NORTH SOUND ACH 2018 PARTNER APPLICATION: Part 1

Please provide the following information in the form below. Additional pages can be used if you need more space.

Organization Name:	EIN/Tax ID:
Organization Name Listed on W9:	
Physical Address:	
Mailing Address, if different:	
CEO/ED Name:	
CEO/ED Email:	Phone:
Application Completed by:	
Name:	Title:
Email:	Phone:

Counties Served by Your Organization: (check all that apply):

☐ Island ☐ San Juan ☐ Snohomish ☐ Skagit ☐ Whatcom

Select sectors that best describes your organization: (You can select more than one)

☐ Behavioral Health ☐ Primary Care ☐ Hospital/Health System

☐ Education ☐ Employment ☐ Emergency Medical Services

☐ Food/Nutrition ☐ Housing ☐ Public Health

☐ Social Services ☐ Transportation ☐ Tribal

☐ Other (please identify)

Select the best descriptive type for your organization: (you can select more than one)

- ☐ Medical Provider (Primary Care, Specialty, Hospital, or Emergency Department)
- ☐ Behavioral Health Provider (Substance Use Treatment and Mental Health Treatment)
- ☐ Tribal Health Clinic
- ☐ Tribal Behavioral Health
- ☐ Fire & Rescue with EMS
- ☐ Law Enforcement
- ☐ Education Organization
- ☐ Community Action Agency/Program
- ☐ County Public Health, Health or Human Services
- ☐ Area Agency on Aging
- ☐ Other Agencies (not otherwise described) _____

How many employees does your organization have in the North Sound region?

- ☐ 1 - 25 Employees
- ☐ 26 - 99 Employees
- ☐ 100 - 999 Employees
- ☐ 1000 or more Employees

Which North Sound ACH project area(s) is your organization prepared to work on (refer to Attachment A for more information about each project area before responding):

- ☐ Community Based Care Coordination
- ☐ Care Coordination During Care Transitions
- ☐ Reproductive/Maternal Child Health
- ☐ Addressing the Opioid Crisis
- ☐ Diversion Interventions
- ☐ Chronic Disease Prevention and Management
- ☐ Access to Oral Health Services
- ☐ Bi-Directional integration of Physical and Behavioral Health

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Does your organization provide care and/or services to people who are eligible for/enrolled in Medicaid (Apple Health)? ☐ Yes ☐ No

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Does your organization track the Medicaid status of your patients or clients? ☐ Yes ☐ No

If yes, for the calendar year 2017, how many Medicaid enrollees (unduplicated) did your organization serve?

_____

North Sound ACH will be facilitating trainings on evidence-Based Models for the initiatives. Some may be in-person while others will be web-based. Partnering providers must commit that staff will learn about models and best practices for any initiative area the organization commits to. How many employees does your organization anticipate taking part in trainings in each of the initiative areas below?

- _____ Community Based Care Coordination
- _____ Care Coordination During Care Transitions
- _____ Reproductive/Maternal Child Health
- _____ Addressing the Opioid Crisis
- _____ Diversion Interventions
- _____ Chronic Disease Prevention and Management
- _____ Access to Oral Health Services
- _____ Bi-Directional integration of Physical and Behavioral Health

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Does your organization enter data in WA's immunization registry (WAIIS)? ☐ Yes ☐ No

Does your organization enter data in WA's Prescription Monitoring Program (PMP)? ☐ Yes ☐ No

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Does your organization use an electronic health/service record (EHR)? (Check only one)

- ☐ Yes, all charts are electronic; no paper charts
- ☐ Yes, although we still have some paper charts
- ☐ No, but we plan to implement
- ☐ No, and we have no plan to implement

If Yes, what system does your organization use?

Does your organization allow patients/clients access to their records/charts? ☐ Yes ☐ No

Does your organization allow patients/clients access to narrative notes in their records/charts?

☐ Yes ☐ No

What services does your organization currently provide to people on Medicaid? (select all that apply)

- ☐ Physical Health Services (Primary Care, Pediatrics, Inpatient Hospital services)
- ☐ Emergency Department or EMS Diversion Interventions
- ☐ Reproductive and Maternal Health Services
- ☐ Behavioral Health Services (Mental Health or Substance Use services)
- ☐ Substance Use Disorder Prevention, Overdose Prevention, Treatment and Recovery
- ☐ Inpatient Mental Health Hospital and Facility Transitional Care Services
- ☐ Dental Care and other Oral Health Services
- ☐ Food Security & Nutrition Services
- ☐ Housing & Homelessness Services
- ☐ Transportation Services
- ☐ Care Coordination with external services/organizations (beyond your own organization)
- ☐ Law Enforcement or Jail Diversion Interventions
- ☐ Jail and Incarceration Transition Services
- ☐ Pharmacy Services
- ☐ Community-based Chronic Disease Prevention & Management (i.e., diabetes, heart disease, asthma)

Identify populations that your organization serves (check all that apply):

- ☐ Chronic and/or high system utilizers (medical, law enforcement and/or social services)
- ☐ At-risk and/or experiencing homelessness
- ☐ Experiencing serious mental illness
- ☐ At-risk and/or previously arrested and/or incarcerated
- ☐ At-risk, misusing, using and/or abusing opioids
- ☐ At-risk and/or experiencing Adverse Childhood Experiences, Abuse and/or Trauma
- ☐ At-risk and/or experiencing co-occurring disorders/conditions (MI/SUD/Chronic Conditions)
- ☐ At risk and/or experiencing disparities in access and utilization of health services
- ☐ At risk and/or experiencing health outcome disparities
- ☐ Women (15-44 year) with high-risk or unintended pregnancy

Does your organization currently have an internal practice transformation, quality improvement, or population health management team that supports transformation activities through data and coaching? ☐ Yes ☐ No

If yes, identify key personnel for these activities _____

_____

Is your organization willing to measure and assess progress and continuously improve processes?

☐ Yes ☐ No

Is your organization able to participate in an online reporting system that may require the upload or submission of data and information related to transformation efforts?

☐ Yes ☐ No

Does your organization include patients and/or clients in:

_____ Governance (please describe)

_____ Operations (please describe)

_____ Decision making (please describe)

Does your organization have the current capacity to implement significant change(s) (e.g., will it compete with other major changes currently being instituted in your organization)?

_____ Yes, we have the capacity currently to transform because:

_____ No, we do not have the capacity currently to transform because:

Organization's Authorized Signer:

I attest that I, the undersigned, have the authority to sign on behalf of my organization, and that the responses provided above are accurate and understand that by submitting the completed Application I am agreeing to the criteria laid out for participation in the 2018 Implementation Planning phase of the Medicaid Transformation Project with the North Sound ACH.

Name (Printed): _____ Title: _____

Signature: _____ Date: _____