

# Greater Columbia Accountable Community of Health

WA State Board of Health  
*11-9-16*



Washington State vision for creating healthier communities and a more sustainable health care system by:

Building healthier communities through a collaborative regional approach

Ensuring health care focuses on the whole person

Improving how we pay for services



# Accountable Communities of Health



*Healthier Washington is bringing together providers, social service organizations, health plans, hospitals, county governments, tribes, and others through nine regional **Accountable Communities of Health**. ACHs will support communities in making informed decisions on health needs and priorities.*

# Community Empowerment & Accountability



## Accountable Communities of Health (ACHs) will:

- **Provide a multi-sector voice** for delivery system reform, shared health improvement goals and regional purchasing strategies.
- **Serve as a forum for regional collaborative decision-making** to accelerate health system transformation, focusing on social determinants of health, clinical-community linkages, and whole person care.
- **Accelerate physical and behavioral health care integration** through financing and delivery system adjustments, **starting with Medicaid.**

# Medicaid's Transformation Goals

- Reduce avoidable use of intensive services and settings
- Improve population health
- Accelerate the transition to value-based payment
- Ensure that Medicaid per-capita cost growth is below national trends

# Waiver Initiatives

## Initiative 1

Transformation through Accountable Communities of Health

### Delivery System Reform

- Each region, through its Accountable Community of Health, will be able to pursue projects that will transform the Medicaid delivery system to serve the whole person and use resources more wisely.

Transformation Projects

## Initiative 2

Enable Older Adults to Stay at Home; Delay or Avoid the Need for More Intensive Care

### Benefit: Medicaid Alternative Care (MAC)

- Community based option for Medicaid clients and their families
- Services to support unpaid family caregivers

### Benefit: Tailored Supports for Older Adults (TSOA)

- For individuals “at risk” of future Medicaid LTSS not currently meeting Medicaid financial eligibility criteria
- Primarily services to support unpaid family caregivers

Medicaid Benefits/Services

## Initiative 3

Targeted Foundational Community Supports

### Benefit: Supportive Housing

- Individualized, critical services and supports that will assist Medicaid clients to obtain and maintain housing. The housing-related services do **not** include Medicaid payment for room and board.

### Benefit: Supported Employment

- Services such as individualized job coaching and training, employer relations, and assistance with job placement.

# Medicaid Population: Greater Columbia ACH

SUMMARY GROUP NAME	Statewide Total	GCACH ADULTS	GCACH CHILDREN	TOTAL 2016	County Population	OFM April 1, 2016
AEM Expansion Adults	298	64	0	64	Asotin	22,150
Apple Health For Kids	797,098	524	131,598	132,122	Benton	190,500
			*18%			
Elderly persons	73,717	7,447	0	7,447	Columbia	4,050
		*1%				
Family (TANF) Medical	33	4	1	5	Franklin	88,670
Family Planning	11,754	1,737	86	1,823	Garfield	2,200
Former Foster Care Adults	2,134	248	34	282	Kittitas	43,710
Foster Care	29,375	35	3,272	3,307	Klickitat	21,270
			*.45%			
Medicaid CN Caretaker Adults	137,374	18,088	0	18,088	Walla Walla	60,730
		*2.5%				
Medicaid CN Expansion Adults	596,958	70,133	0	70,133	Whitman	47,940
		*10%				
Other Federal Programs	21	0	0	0	Yakima	250,900
Partial Duals	60,123	6,849	0	6,849	Total GCACH Pop	732,120
		*.9%				
Persons with disabilities	149,983	14,017	3,497	17,514	Total GCACH Pop Medicaid	260,535
		*1.9%	*.5%			
Pregnant Womens Coverage	17,242	2,901	0	2,901		
		*.4%				
Total WA State 2016	1,876,110	122,047	138,488	260,535		
	26.5%	*17%	*18.9%	*35%		

# Greater Columbia Governance Structure



**Mission: The mission of the Greater Columbia Accountable Community of Health is to advance the health of our population by decreasing health disparities, improving efficiency of health care delivery, and empowering individuals and communities through collaboration, innovation, and community engagement.**



# Backbone Organization

BFCHA  
Carol Moser  
Aisling Fernandez

Eastern WA University  
Dr. Patrick Jones

## Board of Directors

### Public Health

Columbia County  
Martha Lanman

### Hospital

Yakima Memorial Hospital  
Eddie Miles

### FQHC

Tri-Cities Community Health  
Martin Valadez

### Healthcare Provider

Sunnyside Community Hospital  
Brian Gibbons

### Mental Health Provider

Comprehensive Mental Health  
Ed Thornbrugh

### CBO/FBO

Catholic Family and Child Services  
Darlene Darnell

### Social Services

SE WA Aging and Long Term Care  
Lori Brown

### Local Gov't

GCBH Executive Director  
Ken Roughton

### Education

ESD 123  
Les Stahlnecker

### Philanthropy

Three Rivers Community Foundation  
Carrie Green

### Managed Care

Coordinated Care  
Andrea Tull

### Housing

Yakima Neighborhood Health  
Rhonda Hauff

### Business

TBD

### Tribes

Yakama Nation  
Frank Mesplie

### Public Safety

Kittitas Fire  
John Sinclair

### Consumer

Northwest Justice Project  
Jefferson Coulter

### Transportation

People for People  
Madelyn Carlson



# Regional Needs Assessment

Measures for which all counties in the region had outcomes worse than the state

- Access to dentists
- Access to exercise opportunities
- Access to mental health providers
- Children in poverty
- Healthy community design
- Median household income
- Poor academic performance

# Guiding Principles

- Promote a culture of health and health equity
- Facilitate a regional population health approach
- Engage the community
- Focus on prevention and early intervention
- Ensure strategies are data-informed, aligned, culturally competent, and sustainable

# The Culture of Health Framework

Making health a shared value

- Changing mindset and expectations
- Developing sense of community
- Increasing civic engagement

Fostering cross-sector collaboration to improve well-being

- Increasing number and improving quality of partnerships
- Investing in cross-sector collaboration
- Developing policies that support collaboration

Creating healthier, more equitable communities

- Improving built environment/physical conditions
- Improving social and economic environment
- Developing policy and governance

Strengthening integration of health services and systems

- Increasing access
- Improving consumer experience and quality
- Achieving balance and integration



# Building Blocks

## Guiding Principles

- 1) Promote a culture of health and health equity
- 2) Facilitate a regional population health approach
- 3) Engage the community
- 4) Focus on prevention and early intervention
- 5) Ensure strategies are data-informed, aligned, culturally competent, and sustainable

## Strategic Issues

- 1) Foster cross-sector collaboration
- 2) Build healthier, more equitable communities
- 3) Strengthen the integration of health services and systems

## Goals

- 1) Communities have partnerships that improve well-being
- 2) Communities have social, economic, and built environments that improve equity
- 3) Communities have access to care that improves well-being
- 4) Communities have integrated health care and other systems that improve population health

## Strategies

- 1) Develop community capacity to implement collaborative health programs and policies
- 2) Develop community capacity to fund safe, community-based physical activity programs
- 3) Develop and implement behavioral health programs with clinical-community linkages
- 4) Develop and implement diabetes/obesity programs with clinical-community linkages
- 5) Develop and implement oral health programs with clinical-community linkages
- 6) Develop and implement integrated health and education programs
- 7) Develop and implement care coordination programs with clinical-community linkages

# Evidenced Based Community Interventions

## Community-based behavioral health

- Child-parent centers
- Depression screening
- Dropout prevention programs
- Dropout prevention programs for teen mothers
- Group cognitive-behavioral therapy
- Mentoring programs for high school graduation
- Mobile technologies
- Patient shared decision-making
- Preschool programs with family support services
- School-based health centers
- School-based social and emotional instruction
- Telehealth

## Community-based care coordination

- Emergency department diversion dental program
- Mobile technologies
- Patient navigators
- Patient shared decision-making
- School-based health centers

## Community-based diabetes/obesity

- Chronic disease self-management programs
- Diabetes group visits
- Mobile technologies
- Obesity screening (children and adolescents)
- Obesity screening and management (adults)
- Patient shared decision-making
- School-based health centers
- Self-management education in community gathering places (adults)
- Technology-supported multicomponent coaching or counseling interventions to maintain weight loss
- Telehealth

## Community-based oral health

- Community water fluoridation
- Dental caries screening (children)
- Emergency department diversion dental program
- Mobile dental services
- Patient shared decision-making
- Prenatal oral hygiene
- School-based health centers
- School-based services

# State Innovation Model (SIM) Project

- **Care Transitions: Coordinating the medical and social services needed to improve patients' likelihood of readmitting to the hospital within 30 days of their last hospital stay.**
- **Working with Consistent Care Services, the Pilot will identify 40 patients (25 Kadlec, 15 Trios) and transition their care into their home with follow-up visits from WSU Nursing students.**





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**Thank you**