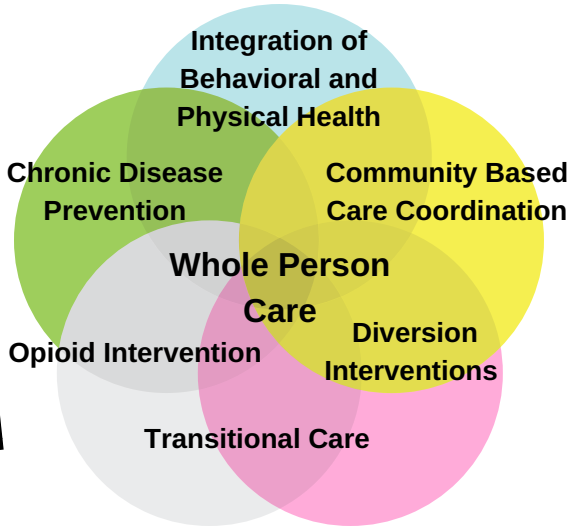
North Central Accountable Community of Health

Who We Are

We are a local group of community leaders who are focused on health, policy, and data-driven approaches. We use **collaborative partnerships** and **innovative solutions** to improve the health of our communities as a part of the state's *Healthier Washington Medicaid Transformation*. Our goal is to activate Medicaid beneficiaries, health and social service providers, payers, and other community members to join in **building a healthier region together.**

Through a five-year demonstration, NCACH is implementing 6 projects to address regional health priorities and improve care by providing high-quality, cost-effective care that treats the whole person.



Whole Person Care more effectively connects patients with resources outside the clinic which help address health-related social issues such as housing, education, and other social determinants of health. Whole Person Care also eliminates the divide between behavioral health and medical care.

Together, we are changing health care in North Central Washington.

200 Valley Mall Parkway | East Wenatchee, WA 98802
509-886-6400 | **info@ncach.org**

North Central Accountable Community of Health

Selected Transformation Projects

Bi-Directional Integration

Address physical and behavioral health needs in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This project will support and advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through Managed Care Organizations, for people enrolled in Medicaid to address the whole person.

Community-Based Care Coordination

Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health. This will rely on the development of the Pathways HUB infrastructure which will coordinate care coordinators and allow current care coordinators to provide more effective and efficient care coordination.

Transitional Care

Improve transitional care services of Medicaid beneficiaries moving from intensive medical care or institutional settings. This includes those discharged from acute care to home or to supportive housing, those with serious mental illness discharged from inpatient care, or client returning to the community from prison or jail. Improvement in these services will lead to a reduction in avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place

Diversion Interventions

Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations. Strategies will be targeted at Medicaid beneficiaries presenting at the Emergency Department for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergency condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.

Addressing Opioid Use Public Health Crisis

Reduce opioid-related morbidity and mortality through strategies that target prevention of opioid misuse and abuse, treatment of opioid use disorder, overdose prevention interventions, long-term recovery, and whole-person care.

Chronic Disease Prevention and Control

Improve chronic disease management and control by using the Chronic Care Model. The Chronic Care Model is an organizational approach to caring for people with chronic disease in a primary care setting. The CCM identifies essential elements of a health care system that encourage high-quality chronic disease care: the community; the health system; self-management support; delivery system design; decision support, and clinical information systems.