Name of Organization: **Aging & Long Term Care of Eastern Washington (ALTCEW)**

Key Contacts(s): Lynn Kimball, Executive Director; Beth Johnson, Planning & Resource Director

Email Address(es): lynn.kimball@dshs.wa.gov ; Elizabeth.johnson@dshs.wa.gov

Phone Number(s): (509) 458-2509

What services does your organization provide?

- Community Living Connections – connection to social service resources and supports, includes information, assistance, and person-centered planning. Target is older adults age 60+, people with disabilities, and individuals with long term care needs. Up to date resources for connection to housing, nutrition, transportation, personal care, and all senior services.
- Benefit and Insurance Counseling – In person and telephonic assistance with online Medicaid applications, applications for public benefits, exchange counseling, and Medicare education and counseling.
- Care Coordination – Provide care coordination for high risk Medicaid only and dual eligible population through the Health Homes program. Can screen for program eligibility. Clients receive monthly visits from care coordinator who provides support in developing a health action plan, coaching for self-management, and assistance with connecting with providers and community supports. Population includes individuals experiencing challenges with chronic disease, mental health, substance use, homelessness and long term care.
- Caregiver Support – Assistance and support to prevent caregiver burnout including respite care, counseling, medical equipment, support groups, and more. Screening and connection to services. Stabilizing caregivers helps support a stable environment for patients. Uses evidence based assessment tool.
- Medicaid In-Home Care – Provide case management for individuals receiving Medicaid In-Home Care, and coordinate support / plan of care so individuals 18+ can receive paid personal care and remain safely in the community and out of institutions.
- Training – Provide evidence-based A Matter of Balance training for senior fall prevention. Provide caregiver training for professional and family caregivers (home care aide certification, nursing assistant certification, mental health specialty, dementia specialty, nurse delegation, and continuing education).

Please describe the target populations you seek to serve:

- Older adults age 60+
- Persons 18+ with long term care needs
- Caregivers, paid and unpaid
- People with disabilities
- People with dementia and their care partners
- High risk Medicaid and dual-eligible clients eligible for Health Home care coordination

What is your approach to culturally-sensitive services? (ex: translation services, racial-ethnic populations served, etc.)

- Provide written, telephonic and in-person translation
- Bilingual and bicultural staff – current language capacity includes Russian, Ukrainian, Farsi, Spanish and Nepali
- Target services to ethnically diverse and limited English speaking populations, including services to immigrant and refugee populations
- Provide training to staff to promote skills in cultural sensitivity

Does your organization play a role in diverting clients from high-cost services (ex: ER, hospitalization)?
If so, please describe:

- Care Coordination clients through Health Homes receive timely care transition services, including hospital visits, follow up visits, and coaching. Services coordinated through EDIE alerts.
- Community Living Connections – by connecting individuals to community services, Medicaid funded services, and other benefits, we can assist in stabilizing client health and help the family develop an in-home care plan.
- Caregiver support prevents caregiver burnout and can help deter "ER dumping" when caregiver burnout reaches significant levels.

In one or two sentences, please tell us why a Partnering Provider would want to include your organization in their plan (related to Medicaid Transformation):

- Persons with long term care needs and older adults are significant cost drivers to health systems. We are your local experts in resources and services for this population. We are willing to partner with organizations to better serve our target populations both within and outside of the waiver.

Are there specific Partnering Providers you hope to partner with? If so, in what capacity?

- We are particularly interested in working with primary care partners, to help connect patients to community resources. We are also interested in working with behavioral health partners to better coordinate and connect patients to appropriate care.

Describe how you see your organization involved in the Partnering Provider Transformation Plans, within the following project areas.

Bi-directional Integration of Care

- Able to connect clients to social service information, supports, and benefits through the Community Living Connection program.
- Able to provide assistance with benefits counseling for individuals aging into Medicare from the Medicaid expansion.
- Screening and application assistance for Medicaid In-Home Care to provide a paid in-home caregiver (a significant percentage of Medicaid In-home population age 18-65 and 65+ have mental health and substance use disorders).
- Caregiver support program for unpaid caregivers to improve caregiver mental health and avoid burnout.

- Care coordination for Health Home population – coaching, support, social service resource connection (includes housing, food, transportation connections), patient engagement, and linkage to treatment supports.

Chronic Disease

- Care coordination for complex care population through Health Homes, including self-management coaching and support.
- A Matter of Balance – evidence based fall prevention program for older adults. Community classes, as well as willingness and ability to target classes to partner sites.
- Community Living Connections – information and connection to community resources for older adults, including connection to evidence based classes offered in Spokane County.

Opioid Crisis Response

- Willing to target current clients with opioid misuse prevention education (258 Medicaid in-home care clients in Spokane County, primarily ages 18-65, have a diagnosed opiate use disorder).
- Able to coordinate linkage to treatment supports for current clients.
- Able to promote home lock-box use for current clients.

Community-based Care Coordination

- ACH target population for care coordination is outside of our agency scope (pregnant women and jail release).
- Funding and availability to serve high risk / high cost Medicaid only and dual eligible through the Health Homes program.

Describe how you see your organization involved in the Partnering Provider Transformation Plans within the following priority areas. (*Note: This section of the Partnering Provider Plan will be completed only by primary care Partnering Providers.*)

Long Acting Reversible Contraceptive (LARC)

- Not applicable.

Application of Fluoride Varnish

- Not applicable.

Name of Organization: **The American Indian Community Center**

Key Contacts(s): Linda Lauch / Francis Devereaux

Email Address(es): lindal@aiccinc.org / francisd@aiccinc.org

Phone Number(s): 509-535-0886

What services does your organization provide?

- The American Indian Community Center's Goodheart Behavioral Health Program provides DUI Assessments, Outpatient and Intensive Outpatient Treatment. We also have a Food pantry, Employment and Training, Indian Child Welfare, Parenting Classes, Parent/Child Visitation, Senior Lunch (Meals on Wheels), Thursday Night Dinners (Campus Kitchen), Community Garden and Family Services – information and referral for basic needs, clothing and shelter.

Please describe the target populations you seek to serve:

- While we primarily serve American Indian/Alaskan Natives, most of our programs are open to all people. We intend to serve anyone requesting services including Homeless, Veterans and those with special needs.

What is your approach to culturally-sensitive services? (ex: translation services, racial-ethnic populations served, etc.)

- We serve all cultures, but Native Americans are the biggest population served. If we need translation services, we would either contract for an interpreter or send the client to a more appropriate program.

Does your organization play a role in diverting clients from high-cost services (ex: ER, hospitalization)?
If so, please describe:

- Rather than send our clients to the ER for detoxification and Medically Assisted Treatment, we will try and refer them to Detox of Spokane and Intensive Inpatient treatment (dependent on the level of care needed).

In one or two sentences, please tell us why a Partnering Provider would want to include your organization in their plan (related to Medicaid Transformation):

- We partner with a great many other programs and invite several to set up an office here at AICC. The ultimate goal is to be able to meet the very widest range of services possible. We look forward to our new partnerships with the other BHT partners.

Are there specific Partnering Providers you hope to partner with? If so, in what capacity?

- Native Health-Referrals from Primary Care. CHAS and Rockwood Clinics for referrals to SUD Treatment and in the next few months, Mental Health and Co-occurring Disorders Treatment.

Describe how you see your organization involved in the Partnering Provider Transformation Plans, within the following project areas.

Bi-directional Integration of Care

- Referring to Primary Care and receiving referrals from Primary Care facilities.

Chronic Disease

- Referring to Primary Care Clinics.

Opioid Crisis Response

- Distributing Information and materials. Refer clients to Opioid programs.

Community-based Care Coordination

- We hope to become a Care Coordination Agency. With our long history of providing quality services for people from all walks of life including ex-felons and those just leaving incarceration, we feel that we would be a great fit for Care Coordination.

Describe how you see your organization involved in the Partnering Provider Transformation Plans within the following priority areas. (*Note: This section of the Partnering Provider Plan will be completed only by primary care Partnering Providers.*)

Long Acting Reversible Contraceptive (LARC)

N/A

Application of Fluoride Varnish

N/A

Name of Organization: **Catholic Charities of Eastern Washington**

Key Contacts(s): Nadine Van Stone, Pam Brown

Email Address(es): nvanstone@ccspokane.org; pbrown@ccspokane.org

Phone Number(s): 509-358-4269 (Nadine); 509-358-4271 (Pam)

What services does your organization provide?

Homeless Services:

- Coordinated Re-Entry and Rapid Rehousing for families
- Diversion Services for families and single persons
- 24/7 Shelter for single men (and overflow for women)
- Emergency Shelter for families
- Transitional Housing for families
- Homeless Student Stabilization Project – Deer Park, Logan, and Stevens schools

Housing Services:

- Housing for low-income seniors and those with physical disabilities; chronically homeless individuals and families (with supports)

Ancillary Services:

- Supported Employment and Housing
- Peer Bridger – targeting those with opioid addictions
- Respite care for Providence/Multicare
- HOC/Providence clinic (medical care for chronically homeless)
- Maternity services – Diaper and clothing bank, Circle of Security parenting classes, Fatherhood group
- Immigration services
- Services to assist elders remain more independent
- Access to healthy food for low-income community members
- Free furniture for those newly moving into housing
- Rising Strong – comprehensive behavioral health, medical, MAT, court advocacy, education support for families involved with Children's Administration.

Please describe the target populations you seek to serve:

- All are low income individuals and families, vulnerable to abuse, homelessness, behavioral health and medical chronic conditions, marginalization from dominant culture

What is your approach to culturally-sensitive services? (ex: translation services, racial-ethnic populations served, etc.)

- Able to access interpreter services when needed using Spokane Translation Service.

Does your organization play a role in diverting clients from high-cost services (ex: ER, hospitalization)?
If so, please describe:

- Yes. House of Charity/ respite program Support Expansion of Providence clinic to PC accepting all patients
- Identify those individuals in this risk category - Case Managers and Peers can help coordinate referrals to health clinics before health conditions worsen. Assist with or assume Care Coordination responsibilities. Help with transportation. Accompany to regular appointments.
- All Case Managers/Peers/others help identify clients at risk

In one or two sentences, please tell us why a Partnering Provider would want to include your organization in their plan (related to Medicaid Transformation):

- Because we serve many of the most medically vulnerable people in our community in a variety of settings; we have existing relationships with hundreds of people who are currently on Medicaid, or need to access Medicaid. Through these relationships we can assist people to make/keep medical appointments or make other connections, educate about/encourage behaviors that increase health or decrease illness. We are committed to providing data driven services that have the highest impact on well-being and recognize the impact health has.

Are there specific Partnering Providers you hope to partner with? If so, in what capacity?

- We are already partnering with Providence (Respite and Clinic) and would like to continue this relationship. We are also partnering to a lesser extent with Multicare (Respite) and, again, would like to continue this relationship. Other than that, we are open to new possibilities.

Describe how you see your organization involved in the Partnering Provider Transformation Plans, within the following project areas.

Bi-directional Integration of Care

- Housing case managers/Peers can help coordinate referrals to and from BH/PC, identify high risk patients at shelters and trouble shoot appointment/transportation problems.
- CCEW staff can work directly with Counseling program clinicians for BH treatment.
- Participate in Pathways program – support for smooth, efficient referral work flow
- Establish one contact/office for all referrals to any CC program who then quickly refers to the appropriate CC program.

Chronic Disease

- Staff can help identify and track those at high risk, coordinating appointments, providing status to other care coordinators; staff/programs support (space/convening) prevention programs offered by partners such as Health District.
- HOC can act as connector for single men and women who use the shelter to PCP's/insurers to help facilitate treatment and compliance with recommendations.

Opioid Crisis Response

- GOSH Peers can help coordinate referrals and case management needs for those individuals with OUD from ER's and in community; look at expanding program for greater outreach.

Community-based Care Coordination –

- Catholic Charities would like to expand our current capacity to provide case management services to include community-based care coordination at the multiple housing and other sites that we currently provide this service. This includes our shelters, coordinated entry and counseling offices, services for young parents, elders and migrants.

Describe how you see your organization involved in the Partnering Provider Transformation Plans within the following priority areas. (*Note: This section of the Partnering Provider Plan will be completed only by primary care Partnering Providers.*)

Long Acting Reversible Contraceptive (LARC)

- Providing referrals to PCP's for family planning.

Application of Fluoride Varnish

- Providing referrals to oral health care providers.

Name of Organization: **Community-Minded Enterprises** (HIP of Spokane County)

Key Contacts(s): Kathy Thamm, Georgia Butler, Lee Williams, Ray White

Email Address(es): kathyt@community-minded.org, georgiab@community-minded.org, leew@community-minded.org, rayw@community-minded.org

Phone Number(s): 509-960-7456

What services does your organization provide?

- Recovery Services: Recovery Café, Child Care Assistance Program, Recovering Smiles, Recovery Coaching, Recovery Coaching training, Health Insurance Navigation, Outreach to the community on SUD Treatment and prevention
- Early Learning: ECEAP free preschool for families in Recovery, Coaching and Training of all licensed child care facilities in Eastern Washington, Infant-Toddler Technical Assistance, Parenting Training.
- Disabilities: Plan to Work-benefit planners for individuals on SSI and SSDI to navigate returning to work without losing their benefits.

Please describe the target populations you seek to serve:

- Families in SUD Recovery, Early learning teachers and directors, Individuals in SUD recovery, Individuals with disabilities on SSI and SSDI, family and friends of individuals with a SUD, individuals seeking treatment resources, marignlized populations.

What is your approach to culturally-sensitive services? (ex: translation services, racial-ethnic populations served, etc.)

- We approach all of our work with a racial-equity lens and offer translation services for inidivudals seeking our services.

Does your organization play a role in diverting clients from high-cost services (ex: ER, hospitalization)?
If so, please describe:

- Yes—show results from Logic Model at RC.
- Members to the Recovery Café are given a survey to determine their status and needs and then the survey is repeaed 6 months later to see if there has been a change while they were engaged as members at the café. Here are some highlights of those results:
  - In a 3 month membership period, none of the members had used the ER for medical purposes. Of those 99% had obtained a primary doctor and 1% accessed an urgent care.
  - Homelessness decreased by 9.2%
  - Housing satisfaction increased by 20%
  - The percent of employed Café members more than doubled from 17% to 35%
  - The Café successfully helped stabilize mental health in 65% of our members

- The Café helped prevent relapse in 91% of our members
- The percent of those who spent any time in jail in the last 6 months decreased by 9.4%

In one or two sentences, please tell us why a Partnering Provider would want to include your organization in their plan (related to Medicaid Transformation):

- Our services would reduce costs for the Partnering provider by referring clients to our services instead of offering them in-house. We can be the connector between in-patient to out-patient treatment and once individuals are released from out-patient. Recovery Café keeps individuals engaged in their recovery, decreases relapse rates, homelessness, decrease incarceration, and decreased visits to the ER by assisting individuals in learning to use their insurance and gain a primary doctor.

Are there specific Partnering Providers you hope to partner with? If so, in what capacity?

- CHAS, Excelsior, Kaiser Permanente, Multicare, Planned Parenthood, Providence, Spokane Teaching Health Center, NATIVE Project, and Unify. We would want them to refer individuals to the Recovery Café to become members and maintain their recovery. They can access our training services to train and offer mentoring to Recovery coaches for their facilities. We can offer training on treatment services available in the community to their staff.
- ABHS, AICC, Frontier Behavorial health, New Horizon, Partners with Families, Pioneer, SPARC, SRHD, Excelsior, STARS, YFA. Pioneer, STARS Detox, continue to use the Child Care Asssitance Program to place and pay for child care for low income individuals in their OP treatment programs. Refer clients to the Recovery Café. Refer families to the ECEAP Program in Brownes Addition, Connect clients to our Plan to Work Program. Contract with us to offer Recovery Coach training and mentoring.

Describe how you see your organization involved in the Partnering Provider Transformation Plans, within the following project areas.

Bi-directional Integration of Care

- Recovery Café can partner with the integration of care at any point in the persons journey into recovery, from the emergency room, primary care doctor, mental health program, Co-occurring and SUD treatment providers impatient and outpatient treatment, to discharge and aftercare planning. Our CPC and Recovery Coaches offer community based peer support allowing us to join them at any stage of their recovery. A person receiving services who as 24 hours alcohol and drug free will be able to become a member of the Recovery Café offering them, Recovery Circles, Recovery Coaching, The School for Recovery and a community of fellow members who developing peers to assist them on their journey. The Café offers support to person on MAT treatment, faith based, 12 step or solo recovery. The Café can assist members with access to community resources. Our community based outreach will also allow us to support the integration of care with education of services available to the community, seeking care and information on mental health and substance abuse.
- Now the Café has two navigators on staff to assist on site with health care information, education and applying for WA Apple Health, we also assist in updates and education for WAH. The members of the Café will be assist and

educated in the changes to primary care services, treatment and community services with the Integration of Care. Our members have received services in the past or our current clients of our partners in the integration process and the Café will assist them on the navigation of the new system of care.

Chronic Disease

- Bringing training from the chronic disease providers to the Recovery Café so members can take charge of their chronic disease while in recovery. Recovery Café then referring remembers to specific chronic disease providers.

Opioid Crisis Response

- CME is well positioned to offer extensive outreach and information about treatment options in Spokane County, specific treatment options for primary provieders to offer to their clients and outreach to families and loved ones concerned about getting their family and friends into treatment. Utilizing the CMTV 14 portion of CME to produce instructional videos for staff and clients and getting out the word for treatment services to the community.
- Recovery Café is a demonstrated partner for recovery services under this plan.

Community-based Care Coordination

- CME has a long history of providing effective sevices in support of individuals and families in transition in Eastern Washington. Since the Fall of 2013 our organization has partnered with Spokane County Detention Services and Community Partners to provide Healthcare access and benefits coordination to those exiting the jail system to access behavioral services and transition into the community. CME currently employs 5 certified Healthplanfinder Navigators as well as 3 Certified Work Incentive Coordinators, trained and certified by the Social Security Administration. CME is also a Washington Connection Community Partner Agency allowing our staff enrollment access to DSHS benefits. Additionally, we have staff who have extensive experience with and access to key contacts within Ethnic communities in the Spokane area as well as the Disability community and services.
- Our experience in the development of individualized resource planning services for individuals in Transition and others in their lives will add value to the efforts of Community Based Care Coordination and Partners to those efforts.

Describe how you see your organization involved in the Partnering Provider Transformation Plans within the following priority areas. (*Note: This section of the Partnering Provider Plan will be completed only by primary care Partnering Providers.*)

Long Acting Reversible Contraceptive (LARC)

N/A

Application of Fluoride Varnish

- Recovering Smiles, an oral health education program in partnership with the EWU Dental Hygiene Program is offered specifically to individuals in Recovery so they can access dental and oral health services. Flouride Varnish is featured in this education program.

Name of Organization: **Consistent Care Services**

Key Contacts(s): Darin Neven, MS, MD

Email Address(es): darin@consistentcare.org

Phone Number(s): 509-290-3173

What services does your organization provide?

- Consistent Care Services (CCS) provides case management and care coordination services using nurse case managers and community health workers.

Please describe the target populations you seek to serve:

- We seek to serve patients with mental illness, substance use disorder and chronic medical conditions. We specialize in coordinating the care of patients who frequent the ED. We also seek to coordinate the care of patients to receive substance use disorder treatment especially patients who are hospitalized with medical complications from opioid use disorder.

What is your approach to culturally-sensitive services? (ex: translation services, racial-ethnic populations served, etc.)

- We employ local community health workers from cultures of the patients we are trying to impact. For example, we have a Russian community health worker who works part time when needed to translate and better relate to Russian patients we serve.

Does your organization play a role in diverting clients from high-cost services (ex: ER, hospitalization)?
If so, please describe:

- Serving high cost patients is the specialty of Consistent Care Services which has contracts with Medicaid Managed Care Organizations to manage their high ED utilizers, hospitalized patients with medical complications of addiction, and high cost medically complex patients with social determinants of health. We also contract with a local FQHC to manage their high cost managed care patients. We have expertise coordinating medical and social services for these patients to improve outcomes and reduce costs in a culturally appropriate way.

In one or two sentences, please tell us why a Partnering Provider would want to include your organization in their plan (related to Medicaid Transformation):

- Our organization has extensive relationships with the medical, SUD, and social service providers of the community that allows us to effectively navigate patients away from high cost venues of care and achieve stability. We are experienced in navigating the local emergency medical system, acute care system, and chronic care system for the Medicaid population to get patients the care they need at reduced cost. We use an outreach based model of service

the meets the patients where they are located and provides them with transportation to the services they need using community health workers under the direction of a nurse case manager.

Are there specific Partnering Providers you hope to partner with? If so, in what capacity?

- **Federally qualified health clinics, Medicaid Managed Care Organizations, substance use disorder residential treatment providers, medication assisted treatment providers, emergency medical service providers, emergency departments, hospital inpatient units.**

Describe how you see your organization involved in the Partnering Provider Transformation Plans, within the following project areas.

Bi-directional Integration of Care

- We see an expanded role for using long acting antipsychotics. These medications lead to fewer psychiatric hospitalizations and ED visits but require provider education and patient follow-up in a population that is difficult to locate and serve consistently. We would like to work with primary care and mental health providers by providing case management to initiate and sustain long acting antipsychotic treatment for patients with schizophrenia. This can include starting these medications in the ED.
- We would like to be a part of coordinating better follow up care for patients who present to the ED for mental health related complaints by partnering with mental health providing clinics to case manage these clients to receive the mental health care they need.

Chronic Disease

- We would like to provide outreach based case management for patients with complex medical conditions for FQHCs.

Opioid Crisis Response

- We are very experienced with starting buprenorphine (Suboxone) and long acting naloxone (Vivitrol) on patients who present to the ED and would like to expand this effort across more EDs in the ACH. We would also like to case manage patients who are in SUD outpatient or inpatient treatment that are receiving medication assisted treatment for opioid use disorder. We would like to develop a system where emergency medical service (EMS) providers can refer patients for medication assisted therapy and hand out naloxone to patients with opioid use disorder who were treated or are at risk for an overdose.

Community-based Care Coordination

- Our founder has been providing community-based care coordination in Spokane for 12 years. He was also one of the founders of the Spokane Hot Spotters Community Action Group and Community Court both of which participate in community based care coordination. CCS would like to provide community based care coordination by partnering with FQHC's to provide outreach based case management for their highest cost and most complex patients.

Describe how you see your organization involved in the Partnering Provider Transformation Plans within the following priority areas. (*Note: This section of the Partnering Provider Plan will be completed only by primary care Partnering Providers.*)

Long Acting Reversible Contraceptive (LARC)

- We could play a role of referring patients from the ED to clinics that provide LARC and then helping these patients navigate to receive LARC with the help of a nurse case manager or peer support counselor.

Application of Fluoride Varnish

- Not applicable.

Name of Organization: **Greater Spokane County Meals on Wheels**

Key Contacts(s): Anna Foucek-Tressider, MPH, PhD GSC MOW Board Member, Marta Harrington, Executive Director;

Email Address(es): martah@gscmealsonwheels.org

Phone Number: (509) 924-6976

What services does your organization provide?

- Greater Spokane County Meals on Wheels is dedicated to providing seniors with the necessary nutritional support to protect them against Food insecurity and Malnutrition to help them continue to live independent and fulfilled lives as long as possible. GSCMOW has been serving the elderly and disabled persons for nearly 45 years. Our primary focus is on the seniors in Spokane County with the most significant physical, economic,and social need. Majority of our clients represent an extremely frail and vulnerable population with substantial health and social support needs. In 1999 we served approx 120 meals/day. Today, we serve approximately 1,200 meals per day across the entire Spokane County. Our 12 Senior Lunch Silver Cafes (Congregate meal sites) cater to seniors who are not homebound and can come together and enjoy a meal, social interaction, nutritional education and activities. We are "More than a Meal" at GSCMOW, in addition to providing much-needed nutrition, friendly visits, and well-checks to our clients, we can connect our seniors to other much needed community-based senior resources, provide personal care, pet, and household items, summer fresh produce bags, birthday cards, gifts, and things such as (fans, blankets, and heaters) during inclement weather. The trust and relationships we can establish with our clients help our partnering agencies such as APS and local Fire Departments facilitate safe outcomes as we work together. GSCMOW is dedicated to providing nutrition, social interaction, care, and hope to our growing aging population while helping to offset health care and emergency service costs to communities.

Please describe the target populations you seek to serve:

- GSCMOW works with the most vulnerable senior population across Spokane County in addition to providing meals to those with disabilities. Low income, those over 75, minority populations and those living in rural isolated areas are a key priority for our organization.

What is your approach to culturally-sensitive services? (ex: translation services, racial-ethnic populations served, etc.)

- We have a deaf translator as volunteer assessor, and in addition, we are working to grow our relationship with the Native Tribes. We have access to outside interpreters if needed for clients unable to speak English.

Does your organization play a role in diverting clients from high-cost services (ex: ER, hospitalization)?
If so, please describe:

- Food, nutrition, and socialization are intregal components in overall care transitions, positively impacting the quality of life for our seniors while reducing the financial burden early placement in nursing care facilities and hospitalization has on our healthcare system and communities as a whole. GSC Meals on Wheels has been working hard to integrate into the healthcare system.
- By providing community based nutritional interventions, we are working to improve the nutritional health of patients following hospitalization, reducing the risk of readmission to the hospital. Part of our services include in-home nutritional assessments, hot nutritionally balanced home delivered meals Monday through Friday and frozen meals for the weekend in addition to critical daily contact.
- Our goal is to improve patient outcomes and reduce healthcare costsn by improving patient nutritional status. In addition, this will help generate additional income to support the Greater Spokane County Meals on Wheels' mission and keep up with growth of our senior population in critical need of our services.
- 1 in 3 patients enter a hospital malnourished and one-fifth of hospitalized patients 65 and older had an average nutrient intake of less than 50% of the required caloric intake. Nutrition is coming to the forefront as one of the chief indicators of outcome. Studies have shown that nutritional intervention leads to significant improvements in patient outcomes, with a 28% decrease in avoidable readmissions.
- We are most often the first and only contact for our clients allowing us to serve as a gateway to many other community-based agencies. We gain the trust of the client to allow other services in to help. We are proud of the relationship we have developed with APS this year. Partnering with them to ensure our clients safely five days a week. Additionally, we have partnered with the SVFD for fire and fall safety education and home visits and will be working with ALTCEW on a fall prevention program. We are able to bring clients on meals within 24-48 hrs and

In one or two sentences, please tell us why a Partnering Provider would want to include your organization in their plan (related to Medicaid Transformation):

- See above. There is no other agency able to provide what we do for our clients on a daily basis.

Are there specific Partnering Providers you hope to partner with? If so, in what capacity?

- We are grateful to begin work with Multicare in the very near future, and hope to work with CHAS as many of our clients are under their care. However, we are a community based organization serving the entire county. We are interested in partnering with all agencies who have clients/patients who would benefit from our services.
-

Describe how you see your organization involved in the Partnering Provider Transformation Plans, within the following project areas.

Bi-directional Integration of Care

- N/A

Chronic Disease

- As part of the Senior Nutrition Program under the Older American Act, our meals provide 1/3 of dietary needs. We are in the process of updating menus to also meet the general needs of those with chronic diseases.

- We have a registered diatian on staff who provides oversite for nutritional assessments, education, and counseling. As a partner in SNAP/ Basic Food, we have the ablity to educate and enroll clients in the basic food program to ensure they have continued access to healthy foods outside of the hot meal delivery.

Opioid Crisis Response

- N/A

Community-based Care Coordination

- N/A

Describe how you see your organization involved in the Partnering Provider Transformation Plans within the following priority areas. (*Note: This section of the Partnering Provider Plan will be completed only by primary care Partnering Providers.*)

Long Acting Reversible Contraceptive (LARC)

Application of Fluoride Varnish

Name of Organization: **Inland Northwest Health Services**

Key Contacts(s): Emily Fleury

Email Address(es): fleurye@inhs.org Direct email, or wellness@inhs.org for customers

Phone Number(s): 509-232-8139 Direct Line or 509-232-8138 Main Line for Customers

What services does your organization provide?

- Living Well with Diabetes and Living Well with Chronic Conditions classes
- CDC Fully Recognized Diabetes Prevention Program called Group Lifestyle Balance
- ADA Accredited Diabetes Self-Management Education (DSME)
- Diabetes Pump Training
- Blood Pressure Self-Management Class with Free Automatic Blood Pressure Cuff
- Tobacco Cessation Classes with Free Nicotine Replacement Therapy
- Weight Management Services
- Telehealth services with in-home capability
- Mental Health First Aid Training

Please describe the target populations you seek to serve:

- Adults over 18 who can access classes in Spokane or have capability to access through telehealth.

What is your approach to culturally-sensitive services? (ex: translation services, racial-ethnic populations served, etc.)

- We work with an in person translation service when needed

Does your organization play a role in diverting clients from high-cost services (ex: ER, hospitalization)?
If so, please describe:

- We provide prevention services where we educate patients about how to manage disease.

In one or two sentences, please tell us why a Partnering Provider would want to include your organization in their plan (related to Medicaid Transformation):

- We are a community provider of Chronic Disease prevention and treatment education and use curriculum that has been determined to be best practices. INHS fully understands the complex HIPAA requirements needed to accept referrals and have a bidirectional exchange of information and regularly uses Meditech, Centricity and EPIC to chart on patients we provide education to.

Are there specific Partnering Providers you hope to partner with? If so, in what capacity?

- INHS is willing to work with anyone who would like to refer to our services and is interested in setting up a system to share feedback about patients and patient outcomes.

Describe how you see your organization involved in the Partnering Provider Transformation Plans, within the following project areas.

Bi-directional Integration of Care

Chronic Disease

- Referral source for Diabetes Education, Diabetes Prevention, Living Well Courses, Hypertension Self-Management, Tobacco Cessation or any other prevention program a patient may need.

Opioid Crisis Response

Community-based Care Coordination

- Referral source for the care coordinators

Describe how you see your organization involved in the Partnering Provider Transformation Plans within the following priority areas. (*Note: This section of the Partnering Provider Plan will be completed only by primary care Partnering Providers.*)

Long Acting Reversible Contraceptive (LARC)

NA

Application of Fluoride Varnish

NA

Name of Organization: **Operation Healthy Family**

Key Contacts(s): Paula Williams

Email Address (es): paula@ohfspokane.org

Phone Number(s): (509) 217-0741

What services does your organization provide?

- Referrals for dental treatment.

Please describe the target populations you seek to serve:

- Operation Healthy Family target population is motivated individuals who are underinsured or uninsured. People who are slipping through income guidelines gap. People who are overqualified, underpay and/or self-employed.

What is your approach to culturally-sensitive services? (ex: translation services, racial-ethnic populations served, etc.)

- We employ minorities. Our staff has access to four languages daily.

Does your organization play a role in diverting clients from high-cost services (ex: ER, hospitalization)?
If so, please describe:

- Yes. We see people who are having dental emergences to avoid ER visits.

In one or two sentences, please tell us why a Partnering Provider would want to include your organization in their plan (related to Medicaid Transformation):

- In order to achieve whole person care, you must take care of the whole body that includes oral health. Oral health is part of the body that affects a person's overall health.

Are there specific Partnering Providers you hope to partner with? If so, in what capacity?

- A partnering provider that provides care coordination where clients work with a social service or with a social worker or a community health worker.

Describe how you see your organization involved in the Partnering Provider Transformation Plans, within the following project areas.

Bi-directional Integration of Care

- Operation Healthy Family will offer oral health care coordination education and services to achieve whole person care thru Medicaid transformation project**.**

Chronic Disease

- Operation Healthy Family will provide baseline diabetics testing and continue motoring for clients with diabetics and/or patients who are at risk with diabetics such as pregnant mothers, when treated in our partnering clinics.

Opioid Crisis Response

- Operation Healthy Family will provide trained dental professionals to work with clients currently dealing with opioid addiction or at risk opioid addiction in/or around oral health.

Community-based Care Coordination

- Operation Healthy Family will coordinate care for clients referred thru dental access partnerships program. Operation Healthy Family will work in concert with other groups who are coordinating dental care.

Describe how you see your organization involved in the Partnering Provider Transformation Plans within the following priority areas. (*Note: This section of the Partnering Provider Plan will be completed only by primary care Partnering Providers.*)

Long Acting Reversible Contraceptive (LARC)

Application of Fluoride Varnish

Name of Organization: **Second Harvest Inland Northwest**

Key Contacts(s): Jason Clark, President and CEO; Kathy Hedgcock, Director of Strategic Gifts

Email Address(es): jason.clark@2-harvest.org; kathy.hedgcock@2-harvest.org

Phone Number(s): 509-252-6262; 509-252-6245

What services does your organization provide?

- Second Harvest was founded in 1971 as a central warehouse for a handful of neighborhood food banks in Spokane. Today, hunger solution centers in Spokane and Pasco are the backbone of a hunger-relief network that includes 250 partner food banks, meal sites and other programs that feed 55,000 people per week in Eastern Washington and North Idaho. Second Harvest provides the equivalent of 69,000 meals per day and more than 25,000 of those meals help people in need in Spokane County. Almost half of Second Harvest's food is nutrient-rich fresh fruits and vegetables.
- Food from Second Harvest stabilizes families and improves their nutrition. Money these people do not have to spend on groceries can be used for everyday needs like rent, utility bills, prescriptions, children's clothing, and gas for a car to get to school or work. When hunger is addressed, children are more focused in school, adults perform better at work, and elderly people see improved health and reduced malnutrition. Food assistance helps move low-income households forward to healthy, self-sustaining ways of life.
- A culture of collaboration with other social service charities in the region uniquely positions Second Harvest to reach the most vulnerable populations with free food and evidence-based nutrition education interventions that empower them to make healthier choices.

Please describe the target populations you seek to serve:

- One out of seven people in Spokane County—including one in five children—is food insecure, according to Feeding America's annual Map the Meal Gap research (map.feedingamerica.org). These people may not be able to afford all the food they need to lead healthy, active lives. Second Harvest fills nutritional gaps for people in poverty, the working poor, seniors and disabled people on very low fixed incomes, homeless people, and children and families in temporary crisis. Many of these people are Medicaid eligible.

What is your approach to culturally-sensitive services? (ex: translation services, racial-ethnic populations served, etc.)

- Second Harvest values a culture of diversity, equity and inclusion that includes serving vulnerable people with dignity and respect. Staff and the more than 8,000 volunteers annually who support this work are called on to reflect the openness, honesty and integrity that are critical to Second Harvest's role in helping people in need.

- Second Harvest's mission-driven activities are framed around a belief that every person deserves healthy food, every day. Second Harvest builds and sustains a broad base of community partnerships designed to provide culturally sensitive hunger-relief services throughout the Inland Northwest.
- Focusing on community-driven approaches to reaching people experiencing hunger and food insecurity, Second Harvest recognizes the diversity of these marginalized populations. This includes not only race and ethnicity, but also the rural and urban geographic areas where people live and work, individual beliefs and values, age, religion, various socioeconomic and cultural factors, and other differences. Second Harvest is committed to learning more about the social inequities faced throughout the region and including people with lived experience in developing solutions.

Does your organization play a role in diverting clients from high-cost services (ex: ER, hospitalization)?
If so, please describe:

- Yes. Second Harvest builds healthier communities through food. Second Harvest has more of a role to play in diverting clients from high-cost health care services by increasing access to nutrient-dense food and opportunities for nutrition education that emphasizes lifestyle and nutrition changes. These preventive-medicine strategies will help move more people toward better health.
- A recent Health Services Research Study—"Food Insecurity and Health Care Expenditures in the United States, 2011-2013" (Seth A. Berkowitz, Sanjay Basu, James B. Meigs and Hilary K. Seligman)—indicates the association between food insecurity and greater subsequent health care expenditures. "A growing body of evidence links food insecurity—limited or uncertain access to adequate food (Coleman-Jensen et al. 2015)—with common, costly, and preventable chronic conditions, including obesity, hypertension, and type 2 diabetes," according to the article. Those experiencing food shortages in the national sample had higher estimated annual health care expenditures (an extra $1,863 per year) than their food secure counterparts. This would amount to $77.5 billion in additional health care expenditures annually for the estimated 41.6 million food insecure Americans.

In one or two sentences, please tell us why a Partnering Provider would want to include your organization in their plan (related to Medicaid Transformation):

- Second Harvest emphasizes healthy food as medicine and can work with partnering providers who are screening the food security of their Medicaid patients to provide referrals to local food pantries and other free nutrition services. Partnering providers also could coordinate sponsorship of Second Harvest's Mobile Market as part of their value-based health care model to serve as a fresh food pharmacy for Medicaid patients identified as at risk of or needing to self-manage diet-related health conditions.

Are there specific Partnering Providers you hope to partner with? If so, in what capacity?

- Second Harvest proposes partnering with clinics and hospitals to empower doctors to prescribe fresh produce and other healthy staples to Medicaid patients. Increased nutritious food access would be part of an overall health care regimen that helps prevent, self-manage or improve diet-related illnesses.

Describe how you see your organization involved in the Partnering Provider Transformation Plans, within the following project areas.

Bi-directional Integration of Care

N/A

Chronic Disease

- People who are food insecure are disproportionally affected by diet-sensitive chronic diseases such as diabetes, high blood pressure and obesity. Second Harvest is well positioned to provide nutrition incentives in the health care space. By partnering with clinicians to fulfill prescriptions for produce and other healthy food for Medicaid patients, Second Harvest would be part of a strategic and collaborative effort to improve health outcomes for low-income, high-risk people in Spokane County.
- Evidence-based nutrition education and recipe sharing would be offered in tandem with healthy food distribution as part of self-management support for Medicaid patients. In most cases, the healthy food provided would benefit not only the Medicaid patient, but also others in the household. This would promote better health outcomes for all, while positively influencing successful behavior changes by the identified at-risk patient.
- Researchers are digging deeper for evidence that lifestyle-modification programs can bolster health outcomes. For example, results are expected this year of a clinical trial led by Dr. Hilary Seligman, senior medical adviser for Feeding America, to measure if food banks can help people with diabetes improve their blood sugar levels through education and tailored food packages.

Opioid Crisis Response

N/A

Community-based Care Coordination

- Connecting Medicaid patients with nutritious food resources as part of a coordinated plan to improve health outcomes does not align with current "Community-based Care Coordination" priorities; however, Second Harvest and other social determinants of health organizations are examples of opportunities to influence prevention-oriented medicine and enhance whole-person care.

Describe how you see your organization involved in the Partnering Provider Transformation Plans within the following priority areas. (*Note: This section of the Partnering Provider Plan will be completed only by primary care Partnering Providers.*)

Long Acting Reversible Contraceptive (LARC)

N/A

Application of Fluoride Varnish

N/A

Name of Organization: **Spokane Fire Department CARES Team**

Key Contacts(s): Sarah Foley

Email Address(es): sfoley@spokanecity.org

Phone Number(s): 509-625-7060

What services does your organization provide?

- The CARES team provides follow up after 911 calls. We receive referrals from the firefighters. The CARES team meets with residents in their homes, assess current needs. The CARES team will then provide referrals and connection to community resources. The CARES team will coordinate services to need client needs.

Please describe the target populations you seek to serve:

- The CARES team works with a wide population (we will attempt to work with anyone referred by the firefighters). High utilizers of 911 services and older adults aging in home are the most common CARES referrals.

What is your approach to culturally-sensitive services? (ex: translation services, racial-ethnic populations served, etc.)

- The CARES team has Spanish/English bi-lingual members. We are able to access interpreting and translation services. We work with individuals based on the needs they have identified and will try to match services to their cultural needs.

Does your organization play a role in diverting clients from high-cost services (ex: ER, hospitalization)?
If so, please describe:

- The CARES team works with individuals after 911 calls to address the concerns that resulted in the call. The CARES team works to prevent further need for 911 or ER services. The CARES team will gather the resources and services so that individuals can be safe in their home (e.g. Home Health, caregiving services, durable medical equipment, etc.).

In one or two sentences, please tell us why a Partnering Provider would want to include your organization in their plan (related to Medicaid Transformation):

- The CARES team can be a valuable resource for agencies that are working with individuals that are utilizing 911 for primary care or behavioral health care needs. The CARES team can bridge the gap between the first responders and the primary health or behavioral health care providers.

Are there specific Partnering Providers you hope to partner with? If so, in what capacity?

- The CARES team would like to build between partnerships with primary health care providers so that when individuals are using 911 inappropriately, the CARES team will have better relationships with health care providers to assist people with establishing health care homes.

Describe how you see your organization involved in the Partnering Provider Transformation Plans, within the following project areas.

Bi-directional Integration of Care

- The CARES team tries to provide both primary and behavioral health care providers with information on an individual's 911 usage. The team will try to work with primary care or behavioral health to address the needs of the individual.

Chronic Disease

- The CARES team works with many individuals with chronic disease and will help them connect to the appropriate care resources.

Opioid Crisis Response

- The CARES team will help individuals get connected to Substance Use Disorder treatments or detox.

Community-based Care Coordination

- The role of the CARES team is to provide care coordination. We work with different agencies to set up the services and care the individuals require. We will also follow up to ensure that the connections have been successful.

Describe how you see your organization involved in the Partnering Provider Transformation Plans within the following priority areas. (*Note: This section of the Partnering Provider Plan will be completed only by primary care Partnering Providers.*)

Long Acting Reversible Contraceptive (LARC)

- NA

Application of Fluoride Varnish

- NA

Name of Organization: **Spokane Housing Authority**

Key Contacts(s): Pam Tietz, Executive Director

Email Address(es): ptietz@spokanehousing.org

Phone Number(s): 509-252-7139

What services does your organization provide?

- SHA owns and manages approximately 850 affordable rental housing units. High demand for affordable units means there is a waiting list for most units of up to 4 years.
- SHA provides approximately 5,300 units of rental assistance in Spokane, Lincoln, Ferry, Whitman, Stevens and Pend Orielle Counties. This provides subsidized rent payments to private landlords for these households. The waiting list for rental assistance is closed and those that are already on the list can wait up to 4 years before being called up for eligibility consideration.

Please describe the target populations you seek to serve:

- The majority of rental units owned or managed by SHA target households at or below 60% of area median income.
- Rental assistance programs target households at or below 50% of area median income; however, 75% of the rental assistance vouchers leased must be to households at or below 30% of AMI.

What is your approach to culturally-sensitive services? (ex: translation services, racial-ethnic populations served, etc.)

- SHA provides translation services either with in-person translators or by utilization of the Lanaguage Line.
- SHA affirmatively furthers fair housing by creating Fair Housing Marketing Plans for its properties and by working with partner agencies specifically serving racial-ethnic populations. SHA is working on a cultural diversity plan and training that will be a component of its 2019-2023 Strategic Plan.

Does your organization play a role in diverting clients from high-cost services (ex: ER, hospitalization)?
If so, please describe:

- No directly; however, we know that safe and stable housing plays an important role in making sure high cost medical services are less of an issue.

In one or two sentences, please tell us why a Partnering Provider would want to include your organization in their plan (related to Medicaid Transformation):

- Safe and stable housing is critical to stabilizing chronic disease.

Are there specific Partnering Providers you hope to partner with? If so, in what capacity?

- We are willing to partner with any organization that is part of the collaborative if it makes sense.
- In partnership with the Spokane Regional Health District, SHA utilizes community health advocates in 9 of its 10 affordable housing properties. These CHW's live in the properties they serve and there role is to help educate residents on chronic disease management and connect them to primary care options.
- The obvious partnership would be to provide affordable housing options for collaborative partners. In some cases, this is already happening through Memorandum's of Agreement with agencies like Frontier Behavioral Health, who receives rental assistance vouchers through our Referral Voucher Program.

Describe how you see your organization involved in the Partnering Provider Transformation Plans, within the following project areas.

Bi-directional Integration of Care

- Coordination of permanent supportive housing options?

Chronic Disease

- Continued use of CHW's at our properties.

Opioid Crisis Response

N/A

Community-based Care Coordination

- Coordination between Property Supervisors (who manage our rentals), our Landlord Liaison (rental assistance and/or housing location services) and other community care providers.
- Coordination of PSH options?

Describe how you see your organization involved in the Partnering Provider Transformation Plans within the following priority areas. (*Note: This section of the Partnering Provider Plan will be completed only by primary care Partnering Providers.*)

Long Acting Reversible Contraceptive (LARC)

N/A

Application of Fluoride Varnish

- Education and/or distribution of information through community health advocates.

Name of Organization: **Spokane Housing Ventures**

Key Contacts(s): Fred Peck

Email Address(es): fredp@spokanehousingventures.org

Phone Number(s): 509-232-0170 x204

What services does your organization provide?

- Permanent Supportive Housing in over 1,300 homes at 36 properties. 924 homes are in Spokane County. 33 homes are in Lincoln Cuounty

Please describe the target populations you seek to serve:

- Those who cannot afford to rent a market rate apartment in the following counties: Spokane, Lincoln, Okanogan, Grant, Yakima, Klickitat, Jefferson, Clallam, Pierce, Kitsap
- Our residents range from the formerly homeless to those at or below 80% of area median income. We serve diverse populations including individuals, families, seniors, and those with disabilities.

What is your approach to culturally-sensitive services? (ex: translation services, racial-ethnic populations served, etc.)

- The residents of the properties that we own and/or manage are ethnically and racially diverse. SHV staff receive training on how to be culturally sensitive when interacting with these diverse populations and how to provide tenants with limited English proficiency (LEP) access to translation services.

Does your organization play a role in diverting clients from high-cost services (ex: ER, hospitalization)?
If so, please describe:

- Yes. Permanent supportive housing is a critical to minimizing the likelihood of incarceration, hospitalization, or the need for emergency room visits, urgent care, fire department/EMT responses, and other services. See the 2014 white paper published by the Department of Veterans Affairs https://www.va.gov/HOMELESS/nchav/docs/Return_on_Investment_Analysis_and_Modeling_White-Paper.pdf

In one or two sentences, please tell us why a Partnering Provider would want to include your organization in their plan (related to Medicaid Transformation):

- We provide stable housing to thousands of individuals across the state. Our on-site staff and the Supportive Services Coordinator we are about to hire can provide a critical link to connect Partnering Providers with Medicaid eligible individuals.

Are there specific Partnering Providers you hope to partner with? If so, in what capacity?

- Frontier Behavioral Health: access to behavioral health care for our residents
- United Healthcare: access to primary care for our residents
- Molina: access to primary care for our residents
- AmeriGroup: access to primary care for our residents
- CHAS Health: access to primary care for our residents
- The NATIVE Project: access to primary care for our residents
- Lincoln County Health Department: access to nursing for our residents
- The Oral Health Program of Operation Healthy Family: access to oral health services for our residents
- Greater Spokane County Meals on Wheels: access to nutritional meals for our residents
- Aging and Long Term Care of Eastern Washington: care for our senior residents
- Washington Dental Service Foundation: access to oral health services for our residents
- Spokane Regional Health District: access to primary care for our residents

Describe how you see your organization involved in the Partnering Provider Transformation Plans, within the following project areas.

Bi-directional Integration of Care

- Connecting our residents with partnering providers

Chronic Disease

- Connecting our residents with partnering providers

Opioid Crisis Response

- Connecting our residents with partnering providers for prevention or treatment

Community-based Care Coordination

- Connecting our residents with partnering providers

Describe how you see your organization involved in the Partnering Provider Transformation Plans within the following priority areas. (*Note: This section of the Partnering Provider Plan will be completed only by primary care Partnering Providers.*)

Long Acting Reversible Contraceptive (LARC)

Application of Fluoride Varnish

COMMITTED TO WHOLE-PERSON HEALTH

Improving Lives Through

Spokane Neighborhood Action Partners (SNAP) is ready to partner with you to provide social determinants of health services to improve the health and quality of life for our neighbors in Spokane County.

WHAT DOES SNAP DO AND WHO DO WE SERVE?

48,950 is the number of neighbors served in 2017. That's equivalent to 1 in 10 Spokane residents!

34 programs available to help our neighbors reach their full potential

448 transitions from homelessness to permanent housing

2,017 total visits to long-term care facilities

314 rides provided by SRTC in 2017 to urgent care facilities

840 affordable housing provided to 840 people in 2017

What We Can Do For You

- Our continuum of services, from providing stability to equipping individuals to exit poverty uniquely positions our agency to provide social determinant of health services
- An active Medicaid biller
- Familiar with HIPAA compliance and BAA agreements
- Has active relationships with several of BHT's partnering providers

SNAP
NEIGHBORS BY YOUR SIDE

Main Hotline: 509-456-SNAP

Website: snapwa.org

Amber Johnson: Ext. 5213

Serving Spokane County *for Over 50 Years*

SNAP fulfills the mission of increasing the human potential of our community by providing opportunities for people in need. Our programs offer the opportunity for our neighbors to:

- **LIVE:** Foundations for basic human needs, which include SNAP housing services, energy assistance, and homeless programs
- **LEARN:** Programs which build frameworks for increased well-being through classes and outreach, such as our energy conservation and financial education series
- **THRIVE:** Services that build toward potential, including those which offer advocacy, health assistance, or enhancements to basic needs

Revised 7/5/2018

SNAP Fine Points

Who Do We Serve?

As a Community Action Agency, SNAP exists to take a lead in educating and empowering our low-income neighbors. Through this, we have come to serve diverse populations:

- 24% non-white residents- nearly twice the demographic average for Spokane
- 23% disabled residents helped
- 1,743 homeless people served

SNAP intends to continue to serve these populations in accordance with our mission of increasing the human potential of our community by providing opportunities for people in need

What We Do For:

Bi-Directional Integration of Care

- Transportation for those who cannot access SMS services
- Homeless Assistance Services
- Community Health Workers who can transport clients and provide in-home education and health assessments
- Actively receive and provide referrals

Opioid Crisis Response

- Community Health Workers
- Transportation for those who cannot access SMS services
- Referrals to providers
- Distribute educational information
- Homeless Street Outreach

Diversion

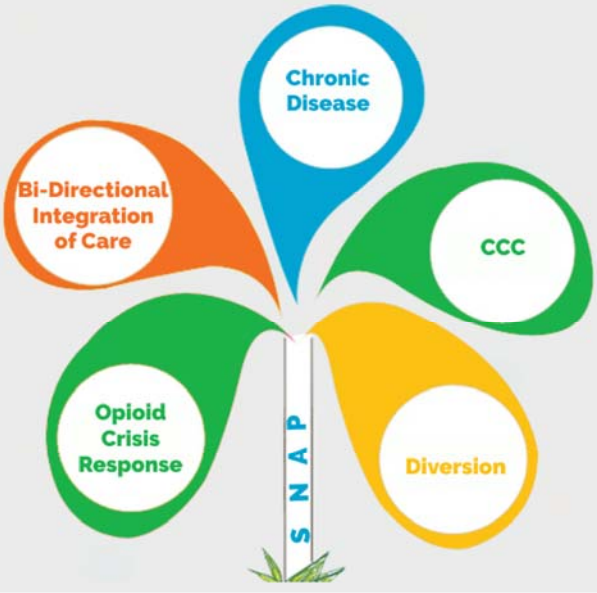
- Spokane Ride to Care is an ED Diversion Strategy currently operating in Spokane County. Your agency should have received a specific value proposition for this program. If not, please contact 509-456-SNAP x5251

Chronic Disease

- Weatherization Plus Health - provides assistance to individuals with chronic respiratory illness make home modifications towards improvement of health
- Transportation for those who cannot access SMS services
- Community Health Workers

CCC

- Interested in being a Care Coordination Agency
- Community Health Workers
- Housing Specialists
- Social Service referrals
- Singles Coordinated Assessment agency



SNAP
NEIGHBORS BY YOUR SIDE

Main Hotline: 509-456-SNAP

Website: snapwa.org

Amber Johnson: Ext. 5213

Revised 7/5/2018

Name of Organization: **Spokane Regional Health District**

Key Contacts(s): Torney Smith, Administrator; Bob Lutz, Health Officer; Misty Challinor, Treatment Services Director

Email Address(es): tsmith@srhd.org; blutz@srhd.org; mchallinor@srhd.org

Phone Number(s): Smith 509-324-1518; Lutz 509-324-1469; Challinor 509-324-1647

What services does your organization provide?

- Communicable disease epidemiology
- Medical Assisted Treatment, MAT, (Methadone and Buprenorphine)
- Syringe exchange
- Tuberculosis control
- HIV case management
- Community Data Center
- Community Health Workers

Please describe the target populations you seek to serve:

- Communicable disease epidemiology – all individuals involved with communicable disease exposure and/or transmission
- Medical Assisted Treatment (Methadone and Buprenorphine) – All individuals seeking treatment for opioid addiction
- Syringe exchange – All individuals who are injecting substances and who do not have access to clean syringes
- Tuberculosis control – All active TB cases and some LTBI individuals
- HIV case management – Individuals with HIV and/or AIDS who are seeking assistance and case management
- Community Data Center – Population health data and research provides a basis for understanding health status of the overall population and sub-populations being studied.
- Community Health Workers – Individuals intergrated into community settings to act as liaisons addressing needs of populations with specific targeted efforts

What is your approach to culturally-sensitive services? (ex: translation services, racial-ethnic populations served, etc.)

- Translators are utilized for individuals who speak languages our staff do not know. Our agency is also providing training on cultural awareness and equity to staff.

Does your organization play a role in diverting clients from high-cost services (ex: ER, hospitalization)?
If so, please describe:

- Public health seeks to provide harm reduction strategies upstream from the need to seek medical services for a negative outcome. Our efforts are specifically targeted to avoid avoidable use of health care system resources.

In one or two sentences, please tell us why a Partnering Provider would want to include your organization in their plan (related to Medicaid Transformation):

- The Spokane Regional Health District provides some unique services (Communicable disease epidemiology, TB control, Syringe exchange, HIV case management, community health workers) and is the largest provider of MAT in the region.

Are there specific Partnering Providers you hope to partner with? If so, in what capacity?

- Yes, as public health we have no primary care clinic and seek alignment with entities that provide physical and/or mental health services.

Describe how you see your organization involved in the Partnering Provider Transformation Plans, within the following project areas.

Bi-directional Integration of Care

- We seek to work as seamlessly as possible with other providers to assure individuals receive needed services in a timely manner that respects the cultural aspects that a person brings. Equally important is attention to health equity to assure that all people are treated with respect and the highest level of appropriate care available. Improvement of communication between partnering providers is essential to continue to achieve our system goals.

Chronic Disease

- Public health's role in chronic disease begins well upstream of the health outcomes. Our focus is prevention of the circumstances that lead to chronic diseases including work on the social detrminants of health and the underlying causes of those social determinants.

Opioid Crisis Response

- From direct provision of MAT services and syringe exchange to broad based strategies that engage multiple sectors in addressing the opioid crisis, public health is coordinating a community wide strategy including community education, provider education,hospital emergency department policies, diversion control, pain patient support, harm reduction, addiction treatment, policy development and enforcement. As the coordinator of the effort public health works to support public awareness, coalition action and use data and evaluation to measure progress.

Community-based Care Coordination

- Our community health workers are a direct linkage to specific poipoulations and are imbedded in community settings. They are closely tied to SRHD staff in areas of their focus.

Describe how you see your organization involved in the Partnering Provider Transformation Plans within the following priority areas. (*Note: This section of the Partnering Provider Plan will be completed only by primary care Partnering Providers.*)

Long Acting Reversible Contraceptive (LARC)

- This is a good linkage to our Nurse Family Partnership program and interventions

Application of Fluoride Varnish

- Through the oral health coalition led by the health district there are providers coordinating fluoride varnish application.

Name of Organization: **Supportive Living Program**

A division of the Spokane County Community Services, Housing, and Community Development Department

Key Contacts(s): Kathleen Torella, Tonya Stern, and Kim Longhofer

Email Address(es): ktorella@spokanecounty.org; tstern@spokanecounty.org; and klonghofer@spokanecounty.org

Phone Number(s): Kathleen Torella 509-477-7561; Tonya Stern 509-477-4510; and Kim Longhofer 509-477-4383

What services does your organization provide?

- The Supportive Living Program (SLP) provides focused behavioral health services to adults diagnosed with mental illness and co-occurring disorders (both mental health and substance use disorder diagnoses) which include comprehensive community support services to assist individuals in:
  - Finding safe and affordable housing chosen by the individual,
  - Negotiating with landlords,
  - Moving into housing,
  - Maintaining housing,
  - Connection to community resources, including assistance in navigating legal, credit, identification, and eviction issues that are impacting an individual's ability to qualify for housing, and
  - Community integration to develop independent living skills, and socialization development.

- Additionally, SLP operates Housing and Recovery Through Peer Services (HARPS), which assists individuals to transition from institutional settings into permanent supportive housing, which may include rental subsidies and peer specialists to mentor hope and empowerment, provide education and advocacy to and for the individual, teach symptoms management to support the individual's recovery and stabilization in the community and permanent

Please describe the target populations you seek to serve:

- SLP and HARPS serve adults (with or without families) who are Medicaid Enrollees or at or below the 220% Federal Poverty Level and homeless or in an unstable living situation. The individuals must be diagnosed with mental illness or co-occurring disorders and need special assistance in locating safe, affordable housing.

What is your approach to culturally-sensitive services? (ex: translation services, racial-ethnic populations served, etc.)

- SLP and HARPS serve individuals of diverse cultural backgrounds. In addition to cultural competency trainings, staff work with individuals in service to learn from the individual about his/her unique cultural experience, beliefs, traditions, and values to ensure services are tailored to the individuals. Individuals are provided interpreter and translation services as needed. Additionally, education and resources pertaining to stigma associated with homelessness, mental health and substance use issues are important factors in service delivery. SLP and HARPS staff work closely with Fair Housing laws and advocate for individual's rights.

Does your organization play a role in diverting clients from high-cost services (ex: ER, hospitalization)?
If so, please describe:

- SLP/HARPS work closely with the individual in assessing need, support and offer of services. This may include locating safe, affordable housing, networking with community resources to maintain housing, life skill coaching, maintain independence in the community to avoid homelessness and readmission to higher level of care including incarceration and hospitalization. This also includes community integration tailored to the individuals needs and wants in hopes to support natural support systems, community involvement and coordination of care. Advocacy, training and role modeling on navigating housing resources, HUD housing programs, addressing barriers and learning dispute resolution. Training on Responsible Renters class, MOU with many housing providers including Spokane Housing Authority Housing Choice Vouchers, transitional housing via the Phoenix and access to HARPS funding.

In one or two sentences, please tell us why a Partnering Provider would want to include your organization in their plan (related to Medicaid Transformation):

- SLP and HARPS is a collaborative partner in the system of care, providing individualized and tailored care to our most vulnerable population in the community. Services are provided to each individuals in the community and include transportation with staff to address barriers, navigate resources and cross system partners, and work for the individual's success in health, treatment, care, housing and independence.

Are there specific Partnering Providers you hope to partner with? If so, in what capacity?

- SLP and HARPS will partner with all healthcare and community providers, and Managed Care Organizations as a comprehensive, collaborative team approach is effective in improving health outcomes and integration into community living. SLP and HARPS can receive referrals for services as a primary behavioral health provider or ancillary behavioral health provider for individuals already enrolled with another primary behavioral health provider.

Describe how you see your organization involved in the Partnering Provider Transformation Plans, within the following project areas.

- ***SLP and HARPS are not involved in any Partnering Provider Transformation Plans at this time.***

Bi-directional Integration of Care
Chronic Disease
Opioid Crisis Response
Community-based Care Coordination

- Assist individuals in their primary behavioral health care needs-in collaboration with all community service delivery systems whether it is health care, housing, SUD, partnering with other providers.

Describe how you see your organization involved in the Partnering Provider Transformation Plans within the following priority areas. (*Note: This section of the Partnering Provider Plan will be completed only by primary care Partnering Providers.*)

Long Acting Reversible Contraceptive (LARC)

- N/A

Application of Fluoride Varnish

- N/A

Social Determinant of Health & Key Partner Showcase

Name of Organization: Volunteers of America of Eastern Washington & Northern Idaho

Key Contacts(s): Fawn Schott, Stephen Miller

Email Address(es): fschott@voaspokane.org; smiller@voaspokane.org

Phone Number(s): Fawn: 509-688-1102, Stephen: 509-688-1140

What services does your organization provide?

- Housing services for all populations from young adult to seniors: Emergency shelter, transitional housing and permanent housing
- Housing and stability services for pregnant and parenting teens, foster youth, street youth,
- Street outreach for teens and chronic utilizers of emergency services
- Respite care for homeless individuals: medical respite, mental health respite, electronic home monitoring

Please describe the target populations you seek to serve:

- Individuals exiting jail
- Pregnant and parenting teens

What is your approach to culturally-sensitive services? (ex: translation services, racial-ethnic populations served, etc.)

- VOA strives to be culturally sensitive in all its services by acknowledging, understand and respond to a diversity of cultures, including: Religion and/or Spirituality, Race, Ethnicity, Familial status, Immigration Experience, Sexual Orientation, Gender identity and Gender expression. Our services rely on the participant experience and self-identification. We endeavor to ensure participants are the owners of their stories and drive our services. We make sure to have staff frequently trained on the above topics, and understand that our participant is the expert in all situations of their lives. Our staff are trained to respond in a culturally sensitive matter for all incidences and consider the cultural attributes in every interaction. We take the likelihood of discrimination and prejudice seriously and have outlined policies to ensure the fair and equitable treatment of all participants. Our staff prioritize participant inclusion for policy making, community engagement activities, and outreach.
- Culturally sensitive services are important to us because attention to cultural issues and the unique needs of diverse cultural groups has been shown to improve access and utilization of services. As culturally sensitive service provider, we make every effort to:
    - Fight stereotypes and discrimination
    - Increase clients access to culturally-relevant services
    - Enhance respect and awareness
    - Acknowledge and use participant's strengths in order to instill a sense of esteem and personal control
    - Gain participant feedback for program policy and decision making
    - Continuous staff training on cultural competence and alternate approaches

There are four aspects of culturally sensitive services that we are continuously working towards:

1) Awareness of our own and other peoples' perspectives and biases
2) Understand the differences and similarities between & within cultures, & how culture affects psychological, family, social and academic functioning
3) Skill, such as culturally appropriate assessment and intervention techniques

4) Continue to develop specialized knowledge and understanding that is inclusive

- All VOA staff are dedicated to providing culturally sensitive support services.

Does your organization play a role in diverting clients from high-cost services (ex: ER, hospitalization)?
If so, please describe:

- Yes. Through our Hot Spotters program - which is an innovative collaborative effort by Volunteers of America, Consistent Care, Spokane Fire Department, Spokane Police Department, Community Court, Frontier Behavioral Health, Spokane Housing Authority, Spokane County, City of Spokane, Better Health Together and numerous other homeless service providers that focus their efforts on high utilizers with complex situations who continually cycle through emergency services without improving their health, behavior, overall stability or quality of life. These individual are utilizing the wrong services to address their needs so there is little opportunity for them to receive the appropriate care unless someone intervenes to coordinate that effort.
- VOA's community health workers, case managers and health coaches utilize the Pathways model that connects clients to community services by creating an individualized care plan that produces positive health outcomes. We work closely with medical providers, primary care teams and numerous other agencies to improve overall care and outcomes. This includes: collaborating with individuals and their families'/support persons (if available) using the care management process for assessing needs, developing an appropriate referral, coordinating delivery of services, ensuring up to date health insurance, monitoring adherence to scheduled services, confirming a primary follow up visit and facilitating the coordinated utilization of healthcare resources to achieve optimal health outcomes, stable housing and effective use of services.
- Our goal is to assist all participants in all our programs to setup and engage a primary care physician, pharmacy, mental health provider, dentist and social support network that will meet their health needs. We work on educating participants to recognize symptoms and triggers so they seek the appropriate care from the appropriate provider in a prevention focused model.

In one or two sentences, please tell us why a Partnering Provider would want to include your organization in their plan (related to Medicaid Transformation):

- We partner and collaborate well with providers every day to improve the health outcomes of individuals enrolled in our programs. We bring an extensive set of skills and experience to help strengthen the services others are providing.

Are there specific Partnering Providers you hope to partner with? If so, in what capacity?

- CHAS, Providence Health Care, Frontier Behavioral Health, Spokane County Detention Services

Describe how you see your organization involved in the Partnering Provider Transformation Plans, within the following project areas.

Bi-directional Integration of Care

- By partnering with bi-directional integration of care providers as part of delivering healthcare, it will create greater opportunity for achieving the quality outcomes and cost reductions that are envisioned in a redesign of the healthcare system by aligning social determinants of health with their transformation plan. The vast majority of

VOA participants are Medicaid eligible, have significant mental health, substance use and physical health issues that often times over utilize the emergency care resources. With bi-directional integration of care VOA would support that effort by using the care management process for assessing needs, developing an appropriate referral, coordinating delivery of services, ensuring up to date health insurance, monitoring adherence to scheduled services, confirming a primary follow up visit and facilitating the coordinated utilization of healthcare resources to achieve optimal health outcomes while remaining stably housed. By aligning our efforts in addressing social determinants of health with the bi-directional integration of care we can realize long term improvements in health for our participants.

Chronic Disease

- By partnering with chronic disease providers as part of delivering healthcare, it will offer improved opportunities for achieving the quality outcomes and cost reductions that are envisioned in a redesign of the healthcare system by aligning social determinants of health with their transformation plan. The majority of VOA participants are Medicaid eligible, have significant chronic health issues that results in over utilization of emergency care resources resulting from the inability to manage their chronic health condition. VOA would support this effort by utilizing case managers, health coaches and community health workers to support the care management process for assessing needs, developing an appropriate referral, coordinating delivery of services, ensuring up to date health insurance, monitoring adherence to scheduled services, confirming a primary follow up visit and facilitating the coordinated utilization of healthcare resources to achieve optimal health outcomes while remaining stably housed.
- Work to empower participants to manage their health and health care
    - Emphasize the patient's central role in managing their health
    - Build self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up
    - Develop a plan for individual ongoing self-management support to participant
    - Participants with chronic illness make decisions and engage in self-management.
- By aligning our efforts in addressing social determinants of health with chronic disease we can realize long term improvements in health for our participants.

Opioid Crisis Response

- By partnering with the opioid crisis response providers as part of delivering healthcare, will offer improved opportunities for achieving the quality outcomes and cost reductions that are envisioned in a redesign of the healthcare system by aligning social determinants of health with their transformation plan. The majority of VOA participants are Medicaid eligible, have significant substance use issues that results in over utilization of emergency care resources resulting from the inability to manage their usage. VOA would support this effort by utilizing case managers, health coaches and community health workers to support the care management process for assessing needs, developing an appropriate referral, coordinating delivery of services, ensuring up to date health insurance, monitoring adherence to scheduled services, confirming a primary follow up visit and facilitating the coordinated utilization of healthcare resources to achieve optimal health outcomes while remaining stably housed. By aligning our efforts in addressing social determinants of health with chronic disease we can realize long term improvements in health for our participants.

Community-based Care Coordination

- By partnering with community based care coordination providers as part of delivering healthcare, will offer improved opportunities for achieving the quality outcomes and cost reductions that are envisioned in a redesign of

the healthcare system by aligning social determinants of health with their transformation plan. The majority of VOA participants are Medicaid eligible, and do not receive care coordination that results in over utilization of emergency care resources resulting from the inability to manage their usage. VOA would support this effort by utilizing case managers, health coaches and community health workers to support the care management process for assessing needs, developing an appropriate referral, coordinating delivery of services, ensuring up to date health insurance, monitoring adherence to scheduled services, confirming a primary follow up visit and facilitating the coordinated utilization of healthcare resources to achieve optimal health outcomes while remaining stably housed. By aligning our efforts in addressing social determinants of health with chronic disease we can realize long term improvements in health for our participants.

Describe how you see your organization involved in the Partnering Provider Transformation Plans within the following priority areas. (*Note: This section of the Partnering Provider Plan will be completed only by primary care Partnering Providers.*)

Long Acting Reversible Contraceptive (LARC)

Application of Fluoride Varnish

Name of Organization: **YMCA of the Inland Northwest**

Key Contacts(s): Nicole Manus, Brad Bushy, John Ehrbar, Steve Tammaro

Email Address(es): nmanus@ymcaspokane.org; bbushy@ymcaspokane.org; jehrbar@ymcaspokane.org; stammaro@ymcaspokane.org

Phone Number(s): 509-777-9622

What services does your organization provide?

- The YMCA of the Inland Northwest is Spokane's oldest not-for-profit charitable organization. We focus on strengthening the foundations of community through youth development, healthy living and social responsibility. Most people know the YMCA for programs such as swim lessons, youth sports and childcare or they may view us as a "gym". We continue to run these high quality programs and operate state of the art wellness centers, as we have more than 130 years in this community, but our offerings and reach continue to broaden as we partner and collaborate with other entities to meet community need.

Some of the things that might be most relevant to Community Based Care Coordination efforts are:

- Childcare
  - Early Learning Center (housed at the Central YMCA): serves 6 weeks through Pre-K. More than 50% of children in enrolled receive subsidy from the YMCA that they may attend a high quality licensed enrichment program with the goal of kindergarten readiness.
  - Before and After School care programs in 7 school districts (Mead, Reardon, Chattaroy/Riverside, Lake Spokane, Central Valley, East Valley and West Valley). As with all of our program offerings, the Y provides financial assistance to families in need that all children may have a safe place to learn, grow and thrive)
  - Out of School Time Camps (e.g., spring and winter breaks and school holidays as well as throughout the summer) the Y provides licensed Day Camps such that working parents may have a safe place where their kids can be cared for by professional role models and engage in enrichment activities
  - YMCA branch based child-watch. Our child-watch centers in each of our facility branches allow for parents with young children – infants to age 6 – (who have family memberships), to get two hours of free childcare per day while they exercise or catch some alone time to socialize with friends, read in our lobbies, do schoolwork or otherwise care for themselves onsite. Many of our members express that this benefit of their membership (included with all family memberships regardless of the level of financial assistance) has as much to do with their mental health as their physical health.
- Summer Meals for kids
  - Nationally, 1 in 6 children under 18 struggle with hunger. During the school year, many of these children are served by breakfast and lunch programs within the schools, but during the summer families in need do not have this support. While the YMCA is not generally thought of as a hunger relief organization, in 2017 we served more

than 31,000 meals (breakfast and lunch) at each of our day camp sites, the American Indian Community Center and Emmanuel Family Life Center. These meals were available not only to our campers and program participants but to any child under 18 in the community with no YMCA program participation required.

- Youth Mentorship
  - Outside the Box – mentorship and enrichment program at North Central high school for kids who have been identified as at risk for non-completion of high school
  - Reach and Rise – Middle School group based mentorship program
  - Youth Investment – program for youth diverted from the court system wherein they complete community service hours in an environment in which they are also receiving mentorship from caring program leaders who believe in their potential and can support them in making different choices in the future. They also learn skills as they work in the green house or participate in our lawn care services that can translate into entrepreneurial or employment opportunities in the future
- DDA Respite Program – Funding is provided by the Developmental Disabilities Administration to allow a break (or respite) for primary caregivers of DDA clients. Respite caregivers can attend the Y with the DDA client for open swim, group exercise classes or use of cardio equipment.
- Chronic Disease Prevention and Management Programs
  - LIVESTRONG at the YMCA cancer survivor wellness program: FREE 12-week program for any cancer survivor in the community and a single caregiver/support person of their choice
  - Adult Weight Loss Program – 12 week
  - Diabetes Prevention Program – CDC recognized year long program -- delivered locally in partnership with the YMCA of Greater Seattle
  - ACT! Actively Changing Together – 12-week Youth obesity intervention for children ages 8-14 (parents engage in the program with their kids)
  - Powerful Tools for Caregivers – 6-week program (2.5 hours per week) based on the Stanford Chronic Disease Self-Management model but designed specifically for caregivers. We currently have staff trained for this program but no funding to run it
  - Pathways to Wellness – Medical Exercise Program developed in partnership with CHAS Health piloting at the Central YMCA July 11-September 5 with schedule to expand to North and Valley branches in September.

Please describe the target populations you seek to serve:

- We seek to give EVERYONE a safe place to learn, grow and thrive. A huge piece of that is the financial assistance that we are able to provide to those who cannot afford the full cost of membership or programs. We are eager to be able to expand service to populations that have not traditionally seen us as 'relevant' or 'accessible'. Some of that relates to the perception that we are 'expensive' (and a lack of knowledge about our financial assistance) and part of that relates to the outdated historical perception that the Y is for white, male, Christians. We want to be able to serve *all* regardless of race, religion, gender, family status, LGBT status, etc.

What is your approach to culturally-sensitive services? (ex: translation services, racial-ethnic populations served, etc.)

- This is an area we have identified for growth. In 2017 we had tremendous success partnering with World Relief Spokane to expand access and supports to refugee families – offering programs in all of our branches during national Welcoming Week and follow up activities in the form of ESL and citizenship classes. We also provided numerous camp scholarships to refugee children. Recently we hosted a focus group with refugee and immigrant community members to help us gain perspective on what is important to them and how the Y can best serve. We have also been engaged for more than a year in a community partnership with a group of African American churches to identify supports they desire for improving the health of their congregations. Much of our branch and senior leadership teams have had the opportunity to take full-day trainings in Dimensions of Diversity and Cultural Lenses and 9 of our team members have completed the WA State Community Health Worker training which includes cultural competency training. We are actively working to hire more staff from racially-ethnically diverse populations that will move us in the direction of being more representative of our community as a whole.

Does your organization play a role in diverting clients from high-cost services (ex: ER, hospitalization)?
If so, please describe:

- N/A

In one or two sentences, please tell us why a Partnering Provider would want to include your organization in their plan (related to Medicaid Transformation):

- Specifically, in terms of chronic disease prevention and management, we have expertise (lifestyle and wellness coaching), facilities and programs that can support *Lifestyle Medicine* interventions. Whether obesity is contributing to health risks/conditions or a patient is *at risk for* (i.e. has prediabetes) or living with diabetes or COPD or chronic pain or depression or anxiety or hypertension or hyperlipidemia or cancer or recovering from a significant illness or injury, we can support a Partnering Provider's patients in making small, incremental changes that cumulatively can lead to significant and sustainable benefits. Some of the other services and programs that I have described (childcare, youth mentoring, etc.) may be of greater benefit to supporting the families of those served with the Pathways Hub (jail transitions, etc.).

Are there specific Partnering Providers you hope to partner with? If so, in what capacity?

- We are currently partnering with **CHAS Health** for the Pathways to Wellness *Medical Exercise* program and hope that this model could extend to other health systems in providing Lifestyle Medicine to support a range of chronic conditions – including mental/behavioral health.
- Anecdotally, we also have had numerous members tell us over the years that a Y membership and the opportunity to *belong* to a supportive community and engage in healthy activity has been a key component of long term recovery from substance abuse and from activities that previously contributed to cyclical involvement in the criminal justice system. From this perspective, we would be happy to engage in conversations around how we might fit into plans that support the opioid crisis response as well as the work to reduce jail recidivism. If there are ways that our

Lifestyle and Wellness coaches who are trained as CHWs to partner in the MTDP, we are also interested in exploring this.

Describe how you see your organization involved in the Partnering Provider Transformation Plans, within the following project areas.

Bi-directional Integration of Care

- Our Pathways to Wellness program is largely modeled off a partnership between an FQHC system in North Idaho and the KROC center. In addition to serving those with identified chronic 'physical health' conditions (diabetes, heart disease, etc.), they have had tremendous success utilizing the program to support patients with mental health diagnoses (depression, anxiety, etc.).

Chronic Disease

- What follows is our current suite of Chronic Disease Prevention and Management programs. The final listing *Pathways to Wellness* (a new partnership with CHAS Health) seems to have the greatest potential for reaching deeply into the Medicaid population and impacting health across a number of metrics.
- Chronic Disease Prevention and Management Programs
  - LIVESTRONG at the YMCA cancer survivor wellness program: FREE 12-week program for any cancer survivor in the community and a single caregiver/support person of their choice
  - Adult Weight Loss Program – 12 week
  - Diabetes Prevention Program – CDC recognized year long program -- delivered locally in partnership with the YMCA of Greater Seattle
  - ACT! Actively Changing Together – 12-week Youth obesity intervention for children ages 8-14 (parents engage in the program with their kids)
  - Powerful Tools for Caregivers – 6-week program (2.5 hours per week) based on the Stanford Chronic Disease Self-Management model but designed specifically for caregivers. We currently have staff trained for this program but no funding to run it. As we know that caregiver burden is a significant concern, we would love to be able to partner in ways that make this program accessible to those who need it.
  - Pathways to Wellness – Medical Exercise Program developed in partnership with CHAS Health piloting at the Central YMCA July 11-September 5 with schedule to expand to North and Valley branches in September.

Opioid Crisis Response

- Similarly, to the notes under bi-directional integration, the program which was the model for Pathways to Wellness also showed promise in supporting individuals in recovery from opioid addiction.

Community-based Care Coordination

- Knowing that the WA State Community Health Worker training is the desired base from which the Pathways Care Coordinators will be operating, we might also be able to engage in supporting CBCC plans. A number of our Lifestyle Coaches have completed the CHW training and also have solid training in Motivational Interviewing. We are not sure what this would look like but are interested in exploring possibilities.

Describe how you see your organization involved in the Partnering Provider Transformation Plans within the following priority areas. (*Note: This section of the Partnering Provider Plan will be completed only by primary care Partnering Providers.*)

Long Acting Reversible Contraceptive (LARC)

- N/A

Application of Fluoride Varnish

- N/A

Name of Organization: **YWCA Spokane**

Key Contacts(s): Regina Malveaux, CEO
Morgan Colburn, Associate Director of Counseling and Outreach Services
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Ms. Colburn: (509) 789- 9286
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What services does your organization provide?

1. Domestic Violence Services: The vision that propels our domestic violence work is a community in which domestic violence is no longer tolerated. For 40+ years we have embraced this vision, establishing a continuum of wrap-around services: 24-hour Helpline and Safe Shelter, Counseling Center (individual advocacy and group support), Mental Health Therapy Services (children and adults), Child Advocacy, Civil Legal Assistance (unbundled services and representation), Hospital Advocacy, Housing Advocacy, Legal Advocacy, and Prevention, Education, and Outreach.
2. Early Childhood Education Services: Our Early Childhood Education and Assistance Program (ECEAP) provides comprehensive nutrition, health, education, and family support services to Washington's most at-risk young children and their families. Additionally, YWCA's Drop-in Child Care Center furnishes free child care for YWCA clients with children.
3. Job Readiness Services: The Women's Opportunity Center specializes in Economic Empowerment Advocacy, providing a "one-stop shop" environment in which economically disadvantaged and homeless women are welcomed, accepted, and provided support in achieving financial self-sufficiency through the development of personal and professional skills. Available services include the Washington State Department of Social and

Health Services (DSHS) WorkFirst Life Skills and Basic Food Employment and Training (BFET) programs.[1] Access to free, professional clothing resources for work, court, and school are available through the Our Sister's Closet program. Further, trauma-informed Yoga for Survivors, Expressive Art, and Circle of Security parenting classes are available to clients.

Please describe the target populations you seek to serve:

1. Intimate partner domestic violence victims
    - Victims with accompanying children
    - Victims without children
    - Children and youth who are primary or secondary victims
2. Three and four years olds whose families are living at 110% of the federal poverty level or less
    - Four year olds have enrollment priority
    - Foster and homeless children are automatically eligible
    - Children with other risk factors also receive priority
3. Low-income women who are seeking employment
    - Women with children and expecting mothers who are receiving Temporary Assistance for Needy Families (TANF) and participating in the DSHS WorkFirst Life Skills program
    - Women who are Basic Food (SNAP) recipients who are participating in the DSHS BFET program
    - Intimate partner domestic violence victims
    - Homeless and unemployed/underemployed women

What is your approach to culturally-sensitive services? (ex: translation services, racial-ethnic populations served, etc.)

Diversity encompasses acceptance and respect for differences that include race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, and other ideologies. Diversity involves understanding that everyone is unique and, as a result, infinitely valuable. If we are to embrace and celebrate the abundant diversity contained within each person, we must purposefully gather a myriad of voices around our table.

[1] Women may not participate in both the TANF WorkFirst program and the BFET program.

Over the last 115 years, we have learned that we cannot empower all women unless we simultaneously work to eliminate racism. Accordingly, our theory of change involves three focus areas: racial justice and civil rights, empowerment and economic advancement of women and girls, and health and safety of women and girls. In order to create change in these areas, we respond to social problems and transform the conditions created by them through three primary activities: direct services to those who are most immediately impacted by the problem, education to the general public about the problem and possible solutions, and advocacy for public policies that will transform the conditions of those most directly impacted by the problem. It is the combination of these activities that will enable us to achieve our mission.

We ensure that victims have meaningful and full access via federally grant-funded interpreter services, ADA compliant facilities, and ongoing staff diversity training via entities such as the Washington State Coalition Against Domestic Violence. For the blind and those with low vision, Braille signage is provided and program documents and forms can be provided in alternate formats (Braille or large print).

Does your organization play a role in diverting clients from high-cost services (ex: ER, hospitalization)?

If so, please describe:

Domestic violence has a devastating effect on the health and wellbeing of victims and families, and is a national public health epidemic.

- Recently abused women have health care costs that are more than twice those of women who have never been abused and about $4,500 higher than women who have not been abused in the past year.[2]
- Women who reported injuries as a consequence of their most recent incident of physical intimate partner victimization visited the emergency room twice, a physician more than three times (3.5), a dentist more than five times (5.2) and made nearly 20 visits (19.7) to physical therapy.[3]
- A 2009 study of more than 3,000 women (ages 18-64) from a large health plan located in the Pacific Northwest found costs for women suffering ongoing abuse were 42% higher when compared with non-abused women. Women with recent non-physical abuse had annual costs that were 33% higher than non-abused women.[4]

[2] Jones AS, Dienemann J, Schollenberger J, Kub J, O'Campo P, Gielen AC, Campbell JC. 2006. Long-Term Costs of Intimate Partner Violence in a Sample of Female HMO Enrollees. *Women's Health Issues*, 16(5): 252-61.
[3] Arias I, Corso P. 2005. Average Cost Per Person Victimized by an Intimate Partner of the Opposite Gender: a Comparison of Men and Women. *Violence and Victims*, 20(4):379-91.
[4] Bonomi AE, Anderson ML, Rivara FP, Thompson RS. 2009. Health Care Utilization and Costs Associated with Physical and Nonphysical-Only Intimate Partner Violence. *Health Services Research*, 44(3): 1052-67.

- The same Pacific Northwest study found that health care costs remain higher even when the abuse is over. Women who suffered physical abuse five or more years earlier had health care costs that were 19% higher than women who were never abused.[5]

Similarly, we know that poverty makes people sick. Research tells us that impoverished neighborhoods have a much higher level of illness and use of health care services than more affluent areas. Thus, poverty and income inequality lead to increased health care utilization and spending.[6]

Across the United States, life expectancy in the poorest neighborhoods is a full 10 years shorter than in the richest. Based on the distribution of household incomes throughout the country, it is true that if the people living in the poorest areas were as healthy as the rich, and therefore used health care at the rate of the most affluent, overall utilization and spending could be as much as 30% less than the current rates.[7]

In light of the facts presented above, and given our mission, we firmly agree with BHT that agencies, both large and small, must work together to provide community members with wrap-around and tailored support. We are an established multi-service agency that takes a "whole-picture" approach to serving the vulnerable. We provide comprehensive, holistic services to meet the needs of those who are coping with trauma that stems from domestic violence, poverty, and unemployment.

Safety planning with a client experiencing domestic violence may help to reduce calls to 911 and trips to the hospital or doctor's office. Additionally, one of the goals of our mental health therapy services program is to reduce PTSD symptoms. Reduction of PTSD symptoms usually coincides with a reduction in generalized anxiety and depression, which may lead to a reduction in the need for doctors' visits and psychiatric medication. Access to employment services, including help with job search, resume building, and access to professional clothing, all contribute to improved individual self-esteem and may reduce anxiety and depression while also increasing a sense of empowerment and productivity.

[5] Bonomi AE, Anderson ML, Rivara FP, Thompson RS. 2009. Health Care Utilization and Costs Associated with Physical and Nonphysical-Only Intimate Partner Violence. *Health Services Research*, 44(3): 1052-67.
[6] Cooper, Richard. *Poverty and the Myths of Health Care Reform.* Johns Hopkins University Press. 2016.
[7] Ibid.

In one or two sentences, please tell us why a Partnering Provider would want to include your organization in their plan (related to Medicaid Transformation):

YWCA Spokane is Spokane County's only certified domestic violence services agency, providing the County's only trauma-informed domestic violence services that conform to the "Supportive Services and Administrative Standards for Domestic Violence Agencies" as codified in the Washington Administrative Code. With ECEAP sites in three different cities (i.e., Spokane, Medical Lake, and Airway heights), YWCA also administers one of the largest ECEAP programs in eastern Washington.

Are there specific Partnering Providers you hope to partner with? If so, in what capacity?

Yes, there are. In addition to deepening our current partnerships with Catholic Charities, CHAS, Lutheran Community Services Northwest, MultiCare, Spokane Valley Partners, Providence Health Care, and Spokane Regional Health District, YWCA seeks meaningful partnerships with each of the agencies and organizations listed on the "BHT Spokane BH & PC Partners" spreadsheet. We say this in earnest, as it is our intent to make our services available to all eligible clients no matter where they first enter the care continuum.

We can support Partnering Providers by offering the above-listed specialized services for their clients who are coping with domestic violence, poverty, and unemployment.

Describe how you see your organization involved in the Partnering Provider Transformation Plans, within the following project areas.

- Bi-directional Integration of Care: As Spokane's only state-recognized domestic violence service provider, we would like to be an integral part of providing trauma-informed mental health care for patients receiving medical or psychiatric care related to domestic violence. Our mental health therapy services include individual, child, and parent-child therapy, and we utilize CBT, Trauma Focused CBT, EMDR, and sand tray and play therapies. In addition, our clinical staff is uniquely trained to understand intimate partner domestic violence and its impact on victims and their families, as well as to provide trauma-informed mental health care to impacted individuals.

  In this project areas, we would like to partner with CHAS, MultiCare, and Providence as their primary referral point for all patients who report intimate partner domestic violence-related mental health concerns.

Please note that we already offer a hospital response on-call program. This program serves victims of domestic violence by providing an on-call advocate who is trained to offer services in the hospital setting. This advocate can provide safety-planning and resource brokering and can connect victims to YWCA's safe shelter, housing, and legal advocacy options.

(Please also see our answer in the Opioid Crisis Response section below.)

- Chronic Disease: As part of a study conducted by the Verizon Foundation, over 1,000 American women were interviewed. The study found that women who reported any kind of domestic violence had higher rates of chronic health conditions than women who had experienced no domestic violence. Forty four percent of participants admitted to experiencing some type of domestic violence, to include physical, emotional, sexual, and/or economic abuse. While 77% of women overall suffer from a chronic health condition, the percentage grows to 81% for those who have experienced any form of domestic violence, which is a statistically significant increase.[8] We also know that high levels of trauma in childhood and adulthood can lead to high rates of chronic health issues because trauma overwhelms the body's natural ability to fight disease, infection, etc.

  YWCA services help reduce each client's stress level through safety planning, therapy, support groups, child advocacy, resource brokering, etc. As a result, we can help complement the work being done by Partnering Providers to address each victim's medical/behavioral health concerns.
- Opioid Crisis Response: According to research, intimate partner domestic violence plays a critical role in the development and exacerbation of mental health and substance use disorders. For example, domestic violence victims face a greater risk of experiencing a range of mental health conditions like depression, PTSD, substance use disorders, and suicidality. Additionally, research indicates that there are high rates of domestic violence among women receiving services in mental health and substance use disorder treatment settings. In 2012, the National Domestic Violence Hotline and the National Center on Domestic Violence, Trauma and Mental Health, conducted two surveys to explore these connections

  Survey results demonstrate that it is common for perpetrators to engage in behaviors designed to undermine

[8] Exploring the Relationship Between Domestic Violence and Chronic Health Conditions. Verizon Foundation. November 2013.

their partner's sanity and sobriety, control their partner's ability to engage in treatment, and discredit them with potential sources of protection and support. While victims may use substances to cope with emotional trauma and/or chronic pain, they may also be coerced into using by their abusive partners, which sabotages the victims' recovery. Abusers also use their victims' substance use condition to further their control.

Particularly salient for Partnering Providers, over 50% of victims who sought mental health services and over 60% of those who sought help for substance use said their abusers tried to interfere with their treatment. These forms of abuse jeopardize the wellbeing of victims and their children, while also compromising the effectiveness of treatment and prevention efforts.

These findings highlight the importance of ensuring that Partnering Providers are trained to recognize and respond to the myriad ways that domestic violence can impact a victim's mental health and substance use. It also is imperative that we work together to keep victims safe, which can include legal advocacy, safe shelter, legal assistance, etc. We must also work together to create policies, procedures, and practices that support victims who are coping with these issues.

- Community-based Care Coordination: We relish the opportunity to partner with Spokane's health care professionals, clinics, urgent care centers, hospitals, specialists, mental health professionals, and co-community service providers to more holistically provide patient-centered, coordinated care.

To the above, we add the following. According to the National Domestic Violence Hotline, it is true that perpetrators become abusive or increase their abuse during pregnancy. This happens for a variety of reasons. Since abuse is based on power and control, it is common for abusive partners to become resentful and jealous because the attention is shifting from them to the pregnancy. They may be stressed at the thought of financially supporting a child, frustrated at the increased responsibilities of parenthood, or angry that their partner's body is changing. Since pregnant women are in uniquely vulnerable positions both physically and emotionally, abuse of any kind can put them and their unborn children at heightened risk. If the abuse is physical, trauma can cause both immediate injury, as well as increase the risk of hemorrhaging, a uterine rupture, pre-term birth, complications during labor, or miscarriage.[9]

[9] http://www.thehotline.org/is-this-abuse/pregnancy-abuse/. Retrieved 7/2/18.

We can help Partnering Providers by assisting pregnant victims in addressing their safety concerns, which can include legal advocacy and/or legal assistance. YWCA services can help decrease the stress and danger that these women experience during pregnancy. This, in turn, can reduce the risk of pregnancy complications. Together with the services of the Partnering Providers, we could offer more holistic assistance for clients and more directly impact their emotional health and wellbeing.

Describe how you see your organization involved in the Partnering Provider Transformation Plans within the following priority areas. (*Note: This section of the Partnering Provider Plan will be completed only by primary care Partnering Providers.*)

- **Long Acting Reversible Contraceptive (LARC)**

  N/A
- **Application of Fluoride Varnish**

  N/A