SECTION I: ACH – LEVEL

<table>
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<tbody>
<tr>
<td>Name</td>
<td>Liz Baxter, MPH</td>
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<tr>
<td>Phone</td>
<td>360.386.5745</td>
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<tr>
<td>Email</td>
<td><a href="mailto:Liz@NorthSoundACH.org">Liz@NorthSoundACH.org</a></td>
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Regional Health Needs Inventory

A Regional Health Needs Inventory (RHNI) is both a framework and resource to support investigating and synthesizing information about our region’s greatest health needs, as a foundational step toward project selection and planning. (HCA, 2017). The aim of the North Sound Accountable Community of Health’s (the North Sound ACH) RHNI is to be a comprehensive collection of Medicaid data, public data sources, workforce information, community assessments, and community improvement plans that support project selection, informs decision-making and project implementation (Figure 1). The data presented throughout the ACH Project Plan Template moves us closer to the goal of providing a compelling data-driven rationale for all selected projects now and into early 2018. The RHNI will be periodically updated, in collaboration with partners, throughout the planning and implementation phases of the Demonstration.

Figure 1: Regional Health Needs Inventory Framework

We have outlined RHNI findings in the ACH Project Plan Template by the categories listed below and provided a high-level snap-shot of findings that are described in greater detail throughout this section and within each toolkit project area:

1. **Data Informed Planning & Implementation**: Describes the process, tools and partners utilized throughout the North Sound ACH’s data-driven decision making for project area selection.

2. **Addressing Health Equity**: Describes the North Sound ACH’s methodology for selecting target populations, measuring regional needs, identifying population segments experiencing health disparities, understanding root causes within population segments and selecting appropriate targeted interventions through Targeted Universalism.

3. **Regional Health Needs Inventory Summary**: Each sub-section provides a high-level summary of overall regional health needs, health needs among Medicaid enrollees, how issues are currently being addressed and highlights how future Demonstration projects in the North Sound will address needs.
   - Demographics: North Sound ACH region has the second largest total and Medicaid population in the state, nearly half individuals with Medicaid coverage are children.\(^1\) The region is

\(^1\) RHNI Starter Kit, HCA, released May 8, 2017.
geographically diverse, some areas are very rural or remote and pose challenges for accessing services.

- **Social Determinants**: Variability of socioeconomic risk factors in key areas throughout the region, poverty, homelessness and unaffordable housing impact segments of the population throughout the region.\(^2\)
- **Life Expectancy & Mortality**: Life expectancy varies greatly by where people live, in the North Sound the average age of life expectancy is 81 years old, though the range by census tract is 71-90 years old.\(^3\) Deaths associated with suicide, drug overdose and chronic conditions are a growing concern among community partners, especially for the Medicaid population.
- **Emergency Department Visits and Hospitalization**: Behavioral health challenges (including mental health and substance use disorder) and chronic disease are a significant causes of emergency department visits and hospitalization in the region.
- **Behavioral health & Substance Abuse**: Medicaid enrollees with mental illnesses and chronic conditions impact over 40,000, these co-occurring illnesses are exacerbated by each other and lead to a shorter life expectancy.\(^4\)
- **Opioid Crisis**: Opioid abuse and overdose involving prescription opioids and heroin are worsening rapidly and negatively impacting families throughout the region, the region lost 607 individuals from 2012-2016.\(^5\)
- **Chronic Disease**: Chronic Disease diagnosis rates are low, though burden of disease and risk factors impact 10-25% of Medicaid enrollees and vary by age.\(^6\)
- **Reproductive, Maternal, Child Health**: Prenatal care in the first trimester among pregnant women with Medicaid ranges from 60-70% by county.\(^7\) The region’s rate for unintended pregnancy is 37% an important measure to monitor as it aggregates a variety of social, behavioral, cultural and health factors- particularly women’s access to tools for family planning.
- **Oral Health**: Only 34.6% of Medicaid enrollees who are eligible for dental services receive care.\(^8\) Low utilization rates may be associated with insufficient capacity to see adult patients, transportation, location, and cost of care.
- **Communicable Disease & Immunization**: Immunizations rates amongst children are some of the lowest in the state, only 31% of toddlers are current on their vaccinations.\(^9\)
- **Preventive Services and Access to Care**: Residents with Medicaid in the North Sound are more likely to experience worse quality of care compared to those with commercial insurance.\(^10\)

### 4. Partner Capacity

- **Regional Health System Capacity**: There are 32 community health center sites, 16 rural health clinics, 46 North Sound BHO contracted behavioral health agencies, 10 health systems and hospitals, 8 tribal health clinics, 4 mobile care services and 1 correctional complex.
- **Community-Based Organization Capacity**: The region has a rich history of CBO’s working together, there are 5 Transportation Services; 5 local health departments, 20 housing services; 17 schools/community colleges; 21 Local, state and federal government agencies; 19 consumer advocacy organizations; 57 social service/human service agencies; 6 local employers; 12

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\(^7\) RHNI Starter Kit, HCA, released May 8, 2017.
\(^8\) RHNI Starter Kit, HCA, released May 8, 2017.
\(^10\) Community Check-Up, Washington Health Alliance, 2015.
homeless shelters; 14 faith based organizations; 24 food banks and 3 immigrant service organizations.

5. **Data Sources**: A comprehensive list of data sources the North Sound ACH has gathered for the RHNI and to inform project area selection.

**DATA INFORMED PLANNING & IMPLEMENTATION**

The North Sound ACH implemented several strategies to ensure data-driven decision making to support project area selection. Initial project planning began in February 2017 with self-formed workgroups organized around the eight toolkit project areas, comprised of diverse stakeholder participants. This approach enabled partners to share local and regional knowledge, identify opportunities for collaboration, evaluate current data, and explore potential strategies to consider projects. Simultaneously, the North Sound ACH Program Council (standing committee of the North Sound ACH Board) made a recommendation to screen potential project areas based on three criteria: whether the data demonstrated a regional need, whether partners existed to meet the metrics, and how projects align with the toolkit models.

In June 2017, the North Sound ACH’s data analyst began preparing to update the RHNI by reviewing and analyzing public data sources and the Health Care Authority’s (HCA) Medicaid data products to identify needs and facilitate selection of possible target populations for project areas. During this same period, the North Sound ACH staff created a crosswalk of the pay-for-performance metrics, creating a visual of what data elements will be tracked to earn incentive dollars, and used the tool with workgroups to drive project selection. The tool (Figure 2) included the most current local, regional, and state metric data, as well as historic trend data when available. This tool became a valuable resource for workgroups and the Program Council to discuss the feasibility of proposed projects meeting the required metrics. An estimated predictive gap analysis was later added to the tool upon the HCA release of metric target selection methodology.

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**Figure 2: Example of Metrics Crosswalk for Active Care Coordination Metrics**

![Figure 2: Example of Metrics Crosswalk for Active Care Coordination Metrics](image-url)
Between July and October 2017, data were shared periodically with workgroups and the Program Council, though challenges persisted in providing timely and reliable data that met the planning needs of each workgroup. One major issue was the varying methods of identifying total Medicaid population for the region. In general, regional counts differed due to selected month and/or year of data and the reporting agency’s definition of Medicaid population. For example, majority of behavioral health and substance abuse data products from the Department of Social & Health Services’ Research & Data Analysis (DSHS-RDA) included Medicaid only and dual-eligibles. These issues have been raised to HCA and a remedy is currently pending.

Despite these challenges, North Sound ACH staff actively participated in bi-weekly ACH-HCA statewide data lead calls and networked with other ACHs to identify useful project area data and utilize existing public data sources from the Washington State Department of Health, Washington Health Alliance and the Washington State Department of Social and Health Services. Pairing the HCA’s Medicaid data products with these additional data sources has created a wide spectrum of information of regional needs and assets used to support project selection, identify possible target populations and most importantly, prepare the North Sound ACH for project implementation in 2018.

While data sources for the RHNI and project area selection are primarily HCA data products and publically available data, improved data sharing agreements and interoperability between the ACH and partnering providers is a priority for improving access to high-quality and timely data. The region’s data sharing capacity has increased with the Snohomish Health District’s award of the WADOH Chief Health Strategist funding, which requires the development of collaborative data sharing agreements among the five local health jurisdictions and the North Sound ACH. As project planning begins in 2018, the North Sound ACH will work closely with HCA to establish data sharing agreements with partnering providers as needed.

ADDRESSING HEALTH EQUITY

While committed to delivery system reform, the North Sound ACH believes in order to achieve improvements in health equity we must continually look downstream, midstream, and upstream, and lean into uncomfortable dialogue about class, privilege, and race. To support this commitment, the North Sound ACH will use Targeted Universalism (Figure 3) for selecting target populations, measuring regional needs, identifying population segments experiencing health disparities, understanding root causes within population segments and selecting appropriate targeted interventions. Targeted universalism defines universal goals for all, then identifies obstacles faced by specific groups, and tailors strategies to address the barriers in those specific situations; it is a different way- a powerful way- to make the transformational changes we need. Ultimately, this approach shows how a universal project area goal can improve health for an entire population, while at the same time it can target approaches to address disparities within groups. The North Sound ACH is also committed to knowledge sharing with partners and has provided trainings for workgroups related to health equity, including one on Targeted Universalism, with Ben Duncan, Multnomah County’s Chief Diversity and Equity Officer.

Figure 3: Targeted Universalism, Haas Institute
REGIONAL HEALTH NEEDS INVENTORY SUMMARY

Demographics

Comprised of five counties (Island, San Juan, Skagit, Snohomish, Whatcom) and eight tribal nations (Figure 4), the North Sound ACH region is geographically large with diverse populations. North Sound is the second largest populated ACH in Washington with 1,184,790 residents, the majority (63%) of whom live in Snohomish County. The majority (63%) of the region’s residents are working-age adults (18-64), while 15% are older adults (65+) and 22% are children (<18). The five counties range from urban to rural settings and are connected by highways, majority of the region’s health services are located in the largest cities of Everett (109,000), Bellingham (88,000) and Mount Vernon (33,000), the further away individual lives from these urban areas creates limited access to vital healthcare services in rural and remote areas. San Juan County is only accessible via ferry, and by ferry from island to island within the county.

Figure 4: County Boundaries and Tribal Lands, North Sound Region, Community Commons, 2015

reported by WADOH’s Office of Community Health Systems Series on Rural-Urban Disparities, rural populations of Island, Skagit, Snohomish and Whatcom counties have become more urban, while San Juan County’s rural population (100%) has remained unchanged (Table 1).

<table>
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<tr>
<td>San Juan</td>
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<td>Same</td>
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<td>29%</td>
<td>More Urban</td>
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<td>11%</td>
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<tr>
<td>Whatcom</td>
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<tr>
<td>Washington</td>
<td>18%</td>
<td>16%</td>
<td>More Urban</td>
</tr>
</tbody>
</table>

Data Source: Community Health Systems Series on Rural-Urban Disparities, WADOH, 2017.

In 2016, 286,760 North Sound residents had Medicaid coverage—accounting for 24% of the region’s total population and making it the second largest Medicaid-populated ACH region. Snohomish County is home to the largest concentration of Medicaid enrollees (172,000), while Skagit County has the highest percent of Medicaid enrollees at 31% (37,318), followed by Whatcom with 27% (57,368), San Juan 24% (3,917), Snohomish 22% (172,919) and Island 18% (15,238). Regionally, more females (53%) and adults (55%) have Medicaid coverage. While the North Sound ACH region has the second largest population in the state, many areas in our region are very rural or remote (such as San Juan and Island Counties, and east Whatcom, Skagit, and Snohomish counties), with significantly less population density and challenges accessing services located in urban centers. North Sound ACH project planning will consider the diversity of our region across the five counties and ensure that project strategies are flexible enough to adapt to rural and remote as well as urban areas (employing adaptations such as telehealth, mobile services, and more).

The average number of months of continuous Medicaid coverage for individuals (including dual eligible) in the North Sound ACH region is 3.3 years, compared to the state average of 3.5 years. Rates of continuous coverage vary across Medicaid population segments such as person with disabilities (6.3 years), elders (5.6 years), non-disabled children (4 years), non-disabled adults (2 years), and newly eligible adults (2 years). The North Sound ACH will continue to advocate for ongoing enrollment access to Medicaid and the organization responsible for Medicaid enrollment activities in the region (Washington Alliance for Health Advancement) is engaged in activities through the ACH, with a presence on the Program Council and among the workgroups.

Within the region’s Medicaid beneficiary population there is greater diversity compared to the general population (Table 2). For example, while 83% of the total population is white, only 61% of Medicaid enrollees are white. Snohomish county has the largest population for all race/ethnic population segments, while Skagit County has the highest percent of Hispanic (19%) population. Over 10,000 American Indian/Alaskan Native individuals with Medicaid coverage reside in the North Sound, which is the largest ACH population in the state, underscoring the North Sound ACH’s commitment to support and collaborate with the eight tribal nations in the North Sound ACH region on Medicaid and other health transformation efforts. Further research will be required with nearly 24% of North Sound Medicaid enrollees reporting their race as Other or Unknown in order to better identify health disparities by race and ethnicity. As we move from planning to implementation, current demographic data for Medicaid enrollees will be necessary for all project areas when selecting targeted interventions.

Throughout the project area selection process, staff and workgroups recognized the importance of social determinants of health (SDOH) and the impact these conditions have on an individual’s health. As we move from planning into implementation with both clinical and community-based partners we must ensure social determinants of health are considered when selecting targeted inventions.

In the North Sound, there is wide variability in health status and socioeconomic risk factors in key areas throughout the region. Using the Washington Tracking Network, the North Sound ACH identified differences in key SDOH indicators across the counties and within communities (Table 3). The number of residents living in poverty by county ranges from 9% (Island County) to 15% (Whatcom County), while nearly 40% of the total population in each county is impacted by unaffordable housing. This disparity is likely contributing to increasing rates and total number of homelessness among non-elderly adults with Medicaid coverage (from 3.7% (3,816) to 4.8% (5,847)) throughout the North Sound region. The lack of access to affordable housing, often a complicating factor to achieving better health outcomes, needs to be addressed as part of any strategy to meaningfully improve population health and chronic disease. Homelessness and the lack of safe, affordable housing has been identified as a barrier to achieving health outcomes and a risk factor for negative health outcomes in all eight project areas. Care Coordination, Transitional Care, and Diversion Interventions

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17 ACH Toolkit Historical Data, HCA, released August 17, 2017.
specifically address homelessness in their project strategies, as Percent Homeless is a performance metric in those three areas, and the North Sound ACH plans to implement strategies that will support community efforts to reduce homelessness. Homelessness greatly limits a person’s ability to address chronic illness, their ability to fully recover after release from the hospital, exacerbates behavioral health challenges (mental health challenges and substance use disorder), greatly increases their interaction with law enforcement, and for children experiencing homelessness, constitutes a significant adverse childhood experience and significantly limits their ability to succeed in school. Many partners in our region are working to address this issue, including housing providers (emergency shelters, transitional and long-term housing), case management support and outreach, community paramedics, and advocates working to increase the amount of affordable housing in our communities.

DSHS’s Community Risk Profiles indicate differences between overall state and county rates of social and economic risk factors associated with youth well-being and substance abuse. In the North Sound region, early criminal justice involvement among adolescents vary by county, some county rates significantly higher than the state average:

- Arrest rate (per 1,000) of adolescents (age 10-17) by county and state:
  - WA-28.00, Island-14.26, San Juan-8.89, Skagit-43.84, Snohomish-25.74, Whatcom-33.21
- Arrest rate (per 1,000) of younger adolescents (age 10-14) by county and state:
  - WA-12.49, Island-4.69, San Juan- 0.84, Skagit-21.42, Snohomish-10.74, Whatcom-14.84
- Arrest rate (per 1,000) of younger adolescents (age 10-14) for alcohol and drug law violations by county and state: WA-1.96, Island-0.61, San Juan-0.28, Skagit-5.56, Snohomish-1.51, Whatcom-3.10

In 2016, 6.5% (7,938) of Medicaid non-elderly adults were arrested at least once during the year, slightly below state averages (6.6%). North Sound ACH work in the Diversion Interventions and Transitional Care project areas in particular address criminal justice involvement and how it overlaps with community health. In the Diversion Interventions project area, coordinated cross-sector care collaboratives will be scaled up across the region to provide support for “high utilizer” community members, who are high utilizers of emergency medical services, jails, and social services, to provide coordinated care and alternatives to these systems. Several of these care collaboratives have proven to be successful in our region, and the North Sound ACH will build on this work. In the Transitional Care project area, strategies will be implemented to support successful transitions from incarceration, including supporting community members with finding access to housing, physical and mental health services, and other resources, to reduce the likelihood of recidivism. Many partners are eager to engage in this work, including county jail services, emergency medical services, housing providers, behavioral health providers, and more. The North Sound ACH is confident that through a collaborative approach, arrest rates can be reduced and health outcomes for this population can be improved.

County level rates of victims of child abuse and neglect in accepted referrals exceeds state average (33 per 1,000) in Island (39 per 1,000), San Juan (39 per 1,000), Skagit (41 per 1,000) and Whatcom (45 per 1,000)

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19 ACH Toolkit Historical Data, HCA, released August 17, 2017.
counties, while Snohomish county has the lowest rate in the North Sound ACH region (33 per 1,000). Early criminal justice involvement and violence against children contribute to damaging adverse childhood experiences (ACEs) that have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity, including poor mental and physical health outcomes and success in education and employment (CDC, 2017). In 2013, between 25% to 36% of adults in the North Sound self-reported three or more adverse childhood experiences.\(^\text{20}\) Community partners, especially early child advocates in the Reproductive, Maternal and Child Health (RMCH) project area, have reinforced the importance of preventing ACEs and educating providers about trauma-informed care in all project areas. Strategies in all project areas will be addressing the needs of adults who are experiencing the consequences of ACEs (such as addiction, poor physical health outcomes, incarceration, mental health challenges, etc.), so a key focus of the RMCH area is integrating a life course perspective into all project area strategies. Work in the RMCH area will specifically work to prevent ACEs through supporting planned, safe pregnancies and reducing unintended pregnancies, improving infant and child access to primary care, and collaborating with partners across the region to address social determinants of health.

**Life Expectancy & Mortality**

While the most recent county health rankings indicate the five counties within North Sound are ranked in the top 10 (of 39) of the healthiest counties in the state, data indicates quality of life varies throughout the region. Life expectancy for all residents in the North Sound region is estimated to be 81 years, though varies by census tract from 71 to 90 years (Figure 5). Life expectancy depends on a range of individual and community influences - such as disease, lifestyle, socioeconomic factors- and represents an inclusive, high-level measure for health. Life expectancy data will continue to assist the project planning process by identifying health disparities among population segments in the region.

**Figure 5: Life Expectancy in North Sound & Washington**

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<tr>
<td>Whatcom</td>
<td>81</td>
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Mortality rates allows us to assess underlying diseases, injuries or circumstances that lead to deaths, and assess linkages between social determinants of health and outcomes. Among Medicaid enrollees in North Sound, the

\(^\text{20}\) Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. Chronic Disease Profiles (North Sound) WADOH, April 2016.
leading causes of death (accounting for 70% of all deaths) are 1) cancer 2) unintentional injury, 3) major cardiovascular disease, 4) chronic liver disease and cirrhosis, and 5) intentional self-harm (suicide).\textsuperscript{21}

The overall rate of suicide in the North Sound is 14.6 per 100,000 and varies considerably by county: Skagit (14.1), Snohomish (15.2) and Whatcom (15.8) county’s rates are lower than the Washington State rates, while Island (19.9) and San Juan (18.5) are the highest in the region.\textsuperscript{22} Between 2012 and 2016, 607 individuals died from an opioid related overdose (intentional, unintentional and undetermined) in the North Sound.\textsuperscript{23}

Suicide and overdose deaths are particularly important to monitor as project planning and implementation begins for Bi-Directional Integration of Physical and Behavioral Health Services and Addressing the Opioid Use Public Health Crisis. Both project areas include target populations at increased risk for suicide and overdose and seek to reform delivery systems to better identify and treat these populations. By comparing the mortality rates with prevalence of certain illnesses and/or risk factors, causal relationships may emerge, allowing a better understanding of how certain community health needs may be addressed.\textsuperscript{24}

**Emergency Department Visits & Hospitalization**

Reducing outpatient Emergency Department visits is a priority across all North Sound ACH project areas, and will be addressed through a variety of strategies, including upstream prevention, increasing access to primary care, and providing diversion programs to promote an alternative to the ED when appropriate. In 2016, the leading diagnostic reasons for emergency department visits among Medicaid enrollees residing in the North Sound region were:

- Symptoms, signs and abnormal clinical and laboratory findings- 31946 visits
- Injury, poisoning and certain other consequences of external causes- 30945 visits
- Diseases of the respiratory system- 16362 visits
- Diseases of the digestive system- 9553 visits
- Mental and behavioral disorders- 9062 visits
- Diseases of the musculoskeletal system and connective tissues- 8568 visits
- Diseases of the skin and subcutaneous tissue- 8221 visits
- Diseases of the genitourinary system- 7190 visits
- Pregnancy, childbirth and the puerperium- 5601 visits
- Diseases of the nervous system- 4059 visits

In the North Sound region, behavioral health challenges (including mental health and substance use disorder) and chronic disease are a significant cause of hospitalization among Medicaid enrollees (Table 4). Bidirectional integration of physical and behavioral health, Opioids, and Chronic Disease project areas will be implementing strategies to address these causes. Diversion Interventions will be implementing strategies to connect community members to non-ED services to address the conditions listed in Table 4, as well as providing care coordination to connect ED “high utilisers” to appropriate community services such as primary care, behavioral health care, and community wellness programs. Transitional Care will be implementing strategies to reduce hospital readmissions by supporting patients transitioning out of inpatient hospital and behavioral health settings. These approaches together should reduce hospitalization rates for the North Sound region and promote better health outcomes for community members.

\textsuperscript{21} RHNI Starter Kit, HCA, released May 8, 2017.
\textsuperscript{22} RHNI Starter Kit, HCA, released May 8, 2017.
\textsuperscript{24} Community Commons: Community Health Needs Assessment, September 2017.
Behavioral Health & Substance Abuse

The prevalence of mental illness and addiction is a complex challenge for the health systems, communities, and families in the North Sound. As reported by WADOH’s Chronic Disease Profiles, 21% of 10th graders in the region reported that they have seriously considered committing suicide and 35% reported feeling sad or hopeless. Overall, 17% of adults reported their general health as fair or poor and 12% experienced severe mental stress. Over 10% of Medicaid enrollees were diagnosed with a mental illness, with the highest rates of depression reported for whites (12.3%), American Indian/Alaskan Natives (10.7%), and Non-Hispanic (11.8%) individuals. Asian (4.1%) and Native Hawaiian/Pacific Islander (4.8%) reported the lowest rates.25

Rates of substance abuse, including use of nicotine, alcohol, opioids and other drugs is prevalent in the North Sound among residents with and without Medicaid coverage. County rates of smoking among adults ranges from 13% to 17%. Similarly, rates of binge drinking range from 13% to 19%.26 This type of information has driven collective community health improvement efforts throughout the North Sound to address mental illness and substance abuse disorders as a priority for the last five years. The opioid crisis in particular has been a strong focus of regional partners in recent years, as opioid use and opioid overdose rates have increased. The North Sound BHO created the North Sound BHO Opioid Reduction Plan in 2017, which proposed multiple strategies to promote opioid use prevention, access to treatment, overdose prevention, and long-term recovery options. This plan has formed the basis for North Sound ACH strategies in the Opioids project area, and will be carried out by many diverse partners, including clinical partners, community-based partners, school-based partners, and more. In addition to opioids, many strong community programs in our region focus on reducing nicotine and alcohol use and reducing chronic disease, such as programs through the YMCA, local Community Action agencies, local health jurisdictions, and more.

Mental illness, substance abuse and chronic conditions exacerbate one another, which is why it is a fundamental priority to identify co-occurring illnesses as we further define target populations for project areas and select project interventions. The importance of this data cannot be overstated, the scale of impact these conditions have among Medicaid enrollees in the North Sound are tremendous and evident in the various data provided by the HCA:

- Mental and behavioral disorders (14.5%) are the leading cause of hospitalizations for Medicaid enrollees.
- 83,176 (33%) of jointly served (HCA/DSHS) Medicaid individuals have mental health needs.

26 Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. Chronic Disease Profiles (North Sound) WADOH, April 2015.
• 30,350 (12%) of jointly served (HCA/DSHS) Medicaid individuals have substance abuse disorder treatment needs
• 21,000 (8%) of jointly served (HCA/DSHS) Medicaid individuals were diagnosed with co-occurring disorders.
• 40,626 of Medicaid enrollees were diagnosed with a Mental Illness and one or more chronic condition
• 20,135 of Medicaid enrollees were diagnosed with a Substance Use Disorder and one or more chronic condition
• Adult Medicaid enrollees who were arrested in the last year are nearly five times as likely to need substance abuse treatment compared to those not arrested.\(^{28}\)
• Adults with Medicaid and behavioral health needs were two times as likely to utilize the emergency department three or more times per year, those with co-occurring disorders were over four times as likely to visit the emergency department.\(^{29}\)

Several North Sound ACH project areas will be implementing strategies designed to address the relationship between mental illness, substance use disorder, and chronic disease, including Bidirectional Integration of Physical Health and Behavioral Health, Diversion Interventions, Transitional Care, Addressing the Opioids Crisis, Chronic Disease, and Care Coordination. Integrating primary care and behavioral health care and promoting a “whole person” approach to will be essential to meeting the health needs of high risk community members with co-occurring behavioral health and chronic disease diagnoses. Diversion Interventions and Transitional Care will support Medicaid enrollees in the community to ensure they have access to appropriate, sustainable care options where they live, and reduce the need to visit the Emergency Department. Care Coordination, through implementation of the Pathways Community HUB model, will support high-risk community members and their families in accessing the clinical care and community-based services they need and navigate a complex system. Finally, Chronic Disease and Opioids project areas will implement strategies designed to prevent and appropriately treat (or manage) chronic disease and opioid use disorder.

**Opioid Crisis**

Communities across Washington, including the North Sound region, are currently experiencing an opioid abuse and overdose crisis involving prescription opioids and heroin (Table 5). Approximately 600 individuals die each year in Washington from opioid overdose with an increasing proportion of those deaths involving heroin.\(^{30}\) Between 2012 and 2016, 607 individuals died from an opioid related overdose (intentional, unintentional and undetermined) in the North Sound (Snohomish-488, Whatcom-69, Skagit-66, Island-38, San Juan-9).\(^{31}\) In 2016, there were 38,546 Medicaid enrollees with at least one opioid prescription in the last year, and over 10,000 had a diagnosis history of opioid abuse and/or dependence.\(^{32}\)

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<tr>
<td>Whatcom County</td>
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<td>WA State</td>
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\(^{32}\) RHNI Starter Kit, HCA, released May 8, 2017.
The North Sound ACH will implement a four-pronged approach to addressing the opioid crisis, which includes prevention efforts (improving prescribing practices, medication safety, and education), increasing access to treatment (including Medication Assisted Treatment), overdose prevention through access to Naloxone, and increasing access to long-term recovery. The North Sound ACH strategies are based in the North Sound BHO’s Opioid Reduction Plan, released in 2017 with strong community partner participation.

**Chronic Disease & Risk Factors**

The WADOH Chronic Disease Profiles indicated variability of chronic disease burden and risk for local populations in the North Sound region. Overall, health disparities within chronic disease risk factors and burden were present in population segments by gender, race/ethnicity, age, education and income (Table 6).

<table>
<thead>
<tr>
<th>Measure</th>
<th>WA</th>
<th>North Sound</th>
<th>Health Disparities by Population Segments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Mental Health Status-Adults</td>
<td>11%</td>
<td>10%</td>
<td>Female</td>
</tr>
<tr>
<td>Asthma-Adults</td>
<td>10%</td>
<td>9%</td>
<td>Female</td>
</tr>
<tr>
<td>Diabetes-Adults</td>
<td>8%</td>
<td>8%</td>
<td>Male</td>
</tr>
<tr>
<td>Personal Health Care Provider-Adults</td>
<td>74%</td>
<td>75%</td>
<td>Male</td>
</tr>
<tr>
<td>Obesity-Adults</td>
<td>27%</td>
<td>26%</td>
<td>Female</td>
</tr>
<tr>
<td>Smoking-Adults</td>
<td>16%</td>
<td>16%</td>
<td>Male</td>
</tr>
</tbody>
</table>

**Data Source:** Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. Chronic Disease Profiles (North Sound) WADOH, April 2016.

Actual chronic disease diagnosis rates among Medicaid enrollees are relatively low as reflected in claims data, with 3% showing billing codes for with diabetes diagnosis, 3% with billing for asthma diagnosis and 10% with billing for major depression diagnosis. However, diagnosis rates may not be the strongest measure to indicate the disease burden of chronic conditions, including behavioral health and substance abuse. Analyzing claims data through the lens of the Chronic Illness & Disability Payment System, burden of chronic illness and/or disease can be seen in the association of claims and disease categories (Table 7). The top five chronic illness diagnoses in North Sound were:

1. Depression

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34 Improving Health-Based Payment for Medicaid Enrollees: Chronic Illness & Disability Payment System, University of California- San Diego, 2000.
2. Pulmonary conditions like asthma, COPD
3. Hypertension
4. Gastro conditions like intestinal infections, ulcers and hernias.
5. Osteoporosis, musculoskeletal anomalies

Through implementation of the Pathways HUB for community-based Care Coordination and the Chronic Care Model, including Healthy Homes, Million Hearts and the Chronic Disease Self-Management Program in the project area for Chronic Disease, the North Sound ACH will work in both community based and clinical setting to improve our regions ability to address chronic disease and focus on the populations suffering the greatest disparities.

Reproductive, Maternal and Child Health

A mother’s experience even prior to conception can alter the development of the fetus and child. Lack of prenatal care, unintended pregnancy, teen births, smoking during pregnancy, and breastfeeding for less than two months increases the likelihood of maternal and infant health risks. These risk factors and birth outcomes vary throughout the North Sound ACH region by county (Table 8) and may highlight a lack of access to preventive care, insufficient provider outreach, and/or social barriers preventing utilization of services. In 2016, there were 5,981 births to women with Medicaid coverage and 62% received prenatal care in their first trimester. Among
pregnant women with Medicaid, Island county had the highest rates of prenatal care with 70% (185) followed by 69% (34) in San Juan, 63% (544) in Skagit, 62% (731) in Whatcom and 61% (2217) in Snohomish.  

Partners in the North Sound region are working together to further improve access to prenatal care through home visiting programs like Nurse Family Partnership and Early Head Start. Additionally, the North Sound ACH will implement strategies designed to promote healthy, intended pregnancies, such as One Key Question (designed to identify a patient’s pregnancy intentions in the following year, which can connect them with appropriate contraception or prenatal care) and HealthySteps, which embeds a HealthySteps child development specialist in a primary care practice who is skilled in supporting families identify, understand and manage parenting challenges (including family planning and pregnancy spacing), which can reduce Adverse Childhood Experiences.

Unintended pregnancy is an important measure to monitor as it aggregates a variety of social, behavioral, cultural and health factors- particularly women’s access to tools for family planning. Overall, unintended pregnancies accounted for 37% of North Sound births. Utilization rates of most or moderately effective contraceptive care among Women (15-44) with Medicaid is 31% and Long-Action Reversible Contraception is only 8% as shown in Table 8.

The North Sound ACH plans to implement family planning-based strategies to reduce unintended pregnancies. These strategies include increasing access to and utilization of LARC through provider training and community education, which will be implemented together with primary care providers, family planning providers, and Obstetrician/Gynecological providers (including those providing care to postpartum women). The ACH will build on the success of our SIM “Early Win” Project focused on LARC access, in which providers were trained on LARC counseling and insertion, and educational materials on LARC for providers and patients were developed. This project continues to be supported by community resources from Kaiser Permanente. Another strategy is pregnancy intention counseling through the One Key Question method, which asks patients (or clients in community-based settings) “do you intend to get pregnant in the following year” and supports patients in accessing appropriate, effective contraceptive methods or preparing for healthy pregnancy. This pregnancy intention counseling can happen in any setting, not just primary care or family planning settings, including social service providers, behavioral health providers, and more. The North Sound ACH plans to work with strong partners and advocates in our region including Planned Parenthood, local health jurisdictions, Community Action agencies, primary care providers, and more.  

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Oral Health

The highest priority in the region for oral health is expanding access to and utilization of dental services by Medicaid enrolled adults. In the North Sound, 32% of adults reported that they had not been to a dentist in the last year and 35% reported not having a dentist.\(^{37}\) Despite being eligible for dental services, North Sound residents with Medicaid coverage have lower rates (34.6%) of receiving dental services compared to the state average (38.2%).\(^{38}\) These rates vary by county from 22.5% to 35.6% (Table 9). Only 19.7% of eligible adults (21+) received dental services, while 51.7% of children (20 and under) did receive care.\(^{39}\) Among the 9 ACH regions NSACH overall ranks third best in access, but 9th for adults and 5 of 9 for children. Island and San Juan counties are in the lowest quartile statewide for the "all ages" population.

\(^{37}\) Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. Chronic Disease Profiles (North Sound) WADOH, April 2016.

\(^{38}\) RHNI Starter Kit, HCA, released May 8, 2017.

Federally Qualified Health Centers accounted for approximately 40% of the Medicaid beneficiary claims for dental care in 2016, with 60% provided by private practice or other dental services\(^40\) (Table 10). Barriers to accessing care include insufficient capacity to see adult patients, transportation, location, and cost of care. Residents living in poverty in all five counties stated, “not enough preventative dental care” as a barrier to accessing care. According to the 2015 Snohomish County Low Income Needs Assessment, 11% of low income households stated the location of dental services as prohibitive to oral health. North Sound ACH oral health strategies aim to expand access to and utilization of dental care by addressing these barriers. These strategies include expansion of existing clinic capacity, implementation of new provider models, integration of dental screening and referral into primary care practices, and mobile dental services in community settings.

**Table 9: Medicaid Dental Services Utilization, North Sound**

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>All Ages</th>
<th>Under 20 yrs</th>
<th>Ages 21+ yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Island County</td>
<td>29.3%</td>
<td>46.0%</td>
<td>17.0%</td>
</tr>
<tr>
<td>San Juan County</td>
<td>22.5%</td>
<td>45.7%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Skagit County</td>
<td>35.6%</td>
<td>54.6%</td>
<td>16.5%</td>
</tr>
<tr>
<td>Snohomish County</td>
<td>35.6%</td>
<td>51.1%</td>
<td>21.7%</td>
</tr>
<tr>
<td>Whatcom County</td>
<td>33.2%</td>
<td>53.3%</td>
<td>17.6%</td>
</tr>
<tr>
<td>North Sound</td>
<td>35.0%</td>
<td>52.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Washington</td>
<td>38.2%</td>
<td>56.3%</td>
<td>22.1%</td>
</tr>
</tbody>
</table>

Data Source: Preliminary Medicaid Provider Files Dental Tables, HCA released June 27, 2017.

Immunizations & Communicable Disease

Immunization rates in the North Sound are consistently lower than the state averages (Table 11). Only 31% of toddlers were up-to-date with their vaccinations\(^41\). Vulnerable populations like young children, immunocompromised adults and elderly are more likely to contract life-threatening vaccine preventable diseases. In 2015, there were 327 Pertussis cases in the North Sound, which accounted for 24% of the statewide total.\(^42\) These low rates may be due to a variety of factors, including parents’ opposition to vaccinations, low

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\(^{40}\) Preliminary Medicaid Provider Files Dental Tables, HCA released June 27, 2017.

\(^{41}\) RHNI Starter Kit, HCA, released May 8, 2017.

rates of well-child visits, limited access to primary care, and more. The North Sound ACH plans to implement strategies to improve immunization rates such as HealthySteps, where a HealthySteps child development specialist is embedded in pediatric practices to support families in effective parenting and child development, and can help educate parents on the importance of immunizations and identify and strategize around barriers to receiving immunizations. Additionally, the North Sound ACH plans to collaborate with area partners on immunization education in our region.

<table>
<thead>
<tr>
<th>Measure</th>
<th>North Sound</th>
<th>WA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent (age 13) TdaP &amp; MCV1 immunization rate</td>
<td>45%</td>
<td>60%</td>
</tr>
<tr>
<td>Adolescent (age 13) HPV immunization rate</td>
<td>16%</td>
<td>19%</td>
</tr>
<tr>
<td>Child (Age 2) Combo 10 HEDIS immunization rate</td>
<td>31%</td>
<td>33%</td>
</tr>
<tr>
<td>Adult Influenza Immunization Rate</td>
<td>39%</td>
<td>42%</td>
</tr>
</tbody>
</table>


Sexually transmitted infections (STIs) have been steadily increasing throughout the North Sound ACH region and typically impacting young adults. The most common reportable STI in the North Sound is chlamydia. In 2015, there were 3,694 cases of chlamydia in the North Sound, with 60% (2,203) of those cases in Snohomish county, followed by Whatcom 21% (765), Skagit 11% (399) 8% (307) and San Juan 5% (20) counties. The percentage of female Medicaid enrollees 16–24 years of age in the North Sound who were identified as sexually active and who had at least one test for chlamydia during the measurement year differs from the state average of 51% and varies by county; Island with 39%, San Juan 40%, Skagit 48%, Snohomish 45% and Whatcom 56%. In the Reproductive, Maternal and Child Health Project area strategies will work to increase screening for chlamydia through provider training, as well as embedding a reproductive, maternal and child health perspective in all project areas. Additionally, the Care Coordination project area can increase access to STI screening by connecting community members to the appropriate screening pathway. The ACH can also work to include STI screening as part of a “whole person care” approach to ensure that it is offered as part of regular primary care visits, so that the ACH’s work to increase access to primary care can increase chlamydia screenings.

Tribal Community Health Assessments

Assessing the overall health needs and assets of tribal nations residing in the North Sound ACH region is important when implementing Targeted Universalism in region-wide project planning and provide ongoing technical assistance for any data needs. As stated by Victoria Warren-Mears, Direction of the Northwest Tribal Epidemiology Center, “American Indian and Alaskan Natives in the Pacific Northwest are a small but diverse population. Northwest Tribes have demonstrated their resilience and leadership in facing multiple historical, social, economic and health challenges. Tribal leaders recognize that valid and reliable health statistics are the foundation of a strong public health system. However, AI/AN are not well-represented in local, state, and national health status reports. Without reliable health information, tribes remain limited in their ability to identify priorities and actions that will improve the health of their communities.” The WA State American Indian/Alaska Native Community Health Profiles produced by Northwest Tribal Epidemiology Center Washington and Northwest Portland Area Indian Health Board measures the health status of American Indian and Alaskan Natives residing in Washington is a comprehensive assessment resource. The report identifies similar risk factors and burden of disease among AI/AN, as well as health disparities including:

1. Disparities in maternal and child health indicators (teen pregnancy, smoking during pregnancy adequate

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44 Washington State American Indian/Alaska Native Community Health Profiles, Northwest Tribal Epidemiology Center Washington & Northwest Portland Area Indian Health Board, 2014.
2. Mortality rates (heart disease, cancer, diabetes, unintentional injuries/violence & stroke)
3. Access to care (primary care-annual screenings and exams, dental care & immunizations)
4. Communicable disease (sexually transmitted diseases)
5. Healthy lifestyles and environments (obesity, access to safe, healthy and nutritious foods, smoking/tobacco cessation, asthma & prevalence air quality

Preventive Services and Access to Care

Preventive services can minimize poor health outcomes through early identification of health problems. In the North Sound, there is variation in individual’s access to care, disease management and health screenings among the counties, as well as differences among those with Medicaid or commercial insurance coverage (Table 12).\(^\text{45}\)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Medicaid %</th>
<th>Commercial %</th>
<th>Medicaid Vs. Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to primary care (ages 12–19 years)</td>
<td>87%</td>
<td>89%</td>
<td>Worse</td>
</tr>
<tr>
<td>Access to primary care (ages 12–24 months)</td>
<td>87%</td>
<td>98%</td>
<td>Worse</td>
</tr>
<tr>
<td>Access to primary care (ages 2–6 years)</td>
<td>75%</td>
<td>89%</td>
<td>Worse</td>
</tr>
<tr>
<td>Access to primary care (ages 20–44)</td>
<td>72%</td>
<td>92%</td>
<td>Worse</td>
</tr>
<tr>
<td>Access to primary care (ages 45–64)</td>
<td>76%</td>
<td>96%</td>
<td>Worse</td>
</tr>
<tr>
<td>Access to primary care (ages 65+)</td>
<td>84%</td>
<td>98%</td>
<td>Worse</td>
</tr>
<tr>
<td>Access to primary care (ages 7–11 years)</td>
<td>87%</td>
<td>90%</td>
<td>Worse</td>
</tr>
<tr>
<td>Managing medications for people with asthma</td>
<td>58%</td>
<td>65%</td>
<td>Worse</td>
</tr>
<tr>
<td>Mental health services for adults</td>
<td>47%</td>
<td>28%</td>
<td>Better</td>
</tr>
<tr>
<td>Mental health services for children</td>
<td>61%</td>
<td>33%</td>
<td>Better</td>
</tr>
<tr>
<td>Statin therapy for patients with cardiovascular disease</td>
<td>20%</td>
<td>83%</td>
<td>Worse</td>
</tr>
<tr>
<td>Spirometry testing to assess and diagnose COPD</td>
<td>25%</td>
<td>42%</td>
<td>Worse</td>
</tr>
<tr>
<td>Staying on antidepressant medication (12 weeks)</td>
<td>57%</td>
<td>71%</td>
<td>Worse</td>
</tr>
<tr>
<td>Staying on antidepressant medication (6 months)</td>
<td>42%</td>
<td>54%</td>
<td>Worse</td>
</tr>
<tr>
<td>Blood sugar (HbA1c) testing for people with diabetes</td>
<td>65%</td>
<td>91%</td>
<td>Worse</td>
</tr>
<tr>
<td>Eye exam for people with diabetes</td>
<td>64%</td>
<td>75%</td>
<td>Worse</td>
</tr>
<tr>
<td>Kidney disease screening for people with diabetes</td>
<td>75%</td>
<td>87%</td>
<td>Worse</td>
</tr>
<tr>
<td>Adolescent well-care visits</td>
<td>40%</td>
<td>41%</td>
<td>Same</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>26%</td>
<td>73%</td>
<td>Worse</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>53%</td>
<td>72%</td>
<td>Worse</td>
</tr>
<tr>
<td>Chlamydia screening</td>
<td>48%</td>
<td>36%</td>
<td>Better</td>
</tr>
<tr>
<td>Colon cancer screening</td>
<td>46%</td>
<td>63%</td>
<td>Worse</td>
</tr>
<tr>
<td>Well-child visits (ages 3-6 years)</td>
<td>60%</td>
<td>71%</td>
<td>Worse</td>
</tr>
<tr>
<td>Taking cholesterol-lowering medications as directed</td>
<td>62%</td>
<td>75%</td>
<td>Worse</td>
</tr>
<tr>
<td>Taking diabetes medications as directed</td>
<td>45%</td>
<td>64%</td>
<td>Worse</td>
</tr>
<tr>
<td>Taking hypertension medications as directed</td>
<td>62%</td>
<td>78%</td>
<td>Worse</td>
</tr>
<tr>
<td>Potentially avoidable ER visits</td>
<td>18%</td>
<td>10%</td>
<td>Better</td>
</tr>
</tbody>
</table>

Data Source: Community Check-Up, Washington Health Alliance, 2015.

\(^\text{45}\) Community Check-Up, Washington Health Alliance, 2015.
While it is too early to determine the causes as to why North Sound’s Medicaid enrollees experience worse or better quality of care compared to those with commercial insurance, the Washington Health Alliance’s Community Check-up allows for a deeper dive into hospital, systems, and clinic level data. Linking this type of data with social determinants data will become invaluable as we continue to advocate for culturally appropriate and trauma-informed care with clinical and community-based organizations in Bi-Directional Integration, Reproductive Maternal Child Health, Care Coordination, Opioids, and Chronic Disease project areas.

**PARTNER CAPACITY**

**Regional Health System Capacity**

The North Sound ACH considers ongoing partner engagement key to project implementation success and necessary for leveraging community resources. In the North Sound, there are 32 community health center sites, 16 rural health clinics, 46 North Sound Behavioral Health Organizations (BHOs) contracted behavioral health agencies, eight tribal health clinics, four mobile care services and one correctional complex. We have 10 health systems and hospitals, three of which are critical access hospitals (Table 13). Physical health and primary care providers are uniformly engaged as a sector through the formation of the Health Systems Advisory Council, an ad hoc gathering of health system leaders advising North Sound ACH staff and self-reporting coverage of over 75% of Medicaid Managed Care assignees in the region.

<table>
<thead>
<tr>
<th>Table 13: Hospitals and Bed Counts, North Sound Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
</tr>
<tr>
<td>Whidbey General Hospital*</td>
</tr>
<tr>
<td>PeaceHealth Peace Island Medical Center*</td>
</tr>
<tr>
<td>Island Hospital</td>
</tr>
<tr>
<td>PeaceHealth United General Medical Center*</td>
</tr>
<tr>
<td>Skagit Valley Hospital</td>
</tr>
<tr>
<td>Cascade Valley Hospital</td>
</tr>
<tr>
<td>Providence Regional Medical Center Everett</td>
</tr>
<tr>
<td>Swedish Medical Center- Edmonds</td>
</tr>
<tr>
<td>Valley General Hospital</td>
</tr>
<tr>
<td>PeaceHealth St. Joseph Hospital Bellingham</td>
</tr>
</tbody>
</table>


In the realm of Behavioral Health, the North Sound BHO is a close partner and takes a leadership role in assuring involvement from the region’s BHA’s, particularly for project planning and implementation such as in the area of Bi-Directional Integration of Physical and Behavioral Health services. Both groups will be integral to success in overall project planning and implementation by assuring engagement from our regional health systems.

Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Populations (MUA/P) help us identify geographic areas, population groups, and facilities with too few primary care, dental, and mental health providers. Within the counties of the North Sound, there are 70 HPSA’s and 10 MUA/P.46 HPSAs are used by several state and federal programs to determine eligibility for payment enhancements and workforce programs, this type of information will be vital to workforce planning activities and enhancing recruitment

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46 Health Professional Shortage Areas (HPSA), Medically Underserved Areas/Populations (MUA/P), Data by Geography, FQHC/CHC, HRSA Data Warehouse, 2017.
strategies. The Department of Health (DOH) conducts the Primary Care and Dental Care Provider Survey to determine HPSA status, and the surveys provide county-level information of the rate of dental and primary providers serving Medicaid patients, the proportion of Medicaid patient in practice, and those accepting new patients (Table 14).

| Table 14: Primary Care and Dental Care Provider Survey, North Sound Counties |
|-------------------------------------------------|-----------------|-----------------|-----------------|
| Provider/County                               | % of providers who treat Medicaid patients | % of providers accepting new Medicaid patients | Average practice % of Medicaid patients |
| Dental Care                                    |                                             |                                             |                                |
| Island                                         | 28.6%                                       | 17.9%                                       | 10.4%                         |
| San Juan                                       | 28.6%                                       | 28.6%                                       | 6.0%                          |
| Skagit                                         | 49.1%                                       | 11.3%                                       | 23.6%                         |
| Snohomish                                      | 37%                                         | 21%                                         | 25%                           |
| Whatcom                                        | 43.8%                                       | 19.2%                                       | 27%                           |
| Primary Care                                   |                                             |                                             |                                |
| Island                                         | 72.7%                                       | 40.9%                                       | 26.2%                         |
| San Juan                                       | 93.8%                                       | 68.8%                                       | 8.1%                          |
| Skagit                                         | 79.7%                                       | 73.4%                                       | 9.9%                          |
| Snohomish                                      | 89%                                         | 54%                                         | 17%                           |
| Whatcom                                        | 43.8%                                       | 19.2%                                       | 27.0%                         |

Recent findings from the Washington State Health Workforce Sentinel Network survey data indicates there are changes in workforce needs and demands that must be taken into consideration as project planning continues and implementation begins. According to the most recent data (April-May 2017), the North Sound ACH region is experiencing exceptionally long vacancies for registered nurses, mental health counselors, licensed practical nurses, nursing assistants and physicians, while simultaneously experiencing increasing demand for medical assistants, nursing assistants, mental health counselors, nurse practitioners and registered nurses. This type of information from the Sentinel Network is essential to building a baseline workforce analysis to be folded into broader assessment processes in 2018, when surveying a cross-section of clinical and community-based partnering providers in conjunction with the Practice Transformation Support HUB for all areas of focus in Domain 1. This analysis will identify gaps at the local, regional and statewide level and seek ways for the North Sound ACH to work with partners to address them.

In early 2018, North Sound ACH staff will work with implementation partners and technical assistance contractors to further assess how regional providers are currently serving the Medicaid population. The aim of such assessments would be to answer the following questions:

- How many Medicaid enrollees are assigned and/or being currently cared for by partnering providers?
- How many providers are currently implementing selected evidence-based approach(es) included in the North Sound project portfolio?
- Where relevant, how are partnering providers currently engaged in selected pay for reporting activities?
- Who is and is not currently accepting Medicaid patients? If not, why?

Community-Based Organization Capacity

Regional community-based organizations (CBO’s) exist throughout the North Sound. These community care providers will be critical for successful project implementation. In addition to robust representation at

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all levels of governance, Community Based Organizations are also filling important roles in the planning process for project implementation. Particularly in the project areas of Chronic Disease with use of a fruit and vegetable prescription program and community based lifestyle classes and Care Coordination with the establishment of the Pathways HUB, Community Based Organizations are poised to take a prominent role in all ACH activities in the region. In the North Sound, we have identified:

- 5 transportation services
- 5 local health departments
- 20 housing services
- 17 schools/community colleges
- 21 local, state and federal government agencies
- 19 consumer advocacy organizations
- 57 social service/human service agencies
- 12 homeless shelters
- 14 faith based organizations
- 24 food banks
- 3 immigrant service organizations

Local health departments and community action agencies routinely assess the needs of their constituents through community surveys and/or community events. These community engagement activities are crucial to planning supportive services that meet individual needs and address barriers to care. In the Island County 2015 Community Health Assessment low-income respondents reported their greatest health priorities and barriers. Around 18% of respondents ranked mental health care as a priority, yet the limited availability of mental health providers—those that accept publicly funded insurance and/or able to prescribe medications—and the lack of community services for clients experiencing mental illness were noted as barriers to care. In Island County 13% of respondents said substance abuse treatment was “extremely important” to their household while 20% said these services were “very hard to get.”

In the 2015 Snohomish County Health Service District Community Needs Report over 25% of respondents reported using public transportation every day, yet the lack of transportation was reported by at least 25% of all people interviewed as a barrier to: going to medical appointment, to dental appointments and getting alcohol/drug treatment. From their 2015 Community Health Assessment Skagit County noted the four biggest barriers/challenges to health were 1) stress, 2) time, 3) income, and 4) physical activity and access to healthy foods. In 2015, the Opportunity Council, a community action agency for Whatcom, Island & San Juan Counties, reported that region-wide the most common reasons for not receiving any of four types of health care (medical, dental, mental health, or medications) are the high-cost and not having insurance. In Whatcom county, there is a high level of unmet need for behavioral health care services and an estimated 70.5% of adults eligible for treatment for substance abuse do not receive care.

The North Sound ACH staff will continue to work with community-based organizations, the Community Health Leadership Council and other implementation partners to further identify what community resources are currently available to the Medicaid eligible population and/or proposed target populations. This will be accomplished by:

- Work with partners to review existing resources maintained by the three community action agencies in the North Sound in order to identify services being provided, populations served and service eligibility.
- Identifying how many Medicaid eligible lives are touched by community-based organizations and which organizations serve as coordinated systems that act as a one stop shop for services.

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48 Prosperity Project: Experiences of Poverty in Whatcom, Island and San Juan County, Opportunity Council, 2015.
• Ensure community-based organizations are invited to participate in the North Sound ACH’s Data Learning Team, where suppressed client intake, risk assessments and referral data/information will be reviewed when appropriate.

DATA SOURCES

Below is a comprehensive list of data sources the North Sound ACH has gathered for the RHNI and to inform project area selection. Sources are referenced throughout the ACH Project Plan Template and within each of the eight project areas.

• 10 Priority Areas to Improve the Health & Wellness of Skagit County Residents, Skagit County Population Health Trust, Skagit County Public Health and Community Services, September 2017.*
• 2015 Annual Report for the Community Health Improvement Plan, Whatcom County Health Department, 2015.*
• ACH Profiles Future, DSHS/RDA, released April 11, 2017.
• ACH Toolkit Historical Data, HCA, released August 17, 2017.
• BH and Co-Occurring Disorders, RDA/DSHS, released October 10, 2017.
• Census Reporter, U.S. Census Bureau, 2017.
• Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015.
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ACH Theory of Action and Alignment Strategy

ACHs are encouraged to think broadly about improving health and transforming care delivery beyond the Medicaid program and population. Advancing a community-wide vision and approach will be critical in ensuring the sustainability of health system transformation.

The term “health equity,” as used in this Project Plan Template, means reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.49

The vision of the North Sound ACH is to improve the health of people living in Snohomish, Skagit, Island, San Juan and Whatcom counties. The Board reaffirmed this vision in July 2017, with the objective of acting as a regional collaborative to strategically leverage investments and improve health across and in five counties, including the people served by eight tribal nations. The North Sound ACH region will:

- Build on the region’s strong history of collaboration
- Change the frame from health care to health
- Leverage Medicaid Transformation dollars but not be held captive to it
- Invest strategically to remove/decrease infrastructure barriers
- Learn how to talk about and address equity and disparities

The values that the North Sound ACH leadership have adopted include:

- Acknowledge conflict between our desire to work upstream, and the Medicaid Transformation’s focus on clinical outcomes
- Acknowledge and respect the sovereignty of our Tribal partners
- Focus on communities most impacted by disparities/inequities
- Leverage evidence and emerging data
- Be innovative, nimble and flexible
- Avoid duplication/reduce waste
- Create system-level, sustainable changes
- Agree to first seek understanding, then seek agreement

The North Sound ACH believes that its people are its greatest asset; therefore, our theory of action and alignment strategies revolve around leadership development, building capacity to meet the region’s needs, and building the workforce of the future. In the required attachments, there are visuals that outline how partners connect to projects, how projects connect to varied outcomes, the critical premises that will guide the North Sound ACH’s planning phase, and the toolkit project areas overlap and intersect as we move toward specific approaches and strategies to positively impact the health of Medicaid enrollees in the North Sound ACH region.

The Project Plan Template lays out our best thinking in relation to the eight toolkit project areas with what we know about regional data, assets and potential partners. Total possible DSRIP funding is unknown, the future of Medicaid expansion is unknown, and we still have significant planning to do in the coming year to explicitly lay out implementation of our projects. The people and partners who live in this region, and the ability of providers to care for the people who live in the North Sound ACH region remains our primary focus, and we will work to foster the leadership our region needs.

The ACH continues to develop and leverage partnerships to address challenges impacting population health, such as access to care, network capacity, workforce, and existing resources. Improving population health requires incorporating strategies beyond the health care delivery system, including social determinants of health, primarily led by non-health care focused entities. The ACH understands that doing things differently, may be

more critical and difficult than doing more of the same. We’re continually looking for opportunities for counties, hospitals, CBOs and foundations to invest together on upstream strategies.

The North Sound ACH region is geographically large with diverse populations, including eight tribal nations. One of our counties is only accessible via ferry, and by ferry from island to island within the county. Being 15 miles from a service is vastly different when those miles are along a major highway, as opposed to across the Salish Sea. While 27% of Washington residents are on Medicaid, 31% of Skagit County’s residents and 60% of tribal members are Medicaid enrollees. The need to embed creativity and flexibility in our project planning, design, and implementation is critical to engaging partners.

Using data from the Washington Tracking Network, we found wide variability in social risk factors in key areas. In 2015, data from the region’s county and hospital community health assessments identified three priority areas for our region: care coordination, behavioral health, and addressing health equity. As updated CHAs/CHNAs become available in 2018, we will refine our understanding of the region’s health needs and priorities.

We are exploring partnerships with our region’s five counties to form and support a Data Learning Collaborative, a regional Epidemiologist, and Public Health Chief Health Strategist. We see the five public health departments as key partners to engage and support with our team, including possible financial support.
Indicate projects the ACH will implement (a minimum of four).

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

The minutes of the January 2017 the Board charged the Program Council (formerly the Program Committee) with responsibility to understand details of the Medicaid Transformation Project, expectations of the Medicaid Transformation Toolkit, the Special Terms and Conditions, and utilize that knowledge to discuss and recommend toolkit project areas. The Jan 20, 2017 Board minutes state: “Based on trust, the Board will accept the strong recommendation of the Program Committee.”

In January 2017, the Program Council’s charter outlined laid out several responsibilities, including “recommend to the Board programs and projects that facilitate accessible, affordable, quality services that improve the health of people in the North Sound ACH region; provide guidance and consultation to the Board in setting priorities for programs and services, including but not limited to, the required projects that ACHs are required to implement by agreement with HCA.”

The Program Council charter allows the Program Council to form ad-hoc workgroups to further its work. To date, eight workgroups have been meeting in relation to each of the eight Toolkit project areas.

The Board’s approach to the Medicaid Transformation Project has been grounded in several assumptions:

1. The total funds that the North Sound ACH region could earn would not be sufficient to pay for the broad scope of meeting the region’s needs. We would use the DSRIP earnings to leverage partnerships and other sources of revenue.
2. Deciding how many Toolkit project areas we would write to, would not be the same as agreeing to implement that same number of distinct projects.
3. After the workgroups explored the toolkit project areas, the next step would be to examine and identify the overlaps, intersections and possible synergies among the eight toolkit project areas, resulting in a portfolio of specific strategies and approaches (what we would then call ‘projects’) that cross the eight toolkit areas.

The North Sound ACH Board and staff understand that partners may have different expectations, and we continue to work to bring partners in alignment with our vision and approach. Since announcement of the Year 1 reduction, we have engaged partner leaders, workgroup leaders and our governance structure into candid conversations allowing them to challenge our decision. To date, most are in agreement that we write to all eight toolkit areas and reaffirm or refine that direction before January 2018.

**Staff and Work Group Process**

The workgroups have been staffed by ACH team members, but chaired by community and clinical leaders. Staff have called upon those Workgroup Leads to:

- Help craft and synthesize the approach toward selection and refinement of the toolkit requirements;
- Shape the recommendation of either including or not including a toolkit area in our final recommendation;
- Identify overlaps, synergies and intersections among the toolkit project areas; and
- Challenge assumptions about availability and capacity of partners to engage in the work needed to positively influence the required metrics.

Workgroups have included perspectives and leadership from clinicians (physical, behavioral and substance use), community based organizations, county services, MCOs, tribal partners, and some unaffiliated community members.

**Brief Description of Process: How**

Workgroups have been meeting since mid-spring 2017. Workgroups were first tasked with providing feedback to staff about participant recruitment, with attention to ensuring populating the work group itself – who was missing, how we could assure additional perspectives and voices were included, and assist with making those invitations to join. The workgroups were also charged with becoming familiar with the Toolkit, and providing insight into how the North Sound ACH region could approach the evidence-based models as laid out in the Toolkit, asking if we have willing partners, regional needs related to the Toolkit areas, and strategies to positively impact the identified metrics.

The Board’s vision is to address health in the North Sound ACH region including Medicaid but not limited to Medicaid. Our partners see community members on Medicaid, Medicare, commercial coverage and those without coverage. Workgroup participants understand that the DSRIP efforts allow the North Sound region to transform the delivery of care and services, and that transformation will have an impact broader than Medicaid.

The North Sound ACH developed a framework for selection of project areas (Figure 6), which identified and differentiated required and desired project factors.

For example, improving region-wide health outcomes, as indicated in the toolkit metrics was one of the required criteria, and each approach has to demonstrate how it will improve health in specific metrics, which we consider to be a proxy for improving region-wide health outcomes. In walking through each toolkit project area with its respective workgroup the staff and work group leads assigned a measure of how well their discussions and partners had addressed each item in the framework, acknowledging that more detailed information would occur while discussing detailed approaches in the planning phase.

The framework was crafted considering priorities of the Board and partners, evaluating the toolkit measures and metrics and translating those into a set of criteria that would allow us to distinguish the toolkit project areas, if such distinctions appeared.

The Program Council approved use of this framework to guide selection of the Medicaid Transformation project areas. This framework (Figure 6) was used by workgroups, and the Program Council, in discussing the toolkit requirements.
area selection decisions. Each toolkit project area was assessed a value to determine current strengths and areas for improvement. Project areas were rated from needing additional work (1), somewhat strong (2), to strong (3). This analysis was used to inform the project selection process and identify project areas that were more likely to be successful than others. This process resulted in a decision to move forward with writing to all eight project areas.

**Figure 6. North Sound ACH Project Framework**

**General**
- The project is transformational and aims to accomplish something new, different, better, or more expansive than current efforts
- The project is not duplicative of other work in the North Sound ACH region (prefer complementary, additive, or expand on other work)
- The project has engaged multiple provider partners

**Evidence**
- The project uses an evidence-based model recommended in the Toolkit

**Data**
- The project addresses the metrics required by the Toolkit
- The project addresses a regional health need, as supported by data

**Population**
- The project is relevant to Medicaid, with potential to improve health outcomes for Medicaid enrollees
- The project targets the population required by the Medicaid Transformation Project Toolkit

**Impact**
- The project has potential to increase access to health care and other services
- The project considers social determinants of health
- The project does not protect obsolete models, but does not break models that are working without an adequate improved model
- The project improves population health through clinical management and addressing underlying determinants of health status
- The project has the potential to significantly impact health outcomes and/or reduce inequities

**Infrastructure**
- The project uses a workforce that is currently available and/or increases capacity of available workforce
- The project builds on, or leverages existing infrastructure and supports local efforts for transformation

**Project Planning**
- The project has a plan for sustainability beyond the Medicaid Transformation project years
- The project has the potential to be scaled up and expanded
- The project has incorporated stakeholder and public input, and has a plan for continued engagement
- The project is feasible to implement, including potential cost impacts
- The project can be flexible, and may be implemented in diverse areas, or with diverse populations
- The project has the potential to address an area of critical need in the region, or an area with high acuity

In addition, data was analyzed for each of the eight toolkit project areas and for each workgroup to provide a preliminary analysis of level of need in the North Sound region so that workgroups would only commit to a project area if there was compelling evidence that need was documented. For example, data was shared for Project 2D indicating the number of Medicaid enrollees that appear at the Emergency department for non-acute conditions. This was shared with the workgroups and with the Program Council during its project selection deliberation.
The North Sound ACH laid out its expected timeline for decision related to project selection during late Spring 2017, and was able to stay on target for the timeline, setting a target date of September 7 for the Program Council decision, and September 29 for Board decision. (Figure 8)
How the ACH plans to improve the region-wide quality, efficiency, and effectiveness of care processes:

Selection of toolkit project areas was driven by looking for alignment with known needs in the North Sound ACH region (tied to the RHNI); clinical and community partners with interest, capacity and influence on large numbers of Medicaid enrollees; and engagement of the five counties and eight tribal nations in the North Sound region. Workgroup leaders reached out to potential partner organizations and learned about regional needs identified through available data, recommending toolkit project areas that would improve health across the North Sound ACH region.

One of the North Sound ACH goals is to advance the adoption of VBP, which is closely tied to outcomes that DSRIP is measuring during the P4P phase. Providers who are better prepared and moving toward VBP adoption will be more efficient, and have higher quality measures than those that stay with the status quo of today’s patterns of practice.

The North Sound ACH will work directly with community-based and clinical providers, including MCOs, health system, physical and behavioral health clinicians, counties, tribal partners, first responders, and community based organizations that provide supportive services such as care coordination, housing, transportation, and nutrition, to build bridges across traditional silos, forging and fostering new partnerships to improve health through actions that occur within clinical settings, enhancing them with supportive activities that occur in the community/non-clinical settings.

For example, improving the P4P metric of Hemoglobin A1Cs requires improved screening in physical and behavioral health settings, greater communication and integrated medical planning, and it requires community partners who can help with medication access, appropriate nutrition, affordable food, cooking facilities and physical activity options that will enhance health. Community Health Workers that emerge due to implementation of the Pathways HUB, can provide linkage among and between supportive services that enhance physical health outcomes.
In order to earn DSRIP dollars, the North Sound ACH plans to financially support partnering providers who take part in training on selected practice models, professional development, assessment and evaluation strategies that will improve the care processes and care delivery system. As an independent entity, the North Sound ACH is poised to coordinate and identify opportunities to leverage efforts across the region, provide high-level strategic insight and support to better align transformation activities, and seek out new revenue and partner opportunities. The North Sound ACH is helping to coordinate system wide efficiencies that are challenging from the perspective of any one sector perspective. With a region-wide perspective, that can expand as needs are identified, the North Sound ACH has the ability to leverage resources in ways that are unique.

For example, as we focus on workforce strategies, the near term needs are aimed at current workforce, and those near to completion of current educational programs. Thinking longer term, the North Sound ACH could engage school districts so that we can entice middle and high school students to see career paths that meet the delivery system needs of the future. That would bring new partners to the North Sound ACH table.

The North Sound ACH is drafting a set of requirements for partnering providers that, in addition to their current capacity to participate in the Medicaid Transformation’s project activities, will improve quality of care throughout the region, including:

- Commitment to workforce assessment
- Participate in North Sound ACH trainings and learning collaboratives
- Enroll in WAIIS and PMP
- Agree to data sharing with ACH and Local Health Jurisdictions
- Partnership between clinical and community-based organizations
- Identify leadership staff for planning teams during ACH Planning Phase
- Incorporate One Key Question into internal patient/client assessment process
- Identify providers to take part in LARC training
- Participate in solicitation of other fund/revenue sources for regional health activities
- Attest that there will be no duplication of funds from other DSRIP initiatives

The North Sound ACH is setting these expectations in order to sustain effectiveness, efficiency and quality for the longer term. Without embedding these commitments to change, the partners may see the Medicaid Transformation as a short term effort that will earn them defined funds, rather than as systemic and fundamental change. The North Sound ACH will use DSRIP funds to bring partners to the region who can provide training, technical assistance, some of which will be through the North Sound ACH’s administrative percentage, but mostly through funds that are tied to specific projects. For example, using funds earned for Reproductive Maternal Child Health to support the cost of provider teams being trained on Long Acting Reversible Contraceptives or One Key Question. Whenever possible we will use local and regional resources to provide training and technical assistance to continue building capacity within the North Sound ACH region.

**How the ACH plans to advance health equity in its community:**
The ACH project area is expected to identify target populations (and/or our ‘starting’ place) for the project-focused work. The North Sound has expectation that communities impacted by disparities will be a key driver in selecting those initial target populations, and will be engaged in refining specific projects. To accomplish this, the North Sound ACH will have laid out three strategies so far:

- Incorporate the North Sound ACH Community Leadership Council (CLC) into the governance structure by end of 2017, adding a representative from the CLC to the Board. The CLC will add perspective and voice of those served by Medicaid. It currently has 22 members, of which more than 50% are people on Medicaid or a family member/caregiver of someone on Medicaid. When the Board adopts the charter, a member of the Council will formally join the Board.

- Provide 3-4 learning opportunities each year on health equity and reducing disparities to participating partners, Board and Committee members. Several ACH regions have expressed interest in partnering on these opportunities, including Olympic Community of Health, Better Health Together, CPAA, and North Central ACH. The North Sound ACH launched an Equity Learning Cohort on October 6th, with a training provided by Ben Duncan, Chief Diversity and Equity Officer of Multnomah County, the largest
The North Sound ACH will bring local, regional and national experts on equity to Washington to enhance knowledge in best practices on embedding equity into practice settings.

The overarching goal for the North Sound ACH is to advance leadership in health equity by providing development and capacity building opportunities that share best practices and project implementation around health equity. Each participating provider within the project areas will be expected to have leadership that takes part in the Equity Learning Cohort and to demonstrate how they are embedding and operationalizing equity in their project area.

**How the ACH plans to demonstrate a role and business model as an integral, sustainable part of the regional health system:**

The North Sound ACH is poised to play a leadership role in planning, assessment and convening/facilitation of tough discussions across the region, acting as an incubator for cross sector/multi-sector projects. With a governance structure that includes appointees from each of five counties, up to eight tribal nations, health systems, physical and behavioral health, long term care, public health, education, first responders and community members, the opportunity to discuss challenges that cross traditional divides in immense.

The DSRIP projects offer an opportunity for the North Sound ACH to demonstrate value to the region. There is a strong history of collaboration in the North Sound ACH region, but the shared ownership and decision making about services that impact multiple systems and such a large number of Medicaid lives has never been tried before. Both addressing the opioid crisis and jail diversion serve as examples where the problem touches police, EMS, county jails, courts, behavioral health, physical health, housing, and many more systems. The North Sound ACH does not aim to replace local decision making, but rather to offer an opportunity to have local decisions and authorities have a place to discuss and align strategies. Tribal partners describe the services that they provide, but their clinics also serve non-tribal members, and tribal members seek services from non-tribal settings. The North Sound ACH provides a unique opportunity to discuss and strategically plan for those overlaps and intersections, resulting in better health across the region.

One key measure of success for the ACH structure will be the continued commitment of partners, including Board leadership, to see and act on strategies that leverage the ACH decision making table to move their respective agendas. The ACH structure is only sustainable to the extent that partners find value in its existence.

One example of looking to a new source of revenue lies in the decision to have the North Sound ACH play the role of the Pathways HUB. We will continue to look for opportunities where a small and nimble organization, with an efficient and lean administrative structure can lean into other efforts in the region. The North Sound ACH is prepared to evaluate its role and appropriate size to meet the needs of the region once the Medicaid Transformation Project is coming to completion, and our success in soliciting other funds and supporting partners to continue to play a regional role.

**How the ACH addressed gaps and/or areas of improvement identified in its Phase II Certification, related to aligning ACH projects to existing resources and initiatives within the region:**

There were no gaps and/or areas of improvement noted in the Phase II certification.

**Governance**

North Sound ACH incorporated as a nonprofit corporation with the State of Washington with a Board of Directors responsible for the corporate entity.

The North Sound ACH Board of Directors has the following standing committees who provide oversight or advisor roles in the following:

- **Executive Committee:** The officers and at least one additional Board member serve as the Executive Committee. Except for the power to amend the articles of incorporation and bylaws, the Executive Committee has all the powers and authority of the Board of Directors in the intervals between meetings of the Board of Directors, and is subject to the direction and control of the full Board.
- **Finance Committee:** The Treasurer chairs the Finance Committee, which includes at least two other Board members, and can include non-Board members at the discretion of the Committee Chair. The Finance Committee is responsible for developing and reviewing fiscal procedures, fundraising and fund allocation.
plans, and an annual budget. The financial records of the organization shall be made available to Board members and the public.

- **Governance Committee:** The Board Chair appoints a Board member to serve as Chair of the Governance Committee, which can include Board and non-Board members. The Governance Committee is responsible for the Board’s effectiveness and continuing development, including recommending nominees for Board membership, setting an annual board calendar, Board self-evaluation, and annual review of the bylaws.

- **Tribal Alignment Committee:** The Committee is responsible for examining all board decisions related to impact on our region’s tribal nations. The committee includes representatives from tribal members who sit on the Board of Directors, plus at least one additional Board member who is not a tribal member.

- **Program Council:** The Board Chair appoints a Board member to serve as Chair of the Program Council, which will include Board and non-Board members. The Program Council is an advisory body to the Board and is responsible for making program and project priority recommendations to the Board for consideration, recommending policies and guidelines to the Board.

- **Community Leadership Council (tent.):** Once the charter is approved by the Board (anticipated December 2017) the Chair of the Community Leadership Council (CLC) will be appointed by the Board Chair. The CLC is framed as an advisory body to the Board and is responsible for bringing forward perspectives of people served by the Medicaid program so that those perspectives are embedding in the North Sound ACH planning, process, decision making and evaluation.

**Financial oversight:** The Board’s Finance Committee has oversight responsibility to review and approve monthly financials, review draft budgets and recommend approval to the full Board, approve financial policies and procedures (including banking and investment strategies) and securing independent firms to complete periodic audits of all financials. The Finance Committee also carries responsibility for recommending strategies to the Board regarding administrative/infrastructure cost and rates; sustainability and business plan development and how Medicaid Transformation funds will be shared with partners.

**Clinical oversight:** The North Sound ACH Program Council has key health system and clinical leadership as participants. The Program Council will hear quarterly reports on regional needs and data reports and make recommendations to the Board about possible policy or program directions, including solicitation of additional partners. Representatives from each of the North Sound ACH region’s five counties sit on the Program Council, including physical and behavioral health, housing, maternal child health, counties, tribal partners and community members. Clinical representation is primarily from medium to large systems; outreach to smaller and more rural practices is an explicit goal.

In addition, an advisory group has been formed with leadership from Providence and PeaceHealth, the region’s largest FQHCs, and independent clinical practices. The BHO’s leadership (BHO Executive Board, BHO Advisory Board and Interlocal Leadership Group) serve as subject matter experts and advisors in relationship to BH and SUD. The newly formed Tribal Alignment Committee will also provide clinical oversight and perspective, including how decisions affect tribal members and practices.

**Community:** In the fall of 2017, the North Sound ACH established the Community Leadership Council (CLC), of which over half of the participants are Medicaid enrollees, or family members/caregivers of people on Medicaid. This CLC will provide feedback and input into North Sound’s decision-making and advise on community engagement efforts. The North Sound ACH is committed to meaningful engagement with community members and other stakeholders, and continues to design opportunities for engagement in project planning and implementation. In addition to the CLC the North Sound ACH Board meetings are open to the public, and each meeting has multiple opportunities for public input.

The North Sound ACH has a separate email address that is publicly used for community members to advise the North Sound ACH (voices@NorthSoundACH.org); there is also an email address to communicate with the Board (Board@NorthSoundACH.org).

Beginning in 2018 Board meetings will rotate across the region, including to tribal locations, fostering greater access for community members to learn about and provide feedback on the North Sound direction and decisions.
Data: The North Sound ACH Program Council is responsible for identifying, assessing, analyzing, and translating available data to inform decision-making and other project processes. The North Sound ACH Data and Research Manager will provide quarterly updates on RHNI changes and available data allowing the Program Council to recommend changes or updates to project approaches for the Medicaid Transformation project.

Program management and strategy development: The Board of Directors, in approving the North Sound ACH Program Council’s charter, delegated responsibility for setting program and project recommendations to the Program Council.

The Finance Committee is responsible for ensuring that the organization’s capacity is reflected in the budget and budget assumptions, and all Finance Committee information and recommendations are heard at the Board meeting in public sessions. The Board has delegated to the Executive Director, through an approved Board resolution, responsibility for ensuring staff capacity to lead and manage the projects that we undertake, including development of strategies to meet the agreed upon goals. The Executive Director provides an Operations Update monthly to the Board of Directors, or more frequently as urgent needs arise. The Operations Updates summarize progress toward goals, administrative and staffing changes, and statewide Healthier Washington updates.

The Board, by its composition, includes sector representatives and regional/county representatives, to ensure that we have broad reach across our five counties.

The North Sound ACH currently has 8 full time staff:

- Liz Baxter, Exec. Director
- Kyle Davidson, Deputy Director
- Nicole Willis, Data and Analysis
- Tiffany Edlin, Exec. and Gov. Coordinator
- Ross Howell, Project Manager
- Heather McGuinness, Project Manager
- Leah Wainman, Community Engagement
- Hillary Thomsen, Admin. and Project Coordinator

The North Sound ACH is currently recruiting for three additional positions: A third Project Manager, a Tribal and Community Liaison, and the Pathways HUB Director. The Executive Director is responsible for all final communications efforts on behalf of the North Sound ACH.

Significant changes or developments related to the governance structure since Phase II Certification:
The Community Leadership Council (with a majority composition that are people on Medicaid or family/caregivers of people on Medicaid) launched in September 2017, and has been working to draft its charter. The Council will provide perspectives of people being served by Medicaid and advise on community engagement strategies and policy decisions impacting people on Medicaid. The Chair of the Council will also be a Board member, ensuring two-way communication between the Board and Council.

Areas of improvement identified in Phase II Certification related to its governance structure and decision-making processes:
None were noted in Phase II application.

Process for ensuring oversight of partnering provider participation and performance, including how the ACH will address low-performing partnering providers or partnering providers who cease to participate with the ACH.

The North Sound ACH anticipates partnering providers that will receive payment and some that will not. For example, a local foundation may want to partner, but not be able to receive payment or not desire payment even though they are a key partner for a specific project. The North Sound ACH currently has each project area assigned to a Project Manager, and MOUs/Contracts will lay out the requirements that partners must agree to in order to participate and earn funds. As we begin the planning phase, we are building reporting measures that will allow partnering providers to report on their progress toward pay-for-reporting measures and eventually pay-for-performance metrics. We will build into all MOUs/Contracts expectations of performance levels with adjusted
levels of payment that align with the varied levels of performance. We do not yet have final versions of MOU/partner agreements, as they are currently under review by our legal counsel.

The North Sound ACH is drafting the approach to partner agreements in three phases following with different methods/approaches to payment: 1) the Planning phase which will pay for time and activities; 2) implementation during P4R will pay for time, activities, project participation and implementation; 3) implementation during P4P will pay incentive payments based on performance levels.

If partners do not meet expectations during any of the three phases, the draft plan is that there will be a period of negotiation with the specific partner to better understand the reason for low performance and determine if there is a mitigation strategy before considering terminating the provider from participating, regardless of whether they are being paid or not. Terminating participation from receiving payment would be distinct from determining a partner is not participating in a project area altogether.

We will require documentation along with numbers, for example, in reporting how many people took part in a training for P4R. Partnering providers may also be asked to provide a list of staff by name, or other unique identifier, so that we can be assured that there is no duplication in reporting from time period to time period.

The North Sound ACH, working with other ACH partners are developing a reporting framework, and exploring potential partnerships with Providence’s Center for Outcomes Research and Evaluation (CORE) and King County’s data and analytics section to support reporting during P4R period of the Medicaid Transformation project.

**Community and Stakeholder Engagement and Input**

Healthcare transformation through Accountable Communities of Health offers a unique opportunity to include those communities facing the greatest health disparities, who have traditionally been underrepresented in the decision-making process. In order to ensure the success of transformation projects, and as a reflection of our commitment to equity, the North Sound ACH Board of Directors approved the development of a plan to actively involve those with Medicaid health coverage in the work of the North Sound ACH.

The community engagement process (Figure 9) reflects the guidelines put forth by the Northwest Health Law Advocates and the WA Community Action Networks advising ACH’s on their community engagement activities. From these guidelines, the North Sound ACH created a multifaceted community engagement plan with equity as the guiding force. The engagement plan is a circular model, acknowledging that community engagement is a continuous, rather than finite process. As a part of the ACH commitment to grassroots-level engagement in the North Sound, the organization hired a Community Engagement Coordinator with experience working with Medicaid eligible populations for a local Community Action Agency.

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**Figure 9: North Sound ACH Community Engagement Plan Framework**
Examples of executed actions from the plan include:

**Community Participation in Governance and Program Oversight**

- The formation of a Community Leadership Council (CLC) to join the North Sound ACH’s governance structure. The CLC contains nineteen community members and represents all five counties. The CLC’s membership is comprised of people who are or have received services paid for by Medicaid (51% of participants), and individuals who provide direct services to people with Medicaid health coverage (49% of participants). The CLC will play a key role in tailoring future engagement activities to the specific needs of the communities they represent.
- Many CLC members have participated in workgroups and project planning activities.

**Public Education & Integration of Community Feedback**

- Updates to the North Sound ACH Facebook page, with locations and times where the public can meet and speak with staff during all public and partner events, including Board and Program Council meetings.
- Hosted public forums and community conversations on Opioid Use and Dependency issues in rural eastern Whatcom County.
- In collaboration with a local Community Action Agency: planned two focus groups comprised of graduates of a Financial Literacy and Renter’s Education workshop, including residents of public housing programs, participants in Work First and Temporary Assistance for Needy Families (TANF).

**Develop & Foster relationships with Partners & Stakeholders**

- Formed partnerships with Community Action Agencies in all five counties, a primary source of direct services for individuals who live at or up to 125% of the Federal Poverty Level.
- Provided education for Whatcom, San Juan, & Island Counties Community Resource Networks on the work of the ACH and invited participation of providers and their engaged clients.
• Education for Community Health Workers from Snohomish County Community Health Center on the work of the North Sound ACH, including invitations to both CHWs and engaged patients to participate in the CLC and project area workgroups.

In September 2017, the Community Engagement Coordinator spent 16 of 20 days in the community engaging stakeholders including community members receiving services paid for by Medicaid and direct service providers. The Board and Program Council will continue to seek public input at each meeting to support decision-making processes. In addition, the Community Leadership Council has reserved time during the monthly meetings for additional public input and/or comment. The ACH prompts and solicits community feedback on the North Sound ACH Facebook page on a weekly basis. At every community/partner event the coordinator will deploy a survey for community members with Medicaid health coverage.

North Sound ACH newsletters go out at least once monthly before public meetings of the Board and Program Council, with a mailing list of more than 500 recipients. Events posted on the FB page are also posted with sufficient lead time to allow for planning and transportation in advance of attendance. In addition, we have remote access to meetings.

**Transparency and public input:**

While the North Sound ACH utilizes digital means to disseminate information, including event dates and times to the public in the form of: 1) the North Sound ACH website, 2) the North Sound ACH Facebook page, and 3) the monthly community newsletter. We also call on our diverse and extensive regional partner network to disseminate information to potential partners and other stakeholders, and in the future, we will work with the Community Leadership Council to disseminate ACH meeting and event information on the grassroots level.

All ACH meetings are open to the public with time reserved within every meeting for public input. Since its formation in August, all 2017 dates, times and locations for the CLC meetings have been posted on the North Sound ACH website and Facebook page. Within two weeks of each CLC meeting, minutes are made available to the public and posted to the North Sound ACH website. The North Sound ACH Community Engagement Coordinator has shared CLC dates, time and location at community meetings and partner events 29 times since September 2017.

All ACH Board and Program Council meetings are posted on the North Sound ACH public-facing website. At least a week before each North Sound ACH Board and Program Council meeting, the meeting agenda and materials are made available to the public. Within two weeks following the meeting, recordings and meeting minutes are made available on the North Sound ACH website. Staff provides remote access opportunities for all North Sound ACH public meetings.

The Program Council and Workgroups include broad cross-sections of stakeholders. Stakeholders on the Program Council voiced concerns regarding available information within which to make project selection recommendations during the July and August meetings. The concerns and responses are recorded in meeting minutes. Staff reviewed questions and concerns, then presented data and evidence in response during the August and September scheduled meetings. At any point in between meetings, stakeholders have the ability to reach out to staff including the Executive Director to voice concerns or questions. Responses are provided directly, included as an agenda item for the next regularly scheduled meeting or information/feedback responses are provided in the monthly newsletter.

Community input from all five counties helped shape elements of the Project Plan. Throughout the project selection phase, the North Sound ACH incorporated community responses and feedback found in partner community needs assessments, including the Prosperity Report for Whatcom, Island & San Juan counties, the 2015 Skagit County Population Health Trust Advisory Committee Report: Community Health Priorities, and the 2015 Snohomish County Low-Income Community Needs Report from Community Action Agency of Snohomish County. Examples of how this feedback was incorporated into project selection and planning include:

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North Sound ACH, Submission: Section 1, Narrative
1. In Washington state, only 22% of eligible Medicaid recipients receive preventative oral health services. As part of the community needs assessment process, when asked, residents living in poverty in all five counties stated “not enough preventative dental care” as a barrier to accessing healthcare. According to the 2015 Snohomish County Low Income Needs Assessment, 11% of low income households stated the location of dental services as prohibitive to oral health. In response to the community needs assessments and stakeholder input, including those with Medicaid health coverage, the North Sound ACH included Oral Health as part of our project plan template and plan to address the issue of access through the project.

2. A tribal member, the mother of a child with Substance Use Disorder and a sitting member of the North Sound ACH Community Leadership Council provided project selection input on both the Diversions and Opioid project areas. During the ACH presentation for the North Sound Behavioral Health Advisory Board and in several CLC meetings she voiced her frustration with silos that exists between behavioral health, the courts and the juvenile justice system. In response to CLC member and other community members interviewed as part of the 2015 Snohomish County Needs Assessment, the Program Council approved the Diversions project area and plans to address the issue of breaking down system silos.

3. In Snohomish County, community members living in poverty reported “social and human services are difficult and confusing to navigate,” “inaccurate and conflicting information,” and fear of judgment from direct service providers. During the October CLC meeting, a member reported that health systems are difficult to navigate for a parent of disabled children. She described her efforts as a mother of a child on Medicaid and navigating the different physical and behavioral health systems. In response, the North Sound ACH embraced the Pathways Care Coordination model and its use of Community Health Workers (CHWs) as a means to address these commonly voiced barriers to care. The use of the Pathways model through data connections with the Hub functions as a way to reduce duplicative and inaccurate referrals and information to Medicaid recipients and their caregivers navigating the healthcare system.

Embedded in the Community Leadership Council draft charter is an ongoing commitment to community engagement on the part of each Council member and the Council as a whole. The diversity among council members includes: socioeconomic, professional, geographic, language, and life experiences which will help tailor the community engagement plan to better reach those populations suffering from health inequities, and who we hope to target for population health improvement. Each CLC Council member will serve a two-year term and the coordinator will recruit new members annually. The CLCs engagement plan will encompass the five-plus years of the Medicaid Transformation period, but will also function beyond the Medicaid Transformation period as a Community Advisory Council for all future work of the North Sound ACH.

**Engaging local county government(s):**

There are several ways that North Sound ACH has approached engaging county governments in the work of the Medicaid Transformation.

- During 2017, County Councils/Commissions from each of the region’s five counties were asked to nominate someone to the North Sound ACH Board to foster two-way communication and collaboration between the work of the ACH and the counties. All five counties have nominated a member, with three of those nominations consisting of county elected officials.
- An Interlocal decision making body was formed in the North Sound ACH region to foster discussion on the mid-adopter process and resulting transition decisions for the BHO. Both the North Sound ACH Executive Director and an ACH Board member sit on the Interlocal decision making body.

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• Leadership from each of the five counties (public health and human services) have been engaged in both workgroup discussions and on the Program Council.
• The North Sound ACH Data and Analysis Manager is developing a Data Learning Team, which will include participation from the Health Departments and community assessment capacity in all five counties.

Areas of improvement, as identified in its Phase II Certification, related to community engagement, partnering provider engagement, or transparency and communications:

Challenges/strategies included:
1) Translation of HCA/ACH-speak into plain language to address literacy and health system literacy, as this will enhance understanding of our approaches. This strategy was executed with the guidance of a public health communication consultant who developed audience specific PowerPoint and presentation materials tailored to 1) professionals; 2) community leaders (i.e. community council’s or advisory councils; and 3) general public and other non-healthcare professional community members including those receiving services paid for by Medicaid.
2) Providing financial resources to address barriers such as limited transportation and child care. For our CLC council and guests, childcare and a transportation stipend are provided.
3) Alternate locations/times for engagement opportunities, including scheduled forums and public engagement events throughout the day and on weekends. Public forums have been scheduled in the evenings to be mindful of families including working families. Throughout the engagement process, plans include a focus on community engagement activities in rural or geographically isolated areas including Eastern Whatcom county, Eastern Skagit county, Eastern Snohomish county and the islands of San Juan county. CLC council members from these regions will play a role in planning our engagement activities in these regions.

Tribal Engagement and Collaboration

The North Sound ACH is honored to have success in engaging most of the eight tribes in the region, including having 5 tribal representatives appointed to sit on the ACH Board of Directors (we have Board seats open for each of the eight tribes). Currently, five tribes (Upper Skagit Tribe, Lummi Nation, Swinomish Tribe, Stillaguamish Tribe and the Tulalip Tribes) have appointed members to the Board, and the Director of the Northwest Indian Health Board serves on the Program Council.

Tribal partners in the North Sound ACH region have been engaged in the region’s ACH since 2014, even prior to submitting the application to become a regional ACH. Tribal partners offer examples of creative strategies to approach care of vulnerable populations that all partners in the North Sound ACH region can learn from. Tribal partners held voting seats on the Governing Body, and each tribe has a full voting seat open to their tribe on the Board.

The North Sound ACH has recognized as a nonprofit corporation we are not in a peer relationship with tribal governments, and have therefore made space for tribal partners to define their role with the Medicaid Transformation Project in their own way and at their own speed. Some of this is developing organically as relationships are built, rather than following a linear timeline. The value of these relationships and potential partnerships is greater than the timeline of the Medicaid Transformation project.

This has been strengthened by the experience and strength of the North Sound Board leadership, which recognizes the value of strong relationships with tribal partners, and created space for flexibility and humility in response to tribal leaders describing their frustration with the HCA and North Sound ACH approaches.

For example, we know that Lummi Nation has communicated with the Health Care Authority, indicating its desire to act as its own ACH. Having participation of tribal partners who are working on tribal-specific DSRIP projects, a statewide tribal ACH strategy while continuing to sit at the North Sound ACH table has enriched our region’s work, while we recognize that our tribal partners are challenged to stay engaged because of competing time and tribal government commitments. Sixty percent of Lummi Nation members are on Medicaid, and Lummi is where we see creativity in meeting the needs of their people. There is need, strength and leadership...
that other partners around the North Sound region can learn from, and this is true of each of the region’s eight tribes.

During the last round of election for officers, Councilman Nickolas Lewis, from Lummi Nation, was nominated and elected as vice-chair of the North Sound ACH Board of Directors. Councilman Lewis presented an introductory training to the Board of Directors on tribal sovereignty, and introduced the idea of having North Sound ACH Board meetings occur at tribal nations throughout the coming year, which the full Board endorsed.

The North Sound ACH has used information and insights shared by the tribal representatives to shape our project selection decision and the work group discussions, and this data has been used to influence partner and project area selection.

The ACH’s tribal partners have demonstrated innovative approaches to housing and its relationship to physical and behavioral health care, building supportive housing units that wrap recovery, addiction, employment and family support services, bringing services to the individual/family rather than requiring that families navigate complex systems when they are in crisis. Several counties in the North Sound region have expressed desire to learn more about these approaches, recognizing that tribal members with physical and behavioral health needs use tribal and non tribal service settings. They recognize the connectedness of the needs and the opportunities that exist to work in partnership.

As an example, selection of the oral health toolkit project area was influenced by the opportunity to work with and learn from the Swinomish Tribe and their plan to train and utilize Dental Health Aide Therapists (DHATs). This led to an opportunity to work with multiple ACHs (Olympic Community of Health and North Central and ACH) and the Arcora Foundation, which is also interested in supporting development of this workforce capacity, inside of and outside of tribal clinic settings. This led to interest in the North Sound ACH region to support training of DHATs for broader populations, and the experiences of tribal partners will enhance the ACH’s ability to strategically grow this workforce.

**Areas of improvement identified in its Phase II Certification related to tribal engagement and collaboration:**

In July 2017, following the Phase I application, Councilman Nickolaus Lewis (Lummi Nation) provided a training on tribal Sovereignty to the Board of Directors. The materials from the training are being made available to Board members to facilitate continuous learning. This training is part of a series of planned trainings, with Board members requesting follow-up to learn about tribal nations, assets and project focus areas, and population health statistics.

The Board has expressed interest in learning more about the disparities faced by tribal members across the region, and the ACH will support this request by providing data, particularly for specific project areas, when available.

In addition to trainings and tribe-specific data, the Board is exploring opportunities to rotate meeting locations to be onsite at tribal locations. This would provide an opportunity to increase tribal engagement, continue to build meaningful relationships, and offer Board members an opportunity to learn more about specific tribes and the impact of ACH decisions and actions. The Board has also added the Tribal Alignment Committee to the governance structure, to ensure Board decisions are evaluated by tribal partners.

**Funds Allocation**

**Funds Flow Oversight**

The North Sound ACH will adhere to the requirements laid out for/by the portal for the Financial Executor. We will have MOUs in place for all partnering providers who will be registered in the Portal who can earn DSRIP funds during the 2018 planning year, clearly articulating what is expected in order to earn DSRIP funds, and what (if any) restrictions may be placed on the DSRIP earnings. The North Sound ACH will have project management oversight around deliverables, and CFO oversight to ensure that distribution of funds earned are carried out correctly.
The North Sound ACH has engaged a local financial firm, Powell Business Solutions, to act as our financial management firm and provide CFO services. Powell Business Solutions, together with the Finance Committee and the Executive Director, will oversee stewardship of DSRIP Funds, and assure transparency of how funds are allocated to partners, reporting on a quarterly basis to the Board of Directors in a public meeting. We will publish in early winter 2018, narrative and visual information to explain how partners can apply to be become funded partners and how funds will flow to participating partners. The North Sound ACH’s Board is responsible for ensuring that we have a robust understanding of the funds flow process. Most of that process is within operations delegated to the Executive Director’s oversight. The Board itself is not directly a part of managing the funds flow process, but will be updated on a quarterly basis as to how funds are flowing to the ACH and participating partners. This could evolve, but at this time we are not anticipating a step for the Board in directing or managing the process. Partners are engaged in the process and are required to provide reports and data, that will in turn, be verified by project managers, then by the Independent Assessor.

While we have strong tracking mechanisms in place to track funds that flow through the ACH, we are still developing tracking systems for those funds that will flow between the Financial Executor and participating partners. We have questions about how those funds are attributed to the individual ACH (e.g., are we taxed on them, reportable on a 990, reportable on our financials, as sample questions that we still need clarity on as we move into the planning phase).

**Project Design Funds**

To date, Design Funds have been used primarily to support staffing up the organization, and setting up core infrastructure that is critical to our success in the Medicaid Transformation and long-term sustainability. We have recently secured a lease for the base of our operations in Bellingham, WA that will support our growing team (we currently have eight of our anticipated 12-person staff) and provide a conference room that is accessible for our team, partners, and community organizations.

In 2018, we plan to partner in Skagit County to create a community meeting space that is usable by the ACH, our partners from all five counties, and community organizations. We intend for this space to have audio/video conference capability, allowing remote access to learning collaboratives, shared tools, and trainers.

For the remainder of the Medicaid Transformation, we anticipate using the Design Funds to support core infrastructure (staffing, facilities, operating expenses) and to build reserves that will help launch the ACH as a resource and asset to the North Sound ACH region beyond the Medicaid Transformation. As part of our infrastructure, we are exploring contracts with:

- Center for Outcomes Research and Evaluation (CORE)
- Center for Evidence-based Policy
- Qualis
- Independent contractors who will provide assistance with data analysis, writing and dissemination of results, communication strategies, cloud based platforms such as the Pathways Hub.

We also plan to support a region wide Data Collaborative, providing financial support for counties and community based providers who want to build capacity in learning about available data, and how to visualize and use data effectively.

In early 2018, the Board will approve a strategic plan that outlines intentional approaches to use of the remaining Design Funds, and the percentage of DSRIP earnings that will come to the ACH for administrative management, building a resilience fund, to support non-clinical community based partners who are looking at upstream social determinants of health, and to support advocacy for other investments in the North Sound ACH region through other initiatives, both government and philanthropic.

**Funds Flow Distribution**

In keeping with the values that the North Sound ACH Board has laid out and agreed to, shown in
In keeping with the values that the North Sound ACH Board has laid out and agreed to, Project Incentive dollars will be prioritized toward sustainability of partnerships, relationships, workforce capacity, capacity building and specific projects that will be finalized during the 2018 planning phase. During the August and October Board of Director meetings, funds flow options were presented to the Board, and in November to the Program Council. There was consensus in several areas, knowing that this is not binding, and will vary in percentage allocations from year to year:

- To keep administrative and project management expenses lean and efficient, aiming for less than 10% of all DSRIP funds;
- To allocate a percentage of DSRIP funds to support upstream, longer term efforts that align with the Medicaid Transformation projects, including housing, food security, transportation, employment, advocacy, medication costs, and other efforts that can either inhibit or prevent community members from achieving positive health outcomes.
- The majority of funds would be set for projects and the supportive areas that enhance the viability of projects being successful, including capacity building, and Domain 1 activities of workforce strategies and population health management. Within this large investment, Board and Program Council discussed having 50% of funds steered toward project planning and implementation (shared between clinical and community providers) and the balance (approx. 30%) supporting Domain 1 activities.

Discussion about how to allocate by organization type is in its early stages, and is leading to formation of a Fund Allocation Committee, which will make recommendations to the Board of Directors at its annual meeting in December 2017. This represents very preliminary thinking; we anticipate having this refined during early 2018, but early discussions by the Finance Committee support:

- Seventeen percent to the North Sound ACH:
  - Approximately 9% to the North Sound ACH as a fee for project management and administrative overhead
  - Approximately 5% to the North Sound ACH to use as a Regional Resiliency Fund to leverage upstream investments
  - Approximately 3% to the North Sound ACH for external technical and subject matter consultants and contractors
- Project Planning and Implementation, including support in areas of workforce strategies, population health management and capacity building
  - Approximately 40% to providers traditionally reimbursed by Medicaid, including primary care providers, oral health providers, mental health providers, oral health providers, hospitals and health systems, as examples.
  - Approximately 25% to community-based and social organizations, corrections facilities, counties, care coordinating agencies.
  - Approximately 10% to tribal partners in the North Sound ACH region
  - Approximately 8% to other organizations, including outsourced project management for specific projects, data collection

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**Figure 10: North Sound ACH Values**
Describe the ACH’s anticipated funds flow distribution. In the narrative response, address the following:

- Attest to whether all counties in the corresponding Regional Service Areas (RSAs) have submitted a binding letter of intent (LOI) to integrate physical and behavioral health managed care.

  | YES | NO |
  | XX  |    |

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

  | YES | NO |
  | XX  |    |

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

  DATE (month, year)
If the ACH attests to not having implemented fully integrated managed care, provide date of projected implementation.

DATE (month, year) 1/1/2020

The North Sound region’s five counties each voted to support moving to fully integrated managed care as a transitional mid-adopter. The North Sound BHO’s Executive Board submitted a binding letter to the Health Care Authority on October 6, 2017. Part of the success in moving this work forward has come because of formation of an Interlocal Leadership Structure, even though the enabling legislation to do so did not pass in the 2017 Washington Legislature. The Interlocal Leadership Structure, which included the North Sound ACH Executive Director, a North Sound ACH Board member, tribal representative, all five MCOs and county leadership, focused on a collaborative approach to learning about the current BHO structure and funding, before asking the individual counties to vote to support mid-adopter status.

At the October 20th Interlocal Leadership meeting, the North Sound ACH Executive Director proposed having the Interlocal Leadership group make recommendations on how the mid-adopter incentive payments would be allocated. This was well received, and allows the Interlocal Leadership group shape where the incentive payments could best be invested across the region.

This proposal was presented to the North Sound ACH Finance Committee and Executive Committee on October 20th and was approved in concept. The Board approved this approach at its October Board meeting. We have not yet outlined anticipated use of mid-adopter incentive funds distinguished from our total allocation plan. Having the Interlocal Leadership group identify those strategies is advantageous as a key partner strategy, as members of the Interlocal Group will know best how those funds will support workforce challenges, health information systems, or changes to MCO required processes, as examples.

Required Health Systems and Community Capacity (Domain 1) Focus Areas

Domain 1 Strategies

Capacity building begins with a regional assessment of current state in each of the three Domain One areas and a dialogue with partnering community-based and clinical/behavioral health providers regarding their priorities. North Sound ACH staff have used data from available sources (e.g., MCO and HCA provider surveys) and external technical assistance to collect the information necessary for a current state/gap analysis. Once the ACH has a sense of the current state, expectations will be set with partnering providers, and investments will be targeted toward meeting milestones as planning and implementation begins.

The North Sound ACH is reorganizing the eight toolkit project areas (which were discussed in separate workgroups) to identify overlaps among target populations, sectors or potential partners, settings in the continuum of care and community, and performance or reporting metrics. This will lead to formation of planning teams. Each planning team will be charged with identifying specific needs to be addressed, and incorporating strategies that will support all project areas. Increasing value-based payment (VBP) adoption is a goal for clinical and behavioral health providers already engaged in contracting for their business models, as well as Managed Care Organizations. Workforce deficits in multiple areas will be assessed, including clinical and behavioral health settings, community-based organizations, and care coordination, specifically including community health workers. Innovations and strategies for population health management will be gleaned from Local Health Jurisdictions, clinical and behavioral health providers, aiming toward increasing interoperability and HIT capacity in the region.

The North Sound ACH has received technical assistance from the Healthier Washington Practice Transformation Support Hub (via Qualis), Providence CORE and the Center for Evidence-based Policy and plans to deepen these relationships during the planning phase of the Medicaid Transformation in order to successfully address Domain 1 focus areas necessary to carry out projects in Domains 2 and 3. The initial work
plan with Qualis centers around a regional assessment of provider capacity, including establishing an analysis in the areas of workforce needs, population health management strategies, current interoperability and Health Information Exchange and Health Information Technology efforts already underway among partnering providers in the region. Providence CORE will work closely with North Sound ACH staff to further leverage data resources and systems with implications in the area of population health management.

For VBP strategies, the North Sound ACH utilizes statewide and regional provider VBP survey results as the basis for dialogue with partnering providers, including behavioral health providers and health systems and to encourage further adoption of VBP models and address identified barriers. A separate strategy for VBP adoption will be employed for smaller and rural practices and providers, including efforts to assist with establishing quality improvement/population health management systems that can facilitate greater adoption of VBP payment models in smaller or rural practices. Finally, these activities are vetted and discussed with Managed Care Organization partners to assure their engagement, particularly in the area of encouraging further VBP adoption.

Domain 1 issues were discussed within all eight workgroups, indicating the level of need to address these domain 1 challenges in order to enhance effectiveness at viability of Domain 2 and Domain 3 project efforts.

**Value-based Payment Strategies**

The North Sound ACH supported and promoted the distribution of the 2017 Provider VBP Survey during meetings with a self-formed Health System Advisory Coalition, a group made up of healthcare and health system partners from across the region. Aspects of the survey and the importance of its completion were presented at two different in-person meetings with the survey subsequently distributed via email with accompanying rationale. The North Sound ACH stressed the importance of survey completion to ensure our region was reflected in the statewide results and that region-specific data would later be provided to the ACH and form the baseline of a conversation to increase levels of adoption. The North Sound ACH also signaled to these partnering providers it intends to take a leadership role relative to increasing VBP adoption in the North Sound ACH region by identifying and addressing barriers, disseminating content for capacity building where possible and serving as a resource to identify best practice partners. The North Sound ACH will continue to play a role in this area in broader presentations to the community, thereby establishing and clarifying our intent to impact this important area of system transformation.

Thirteen North Sound entities responded to the VBP Provider Survey distributed by HCA. They included Behavioral Health providers (5), outpatient clinics or facilities (8), inpatient clinics or facilities (3), critical access hospital (1), hospitals (2), Federally Qualified Health Centers (3), Multi-specialty practices (3) and an Independent, multi-provider single specialty practice (1). Of the 12 respondents reporting any revenue in categories 2C-4B of the Health Care Payment Learning and Action Network (HCP-LAN) payment framework, a majority reported some level of Medicaid revenue in these categories (7), the same number for some level of Medicare and Commercial revenue in these categories (5 each), and a lower number reported some level of other government revenue in these categories (4).

These results indicate there are levels of VBP adoption to build from and leverage in the North Sound region that can continue to foster progress. As such, the North Sound ACH will continue to seek additional information beyond the HCA survey, including data from MCOs, and other provider groups.

In a recent meeting of the self-formed Health System Advisory Coalition North Sound ACH staff sought input from participants about the current state of VBP. Those in attendance (from PeaceHealth, Providence, Swedish, Island Hospital, Snohomish CHC and Skagit Pediatrics) related VBP issues are on their radar, particularly for those health systems maintaining operations across multiple ACH areas and other states, as well as smaller providers glimpsing the approaching changes from volume to value in the wider health care finance space.

According to reported regional results from the VBP survey, of the 13 total North Sound partnering providers completing this section of the survey, one expected the current state to remain the same, four expected adoption to increase by up to 10%, five expected adoption to increase by 10%-24%, two expected change by 25%-50%
and one expected an increase by greater than 50%. These results indicate a continued role for the North Sound ACH to encourage continued adoption, given a majority of providers expect change in the next 12 months.

According to reported regional results from the VBP Survey, the top barriers to further VBP adoption include lack of interoperable data systems and lack of access to comprehensive data on patient populations (e.g., demographics and morbidity data, listed by 9 providers). Next were misaligned quality measures and definitions (8 providers), followed by a lack of availability of timely patient/population cost data to assist with financial management and/or misaligned incentives and/or contract requirements (7 providers,) reported insufficient patient volume by payer to take on clinical risk and regulations or policies (federal, state or others) (5 providers,) insufficient patient volume by payer to take on risk and/or differing clinical protocols and/or guidelines associated with trainings for providers, and lack of trusted partnerships and/or collaboration with payers (4 providers,) inability to adequately understand and analyze payment models, lack of or difficulty developing medical home culture with providers, lack of trusted partnerships and/or collaboration with providers outside your organization (3 providers,) implementation of state-based initiatives e.g., State Innovation Model grant, Healthier Washington; Medicaid Transformation Demonstration (1 provider.)

In addition to these results, providers related the following barriers during in-person meetings:

- Difficulties given the lag time associated with claims data
- Interpretation and relevance in the clinical setting and the challenge of incorporating claims based results into EHRs
- Perceived lack of autonomy and difficulty to validate results from five different MCO partners, particularly for smaller practices
- Confusion over the definitions and specifications of individual measures

The North Sound ACH recognizes its role to advocate for increased levels of VBP adoption in the North Sound ACH region and pursues a strategy to communicate, educate and build capacity where possible. The North Sound ACH will engage partnering providers on these barriers and work with them to increase VBP adoption across the region. The North Sound ACH Deputy Director is a member of the MVP Action Team and works to bring information and the statewide perspective back to the region. With final results from the VBP Provider Survey, the North Sound ACH will disseminate the results of that survey and be sure to include VBP as a central topic in conversations with partnering providers. This initiative will extend across all efforts from within the North Sound ACH to effectively message its role to the community and assure continued relevance and traction on this issue.

**Workforce Strategies**

Successfully identifying and addressing regional workforce needs requires a baseline analysis for the North Sound ACH region and leveraging data to drive strategic improvements in targeted areas. Such an analysis of workforce capacity will be folded into broader assessment processes when surveying a cross-section of clinical and community-based partnering providers in conjunction with the Practice Transformation Support HUB for all areas of focus in Domain 1. Additional questions specific to workforce needs will be added to assessment tools to ensure sufficient partner input in this area and inform project planning and subsequent implementation across all project areas. Other data sources will be leveraged as available.

Broader efforts to identify and prioritize innovations will occur at the local, regional and statewide level. Preliminary planning in workgroups for each of the areas of the Project Toolkit identified anecdotal reports of workforce capacity gaps, such as Chemical Dependency Professionals in the area of Bi-Directional Integration and Opioids or Community Health Workers in the area of Care Coordination. Local conversations have also identified potential linkages with educational institutions including the Area Health Education Center (AHEC) at Whatcom Community College. Local connections are also established with leadership at the two local workforce development councils, including Workforce Snohomish and Northwest Workforce Council, responsible for governance and oversight of the workforce development system in the other four counties of our region. A regional approach includes leveraging data to inform the project planning process and provide a
background to a current state analysis with partners. These data will be generated by the North Sound Data team and shared out to assure a data driven approach.

Contacts have been established and dialogue is ongoing with representatives from the Health Care Authority, the Health Workforce Council, the Health Workforce Industry Sentinel Network, including review of the 2015 Annual Report from the Health Workforce Council with an eye towards generating regional data. HRSA and DOH reports on Provider Shortage Areas will also inform the regional lens, as will dialogue and support from the University of Washington’s Center for Health Workforce Studies. At the statewide level, the North Sound ACH will participate alongside other ACHs in the development of a statewide strategy in the area of workforce issues specific to ACH Medicaid Transformation priorities. Working together for statewide efforts will be necessary to mitigate impacts on the Medicaid population accessing services in multiple ACHs and the partners whose service areas likewise extends beyond ACH borders.

Finally, planning in multiple project areas includes preparation for implementation of models with trainings to support existing workforce and strategies to support team-based care, such as Healthy Steps, the Oral Health Delivery Framework, the Coleman Care Transitions Model, the Collaborative Care Model and the Chronic Care Model. These models will be strengthened by providing opportunities to improve partner knowledge in the areas of cultural competency and health literacy. These initiatives and projects may also require expansion of existing workforce capacity and the North Sound ACH will seek to support these efforts through training and identification of these new workforce models. Ongoing targeted conversations with partnering providers will yield dialogue on their priorities, such as questions of scope for RN’s, LPN’s and MA’s, or a need for Certified Substance Abuse Counselors in Bi-directionally integrated settings of physical and behavioral health.

Population Health Management Systems

The first step in a region-wide approach to Population Health Management systems will be the completion of a clinical practice assessment with our partnering providers in concert with Qualis and the Practice Transformation Hub. The Patient Centered Medical Home Assessment (PCMH-A) is a widely tested and vetted tool for gauging individual practice readiness for practice transformation. Although additional questions can be added to the assessment as needed, the baseline query provides significant insight into identifying Population Health Management capacity. Engaging partnering providers to complete the assessment and reporting out aggregated results will provide the baseline for current Population Health Management systems capability, including capacity and gaps in the North Sound region.

Once this foundational assessment of clinical providers is completed, the aggregated data will be shared with the various project planning teams with the stated expectation to incorporate/align Population Health Management strategies into their process and subsequent implementation. The planning teams will include representatives from partnering providers, Managed Care Organizations and other North Sound ACH stakeholders and can focus on expanding, using, supporting and maintaining Population Health Management systems across all projects. Many of the larger health systems using EHRs such as Epic, NextGen, AthenaHealth, and Meditech 6.1 have built-in Population Health Management tools and registries such as HealthyPlanet in Epic or HQM in NextGen. The activities of the planning teams will seek to leverage these existing capabilities wherever possible.

North Sound ACH is open to consider engagement and training for Population Health Management systems as needs are identified by individual providers and the planning teams, but will also work to identify a best practice regional engagement and training strategy, as well as options for interoperability. For example, the North Sound ACH is examining possible options for regional interoperability and communication across EHRs and HIT platforms, including EDIE/PreManage for Care Management, ImageTrend for EMS and Community Paramedicine, and CCS for Care Coordination agencies. Where EHRs used by providers do not support functional Population Health Management capabilities, the ACH will assist partners in exploring options from compatible third-party tools.

At the level of statewide and regional innovations, the North Sound ACH will partner with other ACH, MCO and statewide partners to identify shared HIT needs and opportunities and partner where possible for expanded purchasing power. Opportunities may include coordination with state-level partners to expand and enhance use
of existing statewide systems such as the Immunization registry, the Prescription Monitoring Program (PMP), the Clinical Data Repository and the Emergency Department Information Exchange (EDIE.) Given that Medicaid enrollees access services across multiple ACH regions and providers likewise have operations across these same borders, maintaining a statewide approach will be both expedient and necessary.
## SUPPLEMENTARY MATERIALS CHECKLIST

### SECTION I: ACH-LEVEL

**Regional Health Needs Inventory**

None

**ACH Theory of Action and Alignment Strategy**

- Attachment(s): Logic model(s), driver diagrams, tables, and/or theory of action illustrations that visually communicate the region-wide strategy and the relationships, linkages and interdependencies between priorities, key partners, populations, regional activities (including workforce and population health management systems), projects, and outcomes.

**Governance**

- Attachment(s): Visual/chart of the governance structure

**Community and Stakeholder Engagement and Input**

- Attachment(s): Evidence of how the ACH solicited robust public input into project selection and planning

**Tribal Engagement and Collaboration**

- Optional Attachment(s): Statements of support for the ACH from ITUs in the ACH region

**Funds Allocation**

- Supplemental Data Workbook: Funds Distribution Tabs

**Required Health Systems and Community Capacity (Domain I) Focus Areas for all ACHs**

None

### SECTION II: PROJECT-LEVEL

**Project Selection & Expected Outcomes**

None

**Implementation Approach and Timing**

- Supplemental Data Workbook: Implementation Approach Tabs

**Partnering Providers**

- Supplemental Data Workbook: Partnering Providers Tabs

**Regional Assets, Anticipated Challenges and Proposed Solutions**

None

**Monitoring and Continuous Improvement**

None

**Project Metrics and Reporting Requirements**

None

**Relationships with Other Initiatives**

None

**Project Sustainability**

None