EMS) system for a non-emergent condition

How the Workgroup Makes Decisions



- The Workgroup Meets 1 time a month to review plans being developed amongst subgroup
- Each specific approach has a smaller group of partners developing the details of the work based on their expertise
- Any recommendations of the workgroup will go to the Board for final approval

Implementation Partner Engagement

- The workgroup will define eligibility for who can be an implementation partner.
- NCACH will develop a plan to address barriers and implement changes including:
  - Training needs
  - Direct Organizational investments (i.e. funding to offset staff cost to train)
  - Enhancements in workforce training and health information exchange(i.e. help with the implementation of EDIE/Pre-Managed across region)

TCDI Implementation Partners

Primary Implementation Partners

- Hospitals/Emergency Departments (10)
  - Transitional Care Models
  - Emergency Department Diversion
- Emergency Medical Services Agencies (10)
  - Emergency Department Diversion

Supporting Partners

- Community Based Care Coordination Agencies
- Law Enforcement
- Crisis Providers
- Other

North Central Accountable Community of Health

Pathways Community HUB Workgroup

Christal Eshelman, NCACH Staff Lead

Pathways Community HUB Workgroup meetings are open to the public!
Generally 4th Wednesday of every month from 3PM – 4:30PM
Find more info at https://ncach.org/care-coordination/

Pathways

Dr. Kathy Burgoyne

Kathyb@healhtygen.org

Kathy@piercecountyach.org

206-498-2993

Endorsers of the Pathways Community HUB Model

Ohio Commission On Minority Health

Institute for Healthcare Improvement

Ohio Department of Medicaid

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

HRSA

Ohio Department of Health

The CMS Innovation Center

NIH National Institutes of Health
Turning Discovery Into Health

NSF National Science Foundation
WHERE DISCOVERIES BEGIN

Community Care Coordination – care coordination provided in the community; confirms connection to health and social services.

A Community Care Coordinator:

- Finds and engages at-risk individuals
- Comprehensive risk assessment
- Confirms connection to care
- Tracks and measures results

Family at Risk

Marisol, 28

- Pregnant
- Lost job
- Can’t pay rent

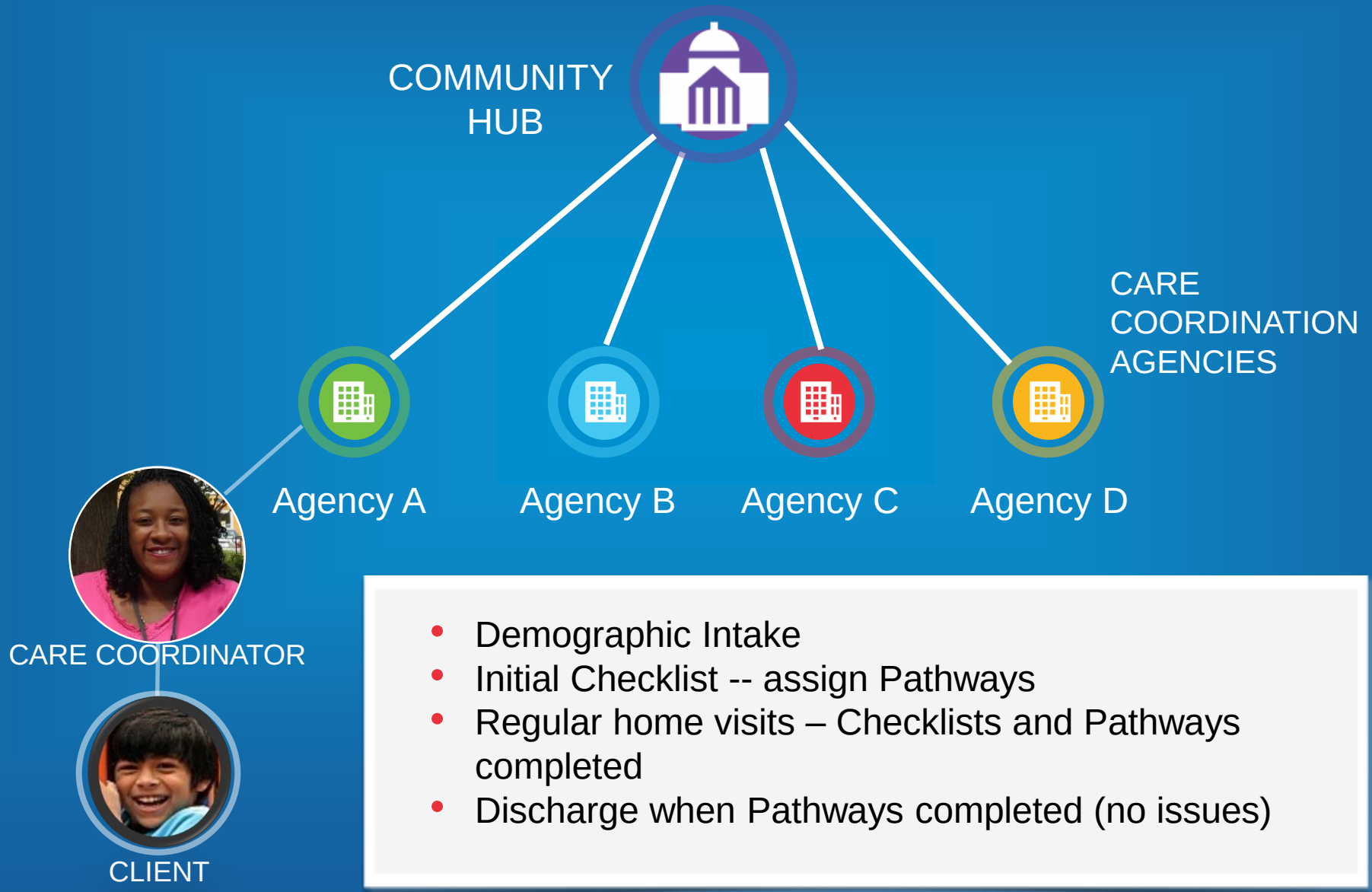
Marcus, 6

- 2 ED visits this month
- No asthma action plan
- Struggling at school

Mrs. Garcia, 50

- One bedroom apartment
- Type 2 Diabetes
- 1 ½ ppd Smoker

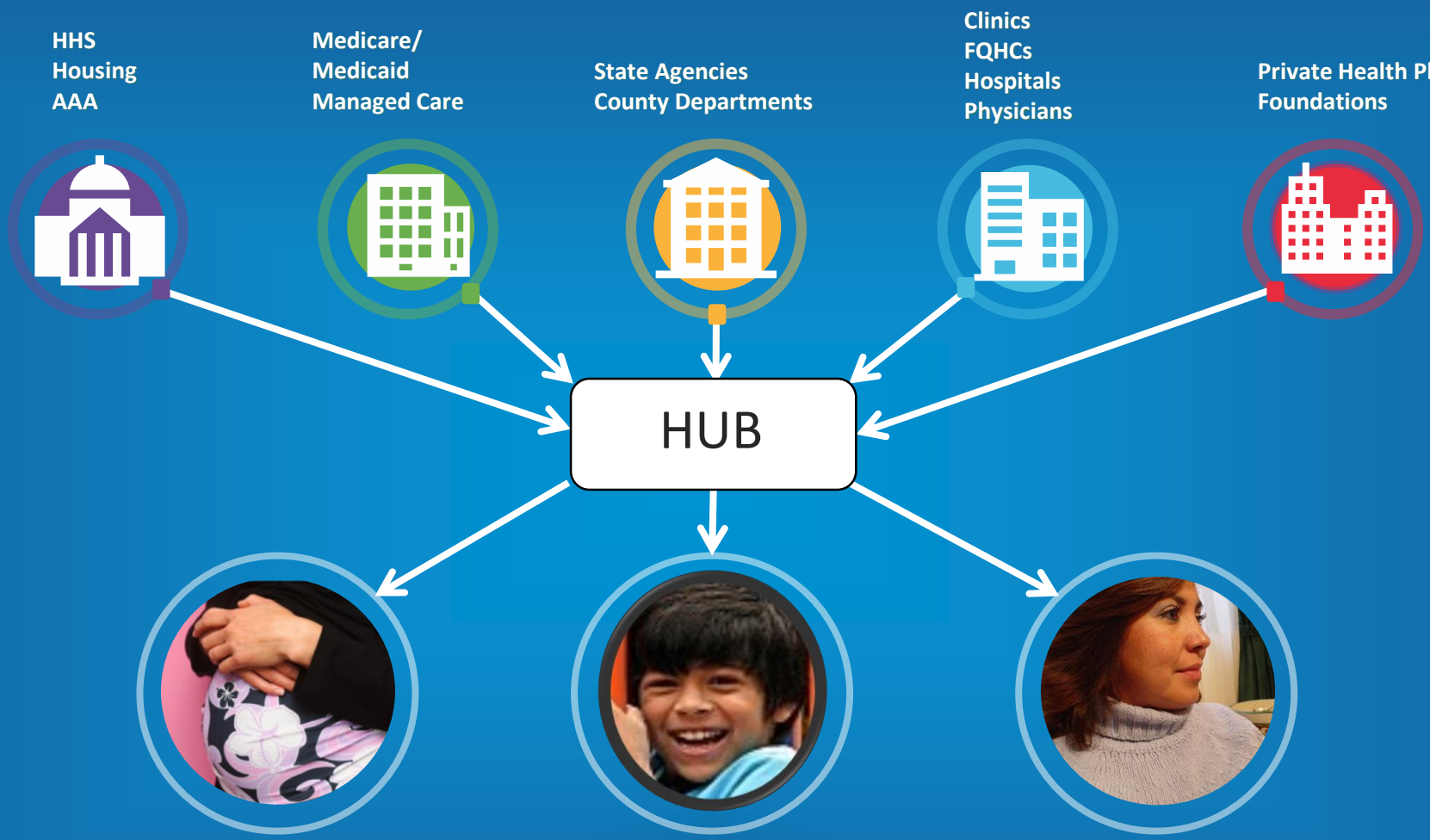
Regional Organization and Tracking of Care Coordination



- Demographic Intake
- Initial Checklist -- assign Pathways
- Regular home visits – Checklists and Pathways completed
- Discharge when Pathways completed (no issues)

20 Core Pathways – National Certification

- Adult Education
- Employment
- Health Insurance
- Housing
- Medical Home
- Medical Referral
- Medication Assessment
- Medication Management
- Smoking Cessation
- Social Service Referral
- Behavioral Referral
- Developmental Screening
- Developmental Referral
- Education
- Family Planning
- Immunization Screening
- Immunization Referral
- Lead Screening
- Pregnancy
- Postpartum



One Care Coordinator for the Entire Family

Measure

Track and Measure Progress with Pathways

By Community Care Coordinator

Name	Medical Home	Pregnancy	Social Service
CHW A	5	2	10
CHW B	1	3	4
CHW C	9	15	18

By Agency

Site	Medical Home	Pregnancy	Social Service
Agency A	50	25	22
Agency B	64	17	35
Agency C	40	32	19

- **Care Coordinator**
- **Agency**
- **HUB**
- **Community**
- **Region**
- **Etc…**

North Central Accountable Community of Health

North Central's Approach

- Workgroup formed in February 2018
- Contracted for Technical Assistance from:
  - Foundation for Health Generations – Kathy Burgoyne
  - Pathways Community HUB Institute – Dr. Sarah Redding
  - Care Coordination Systems – Bob Harnach
- NCACH elected not to be the HUB agency
- Request for Proposals currently open for HUB agency
  - Due April 27th

What's Next?

- Select
  - HUB Agency
  - Target Population
  - Target Outcomes
  - Initial location/geography
- Assess Current State Capacity
- Identify Care Coordination Agencies
- Develop a Referral System
- Develop Implementation Plan
  - Due September 30th

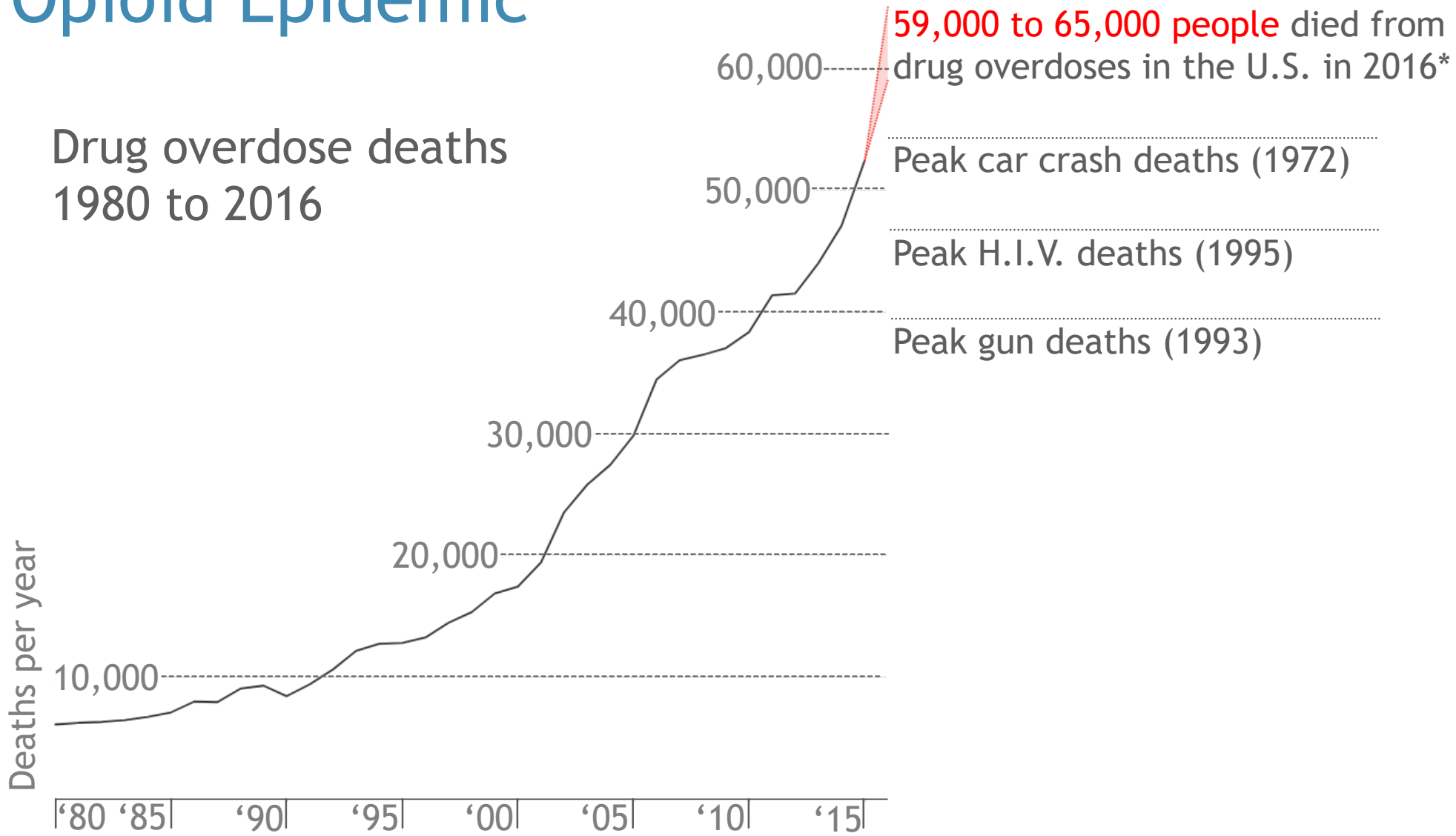
North Central Accountable Community of Health

Regional Opioid Workgroup

Malcolm Butler, Workgroup Chair | MD, CMO, Columbia Valley Community Health
Christal Eshelman, NCACH Staff Lead

Regional Opioid Workgroup meetings are open to the public!
Generally 3rd Friday of every month from 1PM – 2:30PM
Find more info at https://ncach.org/opioid-project/

The Opioid Epidemic



Source: *Adapted from the New York Times, Drug overdose deaths, 1980-2016.*

*Estimates based on preliminary data

Rapidly increasing mortality in middle-aged, lower-educated, whites

Case and Deaton, PNAS, 2015

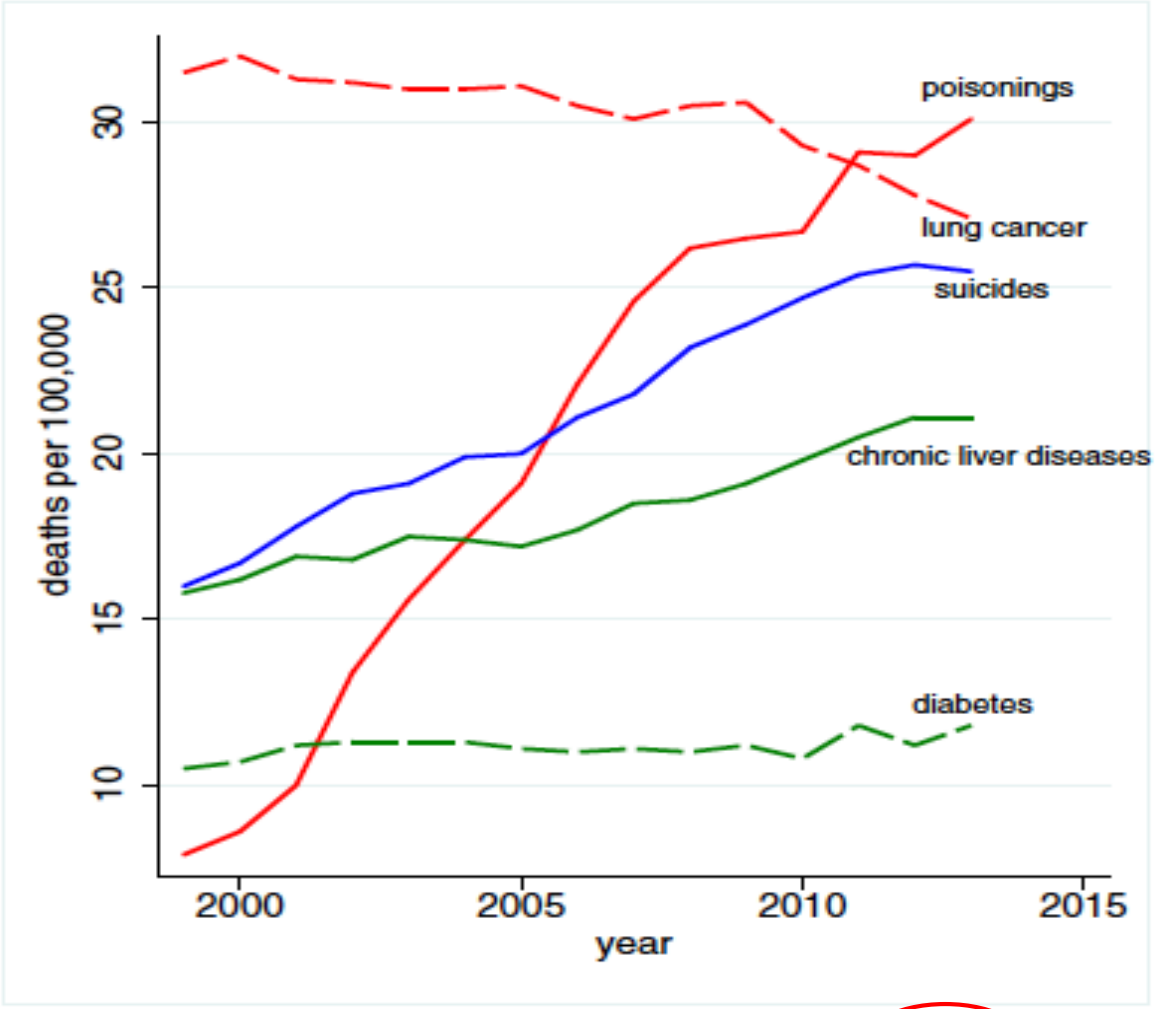
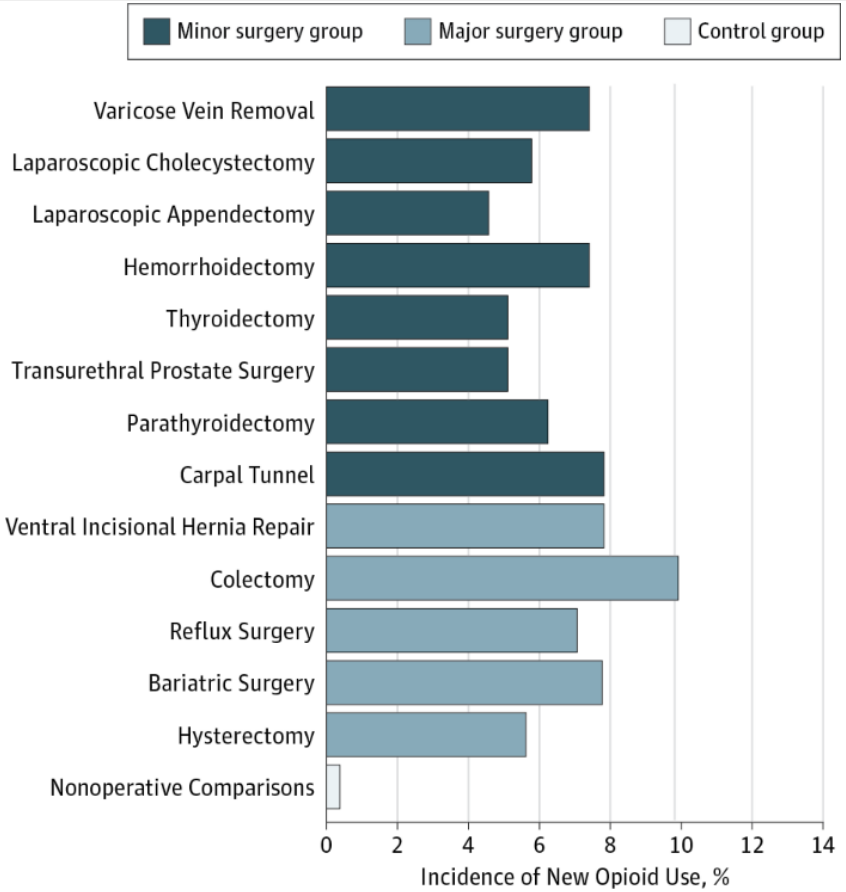


Fig. 2. Mortality by cause, white non-Hispanics ages 45–54.

Opioid Addiction – Generalizations healthcare providers should know

- 1:6 (16%) of humans appear hardwired toward addiction
- If you live on an iceberg, and are never exposed to your chemical, you won't ever get into trouble
- Prescribers MUST be sensitized that the volume of exposure we create correlates directly to the amount of opioid use disorder we must combat – we are complicit

From: **New Persistent Opioid Use After Minor and Major Surgical Procedures in US Adults**
JAMA Surg. 2017;152(6):e170504. doi:10.1001/jamasurg.2017.0504



Incidence of New Persistent Opioid Use by Surgical Condition.The incidence of new persistent opioid use was similar between the 2 groups (minor surgery, 5.9% vs major surgery, 6.5%; odds ratio, 1.12; SE, 0.06; 95% CI, 1.01-1.24). By comparison, the incidence in the nonoperative control group was only 0.4%.

Opioid Addiction – Generalizations healthcare providers should know

- 1:6 (16%) of humans appear hardwired toward addiction
- If you live on an iceberg, and are never exposed to your chemical, you won't ever get into trouble
- Prescribers MUST be sensitized that the volume of exposure we create correlates directly to the amount of opioid use disorder we must combat – we are complicit
- *"Clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids; 3 days or less will often be sufficient, more than 7 days will rarely be needed." – CDC*

Opioid Addiction – Generalizations healthcare providers should know

- The developing brain is at increased risk for addiction, thus extra caution is required prior to age 24.

Acute Opioid Prescribing in Youth by Specialty

Table 6: **Number of pills by specialty, youth age 14–19:** Means, medians, and selected quantiles of the number of tablets dispensed per prescription to children age 14–19 with acute opioid prescriptions between July 1 and December 31, 2015 ($N = 33{,}835$).

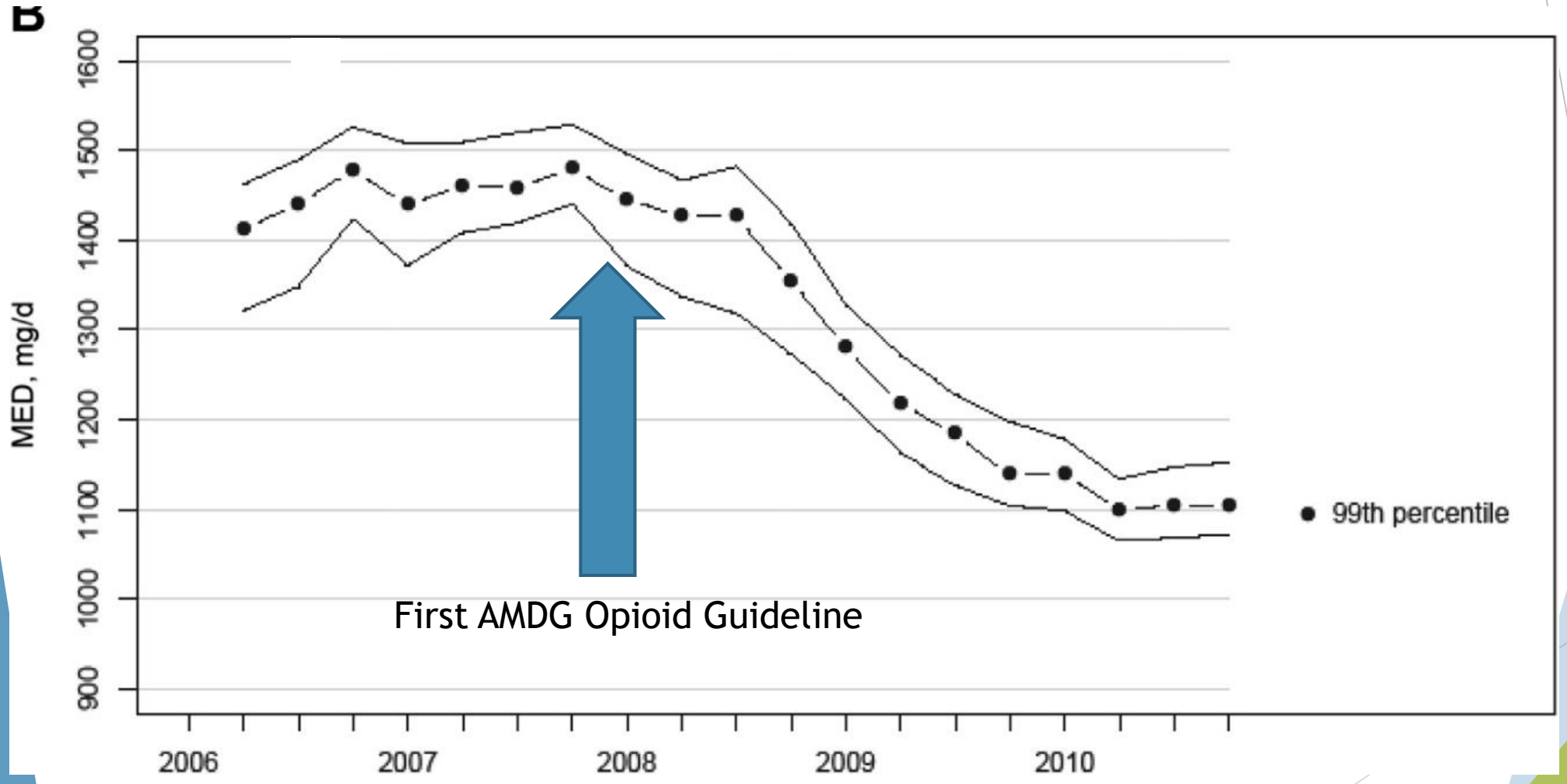
Provider specialty	N	mean	median	75th %tile	90th %tile	99th %tile
State Total	33,835	23.7	20.0	30.0	36.0	80.0
Dentist	13,345	22.3	20.0	30.0	30.0	40.0
Emergency Medicine	2,560	15.2	15.0	20.0	20.0	30.4
Family Medicine	1,295	20.6	20.0	25.0	30.0	60.9
Obstetrics & Gynecology	593	27.7	30.0	30.0	40.0	80.8
Oral & Maxillofacial Surgery	946	24.4	20.0	30.0	30.0	50.0
Orthopaedic Surgery	931	48.9	40.0	60.0	80.0	130.0
Otolaryngology	538	39.5	30.0	50.0	70.0	90.0
Pediatrics	475	18.9	16.0	24.0	30.0	60.0
Podiatrist	354	30.4	30.0	40.0	60.0	81.9
Student	385	22.7	20.0	20.0	40.0	90.0
Surgery	683	33.0	30.0	40.0	50.0	80.0
other	839	28.0	22.0	30.0	50.0	100.0
unknown	10,891	23.6	20.0	30.0	40.0	90.0

Source: DOH Prescription Monitoring Program Data

Opioid Addiction – Generalizations healthcare providers should know

- The developing brain is at increased risk for addiction, thus extra caution is required prior to age 24.
- Risk stratify everyone you might prescribe opioids to as high, moderate, or low risk for opioid misuse.
  - Thorough history, looking for personal or family history of addiction
  - History of emotional trauma (Adverse Childhood Events, PTSD)
  - Central Pain Syndromes (Fibromyalgia, chronic pelvic pain, chronic headache, chronic backache)
  - Query the Prescription Monitoring Program
- Read and understand the Washington State Guidelines
  - http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf
  - http://www.agencymeddirectors.wa.gov/Files/20171026FINALDentalOpioidRecommendations_Web.pdf

Average High Dose Opioid Volumes in Medicaid



Sullivan et al. J Pain 2016;17:561-8

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Medicaid Transformation: Opioid Project

- Addressing Opioid Use Disorder as a Public Health crisis
- Objective: Achieve the state's goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.

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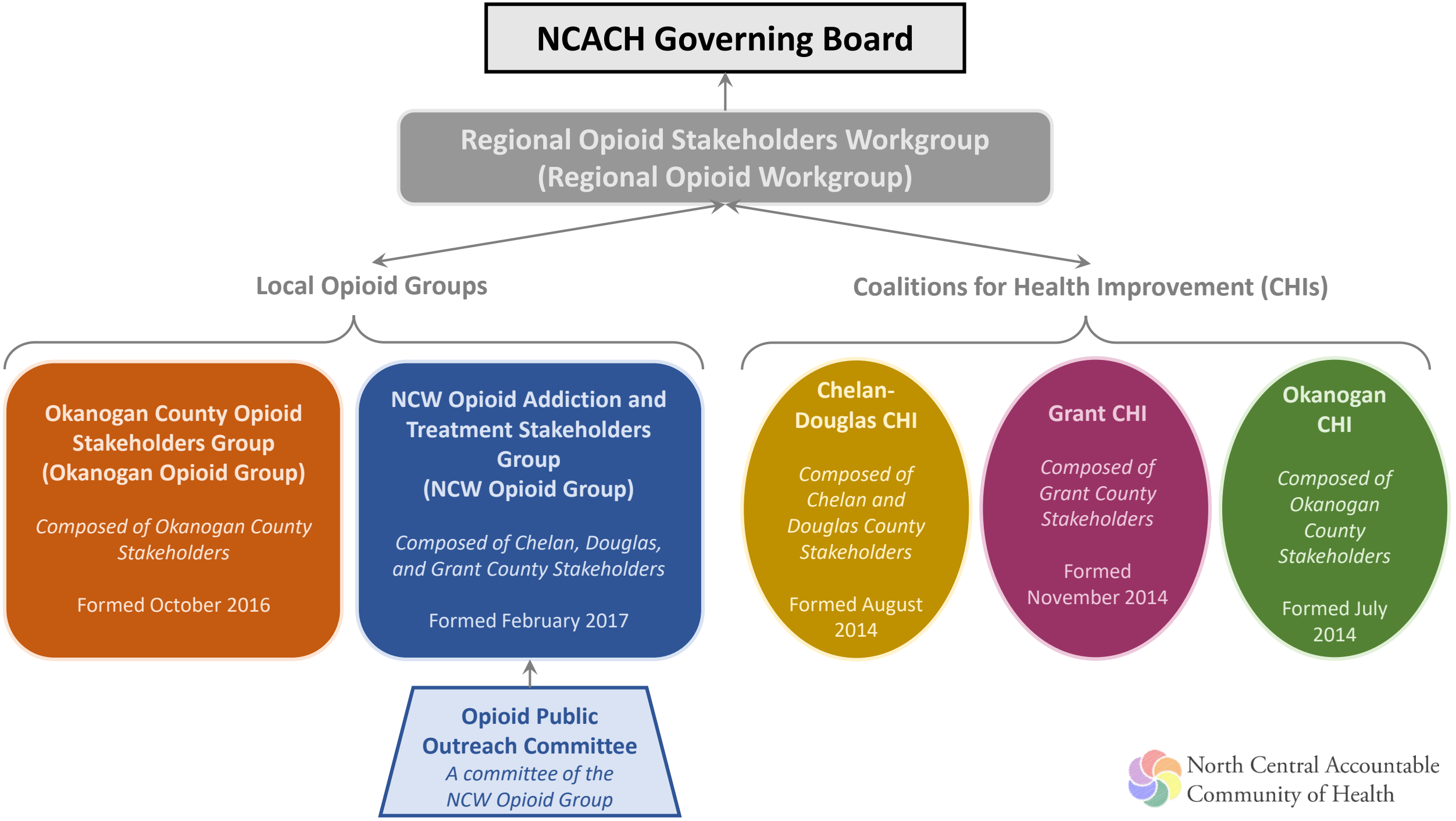
North Central's Approach

- Build off and supplement current work
  - Local Opioid Stakeholders Groups
  - Coalitions for Health Improvement


NCACH Governing Board
Regional Opioid Stakeholders Workgroup
(Regional Opioid Workgroup)
Local Opioid Groups
Coalitions for Health Improvement (CHIs)
Okanogan County Opioid Stakeholders Group (Okanogan Opioid Group)
Composed of Okanogan County Stakeholders
Formed October 2016
NCW Opioid Addiction and Treatment Stakeholders Group (NCW Opioid Group)
Composed of Chelan, Douglas, and Grant County Stakeholders
Formed February 2017
Opioid Public Outreach Committee
A committee of the NCW Opioid Group
Chelan-Douglas CHI
Composed of Chelan and Douglas County Stakeholders
Formed August 2014
Grant CHI
Composed of Grant County Stakeholders
Formed November 2014
Okanogan CHI
Composed of Okanogan County Stakeholders
Formed July 2014
North Central Accountable Community of Health

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North Central's Approach – cont'd

- Conduct a "current state" assessment
- Dovetail with the Whole Person Care Collaborative
  - Primary Care and Behavioral Health Providers
- Select priority approaches from the Medicaid Transformation Toolkit
  - Prevention, Treatment, Overdose Prevention, Long-term Recovery
- Fund partners through an application process
- Build, vet, and distribute the application

North Central Accountable Community of Health

Funding Process

- Rapid Cycle Application
  - Open now
  - Funding Period: July – December 2018
  - Total Funding Amount: $100,000
  - Award Amounts: $2,500 - $10,000

- Exploring additional funding options for 2019-2021

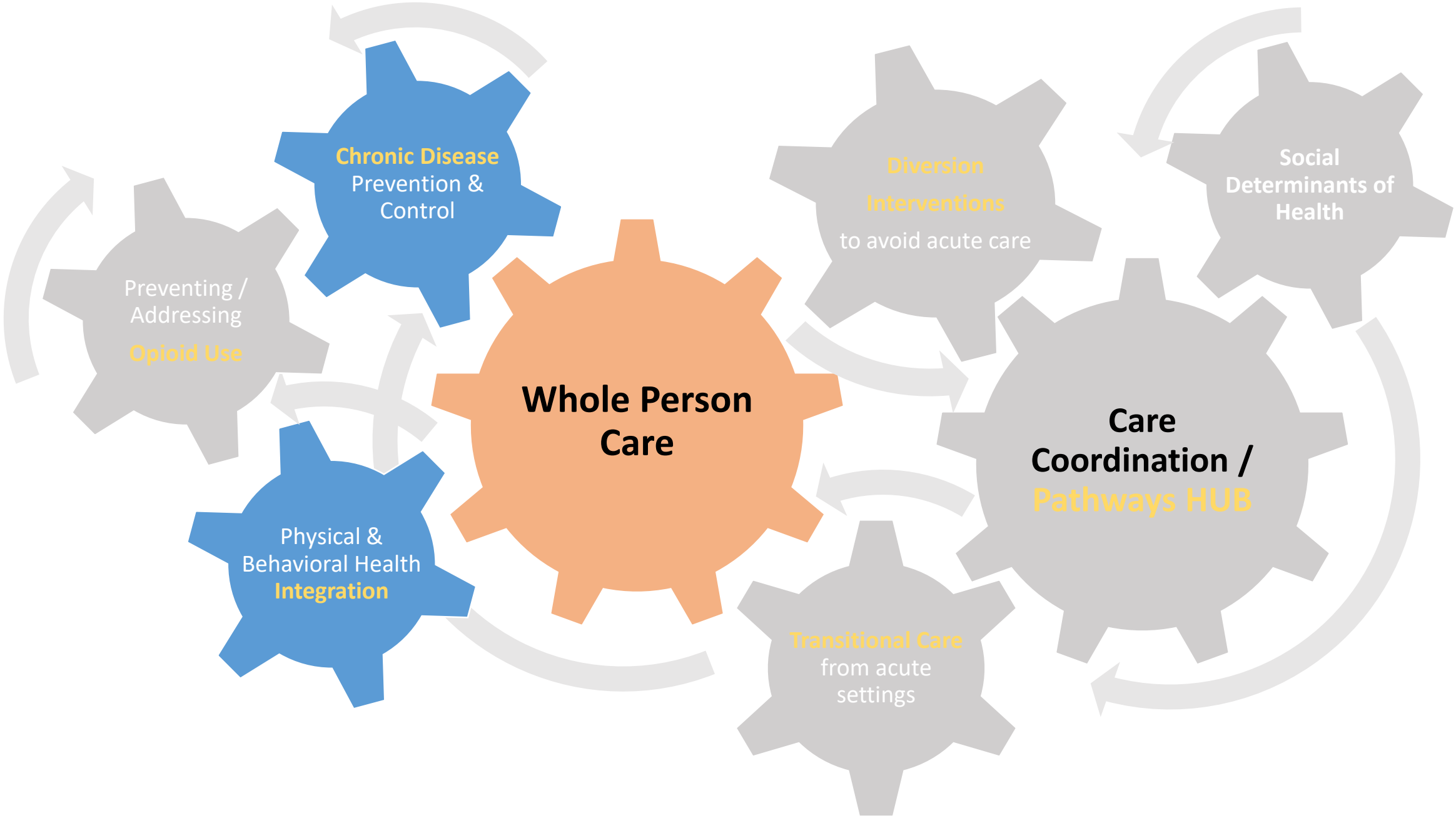
APPLY NOW!!!

RAPID CYCLE APPLICATION IS OPEN!!!

Completed applications due by 5:00pm on **May 11, 2018**

Download application at **www.ncach.org**

North Central Accountable Community of Health


Chronic Disease
Prevention &
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Transitional Care
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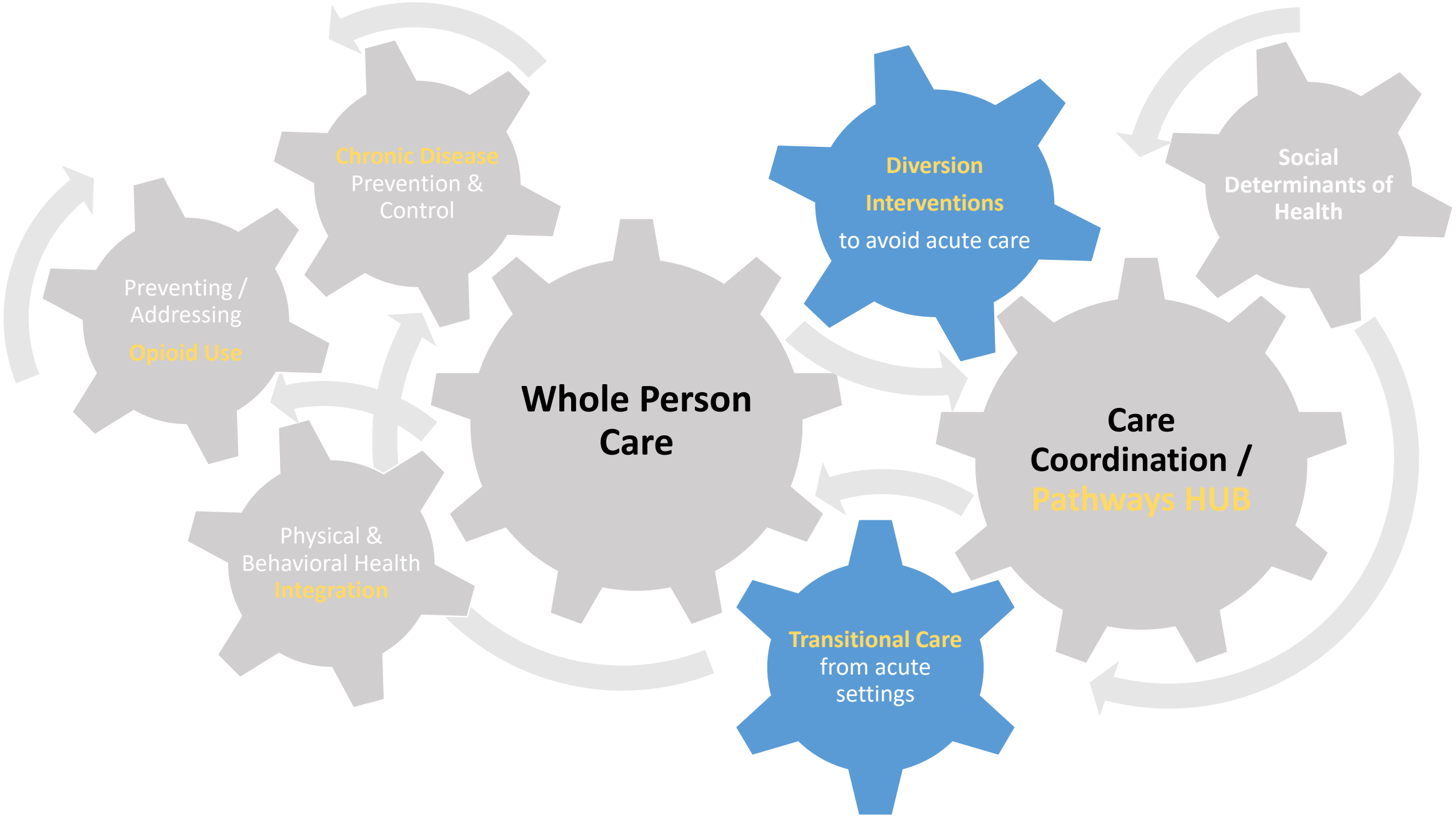
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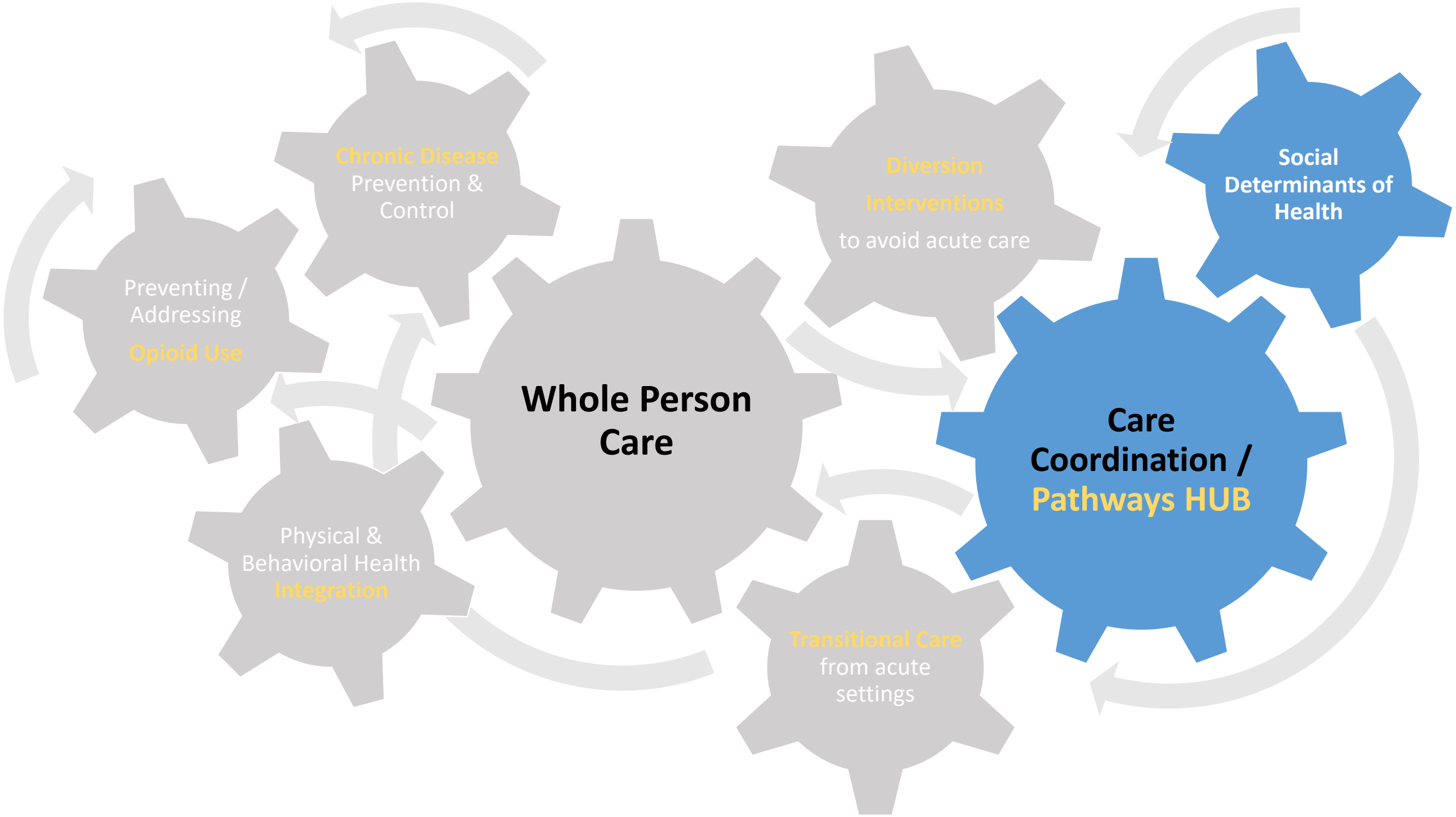
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Behavioral Health
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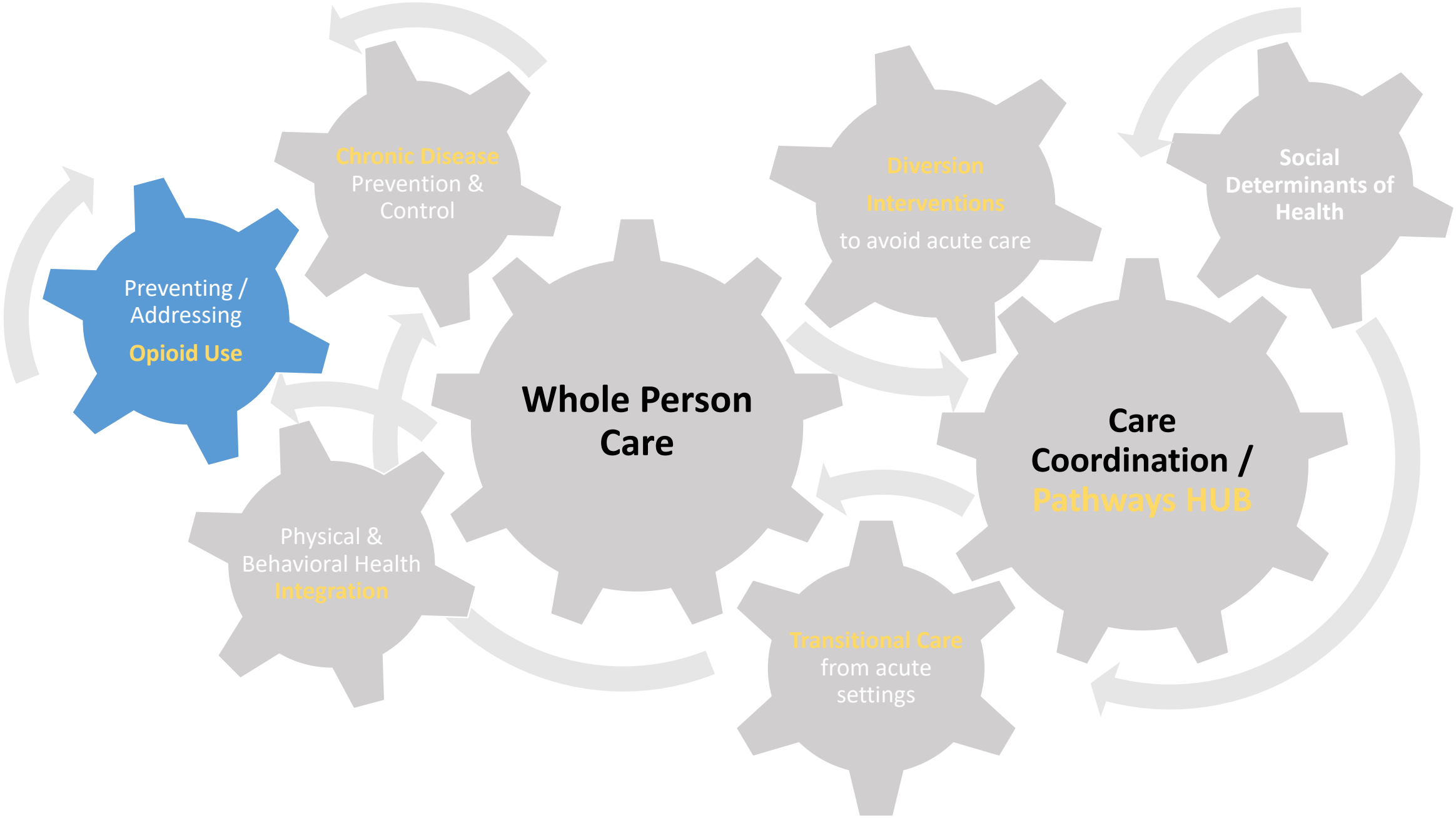
Transitional Care
from acute
settings


Preventing / Addressing Opioid Use
Chronic Disease Prevention & Control
Diversion Interventions to avoid acute care
Social Determinants of Health
Whole Person Care
Care Coordination / Pathways HUB
Physical & Behavioral Health Integration
Transitional Care from acute settings

How it all works….

Our goal is foster whole person care as guiding tenet in our work with regional partners to create healthcare systems that achieve the Triple Aim:

- Improve the patient experience of care
- Improve population health, and
- Reduce the per capita cost of health care

North Central Accountable Community of Health

North Central Accountable Community of Health

How can you get involved?

- Continue participating in your local Coalition for Health and encourage cross-sector participation
  - 2018 Coalitions for Health Improvement Annual Convening – June 2018
- Attend workgroup meetings
  - Meeting calendar can be found at: https://ncach.org/calendar/
- Apply to be a funded partner
  - Opioid Project Rapid Cycle Application – Due May 11th
  - Pathways Community HUB Lead Agency RFP – Due April 27th
- Connect and build relationships with implementation partners within your community (list will be available on NCACH website)
- Provide feedback to NCACH through surveys, forums, and public comment
- Promote education and awareness around services available for Medicaid beneficiaries, and the work of NCACH
  - If you are a social service provider, make sure your WIN211 profile is updated annually

North Central Accountable Community of Health

QUESTIONS?

North Central Accountable Community of Health

NCACH Workgroup Staff

NCACH Workgroup	Staff Leads
Whole Person Care Collaborative (WPCC)	Peter Morgan – peter.morgan@cdhd.wa.gov Caroline Tillier – caroline.tillier@cdhd.wa.gov
Care Coordination (Pathways Community HUB)	Christal Eshelman – christal.eshelman@cdhd.wa.gov
Transitional Care and Diversion Interventions (TCDI)	John Schapman – john.schapman@cdhd.wa.gov
Regional Opioid Stakeholders	Christal Eshelman – christal.eshelman@cdhd.wa.gov

Find the Pause, Awaken the Presence

Kari Lyons-Price, Meditate Wenatchee

OKANOGAN COUNTY HARM REDUCTION

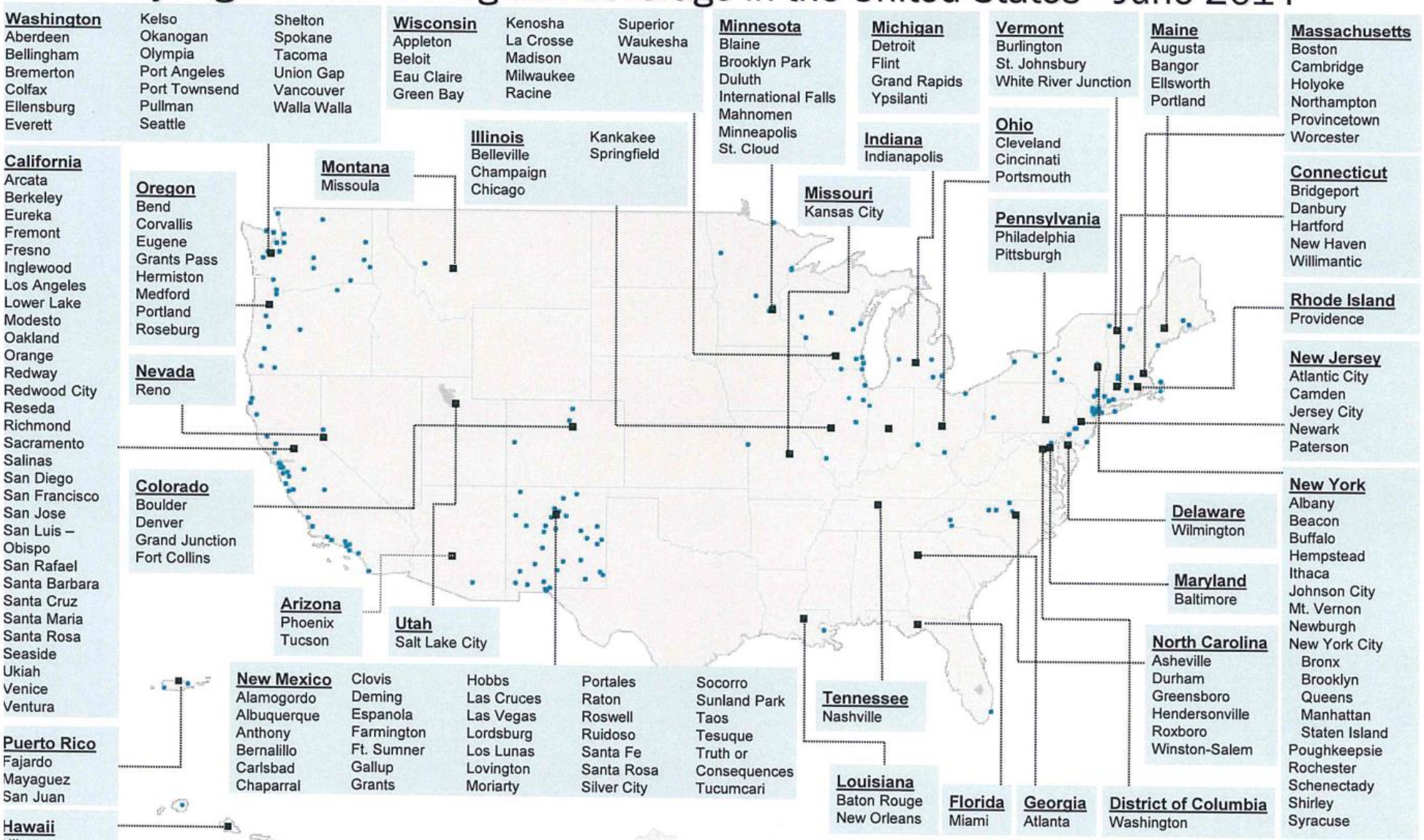
History of Harm Reduction Program

- 2005 HIV Case Management and prevention $$
- Conducted research, literature review, best practices for syringe exchange

- Met with Sheriff, City Police Chiefs

- 2006 started Harm Reduction, Syringe Exchange

Syringe Services Program Coverage in the United States –June 2014



Washington
Aberdeen
Bellingham
Bremerton
Colfax
Ellensburg
Everett
Kelso
Okanogan
Olympia
Port Angeles
Port Townsend
Pullman
Seattle
Shelton
Spokane
Tacoma
Union Gap
Vancouver
Walla Walla

Wisconsin
Appleton
Beloit
Eau Claire
Green Bay
Kenosha
La Crosse
Madison
Milwaukee
Racine
Superior
Waukesha
Wausau

Minnesota
Blaine
Brooklyn Park
Duluth
International Falls
Mahnomen
Minneapolis
St. Cloud

Michigan
Detroit
Flint
Grand Rapids
Ypsilanti

Vermont
Burlington
St. Johnsbury
White River Junction

Maine
Augusta
Bangor
Ellsworth
Portland

Massachusetts
Boston
Cambridge
Holyoke
Northampton
Provincetown
Worcester

California
Arcata
Berkeley
Eureka
Fremont
Fresno
Inglewood
Los Angeles
Lower Lake
Modesto
Oakland
Orange
Redway
Redwood City
Reseda
Richmond
Sacramento
Salinas
San Diego
San Francisco
San Jose
San Luis – Obispo
San Rafael
Santa Barbara
Santa Cruz
Santa Maria
Santa Rosa
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Oregon
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Hermiston
Medford
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Chicago
Kankakee
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Indianapolis

Ohio
Cleveland
Cincinnati
Portsmouth

Missouri
Kansas City

Pennsylvania
Philadelphia
Pittsburgh

Connecticut
Bridgeport
Danbury
Hartford
New Haven
Willimantic

Rhode Island
Providence

Nevada
Reno

New Jersey
Atlantic City
Camden
Jersey City
Newark
Paterson

Colorado
Boulder
Denver
Grand Junction
Fort Collins

Delaware
Wilmington

Maryland
Baltimore

New York
Albany
Beacon
Buffalo
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Ithaca
Johnson City
Mt. Vernon
Newburgh
New York City
Bronx
Brooklyn
Queens
Manhattan
Staten Island
Poughkeepsie
Rochester
Schenectady
Shirley
Syracuse

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Tucson

Utah
Salt Lake City

North Carolina
Asheville
Durham
Greensboro
Hendersonville
Roxboro
Winston-Salem

New Mexico
Alamogordo
Albuquerque
Anthony
Bernalillo
Carlsbad
Chaparral
Clovis
Deming
Espanola
Farmington
Ft. Sumner
Gallup
Grants
Hobbs
Las Cruces
Las Vegas
Lordsburg
Los Lunas
Lovington
Moriarty
Portales
Raton
Roswell
Ruidoso
Santa Fe
Santa Rosa
Silver City
Socorro
Sunland Park
Taos
Tesuque
Truth or Consequences
Tucumcari

Tennessee
Nashville

Puerto Rico
Fajardo
Mayaguez
San Juan

Louisiana
Baton Rouge
New Orleans

Florida
Miami

Georgia
Atlanta

District of Columbia
Washington

Hawaii
Hilo
Kauai
Kona
Maui
Oahu

Alaska
Anchorage
Fairbanks
Juneau

Syringe services programs (SSPs) serve as a safe, effective HIV prevention method for people who inject drugs (PWID) to exchange used syringes for sterile needles, thereby significantly lowering the risk of HIV transmission. Since the 1980s, SSPs in conjunction with other HIV prevention strategies have resulted in reductions of up to

This map was prepared by amfAR, The Foundation for AIDS

- From 2006-2012 injection drug users reported primarily Meth and Rx pain meds
- Shift in 2013 from Rx reporting to Heroin
- 2014-present seeing both Meth and Heroin

- 2015-Partnered with UW ADAI to provide Narcan overdose rescue kits
- 2016-Tracking Emergency Room overdoses
- Held Emergency Overdose Summit due to 42 overdoses
- Need ED's to report OD's to Public Health
- If not voluntarily, Health Officer can mandate

- OCPH Exchange Assessment includes the question:
- “What was the first substance you ever used? (like cigarettes or alcohol)
- We are seeing association with Heroin and early Pot use
- UW researching
- Jan-Mar 2018- 2 confirmed OD Deaths, 4 pending toxicology!!

Where do we go from here?

- http://stopoverdose.org/
- Mobile SEP's due to geography
  - Policy Brief
- Rural Research
- More treatment options including:
  - Peer Recovery/Support
  - Medical Detox
  - In-patient treatment
  - Oxford House model
  - MAT providers
  - **REDUCE STIGMA!!**

Support for Overdose Education and Narcan

- Good Samaritan-RCW 69.50.315 & Opioid Overdose Medication Law-RCW 69.41.095
-
- Policy statements- AMA, APHA
- CDC- MMWR on community based OD programs
- WA DOH Board of Pharmacy

Questions?

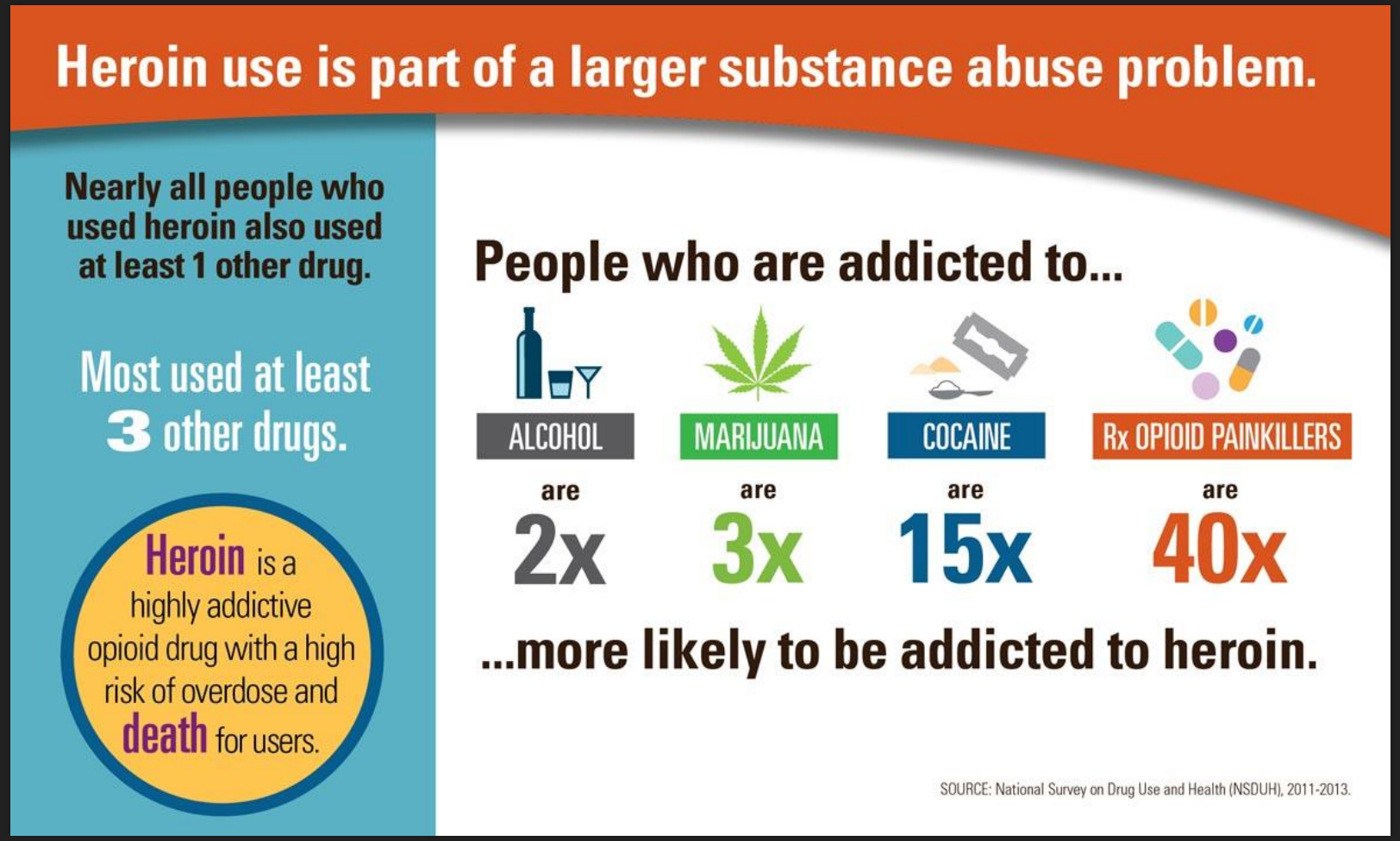
Syringe Service Program in Grant County

A Public Health Harm Reduction and Disease Prevention Strategy

A Grant County Health District Intervention

Facts

- In 2016, more people died of drug overdose than in the entire Vietnam War
- Opioids killed more people than guns or car accidents in 2016



Opioid Crisis, A Local Emergency

- 115 Americans a day die from opioid overdoses
  - Death rate due to heroin overdose more than doubled between 2012 and 2016 in the US
- About 2 people died per day in 2016 in Washington State
- 24 opioid deaths in Grant County, 2012-2016
  - 2012-2014 - 3 heroin attributable deaths

Opioid Crisis, a Local Emergency

- Heroin confiscation
- Needles discarded throughout the community
- Increased risk for heroin use
- Lives being saved by Naloxone in the community

What do we do?

- Washington State Opioid Response Plan, 4 Goals
  - Prevent opioid misuse and abuse.
  - Identify and treat opioid use disorder.
  - Prevent deaths from overdose.
  - Use data to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.

What do we do?

- Interventions in Grant County
  - Syringe Service Program
  - Opioid Communication Plan
  - Youth Prevention Activities
  - Recovery Models for Opioid Treatment
  - Medication Take Back
  - Law Enforcement – Carrying Naloxone and Confiscating Street Drugs

What is Harm Reduction?

- Reduce the harmful consequences of the risks we take.
- Examples:
  - Seatbelts, sunscreen, hard hats, condoms, not driving while intoxicated, life vests
- Emphasizes measurement of health, social, and economic outcomes, as opposed to drug abstinence

What is a Syringe Service Program?

- Evidence based harm reduction strategy for reducing the risk of illicit drug use
- Community Supported

What is a Syringe Service Program?

- Access to:
  - Sterile supplies for injection drug Education
  - Naloxone
  - HIV and STD testing
  - Hepatitis A and B vaccination
  - Condoms
  - Wound Care
- Referral or Linkage to:
  - Primary and behavioral healthcare
  - Substance use treatment
  - Social Services
  - Community Resources

Benefits of a Syringe Service Program

- Prevents HIV and HCV
- Protects the public and first responders
- Connects people with services
- Decreases drug use
  - Participants are 5 times more likely to enter drug treatment than none participants

Ultimate Goal in Grant County: Recovery

- Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

  -Substance Abuse and Mental Health Services Administration

Development of a Syringe Service Program for Grant County

- Health Officer Support
- Partners
  - Build community support
  - Contracts and MOUs

Development of a Syringe Service Program for Grant County

- Funding
- Communication Plan
- Outreach Plan
- Training for staff
- Evaluation

Implementation and Logistics of the Grant County SSP

- Mobile Syringe Services
- Opening May 2018

Implementation and Logistics of the Grant County SSP

- Access to:
  - Sterile supplies for injection drug Education
  - Naloxone
  - Condoms
  - Safe Injection Education
- Referral or Linkage to:
  - Primary and behavioral healthcare
  - Substance use treatment
  - Social Services
  - Community Resources
  - HIV/STD Testing
  - Vaccination

Quick Conversation!

- For:
  - Questions
  - To support the Syringe Service Program in Grant County
  - Or to share information that will help
  - Contact

Shawta Sackett

RNMPHEPI@GMAIL.COM

Reference

- Opiate Trends: https://adai.washington.edu/DBHR_EPI/deaths.htm https://www.cdc.gov/mmwr/volumes/66/wr/mm6643e1.htm?s_cid=mm6643e1_w https://www.cdc.gov/drugoverdose/epidemic/index.html https://www.cdc.gov/mmwr/volumes/66/wr/mm6643e1.htm
- Guidelines for Opioid Treatment Programs: https://store.samhsa.gov/shin/content//PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf https://www.hca.wa.gov/sites/default/files/billers-and-providers/Clinical-guidelines-coverage-limitations.pdf
- Harm Reduction: http://harmreductionactioncenter.org/ http://harmreduction.org/about-us/principles-of-harm-reduction/
- Recovery: https://store.samhsa.gov/shin/content//PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf https://www.hca.wa.gov/sites/default/files/billers-and-providers/Clinical-guidelines-coverage-limitations.pdf
- https://www.nbcnews.com/storyline/americas-heroin-epidemic/born-addicted-number-opioid-addicted-babies-soaring-n806346

Why Drug Courts?

Chelan County Superior Court Drug Court

Judge Kristin Ferrera

Why drug court?

- 63,600 estimated Americans died of a drug overdose in 2016.
- 2/3 of all fatal drug overdoses in the U.S. are due to opioids.
- 65% of all U.S. inmates have a substance use disorder.
- $80 billion is spent in the U.S. annually on incarceration.

From https://www.nadcp.org/treatmentcourts/

What is Drug Court?

From www.nadcp.org

- Judicially-supervised court dockets that strike balance between:
  - The need to protect community safety and the need to improve public health and well-being;
  - The need for treatment and the need to hold people accountable for their actions;
  - Hope and redemption on the one hand and good citizenship on the other.

What is Drug Court?

From www.nadcp.org

- Drug Courts keep nonviolent drug-addicted individuals in treatment for long periods of time, supervise them closely.
- Clients receive the treatment and other services they require to stay clean and to lead productive lives
  - But they are also held accountable by a judge for meeting their own obligations to society, themselves and their families.
- Clients expectation:
  - Regularly and randomly tested for drug use,
  - Required to appear in court for the judge to review their progress, and
  - Receive rewards for doing well and sanctions for not living up to their obligations.

What is Drug Court?

From www.nadcp.org

- The scientific community has concluded that Drug Courts work better than:
  - Jail or prison,
  - Probation, and
  - Treatment alone.
- Drug Courts significantly reduce drug use and crime and do it cheaper than any other justice strategy.
- The success of Drug Courts has led to new generations of problem-solving court programs that are successfully confronting emerging issues for our nation.
  - Veteran's Treatment Courts
  - Mental Health Courts
  - Family Treatment Courts

Drug Courts balance the need for treatment and the need for accountability.

From www.nadcp.org

- Drug Courts provide more comprehensive and closer supervision than other community-based programs, such as probation.
- Drug Courts are six times more likely to keep offenders in treatment long enough for them to get better.

Drug Courts--History

- The first drug court was founded in 1989 in Miami-Dade County, Florida by Judge Stanley Goldstein.
- Instead of putting addicted people behind bars, Judge Goldstein invited treatment providers into the courtroom to try a public health approach.
- Treatment providers developed evidence-based treatment plans and the judge—working as a team with law enforcement, probation, defense, and prosecution—provided the support and strict accountability necessary for the treatment plans to be successful.

From https://www.nadcp.org/treatmentcourts/

Drug Courts—Do they work?

- Do Drug Courts reduce recidivism?
- Are Drug Courts cost effective?
- Do Drug Courts reduce substance abuse and save lives?
- Where are Drug Courts in the United States?

Drug Court Study

- The National Institute of Justice's (NIJ) Multi-Site Adult Drug Court Evaluation (MADCE) was a multi-site, multi-year process, impact, and cost-benefit data collection, analysis, and reporting that required the collaboration of numerous individuals and organizations.
- Published in 2011

From https://www.ncjrs.gov/pdffiles1/nij/grants/237112.pdf

Drug Courts Reduce Recidivism—Study

- Drug court offenders significantly less likely than the comparison group to report engaging in any criminal behavior (28 percent vs. 40 percent);
- Drug court offenders averaged significantly fewer total instances of such behavior (12.8 vs. 34.1 criminal acts).
- Additional significant differences in the prevalence of drug-related, DWI/DUI, and property-related criminal behavior.

Drug Courts Reduce Recidivism—Study

- 2001 Columbia University's Nat'l Center on Addiction and Substance Abuse:
  - Study based on a review of 37 evaluations (updated 2000 study, 48 other evaluations)
  - Average recidivism rate for those who complete Drug Court is between 4% and 29%,
    - Compared to 48% for those who do not participate in a Drug Court program.
- Long-term evaluation of a Portland, Oregon Drug Court found that crime was reduced by 30% over 5 years, and effects on crime were still detectable 14 years from the time of arrest [Finigan, Carey & Cox, 2007]

Drug Courts Are Cost Effective

- Treatment courts produce benefits of $6,208 per participant, returning up to $27 for every $1 invested.
- Mean control group participant committed $16,887 worth of crime during the 18 months following study enrollment.
- Drug court participants, on average, committed only $7,111 worth of crime.
- Drug court resulted in $9,776 of victim crime costs prevented during the 18 months following program entry

From https://www.ncjrs.gov/pdffiles1/nij/grants/237112.pdf

Drug Courts Are Cost Effective

- Drug court reduced police arrest costs from $115 per individual to $44 per individual, for a savings of $71 per participant.
- Reduced costs of jails and prisons from $5,441 to $2,768.
  - Total savings in corrections in the 18 months following program entry of $2,673 per drug court participant.
  - Aggregating across savings from prevented crime, arrests, and incarceration, drug court produces, on average, $11,408 of benefits.
- Drug court participants cost society $11,206 to $13,102 during the 18 months observed behavior.
  - Those who do not receive drug court cost society $16,886 to $19,310 during the same period.
- **The difference in the social costs—the net benefits—is between $5,680 and $6,208**

From https://www.ncjrs.gov/pdffiles1/nij/grants/237112.pdf

Where are Drug Courts located?

- All 50 States.
- Throughout Washington State

Drug Courts Work

Results from National Institute of Justice's Multisite Adult Drug Court Evaluation found:

- Participants reported less criminal activity (40% vs. 53%) and had fewer rearrests (52% vs. 62%) than comparable offenders.
- Participants reported less drug use (56% vs. 76%) and were less likely to test positive (29% vs. 46%) than comparable offenders.
- Treatment investment costs were higher for participants, but with less recidivism, drug courts saved an average of $5,680 to $6,208 per offender overall.

Drug Court Success Factors

Several factors affect a drug court program's success:

- Proper assessment and treatment.
- The role assumed by the judge and the nature of offender interactions with the judge.
- Other variable influences such as drug use trends, staff turnover and resource allocation.

(From https://www.nij.gov/topics/courts/drug-courts/Pages/work.aspx)

Drug Courts Work

- With the right planning and execution, drug courts reduce recidivism and save court and community resources and cost.
- Most importantly, drug courts help those in our society who have struggled the most lead a better life.

JAIL MAT

(MEDICATION ASSISTED TREATMENT OF OPIOID USE DISORDER)

Columbia Valley Community Health

Malcolm Butler MD, CMO, Columbia Valley Community Health

Chelan County Regional Jail MAT Program

- Affiliation of:
  - Chelan County Regional Jail
  - Prosecuting Attorneys' offices
  - Columbia Valley Community Health
  - The Center for Alcohol and Drug Treatment
  - Department of Social and Health Services

Columbia Valley Community Health

The Problem

- Jails are "a target rich environment" for Opioid Use Disorder
  - Prosecuting Attorneys very aware of the "revolving door", and want to intervene
  - Jail staff are equally burdened by "redirection" away into jail instead of into treatment, and want to help
- Risk of accidental overdose is twelve fold higher than would be expected in matched controls*
  - Tolerance wanes leading to death with doses previously tolerated
- Incarceration is a time of forced abstinence, and often a sufficient "wake up call", to consider getting into treatment

*Binswanger IA, Nowels C, Corsi KF, et al. Return to drug use and overdose after release from prison: a qualitative study of risk and protective factors. *Addiction Science & Clinical Practice*. 2012;*7*(1):3. doi:10.1186/1940-0640-7-3.

Columbia Valley Community Health

How it works

Candidate Identified

- Prosecutors
- Jail staff
- Inmates (posters)

Behavioral Assessment

- Staff from the Center go to jail and evaluate
- If "good candidate" then sent for medical assessment

Medical Assessment

- Patient transported to CVCH
- If felt to be good candidate, Rx provided to Jail staff

DSHS Assessment

- "Preloads" system
- Allows rapid activation post release

At release

- Jail staff initiate MAT 2 days prior
- Release with 3 day supply

2 days after release

- f/u at DSHS
- f/u at CVCH
- f/u at the Center

Valley Health

Results

- Went live July 1st 2017
- 14 candidates identified, 11 behavioral assessments completed
- 4 eventually started on Suboxone
- 5 have entered into treatment at the Center
- Still very much a work in progress!

Columbia Valley Community Health

Obstacles and other Thoughts

- Regional Jail vs. State Prison
  - The Jail has contracted medical services
  - Jail must pay for all medical care, misaligned incentive
  - Release dates unclear and unpredictable
  - Period of incarceration often short – need at least 30 days
- Larger centers have capacity to initiate Suboxone at entry (avoids withdrawal), continue through incarceration, but no ability to follow up
- Use of Suboxone inside the Jail is problematic, hard to manage
- Sub-dermal or injectable forms of buprenorphine may be better in the Jail once available.

Columbia Valley Community Health

QUESTIONS ?

Columbia Valley Community Health

Community Formation Process – Consensus-Driven Engagement Model

Joseph Garcia, South Seattle College, King County Community Partnership for Transition Solutions

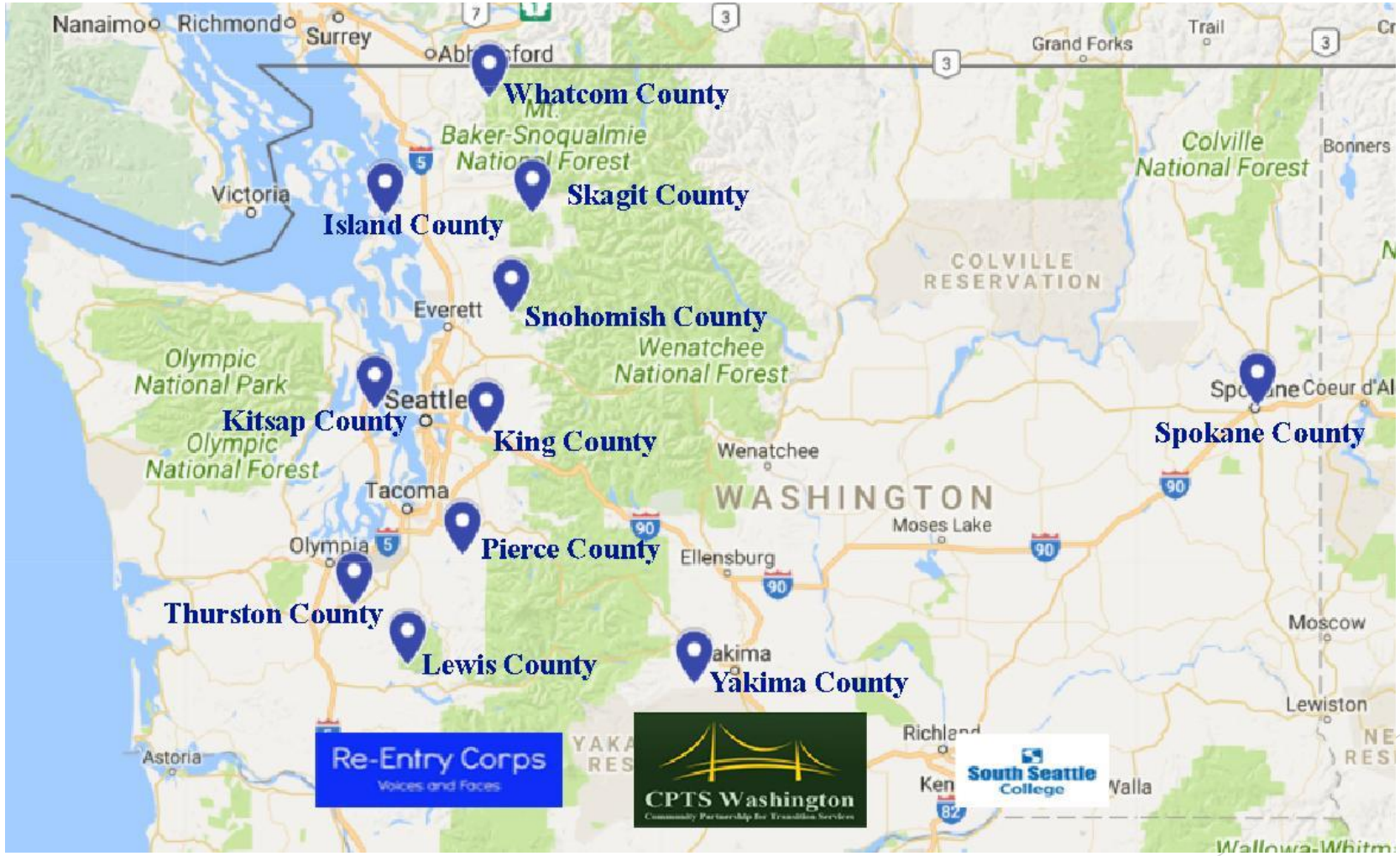
NCACH Annual Summit, April 20, 2018

Regional Community Partnership for Transition Solutions

- **Vision/Value Statement**: To build a community that takes into consideration the talents and contributions of ALL its members, including individuals who are in transition from prison & jail back to their community and families. We aspire to join those in their life changing and defining TRANSITION as they integrate into society through a holistic and comprehensive set of services and support, which will allow them to build and lead more self-sufficient and productive lives. (William A. Ramos)

- **Purpose Driven Mission**: To translate our vision and values through a series of purpose driven community venues that support successful transition for individuals who have earned their return back to the community and their families.

Community Partnership for Transition Solutions, Washington



Re-entry Corps: Voices & Faces

The **Reentry Corps** are advocates who have completed their transition from prisons/jails successfully. Our members consist of former Justice Involved consumers and family members who are supportive of our commitment to "paying it forward" to the community.

Our Advocacy Mission:

- Plug into the network of Community Care Teams - the Archdiocese of Seattle Criminal Justice Ministry, Reentry Ministry, St. Vincent de Paul's 2nd Chance initiatives, Rice Bowl, Campaign for Human Development, Catholic Community Services, Tzu Chi Foundation, 4D and inter-faith Inside/Out teams.
- Lead by example
- Conduct speaking engagements, inside and outside of prisons/jails
- Create a platform for positive testimonials and peer support
- Educate through a proven body of evidence based processes, i.e., Life Skills-To-Work; Breaking Barriers, Moral Reconation Therapy (MRT), and Offender Change Programs

Re-entry Corps, continued

- **Currently**
- Providing Peer Advising to adults in transition from prison & jail
- Providing students with solutions to support their post-secondary education & training needs
- Identifying community partners, start-up investors and applying for appropriate grants

- **Key Points to Take Away**
- Additional dedicated reentry/transition peers to assist in navigating community solutions
- Friend & Fund raising and 2nd Chance Scholarships
- Assistance from community volunteers in form of Advisors, coaches and navigators
- Spread the word by following us on Facebook and Twitter @recseattle
- Forward friends in search of solutions to reentrycorps.org

Transition Navigator Focus – South Seattle College

Learn-to-Learn and Learn-to-Earn!

- The Transition Navigator process provides students with the Learn-to-Learn and Cognitive Behavior skill-sets needed for successful transition from prison and jail back to the community. The focus will emphasize practical skill-sets, assessment tools and application for successful education, training, employment and family reintegration student outcomes.

- ***Rapid Response PREP/GO2WORK*:** Focus with 2nd Chance Employers
- **Solutions for Transitioning Parents (STP):** Family Connections & Child Support
- **College Options – Pathways 2 Careers:** Consultation and planning
- ***4WORK*:** Transitions Solutions
- **GED:** assessment, preparation and testing-to-completion
- Saturdays, 8:15 am – 2:50 pm

Department of Corrections
WASHINGTON STATE

kccpts.org

Re-Entry Corps
Voices and Faces

2018 – 5th Bi-Annual Una Platica: Trauma-2-Resiliency, A New Approach

Your partnerships in assisting returning justice involved consumers in creating second-chance opportunities in their transition back to their communities and families is invaluable and we thank you in advance. Our Una Platica events are user friendly, engaging and please bring any informational materials that can benefit this adult population and those that serve these adults.

- Friday, May 4, 2018
- Omak, Washington – 12 Tribes Resort Casino
- Register by April 27, 2018
- More info on your NCACH thumbdrive

Regional Community Partnerships for Transition Solutions Meetings

King County http://www.kccpts.org info@kccpts.org	3rd Friday of the month 12:15pm – 1:15pm	New Holly Learning Center 7058 32nd Ave S, 2nd Floor Seattle, WA 98118
Kitsap County Port Gamble S'Klallam Tribe Lauriedawson@sent.com jmcfeat@pgst.nsn.us	Last Friday of the month 11:00am – 1:00pm	West Sound Treatment Center 1415 Lumsden Rd Port Orchard, WA 98367 360-876-9430
Lewis County cpts.lewis.county@gmail.com	3rd Thursday of the month 1:30pm – 3:00pm	Varies
Pierce County http://www.cpts.info/pierce_cpts.aspx PierceCPTS@gmail.com	1st Friday of the month 10:00am -12:00pm	Bates Technical College Clyde Hupp Board Room 331 1105 S Yakima Ave Tacoma, WA 98402
Thurston County spcpts@gmail.com	4th Friday of the month 10:00am – 12:00pm	WorkSource 1570 Irving St SW Tumwater, WA 98512
Whatcom County goerkeaa@dshs.wa.gov	4th Tuesday of the month 1:30pm	Whatcom Community College 237 W Kellogg Rd Bellingham, WA 98226
Yakima County cptsyakima@gmail.com	4th Tuesday of the month 1:30pm – 3:00pm	Varies
Skagit-Island Counties skagitislandcpts@gmail.com	February 15, 2018 Dates/ Time TBD	Skagit Valley College Multipurpose Room 2405 E College Way Mount Vernon, WA 98273
Snohomish County CPTSSnoCo@outlook.com	2nd Friday of the month 1:30pm – 3:00pm	Goodwill Training and Education Center 210 SW Everett Mall Way, Suite D Everett, WA 98204
Spokane County jbpace@DOC1.WA.GOV	2nd Tuesday of the month 2:00pm – 4:00pm	Spokane Neighborhood Action Partners 3102 W Fort George Wright Dr Spokane, WA 99224

Joseph Garcia

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Kccpts.org