

## SECTION I: ACH-LEVEL

<b>ACH</b>	North Central Accountable Community of Health
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### Regional Health Needs Inventory

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

North Central Accountable Community of Health (NCACH) used data to assess regional health needs, assets, and disparities, to select projects and preliminary target populations, to engage partners and providers, to inform strategic direction, to prioritize focus areas, and to identify key questions or gaps that need to be addressed in project planning and implementation. NCACH staff have presented data to its various governance committees and groups to inform planning and decisions. The NCACH governance structure includes multiple committees and workgroups to guide planning and decision making. Key groups and committees include: the Governing Board, the Whole Person Care Collaborative (WPCC), Coalitions for Health Improvement (CHIs), (representing each local health jurisdiction: Chelan-Douglas, Okanogan, and Grant), the Transitional Care and Diversion Interventions Workgroup, and the Regional Opioid Workgroup. A Pathways Community HUB Workgroup will be convened once NCACH clarifies engagement of outside contractors involved in the HUB implementation in Washington State.

The region has used data extensively to examine project toolkit measures, including potential earnings, alignment across toolkit projects, and alignment with other statewide and regional performance measurement efforts. For example, NCACH developed proxy improvement targets for pay-for-performance measures and estimated the number of events or individuals that needed to be counted in the numerator for a measure to reach those targets by using the Health Care Authority's (HCA) Historical Data file for toolkit measures, draft methodology from HCA, and National Committee for Quality Assurance (NCQA) Medicaid 90<sup>th</sup> percentile benchmarks. This preliminary proxy information is being used by NCACH staff and may be shared with committees and workgroups to help refine target populations and project approaches and strategies when HCA finalizes the improvement methodologies for project measures

NCACH has leveraged data partnerships with multiple stakeholder groups. In October 2017, our staff initiated monthly meetings with the MCOs in the region (Amerigroup, Molina, and Coordinated Care), providing a forum to address data-related issues, such as measure alignment, Value-Based Payments (VBP), Fully-Integrated Managed Care (FIMC) implementation, and data sharing. The ACH collaborates regularly with local health jurisdictions (LHJs), particularly the Chelan-Douglas Health District, which serves as a backbone organization for the ACH via a hosting services agreement. NCACH staff will reach out to quality improvement and evaluation staff from partnering providers starting in 2018, while also leveraging the expertise of our workgroup members and our contractors at the Center for Outcomes Research and Education (CORE), to support data and analytic needs of the ACH. This includes developing a regional data strategy, identifying data needs and gaps, selecting regional quality improvement metrics, and recommending solutions to meet our regional tracking and reporting needs. NCACH in

partnership with CORE will compile the information gathered from our partners, develop an overall ACH data strategy, and create a recommendation of potential data solutions. And finally, NCACH staff have collaborated with data leads from other ACHs including Greater Columbia, King County, Southwest Washington, North Sound, Olympic, and Pierce County. Cross-ACH partnerships have been useful to align strategies, share learnings, and identify priorities.

As project planning, design, and implementation continues, NCACH will continue to use data to drive decisions. Some key uses of data will include:

- Refining target populations and key partners for piloting or testing project strategies
- Identifying partners and providers
- Estimating project impact and assessing the viability of project strategies
- Identifying barriers in implementation as well as success and learnings that can be shared among partners
- Identifying opportunities to spread and scale projects
- Monitoring progress toward partner, regional, and statewide goals
- Evaluating the progress and impact of project activities

**Describe the data sources the ACH has acquired or gathered to inform its decision-making, noting where data were provided by partnering providers (Managed Care Organizations (MCOs), providers, Community Based Organizations (CBOs), etc.).**

NCACH has leveraged a variety of data sources to inform decision-making, project and target population selection, and regional assessment. The ACH has worked closely with its Regional Coordinator, data consultant (CORE), local health jurisdiction, and HCA Analytics, Interoperability, and Measurement (AIM) Team liaison to identify, procure, analyze, and interpret data from a variety of data sources. Key data sources have included HCA AIM data products (such as the Regional Health Needs Inventory (RHNI) Starter Kit, Provider Report, and Historical Data), Department of Social and Health Services (DSHS) Research and Data Analysis division data products (including ACH Profile and Measure Decomposition), Comprehensive Hospital Abstract Reporting System (CHARS) data, Office of Financial Management population data, and a variety of other sources. Community partners and local health jurisdictions have shared chronic conditions reports, housing survey results, and survey results from the Together for Youth Survey (an annual survey looking at health and social issues for youth).

One key data source for NCACH has been the 2016 Chelan-Douglas Health District Community Health Needs Assessment (CHNA), which was conducted for the entire NCACH region and completed in December 2016. For this assessment, the region fielded a community voice survey to

#### **Community Voice Survey Key Questions and Responses**

*What do you think are the three most important factors that will improve the quality of life in your community?*

1. Improved access to mental health care
2. Healthy economy
3. Good jobs

*What do you think are the three most important "health problems" that impact your community?*

1. Mental health problems
2. Overweight/obesity
3. Access to health care

*What do you think are the three most important "unhealthy behaviors" seen in your community?*

1. Drug abuse
2. Alcohol abuse
3. Poor eating habits

gather feedback from stakeholders across multiple sectors. The survey had 169 participants and asked a number of questions about community health priorities, needs, and strengths. The survey helped identify community priorities through responses to key questions (see side bar).

NCACH collected information from stakeholders in person and through via email and in-person meetings to inform planning and decisions. The region's three local Coalitions for Health Improvement (CHIs) have been instrumental in supporting NCACH in providing feedback from stakeholders on project selection and planning. For example, through a "shift and share" format at a recent Chelan-Douglas CHI meeting (where breakout groups rotated through four different stations focused on our selected projects), CHI members provided feedback on target populations for project planning. This kind of community input is a rich source of qualitative data; staff can pull out key themes, and synthesize results to share with decision-making bodies. NCACH also conducted another short survey during three outreach events in August and September 2017 to collect additional information about regional priorities, by asking community members what they felt was the biggest health concern in the region.

**Provide a high-level summary of the region's health needs relevant to Demonstration project planning. Highlight key sub-regions or sub-population groups if/as appropriate. For each identified topic, cite the data sources and the processes/methods used:**

As described above, NCACH partnered with CORE to analyze multiple data sources to better understand the region's health needs, including the use of data software programs such as Tableau and reviewing the data using various graphs and tables such as pivot tables. Working with our partners, other community stakeholders, and CORE to review qualitative and quantitative data, we have a strong understanding of our region's health needs.



### Summary of Regional Health Needs

North Central Accountable Community of Health (NCACH) includes four counties: Chelan, Douglas, Grant, and Okanogan. The geography of the area is diverse. It includes the eastern side of the Cascade Mountain range, and many lakes. The Columbia River runs through the region, dividing Chelan and Douglas counties. The major industries in the region are agriculture, livestock ranching, and tourism, with outdoor recreation being a big draw for tourists<sup>1</sup>. Part of the Colville Native American Reservation overlaps with Okanogan County.

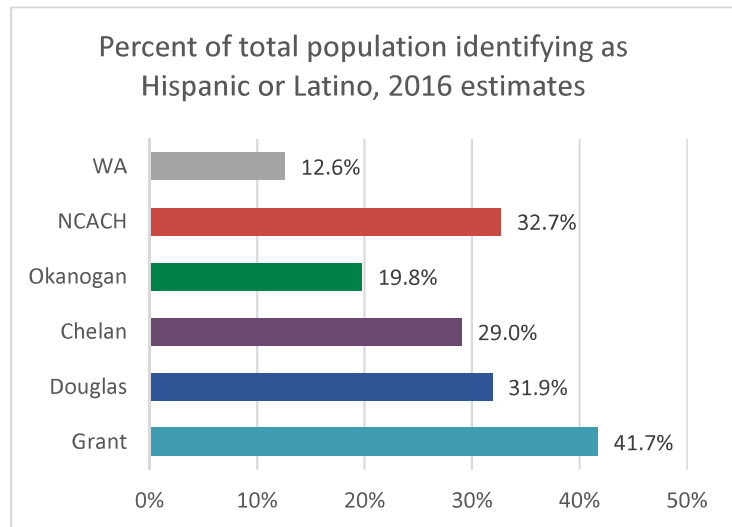
The NCACH region is overwhelmingly rural, with an estimated population of 255,990, or 3.5% of the total population of Washington State in 2017<sup>2</sup>. The region is geographically large, covering 12,684 square miles. It is sparsely populated, with 19.4 people per square mile, compared with the state average of 101.2 per square mile<sup>3</sup>. The highest population density is in the greater Wenatchee area in Chelan and Douglas counties and Moses Lake in Grant County. Because the region is sparsely populated,

<sup>1</sup> Employment Security Department, County Labor Profiles: <https://esd.wa.gov/labormarketinfo/county-profiles>

<sup>2</sup> WA State Office of Financial Management, 2017 population estimates: <http://www.ofm.wa.gov/pop/april1/>

<sup>3</sup> Chelan-Douglas Health District, 2016 Community Health Needs Assessment: <http://www.cdhd.wa.gov/Health%20Data/HealthData.aspx>

residents often have to travel long distances to receive health care. According to 2016 data from the Washington State Office of Financial Management, more than half (54.5%) of the population are adults ages 20-64, about 28% of the population is age 19 and younger, and 17% is older adults ages 65+<sup>4</sup>. In addition, a greater proportion of residents in the NCACH region are white (91.7%) compared with the state average (80.4%). Okanogan County has a large Native American/Alaskan Native population, comprising 12.6% of the population, compared with around 2% in the other NCACH counties.<sup>5</sup> About a third of the population identifies as Hispanic, though this trend varies by county.



**Source:** Washington State Office of Financial Management, 2016 population estimates

NCACH has high rates of individuals who lack health insurance coverage. Medicaid expansion helped uninsured rates decrease across the state, and in 2015, 5.8% of Washington State residents were uninsured across the state (compared to 8.2% in 2014)<sup>6</sup>. Specific to our four-county region, uninsured rates ranged from 6.4% in Douglas and Chelan counties to 12.0% in Grant County (the second highest uninsured rate in Washington State).

The region faces economic challenges. The annual median household income for all counties in the NCACH region are below the state average of \$64,000, ranging from \$41,800 in Okanogan County to \$53,600 in Chelan County<sup>7</sup>. All counties in the region have higher rates of childhood poverty than the state average of 16%; Chelan has the lowest childhood poverty rate at 18%, while Okanogan is highest at 28%<sup>8</sup>.

The region has high rates of incarceration. In 2015, NCACH counties had an average of 875 adult prisoners in a state correctional facility per 100,000 population, compared with the state average of 522 per 100,000 population<sup>9</sup>. Adolescent arrests for alcohol and drug related crimes are also higher than the

<sup>4</sup> WA State Office of Financial Management 2016 age, sex, race, and Hispanic ethnicity population estimates: <http://www.ofm.wa.gov/pop/asr/default.asp>

<sup>5</sup> HCA RHNI Starter Kit, *Demographics-Medicaid* tab. Based on HCA Medicaid enrollment and claims data for the 2015 calendar year.

<sup>6</sup> Washington State Office of Financial Management (OFM), (March 2017) *Trends in County Uninsured Rates in Washington: 2013-15*. (Washington State Health Services Research Project, Research Brief No. 81): <https://ofm.wa.gov/sites/default/files/public/legacy/researchbriefs/2017/brief081.pdf>

<sup>7</sup> HCA RHNI Starter Kit, *Social Det. Of Health-Overall* tab. Based on United State Census Bureau Small Area Income and Poverty Estimates (2015). <https://www.census.gov/programs-surveys/saipe.html>

<sup>8</sup> Robert Wood Johnson Foundation, *County Health Rankings* (2017)

<sup>9</sup> DSHS Risk and Protection Profile for Substance Abuse Prevention by county, July 2017: <https://www.dshs.wa.gov/sesa/research-and-data-analysis/county-and-state>



state average<sup>10</sup>. Juvenile detention is also high in the region. Okanogan County has the highest rate of juvenile detention in the state at 36.4 per 1,000 youth, almost four times the state average of 9.3 per 1,000 youth<sup>11</sup>. Other counties in the region have high rates of juvenile detention as well: rates per 1,000 youth were 21.1 for Chelan County, 18.1 for Douglas County, and 16.2 for Grant County.

High school graduation rates vary across the region. In 2016, 87.5% of high school students in Douglas County graduated within 5 years, compared with 77.8% in Grant County, 79.7% in Chelan County, 85.9% in Okanogan County, and 81.9% statewide<sup>12</sup>. Adults in the region are less likely to have received a bachelor's degree compared with the state average (17.9% for the NCACH region vs. 28.3% statewide)<sup>13</sup>. About 20% of the adult population has no high school diploma, which is twice the state average<sup>14</sup>.

Overweight and obesity rates are high in the region with 65% of adults considered overweight or obese<sup>15</sup>. In a survey of community stakeholders (we received a total of 323 responses from three outreach events), obesity was identified as the second most important health problem affecting the community. In addition, the data collection process during our CHNA in 2016, which included quantitative and qualitative data, resulted in the identification of the top 16 health needs of the community. Obesity was ranked fourth when 39 community leaders (including representatives from the health and social services sector) convened to prioritize the health needs based on a set of criteria. Over the 2013-2015 time-period, adult smoking rates were high in Okanogan County (22.1%) and Douglas County (21.4%) compared with the state average (15.6%), Chelan County (11.0%) and Grant County (16.8%)<sup>16</sup>. During that same time period, nearly 10% of adults in the region reported having diabetes compared to 8% statewide. Teen pregnancy rates are also high in the region. Compared with the state average of 77.2 per 1,000 teens ages 15-19, regional rates range from 80.3 per 1,000 in Douglas County to 92.4 per 1,000 in Grant County<sup>17</sup>.

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<sup>10</sup> HCA RHNI Starter Kit, *Social Det. Of Health-Overall* tab. Based on DSHS Risk and Protection Profiles by county, July 2017.

<sup>11</sup> Washington State Center for Court Research, Juvenile Detention 2016 Annual Report:

<http://www.courts.wa.gov/subsite/wscrr/docs/2016DetentionAnnualReport.pdf>

<sup>12</sup> HCA RHNI Starter Kit, *Social Det. Of Health-Overall* tab. Based on Washington State Office of Superintendent of Public Instruction data for 2016.

<sup>13</sup> HCA RHNI Starter Kit, *Social Det. Of Health-Overall* tab. Based on Department of Health Washington Tracking Network for 2009-2013.

<sup>14</sup> Chelan-Douglas Health District, 2016 Community Health Needs Assessment. See:

[http://www.cdhd.wa.gov/Health%20Data/Docs/2016\\_Chelan-Douglas\\_Health\\_District\\_CHNA.pdf](http://www.cdhd.wa.gov/Health%20Data/Docs/2016_Chelan-Douglas_Health_District_CHNA.pdf)

<sup>15</sup> Ibid.

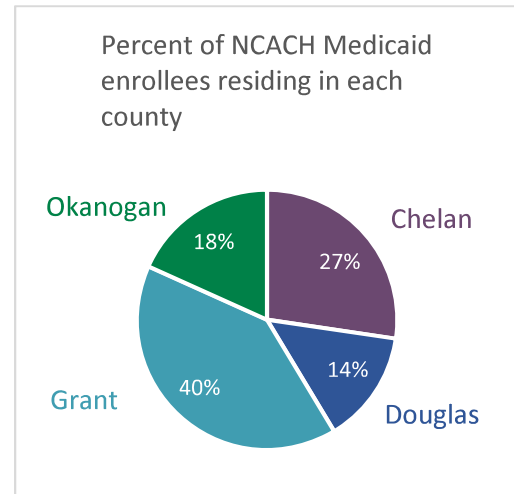
<sup>16</sup> HCA RHNI Starter Kit, *Prevalence Estimates – Overall* tab. Based on the annual Behavioral Risk Factor Surveillance System (BRFSS) using three years combined data (2013-2015).

<sup>17</sup> HCA RHNI Starter Kit, *Project – MCH Repro. Overall* tab. Based on Department of Health data from 2015.

### Medicaid Beneficiary Population Profile

About 94,000 Medicaid enrollees live in NCACH counties, accounting for about 5% of statewide Medicaid enrollment. High rates of residents in the region rely on Medicaid for health care coverage compared to the state average (26%), ranging from 33% in Douglas County to 41% in Okanogan County<sup>18</sup>. Children make up a greater proportion of Medicaid enrollment in the NCACH region; 46% of statewide Medicaid enrollees are ages 19 and under, compared with 55% of enrollees in the NCACH region.

We know that a variety of social and environmental factors – also referred to as “social determinants of health” or SDH – impact people’s health. The previous section details the region-wide SDH factors. Those same factors impact the Medicaid population. A smaller percentage of enrollees in NCACH counties are homeless than in other regions in the state; 2.8% of adult enrollees in the region were homeless for one month or longer in 2015 compared to 4.9% statewide<sup>19</sup>. Adult enrollees who identify as Black, have a substance use disorder (SUD) treatment need, or have co-occurring mental illness and SUD diagnoses are more likely to be homeless<sup>20</sup>.



*Source: Healthier Washington Dashboard, Population Explorer tab. Measurement period Oct 2015 – Sep 2016.*

NCACH has the highest rate of employment among adult Medicaid enrollees of all ACH regions. In 2015, 64.7% of adult Medicaid enrollees in the NCACH were employed, compared with 51.9% statewide<sup>21</sup>. NCACH has a higher arrest rate than the statewide average. In 2015, 6.8% of Medicaid enrollees in the NCACH region were arrested compared to 6.5% statewide<sup>22</sup>. Enrollees who identify as Black or American Indian/Alaskan Native were twice as likely to be arrested; enrollees with an SUD treatment need or co-occurring mental health and SUD diagnosis were about five times more likely to be arrested<sup>23</sup>. Racial and ethnic groups vary by county; overall, the region has lower rates of Black, Asian, and Native Hawaiian/Pacific Islander enrollees than the statewide average. The region has higher than state average rates of Medicaid enrollees who identify as American Indian/Alaskan Native, white, and other. More Medicaid enrollees in the region identify as Hispanic compared to the state average (47% and 21%, respectively)<sup>24</sup>. The charts below show the percent of Medicaid enrollees in the NCACH region by selected racial and ethnic groups.

<sup>18</sup> Healthier Washington Dashboard, *Population Explorer* tab. Measurement period Oct 2015 – Sep 2016.

<sup>19</sup> DSHS Research and Data Analysis Division, “Cross-System Outcome Measures for Adults Enrolled in Medicaid”, *sce\_mco\_wa* data set (Medicaid clients enrolled with Managed Care Organizations). Data for CY 2015. See: <https://www.dshs.wa.gov/sesa/research-and-data-analysis/cross-system-outcome-measures-adults-enrolled-medicaid-0>

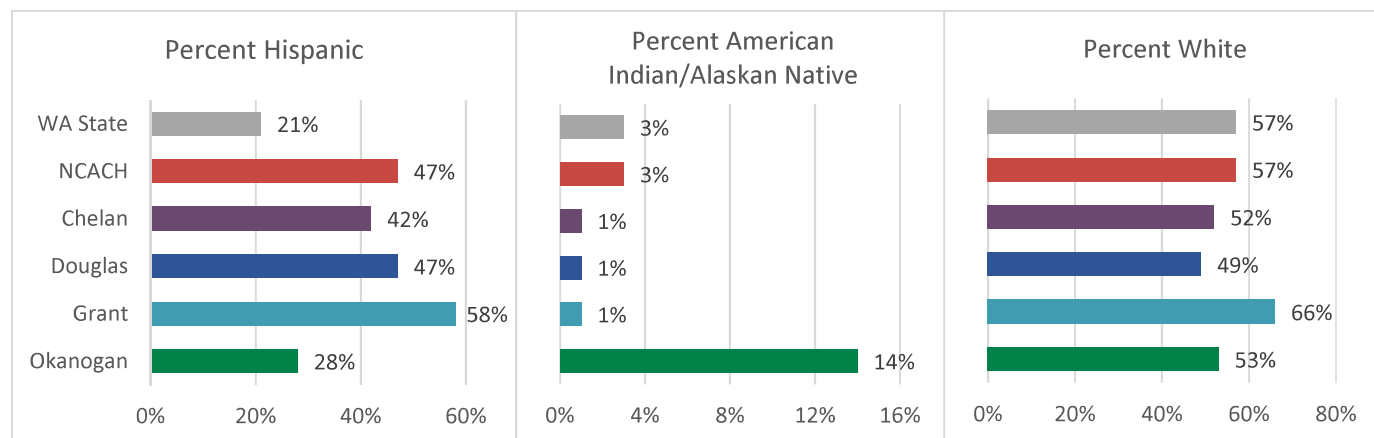
<sup>20</sup> Ibid.

<sup>21</sup> DSHS Research and Data Analysis Division, “Cross-System Outcome Measures for Adults Enrolled in Medicaid”.

<sup>22</sup> Ibid.

<sup>23</sup> DSHS Research and Data Analysis Division, “Measure Decomposition Data” file. As indicated by RDA, likelihood ratios are “designed to identify demographic and health risk factor characteristics associated with favorable and adverse outcomes on selected metrics, to help inform ACH project planning. Demographic and health risk characteristics that are much more prevalent among persons experiencing adverse outcomes may identify high-opportunity populations for intervention.”

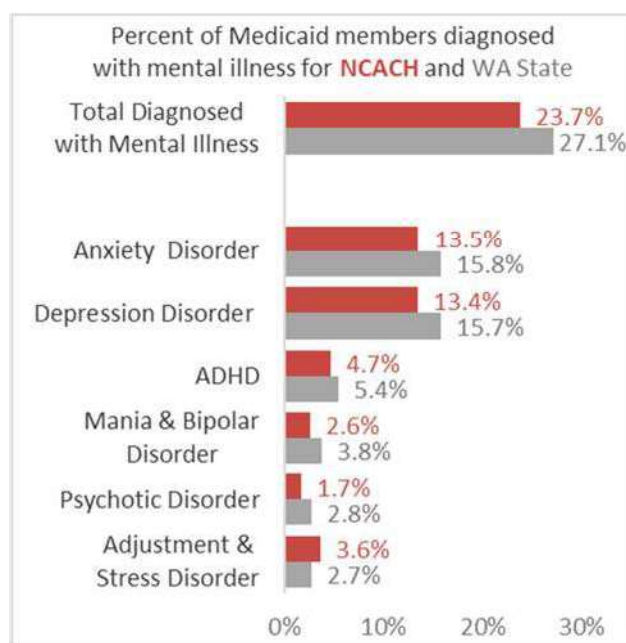
<sup>24</sup> Healthier Washington Dashboard, *Population Explorer* tab. Measurement period Oct 2015 – Sep 2016.



**Source:** Healthier Washington Dashboard, Population Explorer tab. Measurement period Oct 2015 – Sep 2016.

### Medicaid Beneficiary Population Health Status

Behavioral health conditions are widespread in the region. Nearly 25% of Medicaid members in the NCACH region have been diagnosed with mental illness, with anxiety disorders and depression being the most prevalent conditions (see chart). More than 5,000 Medicaid members have co-occurring mental illness and substance use disorder diagnoses<sup>25</sup>. Mental and behavioral disorders are a top cause of hospitalization, comprising 8% of all hospitalizations that are not related to pregnancy or childbirth<sup>26</sup>.

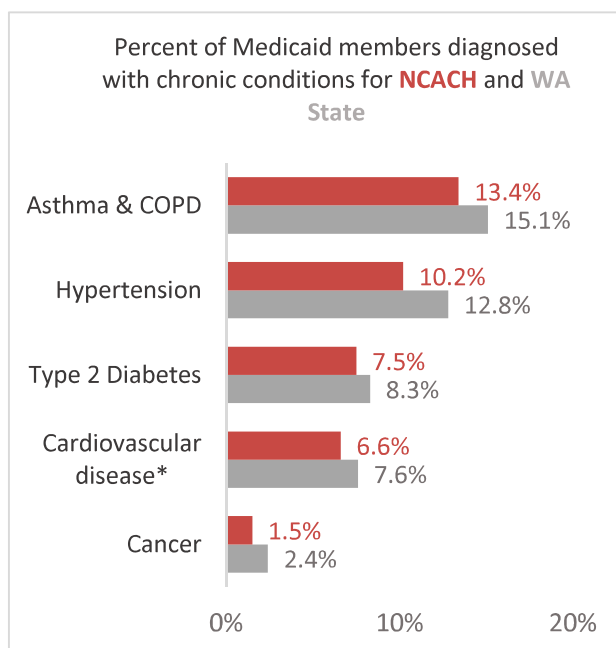


**Source:** DSHS ACH Profiles produced by RDA, North Central Current State spreadsheet.

<sup>25</sup> DSHS Research and Data Analysis Division, ACH Profiles - North Central Current State spreadsheet, *Behavioral Health* and *Diagnoses* tabs. Measurement period based on a 24-month lookback period from June 2016.

<sup>26</sup> HCA RHNI Starter Kit, "Top Ten Most Common Causes of Statewide Acute Hospitalizations Among Medicaid Recipients, Excluding Pregnancy and Child Delivery Related Hospitalizations, During Jan 1, 2015-Oct 31, 2015"

Overall, the region has lower rates of chronic conditions than the statewide average (see chart below). Management of chronic conditions varies across the region. The region's rate of medication management for asthma (23%) is lower than the state average (28%), and county rates range from 19% in Chelan County to 32% in Okanogan County<sup>27</sup>. The region's rates are higher than the state average for diabetes care measures such as blood sugar testing, diabetic eye exams, and kidney disease screening. In fact, we are the highest performing ACH on these measures indicating that comprehensive diabetes care is an area of strength<sup>28</sup>.



**Source:** DSHS ACH Profiles produced by RDA, North Central Current State spreadsheet.

Opioid use in the region has mirrored national trends showing increases in the number of individuals using prescription opioids. From 2002 to 2013, treatment admissions for opiates increased for all four counties in the region. Okanogan County had 21.6 publicly funded opiate treatment admissions per 100,000 population in 2002-2004, and in 2011-2013 there were 99.4 admissions<sup>29</sup>. The region has 492 providers who prescribe opioids<sup>30</sup>. There are 11,068 Medicaid members with opioid prescriptions; 88% of those have no history of cancer diagnosis. Of members with opioid prescriptions and no history of cancer diagnosis, 19% (1,742) are considered heavy users and 19% (1,815) are chronic users with prescriptions for 30 days or more. NCACH rates of prescription opioid use are similar to statewide rates<sup>31</sup>.

Geographic variation is present for birth outcomes. Across the ACH, 4.2% of babies born in the region's hospitals to mothers enrolled in Medicaid have low birth weights. In Chelan County, the rate is 3.8%, while Okanogan County's rate is 5.8%.

<sup>27</sup> Healthier Washington Dashboard, *Measure Explorer* tab. Measurement period Oct 2015 – Sep 2016.

<sup>28</sup> Ibid.

<sup>29</sup> UW Alcohol and Drug Abuse Institute: <http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2015-01.pdf>

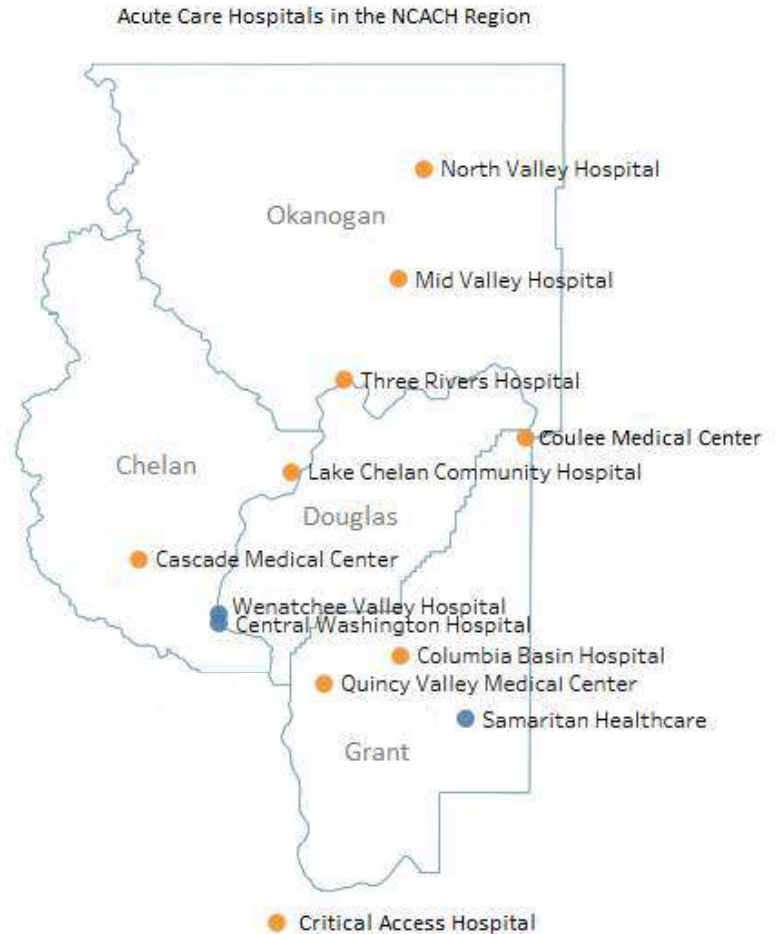
<sup>30</sup> HCA RHNI Starter Kit, *Project-Opioid-Medicaid* tab. Data for Fiscal Year 2016.

<sup>31</sup> Ibid.

### Regional Health System Capacity

The NCACH region has 11 acute care hospitals, most of which are operated by Public Hospital Districts (Wenatchee Valley and Central Washington are the exception; they are operated by Confluence Health). See the table and map below for more information about acute care hospitals. The region has no psychiatric inpatient beds and no licensed mental health crisis facilities<sup>32</sup>. While NCACH counties have used inpatient mental health facilities in other parts of the state (including Eastern State Hospital), plans are underway to convert a former nursing home in Wenatchee into a 32-bed inpatient mental health facility. This will fill a significant capacity gap in our region, providing additional intensive mental health services in the region.

There are also 17 Federally Qualified Health Clinics (FQHCs), and 20 Rural Health Clinics in the region. The region has dozens of individual emergency response agencies, many of which participate in the North Central Emergency Care Council, which works to support a comprehensive emergency care system.



Hospital	Number of beds	Medicaid discharges (2016)	Total discharges (2016) <sup>33</sup>
Cascade Medical Center	12	5	126
Central Washington Hospital	198	3,129	12,044
Columbia Basin Hospital	69	25	278
Coulee Medical Center	25	228	614
Lake Chelan Community Hospital	25	156	610
Mid Valley Hospital	30	466	1021
North Valley Hospital	67	175	554
Quincy Valley Medical Center	25	4	66
Samaritan Healthcare	49	1,233	2,888
Three Rivers Hospital	25	193	377
Wenatchee Valley Hospital	20	42	298

<sup>32</sup> Washington State Institute for Public Policy; Crisis Mental Health Services and Inpatient Psychiatric Care, Dec. 2016; [www.wsipp.wa.gov](http://www.wsipp.wa.gov)

<sup>33</sup> WA State Department of Health CHARS Payer Census, 2016.



The number of practicing physicians varies widely across the region. In 2016, Chelan County had 360 physicians per 100,000 population, the highest rate in the state<sup>34</sup>. Neighboring Douglas County had only 34 physicians per 100,000 populations. Similar patterns emerge for primary care physicians. Per 100,000 population, Chelan had 120 primary care providers; Douglas had 25, Grant had 41, and Okanogan had 72. It's worth noting that many health care providers are located near county lines, so residents of one county may cross over to other counties to receive care.

Behavioral health workforce capacity also varies throughout the region. Overall, there are 162 behavioral health providers per 100,000 population, compared with the state average of 266. Okanogan has the highest ratio of behavioral health providers, with 252 per 100,000 population; Douglas has the lowest with 35 per 100,000.<sup>35</sup>

In addition to our network of regional hospitals, key regional health system partners include:

- Confluence Health, a large health system in the region, operates two hospitals and more than 40 primary care and specialty clinics, including 10 Rural Health Clinics.
- Moses Lake Community Health Center operates FQHCs in three locations, and is dedicated to serving migrant and seasonal farm workers, the uninsured, and others who have difficulty accessing care.
- Columbia Valley Community Health operates 4 FQHCs, providing physical, dental, and behavioral health services.
- Family Health Centers operates FQHCs, largely in Okanogan County. They have 6 medical locations and 5 dental locations.
- Samaritan Healthcare, a multifaceted healthcare organization located in Moses Lake operates a clinic in addition to the hospital.
- Grant Integrated Services manages four community programs including providing mental healthcare, operating a drug and alcohol prevention and recovery center, supportive living for people with disabilities, and an assisted living facility for chronic mentally ill individuals.
- Catholic Family and Child Services provides counseling and behavioral health services in Wenatchee and Moses Lake.
- Okanogan Behavioral Healthcare provides outpatient mental health and substance use treatment services, as well as operating a crisis line and connecting patients to supportive housing.
- Center for Drug and Alcohol Treatment provides inpatient and outpatient substance use treatment services.
- The Confederated Tribes of the Colville Reservation operate a health center in Omak and Nespelem providing medical, dental, and pharmacy services.
- Children's Home Society provides child and family health counseling families with children from birth to 21 years old who receive Medicaid, including Wraparound with Intensive Services (WISe) for children with behavioral health needs and their families. They also focus on children in foster care.

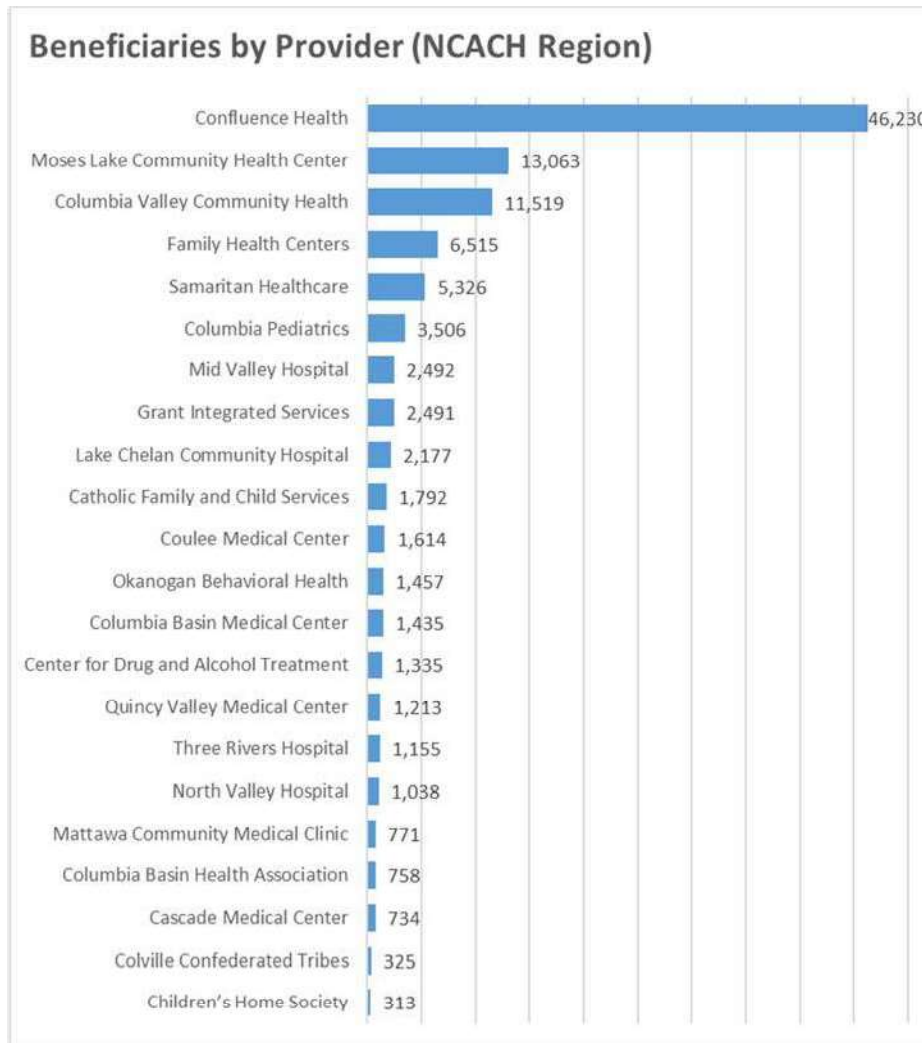
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<sup>34</sup> UW Center for Health Workforce Studies, Washington State's physician workforce in 2016.

<sup>35</sup> Chelan-Douglas Health District, 2016 Community Health Needs Assessment, Appendix A:

[http://www.cdhd.wa.gov/Health%20Data/Docs/2016\\_Chelan-Douglas\\_Health\\_District\\_CHNA.pdf](http://www.cdhd.wa.gov/Health%20Data/Docs/2016_Chelan-Douglas_Health_District_CHNA.pdf)

These health system providers are all engaged through our Whole Person Care Collaborative (WPCC), and the following chart provides an overview of how many Medicaid beneficiaries these providers served in 2016.



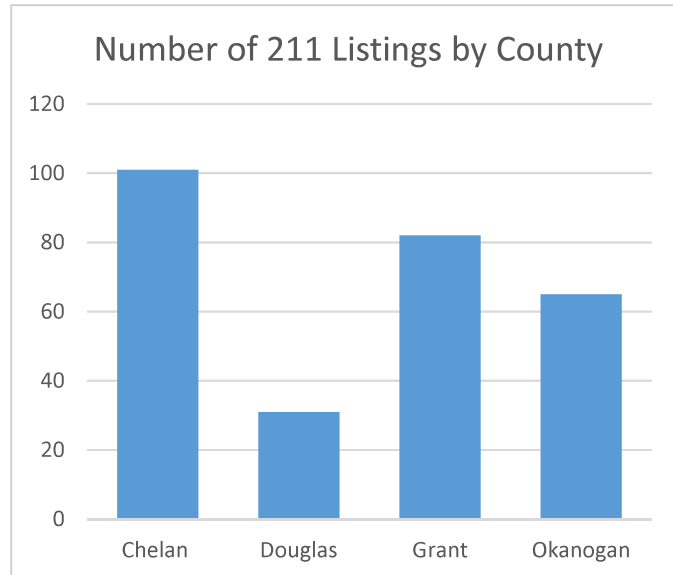
**Source:** Health Care Authority, based on a special data request from NCACH. These counts are based on professional claims data excluding emergency department related procedures.

### Regional Community-based Services Capacity

The region has a number of organizations providing services to support housing and food stability, social services, and employment. Services tend to be located in large population centers, such as Wenatchee or Moses Lake, which may make access to services problematic for residents in more remote areas of the region. Little is known about linkages, collaboration, data exchange, and referrals among community-based service providers, or between community-based organizations and health system providers. Different service providers and sectors have wide variation in resources and available data. As project planning and implementation continues, particularly for the Care Coordination Project, NCACH will explore opportunities to enhance connections between service providers in the region and identify regional capacity, needs, and gaps. Connecting with Washington Information Network's 2-1-1 (WIN 211), which maintains a database of community resources, and our social service providers will be critical as we aim to better understand our network and ways to strengthen existing linkages and build new ones.

There are 243 community-based organizations, healthcare providers, public agencies, and institutions listed in the 211 provider directory for our region. Some of these agencies serve more than one county (e.g., Aging and Adult Care of Central Washington).

These include DSHS community service offices (located in Wenatchee, Moses Lake, and Omak), three local health jurisdictions (LHJs), multiple organizations that provide a variety of social services, such as United Way and Catholic Family & Youth Services, more than a dozen food banks and food assistance organizations, a syringe exchange program in Okanogan County, three district courts, and education institutions (e.g., Wenatchee Valley College and WSU extensions). There are limited transportation resources in the community, though all four counties do operate buses or other forms of public transportation<sup>36</sup>.



*Source: 211 Provider Listing and Taxonomy List (requested from WIN211 for NCACH region).*

Housing instability is rising in many areas of the region; as increases in housing costs outpace median incomes and vacancies lower, affordable housing in many areas is limited<sup>37</sup>. Housing and rental assistance is available from housing authorities in each county, though access to support does not always meet demand (e.g., the Housing Authority of Okanogan County has closed its waiting list for Section 8 Housing Vouchers). Several other organizations in the region provide permanent and transitional housing support, such as Chelan Douglas Community Action. In addition, local jurisdictions are working on initiatives to address homelessness. For example, the City of Wenatchee developed a coordinated entry system to help homeless individuals quickly and easily locate and connect with social services that best meet their needs.

### Medicaid Population's Connection to Care

Access to care has been identified as a priority in multiple assessments and community surveys, including the CHNA<sup>38</sup>. The CHNA identified insufficient numbers of providers, travel distance to health care providers, and lack of providers willing to accept Medicaid and Medicare (especially among dentists) as key barriers to accessing care. Qualis Health reports that all MCOs in Washington State showed decreases in adult access from the 2015 to 2016 reporting years, and that the state rate is now more than 5 percent lower than the national average of Medicaid plans<sup>39</sup>.

<sup>36</sup> Washington Information Network 211.

<sup>37</sup> WA Dept. of Commerce, Affordable Housing Needs: <http://www.commerce.wa.gov/housing-needs-assessment/>

<sup>38</sup> NCACH Community Health Needs Assessment: [http://www.cdhd.wa.gov/Health%20Data/Docs/2016\\_Chelan-Douglas\\_Health\\_District\\_CHNA.pdf](http://www.cdhd.wa.gov/Health%20Data/Docs/2016_Chelan-Douglas_Health_District_CHNA.pdf)

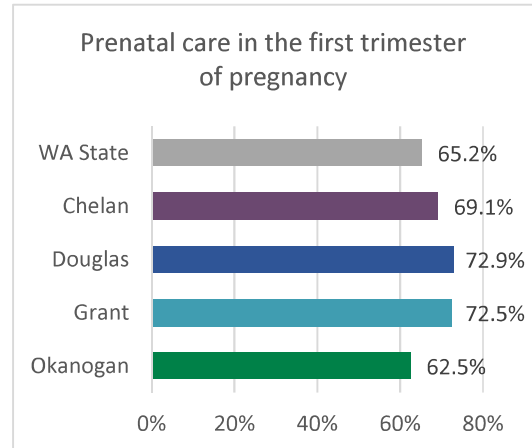
<sup>39</sup> Qualis Health (December 2016). 2016 Regional Analysis Report, Washington Apple Health, Washington Health Care Authority: <https://www.hca.wa.gov/assets/program/eqr-regional-analysis-report-2016.pdf>

Access to and utilization of primary care among Medicaid enrollees varies throughout the region. Rates for primary care visits among children ages 1-19 were generally at or above the state average, though Okanogan County consistently had lower rates. Okanogan County is below the state average for access to primary care for children ages 12-24 months and 2-6 years. Rates of adults' use of ambulatory or preventive care are also typically at or above the state average. Among adults, women are far more likely than men to have had an ambulatory or preventive care visit in the last year (88% for women vs. 73% for men).

Engagement in first trimester prenatal care by Medicaid enrollees is higher than the state average for Chelan, Douglas, and Grant counties; however, Okanogan County is below the state average<sup>40</sup>. Rates of chlamydia screening among women ages 16-24 are below the state average (47% compared to 51%, respectively), with Okanogan County having the lowest rate in the region (40%).

NCACH has some of the lowest rates of emergency department (ED) utilization in the state, at 40 visits per 1,000 member months (MM), compared with the state average of 54 visits per 1,000 MM. This measure includes ED visits related to mental health or substance use. Racial and ethnic variations exist for ED utilization. American Indian/ Alaskan Native and Black Medicaid enrollees have much higher rates (61 and 60 per 1,000 MM, respectively). Non-Hispanic members have higher rates of ED use than Hispanic members (51 vs. 32)<sup>41</sup>.

NCACH's rates of follow-up after hospitalizations for mental illness are higher than the state average (88.9% vs. 79.8% for 30-day follow-up), and they are among the highest rates in the state. Similarly, NCACH rates of follow-up with Medicaid members after an ED visit for alcohol or drug dependence are well above the state average (44.4% vs. 29.4%), as are rates of follow-up after an ED visit for mental illness (80.6% vs. 72%)<sup>42</sup>.



Source: HCA Pregnancy and Birth data:  
<https://www.hca.wa.gov/about-hca/reproductive-health>

**Outline any identified capacity or access gaps between the Medicaid population's identified health care and health care access needs, and the services (or service capacity) currently available from identified providers and CBOs.**

NCACH faces many challenges that are common for rural communities: high poverty rates, limited employment opportunities, lower median incomes, shortages of care providers, rapid demographic shifts, areas of geographic isolation, and high rates of residents covered by Medicaid. Residents of rural areas typically travel two to three times further than urban residents to access health care services. These greater distances can be a barrier to receiving care. Weather can further compound transportation issues, especially for residents in mountainous or high elevation areas. The NCACH region

<sup>40</sup> HCA Pregnancy and Birth data: <https://www.hca.wa.gov/about-hca/reproductive-health>

<sup>41</sup> Healthier Washington Dashboard. *Population Explorer* tab. Based on October 2015-September 2016 measurement period.

<sup>42</sup> DSHS Research and Data Analysis Division, "Measure Decomposition" file.

is home to large Hispanic and Native American/Alaskan Native populations, both of which experience disparities in social and health outcomes, and may face language or cultural barriers in accessing care.

Workforce capacity is a significant challenge for the region. Three of the four counties in the region are designated as Medically Underserved Areas (Douglas, Grant, and Okanogan). The entire region is designated as a geographic Health Professional Shortage Area (HPSA) for primary care, mental health, and dental care<sup>43</sup>. Large areas of the region also have population-based HPSA designations for migrant workers, low-income individuals, and Native Americans. Health care employers have experienced difficulty in filling vacancies for positions for registered nurses, clinical social workers, and mental health counselors<sup>44</sup>. Based on population/primary care provider ratios, workforce shortages are most prevalent in Grant and Okanogan Counties. The Medicaid Demonstration projects provide a crucial opportunity for NCACH partners to address workforce capacity issues, through regional collaboration and planning to implement strategies such as telehealth to build workforce capacity.

Access to behavioral health care is another challenge. There are no designated psychiatric inpatient beds in the region, despite the fact that mental and behavioral health diagnoses are among the top reasons for hospitalization. The region's rates of mental health treatment penetration (40.5%) and substance use disorder treatment penetration (22.2%) are below the state average for these indicators (42.9% and 26.7%, respectively)<sup>45</sup>. This suggests that there are Medicaid members with treatment needs who may not have adequate access to care.

Access to affordable housing is an emerging challenge for the region. NCACH has 184 HUD assisted units per 10,000, compared with the state average of 303 HUD assisted units per 10,000<sup>46</sup>. Access to stable housing is an important driver of health outcomes. This will be a crucial issue for the region to address as it implements transformation projects.

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

<sup>44</sup> Washington State Health Workforce Sentinel Network: <http://www.wtb.wa.gov/HealthSentinel/findings.asp>

<sup>45</sup> HCA AIM, ACH Toolkit Historical Data file.

<sup>46</sup> NCACH Community Health Needs Assessment: [http://www.cdhd.wa.gov/Health%20Data/Docs/2016\\_Chelan-Douglas\\_Health\\_District\\_CHNA.pdf](http://www.cdhd.wa.gov/Health%20Data/Docs/2016_Chelan-Douglas_Health_District_CHNA.pdf)