Washington State Health Care Authority

Report to the Legislature

Evaluation of Community Health Care Collaborative Grant Program

Chapter 67, Laws of 2006
Engrossed Second Substitute Senate Bill 6459

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Executive Summary

The Community Health Care Collaborative (CHCC) Grant Program was established by Engrossed Second Substitute Senate Bill (E2SSB) 6459 and enacted as chapter 67, Laws of 2006. Section 6 of the act directs the Health Care Authority (HCA) to provide the Governor and Legislature with an evaluation of the program, which will expire June 30, 2009, unless the Legislature takes action.

The 2006 Washington State Legislature found that despite federal and state efforts, too many Washington residents continue to be without access to quality, appropriate health care. The intent of the Legislature was to enhance and support the development of collaborative community-based organizations working at the local level to improve access to quality health care for Washington residents.

About one in 11 Washingtonians is uninsured, which is 9.3 percent or about 593,000 of the state's population. Of those uninsured, 66 percent have incomes under 200 percent of the federal poverty level.[1] The Washington State Health Care Planning Grant Access to Health Insurance Project defined the uninsured as, generally, young, low-income, part of a working family, without children, and with limited education.[2] Additionally, a disproportionate number of Hispanic and American Indian/Alaskan Natives are more at risk of being uninsured than any other race or ethnic group.

The Legislature was particularly concerned that the most vulnerable populations are left to navigate a fragmented treatment system that fails to support their long-term well-being. They found that many community-based health organizations had recently demonstrated promising results in improving access to health care. By effectively leveraging funding and support through collaboration with other local organizations these groups were addressing health care access issues on a local level.

The Legislature created the CHCC Grant Program and authorized the HCA to administer a competitive grant to fund community programs that addressed access to medical treatment, efficient use of resources, or improvements in quality of care. The CHCC grants began in April 2007.

Upon examining the first year of the 14 CHCC grant-funded programs, the results show the programs have been a worthy investment for the state. Services have been provided to over 60,000 individuals who needed access to health care. State dollars have been leveraged by an estimated 4.8 to 1 return. Nearly $5 million of volunteer medical services have been coordinated. Many of these programs would not exist without the CHCC grant funds.

Overall, the results demonstrate that the CHCC grant-funded programs have potential beyond what has been accomplished in the first year. It takes time and effort for these programs to effectively establish commitments of funding, resources, time, and the local support necessary to

[1] 2006 Washington State Population Survey: The Uninsured Population in Washington State.
[2] Washington State Blue Ribbon Commission Presentation, Health Care Costs and Access, October 27, 2006, Vicki Wilson, Ph.D., Director, Washington State Planning Grant Access to Health Insurance Project.

sustain them in the long term. There continues to be a role for the state in supporting and sustaining community-based health care collaboratives. Based upon the findings of the first year's results, the HCA recommends the following actions:

1. Continue the CHCC Grant Program with sufficient funding for both the grants and program administration.

2. Adjust CHCC Grant Program funding to operate concurrently with the state's biennial budget cycle. Address the funding gap for Cycle 1 grant recipients—the first year of the two-year grant cycle should coincide with the first year of the biennial budget cycle.

3. Continue to provide funding for start-up programs, expansion projects, and programs developing emerging models.

4. Coordinate discussions with CHCC grant-funded programs and state agency partners regarding barriers to program success.

5. Collaborate with Washington Community Connect to coordinate a "best practices" meeting for CHCC grant-funded programs to share program information, discuss suggestions made by grant recipients, standardize performance measures, and share strategies for reduction of inappropriate Emergency Department (ED) utilization and Return on Investment (ROI) throughout the state.

6. Require CHCC grant-funded programs to develop a measure related to long-term sustainability of their program and to report on the measure as part of the quarterly reporting process.

Background

The Community Health Care Collaborative (CHCC) Grant Program was established by Engrossed Second Substitute Senate Bill (E2SSB) 6459 and enacted as chapter 67, Laws of 2006 (see Appendix A) to enhance and support the efforts of collaborative community-based organizations to develop innovative health care delivery models that can be replicated throughout the state.

The Washington State Health Care Authority (HCA) was authorized to provide competitive grant awards to eligible community-based organizations, in consultation with the Department of Health (DOH), the Health and Recovery Services Administration within the Department of Social and Health Services (HRSA/DSHS), and the Office of the Insurance Commissioner (OIC). The HCA designated Community Health Services (CHS) as the agency program to implement and administer the grant program. The program became effective July 1, 2006, and expires June 30, 2009.

Section 6 of the act directs the HCA to provide the Governor and Legislature with an evaluation of the program, which will expire June 30, 2009, unless the Legislature takes action. The agency evaluation is to include recommendations related to statewide replication of particularly successful community programs. Further, the report is to include recommendations from participating organizations on CHCC program improvements and other options for state support of community-based health care access efforts.

The Legislature created the CHCC Grant Program because it found that community-based health organizations had recently demonstrated promising results in improving access to health care. The program was to provide grants to serve employed low-income persons who are uninsured and underinsured through local programs that address access to medical treatment, efficient use of health care resources, or improvements in quality of care.

Some eligible community organizations in Washington State had been funded by the Healthy Communities Access Program (HCAP), a federal initiative of the Department of Health and Human Services (DHHS). HCAP supported local collaborative efforts to coordinate and strengthen health services for the uninsured and underinsured. The federal grant was discontinued. Funding ended in 2007, placing local efforts to improve health care access at risk.

The Legislature appropriated $1.4 million in the 2006 supplemental budget to fund the CHCC program; $700,000 for grant awards in fiscal year 2007 and $700,000 for fiscal year 2008. The enabling legislation (Engrossed Substitute Senate Bill 6386, Section 213(12), enacted as chapter 67, Laws of 2006 [see Appendix B]) specified that the awards were to be capped at $250,000 per organization on a two-year grant cycle with matching funds of $2.00 for every $1.00 awarded. An additional $200,000 was appropriated for administrative costs; $100,000 for each fiscal year. The HCA provided $50,000 in fiscal year 2007 from agency funds for start-up costs.

In 2007, the Legislature appropriated an additional $500,000 for continuation of the CHCC Grant Program. It specified $250,000 to be awarded in fiscal year 2008 and $250,000 in fiscal year 2009. No additional funds were appropriated for administrative costs. (Substitute House Bill 1128, Section 214(11), enacted as chapter 522, Laws of 2007 [see Appendix C]).

Program Implementation

The HCA regulations further defined fair and equitable procedures for determining eligibility and distribution of state funds for the CHCC Grant Program. (See Appendix D, Washington Administrative Code (WAC) 182-20-600, 182-20-610, and 182-20-620.)

Eligibility for the grant awards was limited to nonprofit organizations (including governmental and tribal entities) that serve a sub-state region, maintain a formal collaborative governance structure, and have a decision-making process for improving access. Additionally, only organizations that could provide at least two dollars in matching funds for each dollar awarded could be considered.

Minimum application requirements established in the legislation called for applicants to:

- Define the geographic region served.
- Demonstrate that the structure and operation of the organization reflects the interests of and is accountable to that region.
- Specify a dollar amount requested and how it would be spent.
- Provide sufficient information for an evaluation of the application based on the criteria established by the HCA.

The grant application was developed, in consultation with DOH, HRSA/DSHS, and OIC, with a focus on creating a format to determine the applicants which would best serve the Legislature's intended purpose: improving access to medical treatment, efficient use of health care resources, or quality of care. (See Appendix E, Grant Application Review Criteria.)

The grant program was officially announced on November 6, 2006. The deadline for grant applications to be submitted to the HCA was January 5, 2007.

Grant Recipients

Twenty-seven grant applications were received. Ten grant recipients were selected based upon information in their applications that demonstrated their ability to achieve at least one of three legislative goals: provide access to medical treatment, demonstrate efficient use of health care resources, or improve quality of care. The HCA Administrator selected the recipients in consultation with DOH, HRSA/DSHS, and OIC. All ten finalists were awarded grants following site visits conducted in March and April 2007. (See Appendix F, May 22, 2007, Press Release.)

The first ten recipients were granted funding in the first cycle of a two-year grant, running from April 1, 2007, through March 31, 2009. Following the appropriation of additional funds in 2007, four more programs (designated as alternates in the original review process) were granted funding. These four programs received grants in the second cycle of a two-year grant running from October 1, 2007, through September 30, 2009. (See Appendix G, December 13, 2007, Press Release.)

Program Funding

The CHCC Grant Program was created during the 2006 supplemental budget year. The authorizing legislation directed the HCA to award the grants on a two-year cycle, resulting in the disbursement of grant funds to be split between two separate biennial cycles. Administrative funding began July 1, 2006 (FY07).

Following development and implementation of rules and the grant application process and organization of the review panel and selection process, ten Cycle 1 awards began April 1, 2007. Cycle 1 awards continue through March 31, 2009. Funding for four Cycle 2 awards began October 1, 2007, and continue through September 30, 2009.

Table 1: Grant Program Funding Cycles

FY07	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Cycle 1												
Cycle 2												
Admin												

FY08	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Cycle 1												
Cycle 2												
Admin												

FY09	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Cycle 1												
Cycle 2												
Admin												

FY10	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Cycle 1												
Cycle 2												
Admin												

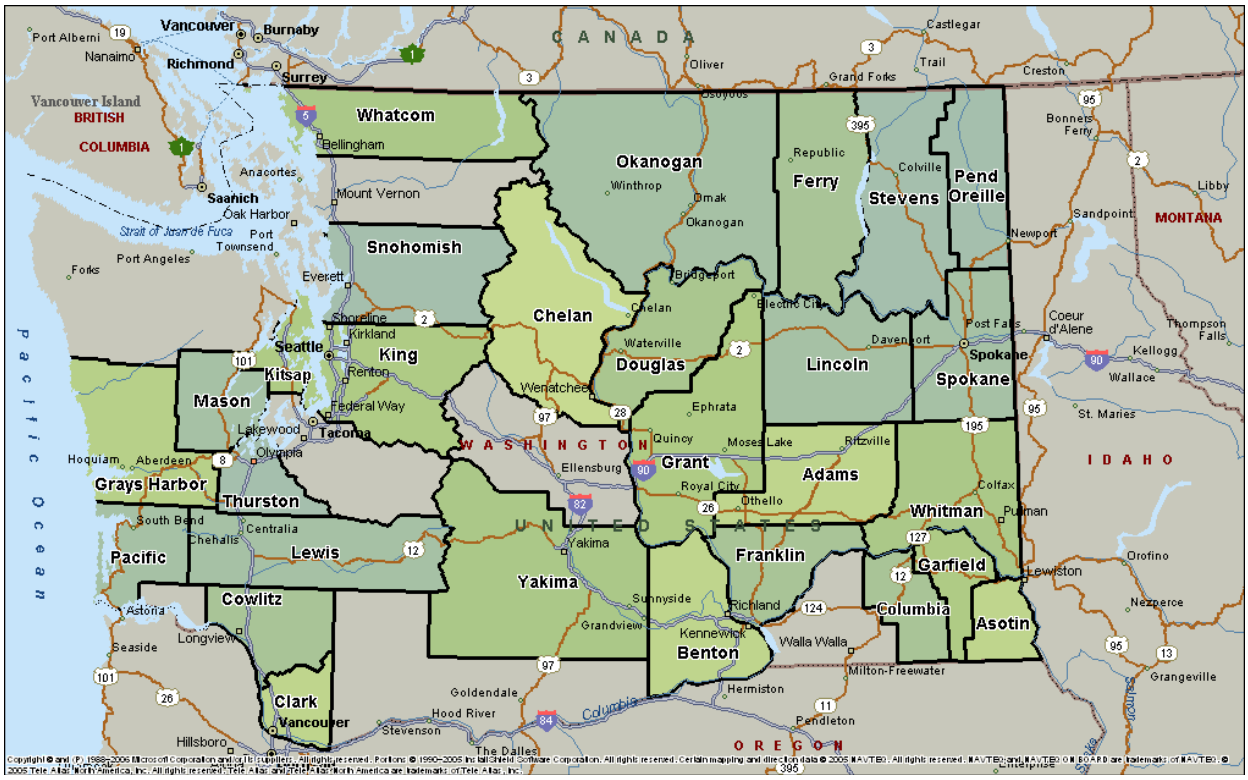
The program funding schedule was complicated by initiating funding during a supplemental budget year and granting program awards on a two-year cycle split between two biennia. It was further complicated by running two cycles of grants with overlapping schedules following the appropriation in 2007.

The Legislature allocated a total of $2.1 million for the CHCC Grant Program during the 2006 and 2007 legislative sessions; 90 percent of these funds went to fund grant programs and 10 percent was expended on administrative costs. Disbursement of funds is made on a quarterly basis. Initial disbursement of funds for Cycle 1 began April 2007. The second year of funding began April 2008 following the review of grant performance and satisfactory determination by the HCA Administrator. The Cycle 2 disbursements began October 2007 and are also made on a quarterly basis.

Grant Programs

There are a total of 14 CHCC grant recipients spread equally throughout eastern and western Washington counties. Services are available through CHCC grant-funded programs in 28 counties.[3] (See Figure 1 below.)

Figure 1. Map of CHCC Counties



The CHCC Grant Program serves uninsured and underinsured populations in rural and urban settings. Some programs are mature organizations and some are start-up programs that used CHCC grants to fund development. Table 2 (on following page) provides an overview of the organizations funded including the funding cycle, whether the funding is for a start-up or the expansion of a mature project, the funding level, the counties served, and the program focus.

[3] Services are no longer available in Benton and Franklin Counties effective May 1, 2008, due to the closing of Benton-Franklin Access to Care.

Table 2. Overview of Grant Recipients

Cycle	Overview of Grant Recipients	Type	Funding Level	Counties Served	Access to Medical Treatment	Efficient Use of Resources	Quality of Care
2	Community Health Partners (CHP) to develop a place-based community advocacy program.	Start-up	$50,000	Cowlitz	√		
1	Free Clinic of Southwest Washington to start Project Access of Clark County (PACC).	Start-up	$75,000	Clark	√		
1	Community Health Center of Snohomish (CHCS) County for their Kids Get Care (KGC) dental program.	Expansion	$75,000	Snohomish	√	√	√
1	International Community Health Services (ICHS) to develop a community collaborative for culturally, linguistically, and medically appropriate prevention and self-management.	Start-up	$100,000	King	√	√	√
1	Port Gamble S'Klallam Tribe (PGST) to implement digital technologies.	Start-up	$100,000	Kitsap	√	√	√
2	Yakima County Department of Community Services for Yakima County Health Care Coalition for Kids Connect.	Expansion	$100,000	Yakima	√	√	√
1	Peninsula Community Health Services (PCHS) for Kitsap Partnership for Access to Health Care (KPAH) Services to integrate primary and behavior health care services.	Start-up	$125,000	Kitsap	√	√	√
1	Yakima Valley Farm Workers Clinic for the Yakima County Asthma Project (YCAP).	Start-up	$125,000	Yakima	√	√	√
2	Benton-Franklin Access to Care (BFAC) for Project Access expansion, a pharmacy network program, and to reduce the unnecessary use of emergency rooms.	Expansion	$175,000	Benton, Franklin	√	√	√
2	Community Minded Enterprises for Health for All (HFA) for access for the uninsured/underinsured and efficiencies in the delivery system.	Expansion	$175,000	Spokane, Stevens, Pend Oreille, Ferry, Lincoln, Grant, Garfield, Whitman, Asotin, Adams, Columbia	√	√	
1	Community Choice Physicians Hospital Community Organization (PHCO) for Project Access expansion of benefits enrollment services and a mobile mental health unit.	Expansion	$175,000	Chelan, Douglas, Okanogan, Grant, Adams	√	√	√
1	Spokane County Medical Society Foundation for Project Access Spokane (PAS) expansion.	Expansion	$175,000	Spokane	√	√	√
1	Whatcom Alliance for Healthcare Access (WAHA) for Project Access for a hospital ED referral system and to develop a small business insurance connector.	Expansion	$200,000	Whatcom	√	√	√
1	CHOICE Regional Health Network for Project Access Program to implement the Patient Access Link (PAL).	Expansion	$250,000	Grays Harbor, west Lewis, Mason, Pacific, Thurston	√	√	√

Patient/Client Demographics

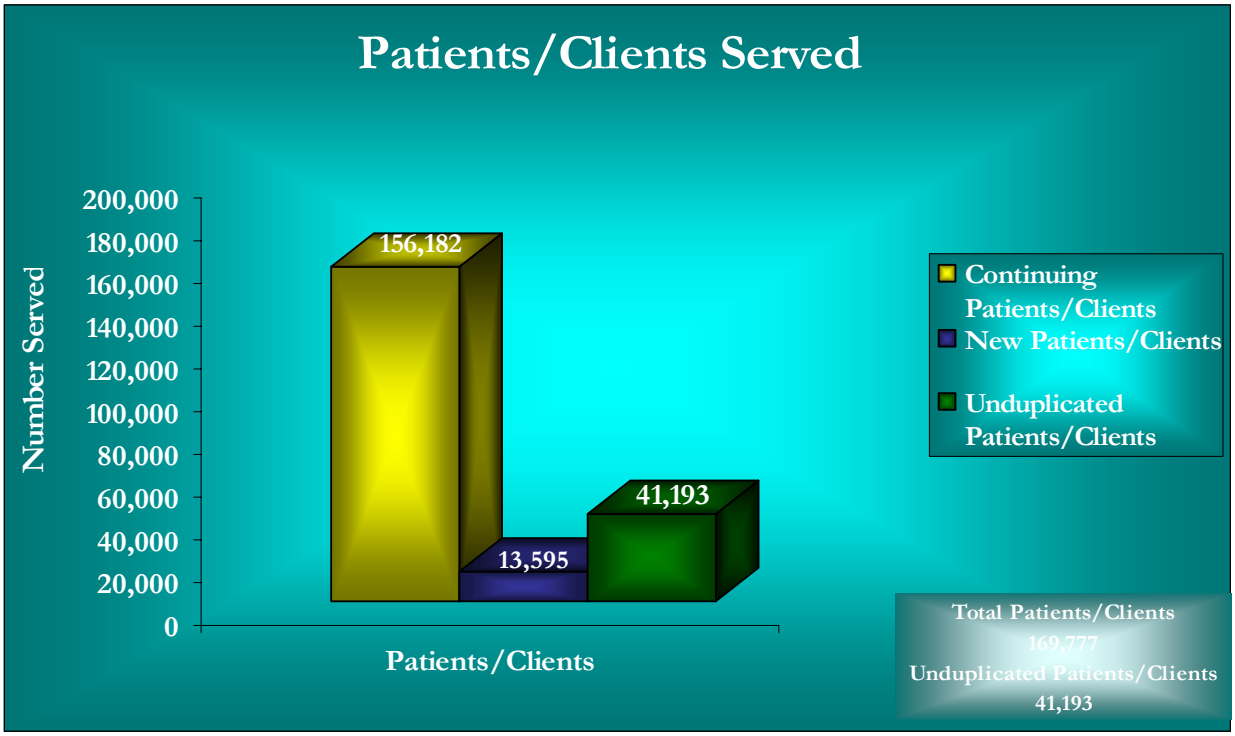
CHCC Grant Program recipients are required to provide the HCA quarterly program performance and patient/client demographic reports. The information presented in this evaluation represents one year of program data for the ten grant programs funded in Cycle 1 and six months of data for the four programs funded in Cycle 2.

Since the CHCC is a new program, the reporting requirements were new for the grant program recipients. Some recipients experienced challenges implementing the new data collection requirement into already developed management systems. The HCA continues to work to improve the data collection and reporting process through collaboration with the recipients and streamlining/standardizing the format. (See Appendix H, Quarterly Reporting Requirements.)

For this evaluation, aggregate program data is presented in the following graphics based upon the grant programs' quarterly report submittals. We believe these numbers are a conservative reflection of actual patients/clients served, due to some of the reporting challenges experienced by grant recipients. The number of employed and unemployed patients/clients is not included in the data findings. The recipients did not have the ability to capture this information to a degree that would be significant to report.

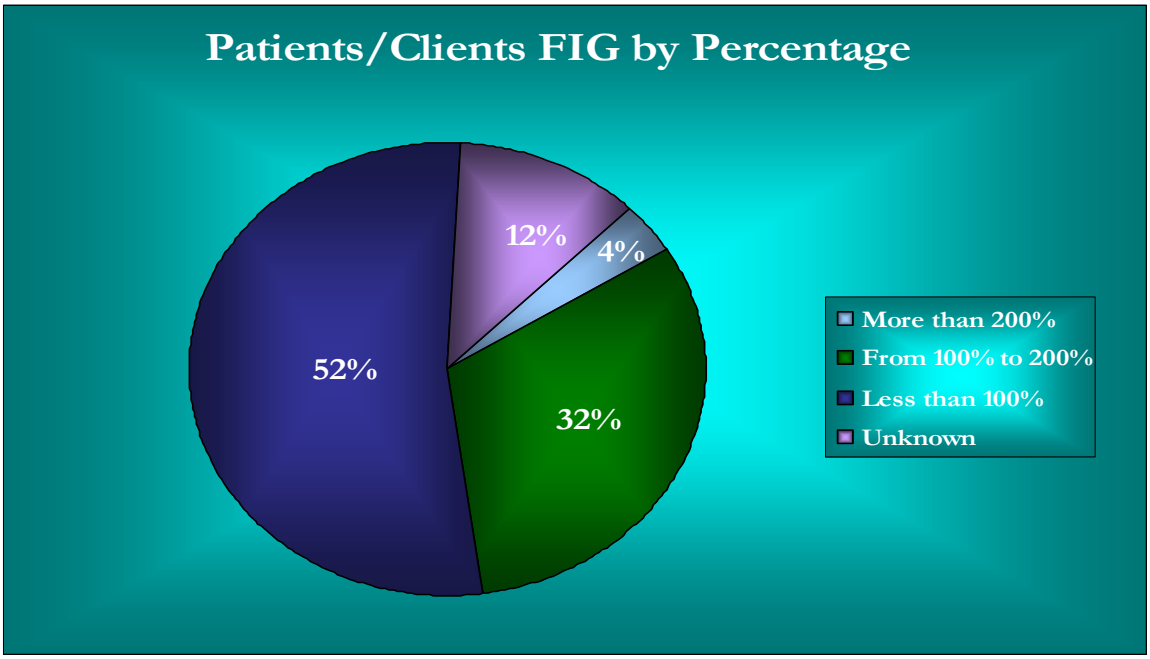
CHCC grant-funded programs reported 41,193 unduplicated patients/clients served, and 13,595 of this population were identified as new patients/clients. The programs provided a total of 169,777 services to this population. (See Figure 2.)

Figure 2. Patients/Clients Served



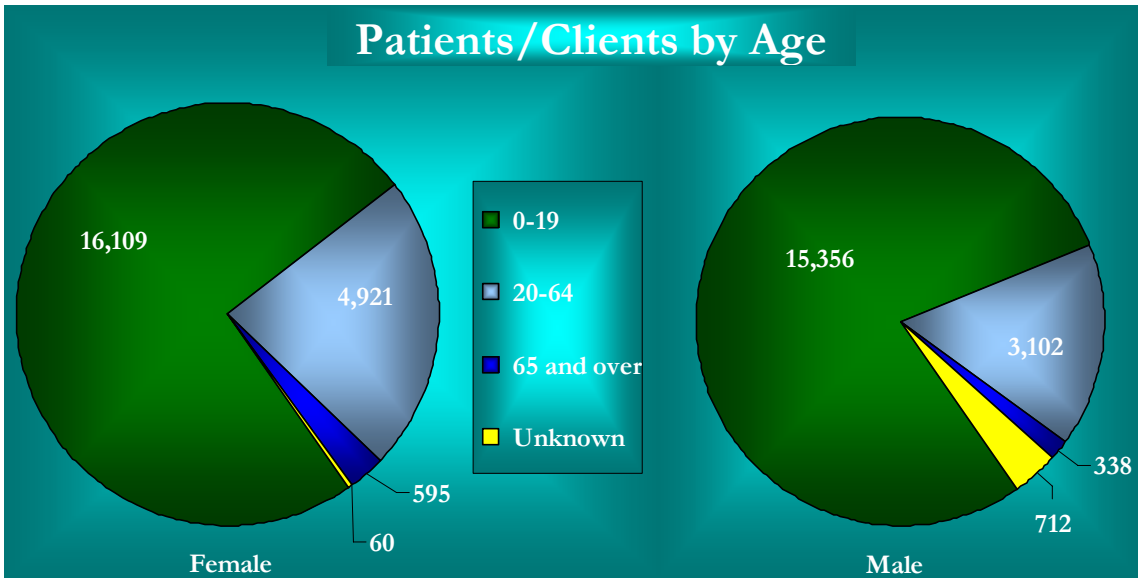
Nearly 85 percent of the patients/clients served reside in households with incomes at or below 200 percent of the Federal Income Guidelines (FIG). Fifty-two percent of the patients/clients served reside in households with incomes under 100 percent of the FIG. (See Figure 3.)

Figure 3. Patients/Clients FIG by Percentage



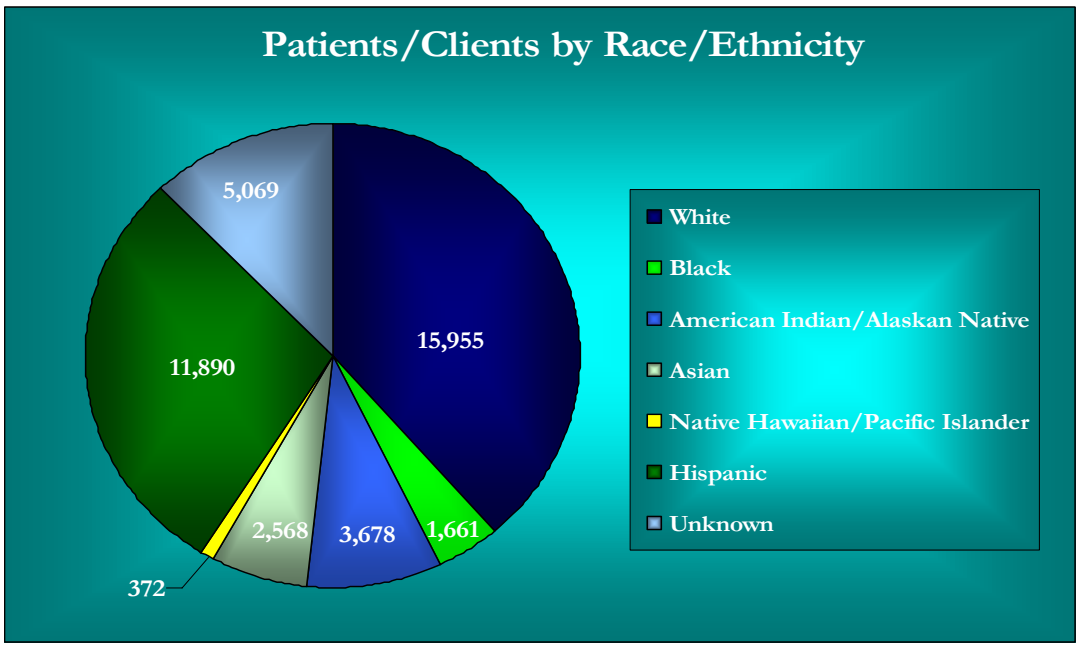
Three of the CHCC grant-funded programs targeted services for children. This emphasis is reflected in the distribution of patients/clients served by age data. As seen in Figure 4, 76 percent of the unduplicated patients/clients served are under the age of 19. The 20-64 age group accounts for 20 percent of the patients/clients served and the 65 and over age group is only 2 percent of the population served. The ages of a small portion of the population served are unknown.

Figure 4. Patients/Clients by Age



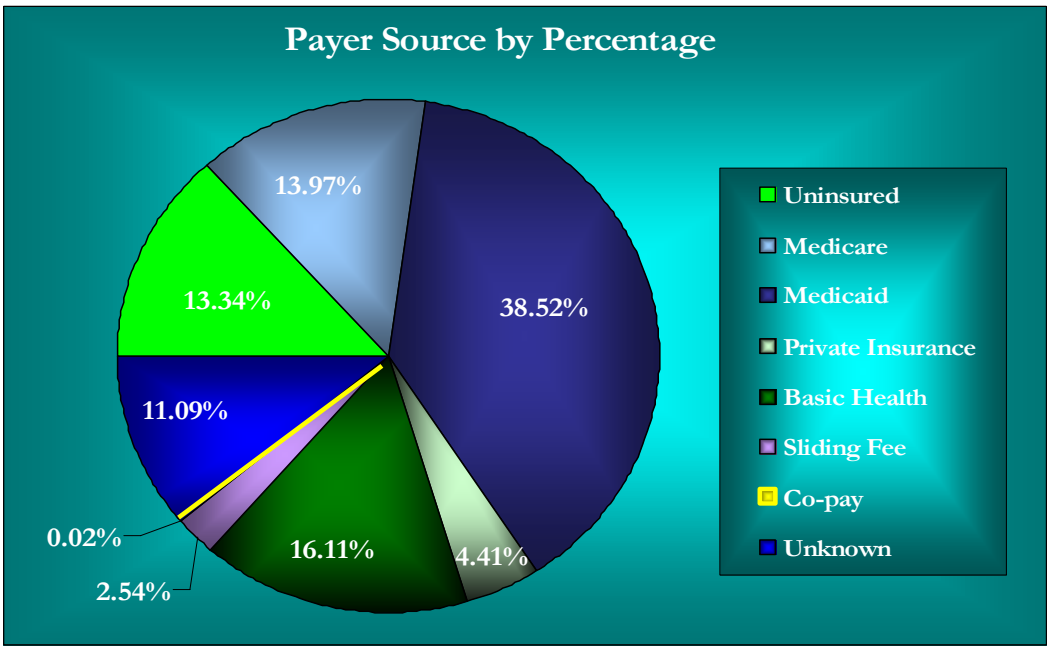
Several CHCC grant-funded programs offer services targeted to meet specific needs of certain racial and ethnic populations. As seen in Figure 5, the distribution of unduplicated patients/clients by race/ethnicity is consistent with the populations served by those programs.

Figure 5. Patients/Clients by Race/Ethnicity



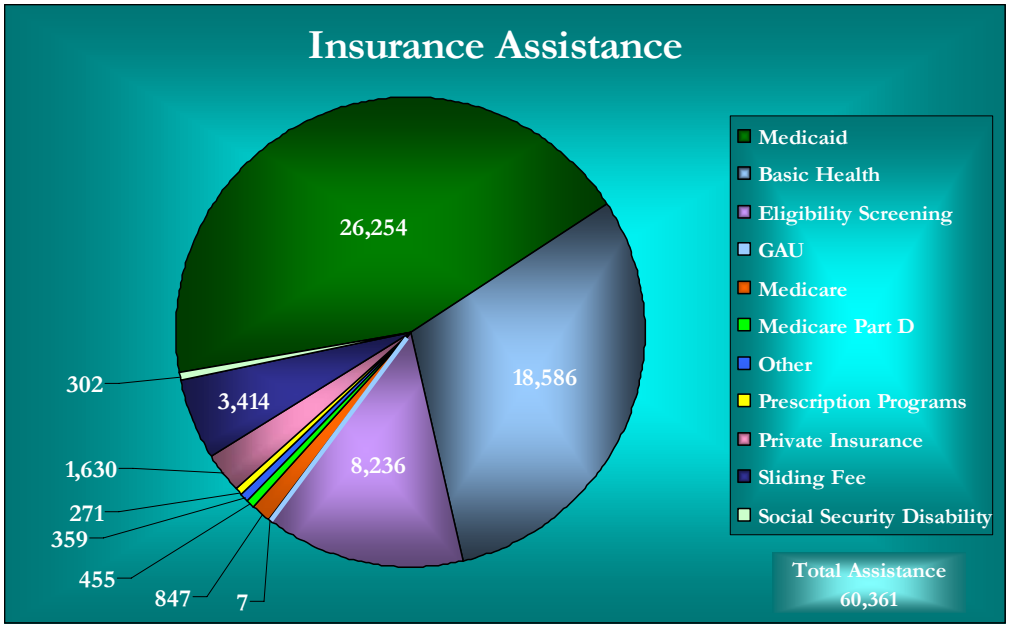
Payer source data is based on client-reported insurance status at time of initial contact with the grant-funded program. (See Figure 6.)

Figure 6. Payer Source by Percentage



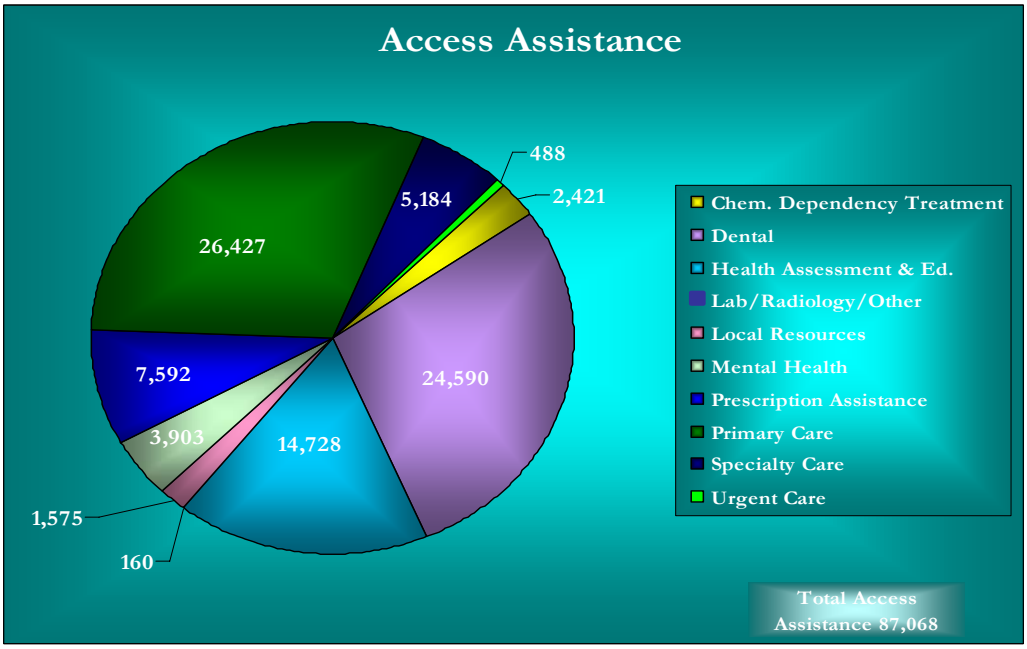
Twelve of the grant-funded programs have designated performance measures to track access to health care benefits by connecting the uninsured to publicly funded programs. The programs assisted patients/clients over 60,000 times to apply for or maintain insurance or coverage for medical care. (See Figure 7.)

Figure 7. Insurance Assistance



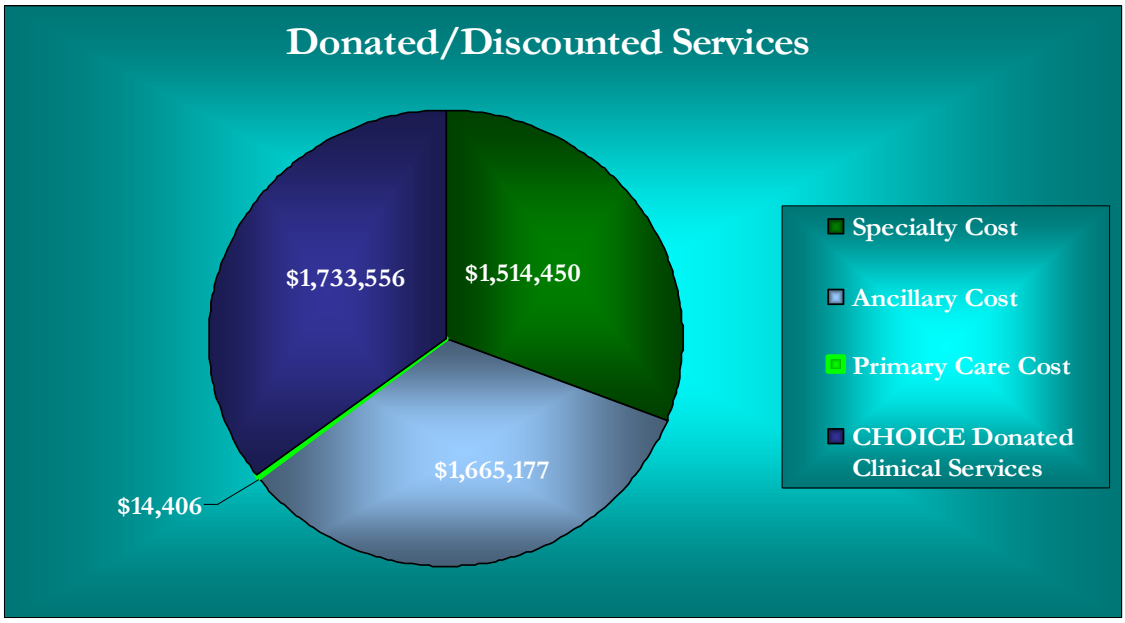
The majority of patients/clients seeking services were in need of primary medical or dental care. Only six percent sought assistance to access specialty care. (See Figure 8.)

Figure 8. Access Assistance



Nearly $5 million of donated care was reported for the first year of the grant. Eight programs make and track referrals to specialty care; of those, six reported the dollar value for donated care. This includes specialty care, primary care, and ancillary services (lab, x-ray, etc.). Figures 9, 10, 11, and 12 describe the types of referrals made and the value of the donated services provided.

Figure 9. Donated/Discounted Services



Note: CHOICE Regional Health Network donated clinical services are noted separately. CHOICE tracks the total value of donated services; however, it is unable to report them by category.

Figure 10. Specialty Care

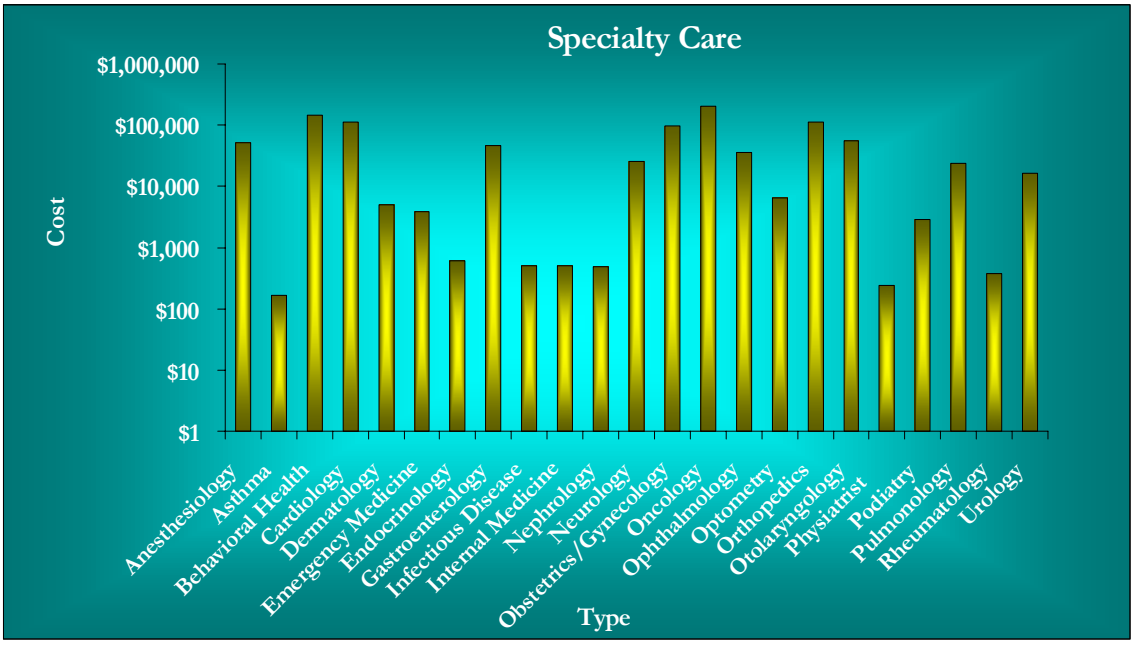


Figure 11. Specialty Care – Surgical

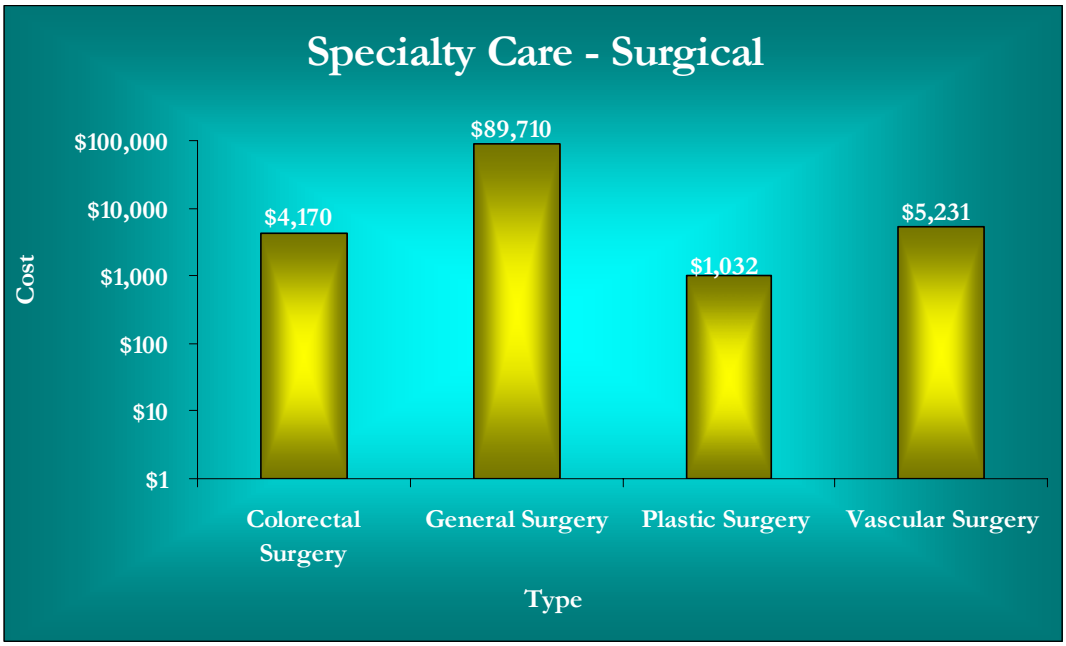
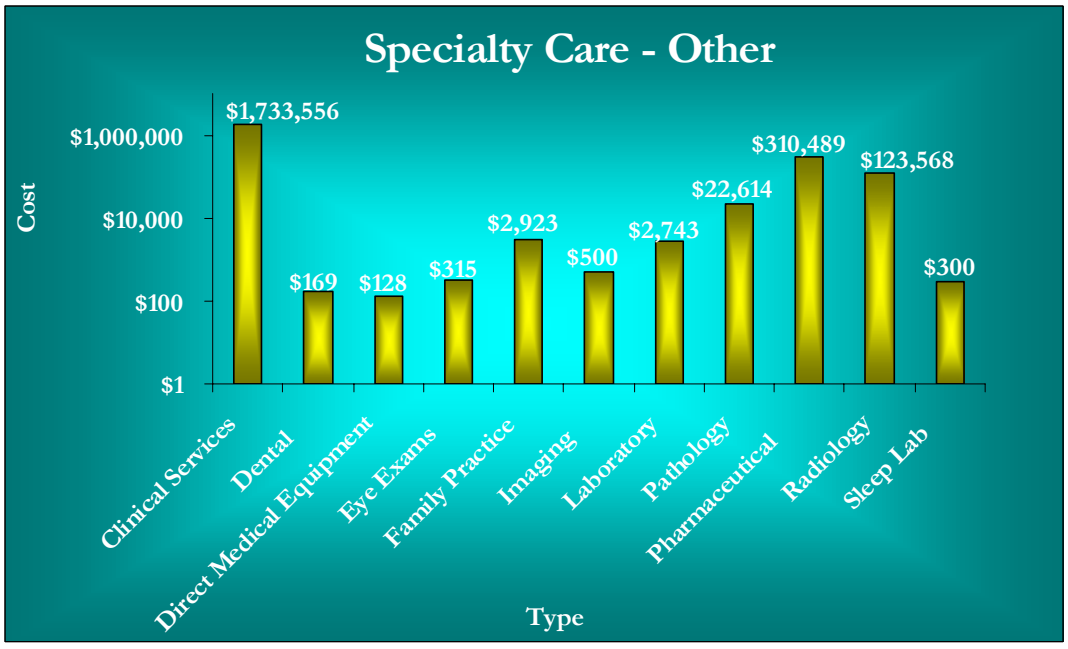


Figure 12. Specialty Care – Other



CHCC Grant Program Highlights and Dashboards

The CHCC grant-funded programs vary; some are mature organizations with developed local networks and partners that have well-established procedures and systems. Conversely, there are start-up programs in the early stages of development that CHCC grant funding assisted. The grant-funded programs also differ in size and scope, and in their approaches to address defined community health care needs. However, many of the programs' goals and objectives are similar and produce similar outcomes.

Table 3 (see next page) provides an overview of the services addressed by the 14 programs through performance measures or significant achievements demonstrated in their results.

Table 4 (see following pages) provides a section of dashboard overviews for each of the 14 grant-funded programs. The dashboards highlight the individual accomplishments of each program.

Table 3. Grant Recipients' Services Addressed Through Performance Measures and Outcomes

Grant Recipients' Services Addressed Through Performance Measures and Outcomes	Behavioral Health Services	Culturally Appropriate Services	Dental Assistance	Evidence Based Care	Health Literacy	Health Status	Insurance Coverage	PCP/Medical Home	Pharmaceutical Assistance	Physician Networks	Referral to Specialty Care	Small Employers	Technology	Emergency Dept Reduction
Community Health Partners	√						√	√			√			√
Free Clinic of Southwest Washington						√	√		√	√	√			√
Community Health Center of Snohomish/Kids Get Care		√	√		√		√	√						
International Community Health Services		√		√	√	√	√							
Port Gamble S'Klallam Tribe		√		√	√	√	√	√			√		√	√
Yakima County Department of Community Services/Yakima Kids Connect		√	√		√		√	√						√
Peninsula Community Health Services/Access to Health Care				√		√	√				√			√
Yakima Valley Farm Workers Clinic/Yakima County Asthma Project		√		√	√	√								√
Benton-Franklin Access to Care			√				√	√	√	√	√			√
Community Minded Enterprises/Health for All					√		√	√				√		√
Community Choice Physicians Hospital Community Organization	√	√			√	√	√	√						√
Project Access Spokane					√	√	√	√	√	√	√	√		√
Whatcom Alliance for Healthcare Access							√	√		√	√	√		√
CHOICE Regional Health Network	√	√			√	√	√	√	√	√	√			√

Table 4. Dashboard Overviews – Community Health Partners

Community Health Partners (CHP) to develop a place-based community advocacy program to provide access to health insurance coverage, prescription assistance, and other health services.	Start-up Funding: $50,000 $25,000 per year—Cycle 2
Served: 488 Specialty Care Referrals: 163 Value of Donated Care: $4,989 Insurance Assistance: 213 Access Assistance: 970	Emergency Reduction Strategy: New question added to the intake process at the free clinic—"If not seen at the free clinic where would they have gone for care?" Responses: ER 171; MD 1; Don't know 14; FHC 13; Vancouver 15; Health Dept. 1; Nowhere 10; MD office 2; Other 36. Return on Investment Method: Specialty care—providers do not provide documentation for patient care beyond the first appointment. The value of $165 is used for the first appointment. All care is donated.

Goal 1. To understand and serve the health and wellness needs of the uninsured and medically under-served in the Cowlitz County region, thereby reducing health disparities and eliminating barriers to access.

Maintain the Cowlitz Free Medical Clinic at an easily accessible location for community residents.

- 389 patients seen at the free clinic.
- Patient satisfaction surveys and triage nurse questionnaires identify areas of patient concern; surveys reviewed weekly and reported to the board.

Regularly schedule patient case reviews with providers and agencies with focus on barriers to care.

- 3 provider meetings; part of regular quality assurance review; no patient issues raised.

Actively refer patients to local health care providers for medical and mental health services.

- 527 referrals of patients to local medical and mental health providers.

Assist community residents and free clinic patients who qualify for state and/or federally sponsored programs; assist clients in developing knowledge and skills to complete applications.

- 106 clients assisted to complete insurance applications.
- Insurance forms being completed through free clinic and off-site at Cowlitz County Health Department.
- AmeriCorps person trained to assist clients and supported by Community Health Advocate (CHA).
- Plans to develop single community resource directory and supplement for people who are low-income.

Goal 2. To function as a community collaboration for the delivery of medical and social services.

Develop and maintain place-based services to neighborhood residents through agreements.

- While working closely with the free clinic and the health department, project is negotiating with two community organizations in low-income neighborhood.
- Cowlitz County Health Department has signed partnership agreement.
- Goodwill Industries-Vocational Services signed Memorandum of Understanding (MOU) to provide site and support.

Develop and maintain place-based services to neighborhood residents through agreements with community health care providers.

- Regional Support Network (RSN) and Family Health Center signed MOU.

Goal 3. To increase local community awareness and support for the free clinic and community health advocacy services.

Establishment of a sustainability plan through the CHP for continuation of activities beyond the end of the CHCC grant.

- CHP received a $2,500 Technical Assistance grant from Kaiser Permanente for fund development.
- Technical Assistance for Community Services (TACS) of Oregon will assist CHP with fund development plan; scheduled workshop on funds development and sustainability.

Unanticipated Results

Connection made with vocational training and drug rehab programs.

Table 4. Dashboard Overviews – Free Clinic of Southwest Washington

Free Clinic of Southwest Washington Project Access of Clark County (PACC) to start a Project Access of Clark County. The program will coordinate donated specialty and primary care services to low-income residents.	Start-up Funding: $75,000 $37,500 per year—Cycle 1
Served: 2 Specialty Care Referrals: pending Value of Donated Care: N/A Insurance Assistance: 2 Access Assistance: N/A	Emergency Reduction Strategy: Primary component of PACC; strategy is to enroll patients before the need for ED arises. Return on Investment Method: Pending; all data will be tracked through a central system. Two strategies will be used through: 1) physicians specialty care system and 2) tracking provisions of physician, hospital, pharmacy, and ancillary care to quantify the cost and relationship to patient health care outcomes and quality of life.

Goal 1. Uninsured people in Clark County will have access to quality specialty health care.

Start-up program has focused on development of administrative structure of program, patient referral system, physician recruitment, and partner trainings.

- Continued efforts to build relations with members of local health care community.
- Worked with six organizations for potential funding.
- Developed policies and procedures manual.
- Developed Project Access website.
- 2 newspaper/press releases announcing program.
- Purchased Project Access Data Management system; 16 hours of database training for staff.
- Developed patient flowchart process.
- PACC to "go-live" on March 3, 2008: 10 (≈) referrals per month from two safety net clinics on target for pilot March thru May.
- Collaborated with Statewide Health Insurance Benefits Advisors (SHIBA) and Retired and Senior Volunteer Program (RSVP) to develop screening and eligibility processes.
- "Patient Referral" trainings with two safety net primary care clinics, one training with hospital; developing training plan and materials for participating providers; developing dispensary training.

To increase coordination for 30 patients needing specialty care during pilot.

- 2 eligible patients enrolled; 24 referrals in eligibility determination process.

Goal 2. Participants in PA Clark County will have increased productivity.

To increase the number of patients who are available to return to work as a result of services.

- Created pre-patient survey: 2 completed; post-patient survey is developed, but not yet relevant.

Goal 3. Improve the overall health status of uninsured people in Clark County.

Objectives/Results

Improve quality of life and perceived health status of 95% of PACC patients.

- Tested the Behavioral Risk Factor Surveillance System (BRFSS) survey tool with first two patients.

Goal 4. Reduce the high cost of un-reimbursed charity care for hospitals and safety net clinics in Clark County.

In developmental stages.

Goal 5. Increase health care satisfaction of the community by providing equitable care spread across the community by a broad range of specialties.

Increase the number of medical providers and ancillary services participating in PACC to 70% by 2009 (end of grant).

- Developed physician recruitment procedures for specialty recruitments; recruited 22.9% of target specialists.
- Management of physician recruitment process; developed targeted recruitment plan.
- Created protocol to recruit physician groups by using champions.
- Planned and facilitated 120 meetings with physician groups and hospitals.
- Designed, created, and distributed over 300 physician recruitment packets.
- 170 agreements with practicing physicians signed.
- 72 new participation agreements obtained.
- Received 22 referrals from safety net providers.

Goal 6. Demonstrate accurate financial "return on investment" of PACC.

- Columbia United Providers providing claims processing and will generate in-kind donation report.
- Argus/Providence system to track all prescriptions.
- No Return on Investment method to report yet.

Unanticipated Results

- PACC has successfully directed potential patients to other programs for medical help: a patient to the Breast and Cervical Health Program for a breast biopsy and a patient to Southwest Washington Medical Center for urology surgery. They were outside the scope of the program, but we were able to assist in getting medical help for these people.
- Through working with SHIBA, have helped patients find access to other health insurance available to them.

Table 4. Dashboard Overviews – Community Health Center of Snohomish County

Community Health Center of Snohomish County for Kids Get Care Dental Program (CHC-KGC) to identify and link families in need of health care with dental and medical health care homes. Emphasis will be given to families that experience barriers because of ethnicity, ancestry, or linguistic isolation.	Expansion Funding: $75,000 $37,500 per year—Cycle 1
Served: 34,496 Specialty Care Referrals: N/A Value of Donated Care: N/A Insurance Assistance: 43,510 Access Assistance: 42,677	Emergency Reduction Strategy: N/A Return on Investment Method: N/A
Goal 1. Improve effectiveness, efficiency, and continuity of care.	
Expand KGC program to seven locations. • Hired 4 staff. Placed 3 to 3 clinics connecting to 2 Dental clinics and 2 WIC offices. One Newborn Access Specialist (NAS) works with 2 hospitals. Includes Vietnamese-, Spanish-, and Russian-speaking staff.	
Goal 2. Develop self-sustaining networks between community-based organizations and health care organizations.	
Develop training and coordination meetings. • 20 collaborative meetings between KGC staff, Snohomish Health District, and other community-based organizations (CBO). Conduct Oral Health Education Presentation to WIC participants at Snohomish Health District offices. • 26 presentations made to: WIC Oral Health Training, Everett Shelter, Everett School District Nurses, Get Moving program, Early Call Center, Families and Children Early Support (FACES), Everett Community College Head Start, and Childhood Education Assistance Program (ECEAP).	
Goal 3. Improve access to medical care.	
Establish new medical homes for 400 children (newborn to 21 years) per year. • 1,318 children establish medical homes. • Daily contact with hospital social services staff at Providence Everett Medical Center and Stevens Hospital, and the KGC Newborn Access Specialist; Newborn Access Specialist is ensuring mother has access to health care prior to leaving the hospital. • Vietnamese and Russian outreach workers conducting home visits.	
Goal 4. Improve health status of children and youth.	
Increase Well Child Checkup (WCC) Visits by 10% per year. • First year served: 0-2 years 4,907, 54%; 3-6 years 1,498, 36%; 12-21 years 1,762, 22%. Age-specific reports generated from new Electronic Medical Record (EMR) system. Increase immunization rates to 62% for 0-2 years, 70% for 3-6 years, and 41% for adolescents. • Age-specific reports to verify patients are up-to-date in recommended WCC for each age group. • 0-2 years 4,907 WCC, 54%; 3-6 years 1,498 WCC, 36%; 12-21 years 1,762 WCC, 22%. Increase number of children 1-4 years who have a structured developmental assessment by 15% per year. • 2,734 1-4 year-olds assessed; trained providers on new EMR Developmental Screen tool; previously assessments tracked manually. Increase the number of youth that receive tobacco use screening to 80%. • 861 3rd quarter tobacco use screenings of 13-19 year-olds; conducting provider training on EMR Social History-tobacco usage template.	
Goal 5. Improve access to dental care.	
Establish new dental homes for 400 children per year. • 2,593 new youth patients served with preventative or acute visits at CHC Dental Clinics.	
Goal 6. Provide early prevention, identification, and treatment of childhood caries.	
Increase by 15% per year the number of children with a dental visit before 2 years old. • 723 children less than 2 years old received a dental visit. Increase by 10% per year the number of children, less than 2 years of age, that receive both a medical and dental visit. • 453 children less than 2 years old received a medical and dental visit. Increase by 15% per year the number of children under 5 that receive fluoride varnishes, as indicated based on risk. • 674 children less than 5 years old received fluoride varnishes based upon risk through medical provider.	
Goal 7. Increase access to mainstream health insurance resources.	
Increase access to mainstream health insurance resources. • 1,818 children enrolled in public insurance programs. Goal is 400 new children per year.	
Unanticipated Results	
Connect with educational institutions and social service agencies. Collaborating between these 'service silos' has enabled the collaborative to efficiently connect children to preventative health care services and optimize use of resources. For example, it is well documented that children with well child visits are half as likely to have avoidable hospitalizations; in 2007, supported by the Kids Get Care team, Community Health Clinic provided 7,172 children with well child visits, an increase of 7.1% over the previous year.	

Table 4. Dashboard Overviews – International Community Health Services

International Community Health Services (ICHS) to develop a community collaborative for culturally, linguistically, and medically appropriate prevention and self-management of chronic conditions prevalent among Asian/Pacific Islander communities.	Start-up Funding: $100,000 $50,000 per year—Cycle 1
Served: 382 Specialty Care Referrals: N/A Insurance Assistance: N/A Access Assistance: 263	Emergency Reduction Strategy: ICHS patients enrolled in Basic Health are tracked for ER use via reports provided by CHPW. ICHS currently has low ER utilization rate. Non-Basic Health patients are not easily tracked for ER use; there is not an EMR field related to this currently in use. Return on Investment Method: Overall 4 to 1 CHCC funding.

Goal 1. In-language, culturally appropriate and relevant health education information available re: risk factors for and behaviors to prevent and/or better self-manage chronic diseases.

Inventory maintained of translated, culturally appropriate materials for diabetes, hypertension, hyperlipidemia, cardiovascular disease, and smoking cessation in Chinese, English, Korean, Tagalog, and Vietnamese.

- 65% developed and completed health education materials to ensure medical accuracy, and culturally and linguistically appropriate. Approved by medical director and health education manager. Including: Diabetes, Pre-Diabetes, High Cholesterol, High Blood Pressure. Drafts of Smoking Cessation, Carbohydrate Foods, fiber facts, healthy eating, Stress and Relaxation, Weight Management, Physical Activity, and Asthma are in review. Cancers, Osteoporosis, and Menopause are to be developed. Health Literacy tools and presentation on Western Health Care are in development. Patient Guide for ICHS services is in development.
- 35% health education materials available in languages other than English for top four health conditions.

Resource list of current services supportive of preventing and/or self-managing chronic diseases.

- 25% health education guidelines drafted and used routinely.
- 25% complete community survey of supportive services and resource list.

Goal 2. Participants learn how to prevent and/or better self-manage chronic disease(s).

Individual, family, and/or group health education sessions and classes equip participants to prevent and manage chronic disease.

- 132 referrals to one-on-one and group interventions in 1st year.
- 88 scheduled appointments/groups in 1st year.
- 92% appointments kept.
- 75% written policies and procedures regarding health education referrals and tracking and/or self-management.

Participants discuss "teach back" health education information accurately.

- Classes in participant's language used 75% of the time.
- Teach back method, used for competency development, is standard 50% of the time for Limited English Proficiency (LEP) population.

Participants analyze their own chronic disease risk behaviors (using self-assessment tool).

- 50% of participants developed self-management goals in EMR.

Participants identified lifestyle changes that are necessary for them to prevent and/or better self-manage chronic disease(s).

- Personal relevance emphasized in sessions and lifestyle changes necessary to prevent and manage chronic disease are identified.

Goal 3. Participants develop personal health goal(s).

Identify action steps for health goals over which they have control to achieve.

- 50% of participants have documented self-management goals for chronic disease in EMR.

Identify appropriate support services and activities, including regular physical activity, to achieve their health goals.

- Participants identified action steps for specific health goals.
- Participants established timelines for implementing.

Goal 4. Participants develop personal, individualized "Personal Health Plan" (PHP).

Establish realistic timeline for implementing steps and achieving goals.

- 50% of the participants developed PHPs and implementation steps, established realistic methods for tracking, and finalized their PHPs.

Goal 5. Participants implement Personal Health Plan.

Implement lifestyle changes to achieve personal goals.

- 50% of participants implemented changes; evaluation of effectiveness to begin in 2nd year of grant.

Goal 6. Participants progress in achieving personal health goal(s).

- 50% of participants maintain self-determined acceptable level of compliance with PHP and modified as necessary.

Goal 7. Improved participant health indicators (consistent with Healthy People 2010), particularly re: referral for chronic disease.

Tracking begins 4/1/08 — results not available yet.

Goal 8. Improved satisfaction with ICHS health care services.

Tracking begins 4/1/08 — results not available yet.

Unanticipated Results

- Translated health education materials; collaborations with local Community Health Clinic for AmeriCorps.
- Community support for program: partnered with local libraries, churches/temples, grocery stores, community groups.
- Sustained community advocacy for the Chinese, Vietnamese, and Filipino communities.
- Enhanced outreach to the Samoan/Pacific Islander communities.

Table 4. Dashboard Overviews – Port Gamble S'Klallam Tribe

Port Gamble S'Klallam Tribe Community Collaborative Health Care Project (PGST) for implementation of digital technologies with focus on electronic medical records and continuity of care.	Start-up Funding: $100,000 $50,000 per year—Cycle 1
Served: 4,013 Specialty Care Referrals: 1,039 (not donated care) Insurance Assistance: 1,275 Access Assistance: 27,059	Emergency Reduction Strategy: RN, PA, and ARNP staff take after-hours calls. Calls are triaged to ensure appropriate responses to medical needs and containing ED use. Measurable decrease in ED use since implementation. Return on Investment Method: N/A

Goal 1. Native Americans and other low-income individuals and families in Kitsap County will have access to medically necessary health care.

Increase number of patients who have insurance.

- 351 patients assisted with applications to obtain insurance; 98% successfully obtained insurance coverage.
- 245 patients assisted with insurance re-certification to retain insurance; 98% successfully retained insurance without having a gap in coverage.

To increase the number of patients who receive medically necessary specialty care.

- 1,022 referred for specialty care (not donated services); 100% referred to and accepted by providers—when no providers in Kitsap County will accept uninsured or underinsured, clients were referred to care outside the county.
- Protocol established to determine whether referrals are medically necessary.
- Chart review completed to obtain a baseline measure of the proportion of referrals deemed medically necessary according to established guidelines.

Goal 2. The providers in the Port Gamble S'Klallam Health Department's network of care will work at maximum efficiency.

To eliminate duplication of collection, data entry, and management of patient registration and of demographic information.

- 25% reduction from 4 to 3 locations where patient registration and demographic data are being stored.

To eliminate the use of transcription services for documentation of patient medical records.

- 100% elimination of transcription services for documentation of patient records.

To eliminate the need for staff time to verify patient coverage for non-Port Gamble (Tribal) Health Services Department (PGHSD) providers.

- Protocol established and time study conducted to obtain a baseline time required to verify patient coverage: 30 minutes per week. (Target for change is December 2008.)
- Protocol established and time study conducted to obtain a baseline time required to process a referral to a non-PGHSD provider: 759 minutes. (Scheduled change is August 2008.)

To eliminate the need for staff time to process claims manually.

- Protocol was developed and a time study conducted to obtain a baseline time required to process a claim manually: 1 hour. (Scheduled change is August 2008.)

Goal 3. Native Americans and other low- income individuals and families in Kitsap County will receive the highest quality health care.

To increase the use of evidence-based medicine. Evidence-based clinical guidelines will be incorporated into the EMR system for access at the point of care to ensure quality of treatment plans.

- Diabetes care protocol developed for evidence-based care guidelines. Review of 100% of diabetic patient charts to establish baseline data.
- Chronic pain management protocol was developed; chart review conducted.

To increase the number of patients who complete age-appropriate health screenings.

- Protocol for age-appropriate screenings was developed for patient population; chart review was conducted to establish baseline data.
- 76% of patients in different age groups have documented up-to-date screenings according to established guidelines.

To increase the efficacy of medication management for patients.

- Chart review conducted to establish baseline of up-to-date medication lists.
- Protocol was developed to establish guidelines for up-to-date charting and chart completeness.

Unanticipated Results

A reduction of non-clinical staff and reallocated resources to increase access and quality.

Table 4. Dashboard Overviews – Yakima County Department of Community Services

Yakima County Department of Community Services for Yakima County Health Care Coalition (YCHCC) to help families with children establish medical homes, reduce unnecessary emergency department visits, and assist in accessing insurance coverage.	Expansion Funding: $100,000 $50,000 per year—Cycle 2
Served: 312 Specialty Care Referrals: N/A Value of Donated Care: N/A Insurance Assistance: 97 Access Assistance: 608	Emergency Reduction Strategy: 1. Access Specialists located at 2 hospital ERs; those without a medical home are referred and follow-up is made by CHC. 2. Plan is to measure the return rate after the connection to CHC is made and education provided. 3. Access Specialists to follow up with clients. Information system will be used to record and track information through web-based case management system at 6 months after intake to report if client has used ED for potentially avoidable reasons. Return on Investment Method: Families referred to a medical home will be surveyed after 6 months to identify if the family is still connected to the medical home, if they have health coverage for the child/children, and if they still remember how to access their primary care provider after-hours.
Goal 1. To reduce the unnecessary use of the Emergency Rooms by the clients assisted in the project throughout the grant period.	
Track ER usage of Kid Connect families prior to project assistance and throughout project participation, and compare. • 54 kids who appeared at Emergency Rooms in Yakima and Sunnyside and said they did not have a medical home were referred to Kids Connect Access Specialists to assist in finding a medical home.	
Goal 2. Reduce the number of uninsured children in our county.	
Identify uninsured participants (children and family members) and document reasons for lack of insurance at intake. • Identified 79 uninsured children and their family members through this project and offered assistance. Access Specialists assist in application processes for clients to obtain insurance. • Assisted with 97 health coverage applications for children and their families – Medicaid, Children's Health, and Basic Health.	
Goal 3. Assist clients seen at the ERs to engage in the process of finding a primary care physician and/or a "medical home."	
Access Specialists explain the benefits and encourage voluntary referral assistance to finding a PCP local to the client. • 54 families referred by Access Specialists to medical homes for ongoing care.	
Goal 4. Provide clients with educational materials and consultation regarding appropriate use of the health care system and where and how to find resources for their families' needs and promote greater responsibility for their care and healthier living.	
Document consultations and materials exchanged with clients by Access Specialists and referral services used. • 468 documented consultations and materials exchanged with clients by Access Specialists and referrals services used.	
Goal 5. Obtain client and participant feedback to identify broader system improvements in access to services, service quality, and delivery.	
No results yet.	
Goal 6. Host a series of forums to provide public awareness of the project and to engage community leaders and providers in supporting larger strategic plans to address demographic and geographic health care service delivery in Yakima County.	
No results yet.	
Unanticipated Results	
The level of knowledge in our network of local community organizations has been increased, not just among the Access Specialists, but among the people who refer to them.	

Table 4. Dashboard Overviews – Peninsula Community Health Services

Peninsula Community Health Services (PCHS) for Kitsap Partnership for Access to Health Care Services (KPAH) to integrate primary care and behavioral health and improve access to appropriate care.	Start-up Funding: $125,000 $62,500 per year—Cycle 1
Served: 913 Specialty Care Referrals: 1,117 Insurance Assistance: 729 Access Assistance: 1,404	Emergency Reduction Strategy: Tracking using 3 strategies, all in early stages: 1) Chronic Care Manager receives copy of ED report for patient, contacts patient for follow-up, and tracks number of visits; 2) BH therapists record patients' self-report of ED use; and 3) PCHS patients of record inpatient hospital admits—a quarterly report to find relationship between physical health and behavioral health. Return on Investment Method: N/A

Goal 1. Kitsap County residents requiring behavioral health services will have access to an integrated primary care and behavioral health medical home.

Increase access to integrated primary care and behavioral health population-based health care among 2,240 PCHS clients.

- 100% integrated care staffing model in place: 1.8 FTE MS BH therapist, .1 FTE ARNP, .2 FTE Chronic Care Coordinator.
- 133 ARNPs carry cell phones; calls assigned to Kitsap Mental Health Services (KMHS)/psychiatric consultant when off-duty.
- ARNP psychiatric consultation and case review available to PCPs.
- 1,273 Behavioral Health (BH) therapist-provided brief BH interventions.
- ARNP provided 2 BH trainings and mentoring to PCP.

To support implementation of the Kitsap County Behavioral Health Alliance's strategic plan to achieve access to effective, quality behavior health services for county residents.

- Describe barriers to integrated care, include financing and possible means to reduce barriers—end of year report.

Goal 2. Health care service providers in Kitsap County will manage integrated primary care and behavioral health services resources efficiently consistent with medical home and mental health standards of care.

Improve efficiencies when behavioral health is a component of patient's treatment plan:

- Developed flow chart of PCHS referral process.
- Exceeds goal of length of time to post first BH visit to PCP referral—result suggests immediate transition; BH perception of ease of consult with PCP.
- Exceeds goal of less than 24 hours ARNP return call to PCP's consult; result suggests immediate response.

Improve cross-system coordination, collaboration, and integration.

- Established staff person at each agency as single point of contact for referral processes.
- Established data sharing agreements.
- 100% (≈) of PCHS patients referred to KMHS with feedback to PCHS within 30 days regarding referral status.

Goal 3. Kitsap County integrated primary care and behavioral health services will provide high quality patient care consistent with medical home and mental health home standards of care.

To institute a successful integrated primary care BH brief treatment model with PCP, Master's level therapist and chronic care manager for patients in need of services.

- 40 chart reviews indicate elements adhere to consistent quality care and standardized brief treatment protocol.
- 100% PCP referrals of patients with BH concerns to BH staff for improved coordination of appropriate level of care.
- Conducted qualitative review via focus groups and interviews.
- 90% BH clients with follow-up plan charted in EMR.
- 100% PCPs assessing, treating, and referring BH appropriately per PCHS protocol.
- Completed review of operations (once per quarter) by PCHS/KMHS Medical Directors to make adjustments in model if indicated.

To increase appropriate assessment, treatment, and referrals for BH care by PCHS PCP.

- 100% staff training in cross-cultural staffing model.

To increase appropriate assessment, treatment, and referrals for BH care among Kitsap County PCPs and clinical care staff.

- Produced pre- and post-questionnaire re: treatment, barriers, and solutions.

Unanticipated Results

- Increased cross-system collaboration administratively, technologically, and provider-to-provider.
- Acculturation between two disciplines through co-location of services and adherence to a brief treatment model appropriate in a medical setting.
- PCPs reported increase in productivity and increase in confidence for diagnosing and treating Behavioral Health conditions.
- PCPs reported new feeling of being supported in their work to treat patients and better able to respond to patients; i.e., "don't know how they practiced without them (BH therapists)."
- Client perception of change at Peninsula Community Health Services resulting in more comfortable place for behavioral health care.

Table 4. Dashboard Overviews – Yakima Valley Farm Workers Clinic

Yakima Valley Farm Workers Clinic for the Yakima County Asthma Project to provide training, education, assessments, action plans, emergency care plans, and changes to policies in home and school environments to care for children with asthma.	Start-up Funding: $125,000 $62,500 per year—Cycle 1
Served: 73 Specialty Care Referrals: N/A Value of Donated Care: N/A Insurance Assistance: N/A Access Assistance: 73	Emergency Reduction Strategy: Program expects to decrease utilization. Students in the program will be self-reporting ED visits. Tracking system is in the planning stages. Return on Investment Method: Estimates a minimum cost savings based upon hospitalization rates for high-risk patients.

Goal 1. Yakima County students with asthma in the targeted Local Education Agency (LEA) will have access to appropriate, affordable asthma home education and health care resources.

Increase the number of families and students with asthma that have asthma management knowledge by 10%.

- 41 new clients/children in Wapato school district with asthma received Asthma Home Education during the first year (a 15% increase).

Increase the number of students with asthma that have self-management knowledge by 20% by March 2008.

- 79% of asthmatic children in LEA have action plans and/or emergency care plans: 10 with asthma actions plans and 213 with asthma emergency care plans.
- 270 children have been identified as having asthma in the LEA.
- Wapato School Nurses planned to contact parents at kindergarten registration this spring to get children's asthma history and parent's authorization on medication forms.
- Nurses are also developing Asthma Kit for student to take home to parent and return to school when forms are completed.
- Working with Sunnyside physician to develop outreach to physicians to increase the number of student asthma action plans.

Increase the number of students that have asthma with self-management skills by 20%.

- 94% or 253 asthmatic children in the target LEA have authorization to self-administer medications on file.
- 97 students met with the Asthma nurse for the assessment of ability to self-carry/self-medicate at school.
- Developed plan to provide school forms for permission to self-administer medications to YVFWC AHE to distribute to the families that they visit.

Goal 2. On behalf of Yakima County, health care, school, and community providers will make efficient use of health care resources for target LEA students with asthma.

Decrease the number of students with asthma that have self-reported asthma related ED visits and/or hospitalization by 5%.

- Developing plan to collect information at parent interview during kindergarten registration and parent night.
- Collecting information at home visits.
- Data not yet available.

Increase the number of coordinated local health care resources for residents with asthma by 20%.

- 50% of projects coordinated by Yakima Asthma Action Coalition members; including promotional activities, funding activities, and coordinated service delivery.

Goal 3. Yakima County health care, school, and community providers will improve the quality of care for residents with asthma.

Increase the number of health care providers/staff trained to improve the quality of care for residents with asthma by 10.

- Providers/staff attended Asthma Educator Institute training: 5 physicians, 2 pharmacists, 20 nurses, 2 respiratory therapists, and 2 certified asthma educators.
- Providers/staff attended Asthma Management in Educational Settings (AMES) training: 27 participants—21 school nurses from Yakima County.

Increase the number of school personnel in the target LEA trained to improve the quality of care for students with asthma by 50%.

- School personnel attended Asthma Educator Institute (AEI) training: 7 Yakima County school nurses and one assistant principal.
- School personnel attended AMES training: 20 Yakima County school nurses.

Increase the number of child care providers trained to improve the quality of care for children with asthma by 30.

- Childcare providers attended Little Lungs Breathing training: 16 childcare providers.

Unanticipated Results

- The project area is Wapato School District; however, the funding resulted in bringing training to the area that benefited all the local partners. Also, the training brought in different individuals from the lower valley which increases our contacts and possible collaborative partners for future projects.
- School nurses who attended the training have increased knowledge and confidence in asthma management. All nurses in ESD 105 area have increased knowledge and motivation to use new asthma guidelines.
- School nurses from other school districts who have heard of the collaborative effort from Wapato are also starting to refer students with asthma to the project.

Table 4. Dashboard Overviews – Benton-Franklin Access to Care

Benton-Franklin Access to Care (BFAC) to expand existing general and specialty physicians' pro bono network, develop a pharmacy network program, and work with hospitals to reduce the unnecessary use of emergency rooms.	Expansion Funding: $175,000 $87,500 per year—Cycle 2
DISCONTINUED PROGRAM: BFAC closed their doors effective May 1, 2008. Despite BFAC's achievements in effectively addressing access in Benton and Franklin Counties, they did not have adequate local support from the counties and some of the local hospitals to continue the necessary funding match of $2 for every $1 awarded.	
Served: 2,624 Specialty Care Referrals: 569 Value of Donated Care: 365,973 Insurance Assistance: 642 Access Assistance: 577	Emergency Reduction Strategy: BFAC follows up with clients who utilize the ED and counsels them about appropriate use, redirecting them to PCP. HIPAA is difficult issue and prevents getting the ED data from one hospital. Return on Investment Method: Based on total program cost versus value of services documented as received. ROI for 2nd quarter is $2.13 per $1 invested. The cost per active client in the 2nd quarter was $55.22; the value of services received per active client in the same period was $126.00.
Goal 1. BFAC will increase access to medical care by connecting the uninsured to public-funded health insurance programs for which they appear to qualify and/or BFAC services.	
Track number of people screened and number enrolled in BFAC. • Referral system set up with Grace Clinic and Miramar Clinic. • 507 clients screened for services. • 392 new clients enrolled. • Hired highly-qualified bilingual care coordinator. • Developed/evaluated an off-site registration/enrollment pilot with Miramar Clinic. • 100% of clients offered assistance in completing Basic Health enrollment application.	
Goal 2. BFAC will promote the efficient use of health care resources by referring uninsured clients to primary care and connecting them to specialty care, thus reducing the number of visits to the Emergency Departments for non-emergent care.	
Maintains and expands a network of general practice and specialty physicians and ancillary service providers who will provide pro bono or reduced cost medical treatment to clients. Track number of referrals to various forms of care. • 204 primary care homes assigned in 1st quarter; discontinued assigning homes; instead clients are referred to a federally qualified health center (FQHC). • 57 referrals; 53:48 ratio of need in 1st quarter and 1:1 in 2nd quarter. Clients will appropriately utilize Emergency Department care. Track number of post-enrollment client visits to ED. • 2.3% of active BFAC clients made visits to the ED; all visits were coded appropriately, although many could have been avoided if client went to PCP first; working with Community Health Alliance to develop a better system of care for bi-county uninsured.	
Goal 3. BFAC will connect the uninsured to affordable pharmaceuticals through its Pharmacy Network Program.	
Assists clients with Prescription Assistance Program (PAP) application and refills or finds alternative ways to meet the Rx need of clients. Track number of scripts filled and value. • 875 prescriptions filled in two quarters. • $309,844 value of donated prescriptions.	
Goal 4. BFAC will explore increasing access to dental care for uninsured, low-income adults.	
Work with dentists and other dental professionals to develop a Dental Access to Care model program. Report on progress. • Under development.	
Goal 5. BFAC will establish capacity to carry out the "community engine work" in association with community partners to create a sustainable health care safety net for the uninsured.	
Develop administrative/staffing capacity to carry out collaborative activities. • Due to reduction in force at BFAC, the Benton-Franklin Community Health Alliance is assuming the lead in developing engine work capacity. "A System of Care for the Uninsured" Provider Summit scheduled for April 17, 2008. Achieve sustainability by end of grant (9/30/09). • Lack of county support, and some of the hospitals continued support, for the BFAC resulted in the closing of the program.	
Unanticipated Results	
As a result of the loss of the program, we are taking a fresh look at developing a system of care for the uninsured in Benton and Franklin Counties.	

Table 4. Dashboard Overviews – Community Minded Enterprises

Community Minded Enterprises for Health for All (HFA) to increase access to affordable, appropriate health care services and insurance coverage, and to reduce the inappropriate use of emergency rooms and uncompensated hospital care.	Expansion Funding: $175,000 $87,500 per year—Cycle 2
Served: 122,455 Specialty Care Referrals: N/A Value of Donated Care: N/A Insurance Assistance: 2,959 Access Assistance: 642	Emergency Reduction Strategy: Referral system for uninsured designed. Only 1 ED uses the system. Efforts to establish similar system in other ED in area. Return on Investment Method: Two reports completed: one shows $1 to $4 return to hospitals. Another conducted by providers shows a Return on Investment Method of $16 to $1 of clients who were linked to HFA.

Goal 1. The uninsured and underinsured in eastern Washington will have access to affordable, appropriate health care.

To increase the number of people enrolled by HFA from 681 to 1,021 in year one and 1,361 in year two of funding period.

- 1,670 people enrolled in coverage by HFA.
- There were 6 volunteers during this quarter and another PT staff was added.
- 127 hrs of volunteer time.
- 393 households referred by partners; marked increase over the previous 4 quarters in number of referrals from other agency partners.
- 112 callers report contacting the program as a result of Public Service Announcement (PSA).
- Helpline for health care access handled 109 households with issues in 1.5 hours; 42 with issues in 2 hours in first quarter.
- PSAs are running daily on CMTV, Cable Channel 14. Three versions: a woman who was pregnant without insurance, a young athlete without insurance, and a middle-aged man who lost his job and employer-sponsored insurance.

To educate and refer 100% of individuals who become insured through this program and who do not have a medical care home to a primary care home during the funding period.

- 1,045 callers recommended for HFA enrollment.
- 696 HFA applications submitted.
- 493 successful HFA enrollments.

To increase the number of individuals, for whom an insurance solution is unavailable, that receive education and referral to appropriate primary and preventative care services.

- Preventative/primary care continues to be a main topic of discussion not only when we engage a new client, but also when we are working with established clients.
- Referrals are made to no less than 8 community clinics (2 have closed or are closing and 1 opened), as well as to private practices and other health care resources. Still working on reporting tool to aggregate this information.

To reduce barriers to accessing other services for 25 people in year 1 and 100 people in year 2, whose screening reveals multiple, complex challenges during the final 18 months of the funding period.

- 1,154 households screened.
- 18 clients receiving coaching and referral.

Goal 2. The uninsured and underinsured in eastern Washington will receive high quality health care services regardless of insured status.

To increase the quality of doctor visits among all Columbia Care clients, they will receive information and education from a HFA Resource Specialist prior to initial doctor visit.

- 24 clients enrolled; clients appreciate the information about making the first appointment with the new doctor and how to prepare for it.

Goal 3. The hospital system will experience increased efficiency in serving patients.

To reduce uncompensated care in the aggregate of the hospitals referring un/underinsured ER patients to HFA.

- 768 referrals from ER; there was a major increase in referrals this quarter; they exceeded the number of referrals from the entire CY 2007.

Unanticipated Results

- Thankfulness of the people who are totally unaware of what is available for them.
- That there is no waiting list for Basic Health and that someone local is able to help them.

Table 4. Dashboard Overviews – Community Choice Physicians Hospital Community Organization

Community Choice Physicians Hospital Community Organization (PHCO) to expand benefits enrollment services and a mobile mental health unit to work with primary care providers.	Expansion Funding: $175,000 $87,500 per year—Cycle 1
Served: 451 Specialty Care Referrals: 716 (Behavioral Health) Value of Donated Services: $158,261 Insurance Assistance: 5,042 Access Assistance: 4,799	Emergency Reduction Strategy: 34 (10%) estimated referrals by participating hospitals. Return On Investment Method: Exploring methods.

Goal 1. Increase Access to Health Care by reducing the uninsured and underinsured through enhanced outreach, education and benefits enrollment services, ER diversion activities, establishing "medical homes" and increasing continuity of care—linguistically and culturally appropriate.

Increase the number of people helped in accessing health care benefits by at least 30% per year. Track and document individuals helped with each service.

- 4,145 people helped by outreach, education and enrollments, referrals.
- Estimates over 20,500 residents reached through radio. Spanish-speaking outreach and education reaches 10 counties.

Increase the number of referrals of individual to a "medical home" and follow-up care by at least 30% per year; with a special focus on individuals with complex and/or chronic health problems.

- 883 people helped.
- 10 surveys completed for Chelan and Douglas Counties with positive results.
- 3 hospital partnerships—established referral points in hospitals.
- Developed score card for chronic patients.

Goal 2. Provide mobile Mental Health Unit/services to low-income uninsured/underinsured patients in Chelan and Douglas Counties.

Establish a minimum of 2 sites for delivery of care with proximity to the largest number of target population in Chelan and Douglas Counties. Work towards a patient panel of 12 sessions a day, 2 days a week.

- 24 radio segments—estimates reaching 20,000 residents in Chelan and Douglas Counties, alone.
- 654 reached through direct staff contact.
- 4 outreach meetings.
- All 4 hospitals have established HIPAA-compliant Business Association Agreements.
- 100% tracking and documentation of service hours/investment per site, referral sources, demographics of patients through patient panel.
- 100% tracking and documentation of enrollments, access referrals of patients from all sites.

Unanticipated Results

Increased capability to reach the Spanish-speaking communities. Partially supported by this grant, developed a network of affiliate Spanish radio stations that reaches well beyond the initial service area...almost half of the state!

Table 4. Dashboard Overviews – Spokane County Medical Society Foundation

Spokane County Medical Society Foundation for Project Access Spokane (PAS) to expand the volunteer network of physicians, hospitals, and medical professionals providing total health care to the low-income uninsured population.	Expansion Funding: $175,000 $87,500 per year—Cycle 1
Served: 1,004 Specialty Care Referrals: 788 Value of Donated Care: $2,655,671 Insurance Assistance: 1,918 Access Assistance: 6,004	Emergency Reduction Strategy: Patient enrolled in PAS receives orientation on how to access care through the program, including instruction on ED use. Patients are financially responsible for ED use and sign acknowledgement of such. Patients identified in ED as needing a different level of care are referred to community clinic or PAS to establish a medical home. Return on Investment Method: Measured by medical claims submitted by volunteer providers and hospitals. Specialty and pharmacy are tracked separately.
Goal 1. An adequate number of volunteer providers to achieve rapid access for Project Access patients.	
Increase number of providers participating by 9% (80). • 989 additional provider pledges for donated health services. Increase number of patient enrollment slots by 9% (627). • 4,089 additional patient slots created by working with providers to increase numbers.	
Goal 2. Enrollment, scheduling, and gathering of medical records is quickly accomplished to facilitate patient care efficiencies.	
Electronic connectivity with CHAS patients record system—no results yet. • Electronic connectivity with hospitals—no results yet.	
Goal 3. All eligible Spokane County residents have access to Project Access services.	
Increase enrollment by 15%. • 520 patient enrollment increased by 15% through outreach by community clinics, hospitals, social service agencies, and PAS.	
Goal 4. All providers in Spokane County refer qualified patients to Project Access.	
Increase NEW referrals from private practice providers and hospitals by 20%. • 341 referrals received from private offices and hospitals in 2008.	
Goal 5. Small business employers are aware of Project Access resources for their qualified employees.	
Conduct 15 presentations to employers/employer groups. • Conducted 59 presentations to promote PAS. Utilize media for community awareness with 6 articles/TV/radio pieces. • 18 articles and media pieces produced in 2008.	
Goal 6. Project Access has adequate number of primary care providers donating health care.	
Add 40 Group Health primary care patient slots. • 87 patients without insurance placed and established with Group Health doctors. Recruit 10 primary care providers. • 57 primary care doctors solicited to join PAS.	
Goal 7. Primary care providers know how and when to refer a patient for Project Access donated specialty and hospital services.	
Project Access Therapeutics Committee will develop MRI, PET, and CT imaging guidelines and review 20 cases to recommend treatment. • 42 individual cases reviewed by PA Therapeutics Committee.	
Goal 8. All Project Access patients receive prescribed medications, at the lowest cost possible to Project Access.	
Pharmacy Committee will review utilization and cost data quarterly to determine best drug formulary. Patients established at FQHCs will fill prescriptions at that pharmacy to obtain federal 340(b) pricing. • 100% of patients issued a pharmacy card and assigned to correct pharmacy in 2008.	
Goal 9. Hospital Emergency Department use by Project Access patients is reduced from prior utilizations.	
Conduct longitudinal study in 2008 of ED utilization before and after PAS—no results yet.	
Goal 10. Demonstrate that patients are able to return to work/school, and have improved health status following enrollment in Project Access.	
Budget $10,000 per year to conduct follow-up research and to report finding—no results yet.	
Goal 11. Ensure sustainability of the Project Access program.	
• Create local health services district through legislative action—legislation passed. • Increase business financial support by 20%; $73,000 donations received in 2008.	
Goal 12. The Washington State Prescription Drug Program implements Patient Assistance process to obtain donated drugs.	
Spokane participates in program—system in place.	
Unanticipated Results	
What is not shown in the reports is that actual medical care is being provided to hundreds of people who otherwise would not receive care. Every person counted on our reports is a real person who has experienced a positive outcome due to the program.	

Table 4. Dashboard Overviews – Whatcom Alliance for Healthcare Access

Whatcom Alliance for Healthcare Access (WAHA) for Project Access Program to add screening and referral program for uninsured people who are referred from the hospital Emergency Department. The grant will also help develop a small business insurance connector, which will focus on health insurance issues for small business owners and employees.	Expansion Funding: $200,000 $100,000 per year—Cycle 1
Served: 84 Specialty Care Referrals: 16 Value of Specialty Care: $9,356 Insurance Assistance: 179 Access Assistance: 182	Emergency Reduction Strategy: Working with St. Joseph Hospital to learn how they define and track inappropriate utilization. Return on Investment Method: Developing a model that evaluates the impact of connecting clients with insurance (including Medicaid, Basic Health, and SCHIP) and a medical home.

Goal 1. Working people in Whatcom County will have access to affordable health insurance.

To evaluate resource opportunities for increasing the number of employees of small businesses with insurance and/or wellness programs within nine months, instead of six months as noted in the Quarter #1 report.

- 200 responses to a comprehensive web-based survey of members of the Chambers of Commerce and Counsel of Nonprofits network.
- Small Business Health Inventory cross tabs complete. Review and evaluation resulted in clarification of target market and focus.

To develop a menu of insurance options and wellness programs that is considered affordable and of value by small businesses and their employees within six months.

- Conducted 10 meetings with small business owners.
- Conducted meetings with Group Health and Regency re: products and resources for the small group market; products list and research tool developed.

To evaluate resource opportunities for increasing the number of employees of small businesses with insurance and/or wellness programs within six months.

- Developed Inventory of state sponsored health programs; complete.
- Evaluated Health Insurance Partnership impact on small business market; complete.
- Evaluation of wellness programs determined wellness programs are not meaningful in small employer market; will not be included in further work.

To determine acceptable out-of-pocket expense for insurance and needs/preferences of uninsured workers and employers for insurance/wellness programs.

To develop and implement a communication plan for promoting health insurance coverage and wellness programs to small businesses that currently do not offer health insurance or are considering reducing benefits. (In development stage.)

To provide information and assistance with insurance and wellness programs to a minimum of 50 Whatcom County small businesses that currently do not offer health insurance and their employees within two years. (Results due later in work plan.)

Goal 2. All Whatcom County residents will have timely and appropriate access to specialty care and supporting primary care and ancillary services.

To enroll 12.5% of patients who are referred from the ED, have household incomes below 200% of the FPL, and are not eligible for other forms of insurance covering donated specialty care and ancillary services.

- Hospital EMR conversion resulted in delay of implementation of the referrals.
- Worked with hospital IT to recreate daily and weekly ED reports in new system.
- On October 14, began receiving the daily and weekly ED reports and were able to begin calling patients referred from the ED to on-call specialists.
- 121 patient referrals from ED to an on-call specialist.

To schedule follow-up with local CHCs within 72 hours of the referral, when appropriate, for all WAHA patients from the ED who do not have a PCP.

- 21 patients assisted with application for public insurance.
- 6 patients referred from ED and enrolled in PA.
- 8 patients referred from the ED got counseling or information about commercial options.

Unanticipated Results

- Small Business Health Insurance Connector (SBHIC): The commitment and enthusiasm of our partners to the success of this program addressing the needs of the small employer who is uninsured, including the Chamber of Commerce, Western Washington University Small Business Development Center, the Whatcom Economic Development Council, and the local commercial health insurance broker community. Also, all partners now clearly understand that the target market for this service is small employers of 10 or fewer employees.
- Emergency Department Project: Successful data collection that results in Whatcom Alliance for Healthcare Access receiving a daily list of all uninsured ED patients referred to a specialist provider within the last 24 hours. Follow-up on list has resulted in the discovery that a large percentage of individuals actually have insurance, so the size of the problem is much smaller than expected and more manageable. There is also a high success rate in getting coverage for these patients who are uninsured.

Table 4. Dashboard Overviews – CHOICE Regional Health Network

CHOICE Regional Health Network for Project Access Program to implement the Patient Access Link (PAL) initiative, which will integrate the operations of successful existing programs to increase health care access and implement a common community case management and information system.	Expansion Funding: $250,000 $125,000 per year—Cycle 1
Served: 2,585 Specialty Care Referrals: 1,201 Value of Donated Care: $1,733,556 Insurance Assistance: 3,795 Access Assistance: 1,810	Emergency Reduction Strategy: 392 visits Return on Investment Method: An estimated 5:1. (Coordinates with member organizations to measure reduction in uncompensated care resulting from reimbursement for patients that are used to calculate Return on Investment Method.)
Goal 1. Residents 250% of FPL in service region will have access to medical treatment.	
Conduct outreach and assistance necessary to enroll a total of 3,900 residents into existing state subsidized health care programs. • 1,759 clients enrolled in Medicaid, SCHIP, and Basic Health, including 596 children and 747 clients of Hispanic ethnicity. • $292,293 in reduced uncompensated care by hospitals due to enrollment during the grant year. Enroll 1,000 new clients to receive donated clinical services. • 327 clients enrolled in Project Access or other donated services. • 46% of clients exit PA with insurance coverage. • $1,733,556 – value of donated medical services in PA. Conduct coordinated community-based outreach activities that maintain enrollment targets for multiple programs. • 47 public events and presentations. • 59 meetings with community agencies to coordinate services.	
Goal 2. Use of health care resources by target population and provision of health care by the provider system will be efficient.	
Reduce inappropriate ED use by 1,013 visits for 150 newly referred patients who have a history of repeated inappropriate use. • 74 referred to Emergency Dept. Care Coordination Program (EDCCP). • 500 estimated reductions in inappropriate ED visits compared to levels prior to clients' involvement in EDCCP. • $399,600 estimated savings as result of EDCCP enrollment. Serve 1,400 clients through the ConneXions program to assess client needs and make referrals to other services. • 19 ConneXions learning activities: joint training. • 885 clients with multiple needs screened: motivational interviewing techniques used. • 211 clients with active case plans.	
Goal 3. Target population will benefit from improved quality of care.	
Assist clients to obtain free or reduced-cost prescription drugs through pharmaceutical companies' programs. • 95% of prescriptions were for drugs prescribed for treatment of chronic conditions. Create shared care plans for 450 clients with complex care needs to assist providers to deliver appropriate interventions and levels of care. • 285 shared case or care plans created for clients with multiple, complex needs through EDCCP, ConneXions, or other integrated programs.	

Table 4. Dashboard Overviews – CHOICE Regional Health Network (continued)

Goal 4. CHOICE will maintain and improve capacity to carry out the community engine work to create a sustainable care safety net.
Maintain the administrative arrangement and staffing necessary to carry out collaborative activities. • Ongoing efforts to increase case management capacity among staff; added bilingual Cambodian-speaking individual, culturally competent. Convene safety net leaders to develop access improvements. • Three counties with an access task force, safety net council, or similar body that is participating in the broader PAL effort. • Active participant in the statewide Cover All Kids Advisory Committee—children's enrollment expansion. On Board of Puget Sound Health Alliance. Believe to Achieve event scheduled for 2008. Member of statewide Primary Care Coalition. • $2.5 million in reduced uncompensated care, donated clinical services, reduced hospital billing for unnecessary ED use, and value of prescriptions. (Value of Free Prescriptions for year $98,145.) • Reached agreements with all five health jurisdictions for subcontracts to receive DSHS outreach funds under the Cover All Kids initiative. Capital Medical Center, Sea Mar CHC, and Behavioral Health Resources, who are all new financial contributors, have joined the CHOICE board. Support the success of emerging state initiatives and programs to expand access. • $286,900 federal appropriation for expansion of EDCCP and $277,000 for language access improvements. Achieve sustainability of the collaborative and its major activities. • Board developed plan for increasing sustaining community support. Maintain accountability reporting and complete key evaluation studies. • Client satisfaction study completed based upon 94 client interviews; positive results. • Evaluation of EDCCP at Providence St. Peter Hospital is near completion—study is underway.
Unanticipated Results
• Supported creation and operation of the Mental Health Access Program, a free mental health clinic using time donated by psychologists, and integrated its client support with aspects of the Patient Access Link (PAL) initiative. • The ConneXions community partnerships and agreements on vision and common outcomes have had a major impact on a United Way-convened Asset Development Coalition in Thurston County, which has decided to proceed using a multiple "service hub" model. This model builds directly on ConneXions ideas and leverages community effort and potentially other resources for even broader alignment of services around a client-centered, coordinated vision.

Survey of Grant-funded Programs

In May 2008, the CHCC Grant Program recipients were asked to respond to the following questions as part of a survey; there was a 100% response rate. See Appendix I, Survey Results, to find a complete report of the responses.

Question 1: What unanticipated accomplishments have been achieved by your program that may not be reflected in the quarterly reports?

Question 2: At the end of the day, what is different as a result of the Community Health Care Collaborative grant funding?

Question 3: What value has resulted from the connections made from creating/enhancing a collaborative model?

Question 4: What unique characteristics of your program could be considered for replication throughout the state?

Question 5: What recommendations would you make on how the state can support the collaborative grant programs in addition to continuous funding?

Question 6: Please rate your level of satisfaction of the service provided by the Health Care Authority's Community Health Care Collaborative grant program staff.

Question 7 (Optional): Organization Name

The individual Grant Program Dashboard Overviews highlight some of the unanticipated accomplishments provided in response to Question 1. Responses to Questions 2 through 6 are addressed below specifically or were considered in the development of the key findings.

Recommendations and Suggestions from Grant Program Recipients

The Legislature directed the HCA evaluation of the CHCC Grant Program to include suggestions from the grant recipients. Specifically, the evaluation is to include recommendations from the participating organizations related to how the CHCC Grant Program could be improved and how the state could otherwise support community-based health care access efforts.

The CHCC Grant Program participant recommendations regarding CHCC improvements and state support for community-based efforts were organized in the report into four categories:[4]

[4] Some suggestions have been slightly edited for clarification.

Coordination of Activities

- Coordinate a "lessons learned" session on how to overcome obstacles in collaborations with limited time available.
- Provide an opportunity for grant-funded programs to share successes and failures and learn from each other to strengthen future collaborative efforts.
- Share proven models and strategies to increase efficiency, improve quality of care, and maximize access.
- Help similar projects identify shared outcomes and results to measure.
- Support shared infrastructure among collaborative models through Communities Connect.

Supporting Initiatives

- Obtain data from the state on the financial impact of our enrollments to the revenues providers receive as a result of our work. Collaboratives need a good level of ongoing "base funding" as a foundation to allow them to continue to provide services. Our ability to engage local funding support for these services from providers in our service areas depends on our ability to demonstrate "actual ROI."
- Share information electronically with agencies such as DSHS, Medicare, and Medicaid to enable patient services to occur in a timelier manner with a higher degree of accuracy due to access to complete, up-to-date information.
- Remove funding barriers to allow for change in Regional Support Network (RSN)/Medicaid rules to allow Fee for Service (FFS) reimbursement for behavioral health services at community health centers. Continue and expand co-location of services.
- Make Asthma Educator services part of the Washington Health Care Authority's covered services.
- Assist CHCC grant-funded programs to find ways to share information about shared clients without violating HIPAA regulations.
- Support advocacy for access to health care, offering support in filling gaps in state programs and identifying trends or unmet needs in the community and state that we can help fulfill.
- Regularly advertise all the state programs (DSHS programs, HCA programs, etc.) because the negative branding over time has led many eligible people to believe that these programs are not for them.
- Use local or regional contacts in the advertising business so that potential clients may connect with advocates who are aware of community resources, the situations local people face, and other potential resources.

Reporting

- Support the CHCC quarterly reporting structure, which was invaluable because the outcomes were quantifiable and helped to keep focus on program process.
- Request earlier involvement of grantees and Communities Connect in preparation for value-oriented reports to the Legislature.
- Perform a formal evaluation (perhaps through the Joint Legislative Audit and Review Committee or the Washington State Institute for Public Policy).

Additional Funding

- Provide technical assistance funding through Communities Connect with purchase of services from more mature collaboratives to help those earlier in the process.

- Matching funding is key; provide incentives for local governments and others to work collaboratively at the community level.

Key Findings in First Year of CHCC Grant Activities

The following general findings, models, and strategies have potential for statewide replication based on the evaluation of 14 CHCC grant-funded programs:

General Findings

1. CHCC grant-funded programs are able to effectively leverage state funds through developing relationships at the local level with organizations that work together to serve common populations seeking access to health care. In the first year of funding, CHCC grant-funded programs estimated a 4.8 to 1 return ratio for every dollar funded.[5]

2. CHCC grant-funded programs have successfully organized nearly $5 million of volunteer medical services through development of coordinated networks of specialty care physicians, hospitals, pharmaceuticals suppliers, primary care providers, and ancillary services.

3. The most successful CHCC grant-funded programs have established commitments of funding, resources, time, and local support from state and local government agencies, hospitals, medical societies, individual physicians, businesses, and community nonprofit organizations. It takes effort to develop and sustain these networks.

4. CHCC grant-funded programs report reductions in inappropriate Emergency Department (ED) use by the programs that have developed and implemented strategies to track utilization and effective referral systems with the hospitals. Other programs are exploring methods or are in the early stages of implementing strategies and do not yet have results to report. The strategies to address the inappropriate use of ED and barriers for tracking utilization are varied.

5. Return on Investment (ROI) strategies vary by organization; it would be worthwhile to share strategies among programs.

6. Standardized performance measures would be useful to measure overall results of CHCC grant-funded programs.

7. Successful programs without local support are not sustainable. Benton-Franklin Access to Care had been a successful, well-run program; however, it was not able to continue operation due to the lack of local support.

8. Sustainable programs are those that are able to garner a funding match through commitments of actual funding dollars from other sources, not just in-kind support.

9. Long-term sustainability planning is important for programs to endure the test of time.

10. Washington State Communities Connect has been a valuable partner to the HCA and the CHCC grant-funded programs. It provides leadership in promoting and sharing best practices

[5] ROI estimate is based on the applications of the 14 CHCC grant-funded programs.

across the state to affect changes in state programs that support community solutions to health care access.

Models

1. Project Access (PA) is a national model with demonstrated success. Many of the CHCC grant-funded programs are PA programs. Project Access is an effective model of access services based upon local collaboration between community partners to offer a cadre of services for the uninsured and underinsured to help them gain access to health care. The framework includes eight critical activities:
   - Outreach and enrollment in existing programs.
   - Establishing health homes with coordinated services.
   - Access to affordable prescription drugs.
   - Chronic disease management.
   - Coverage of low-wage workers.
   - Organizing donated medical care services.
   - Prevention and wellness services.
   - Maintenance of an adequate and stable public and private provider safety net.

   Many PA programs are engaged in activities that are funded by sources other than CHCC grant funds. Those activities are not necessarily reflected in the data provided to the HCA and therefore may not be included in the performance results.

2. Small Business Health Insurance Connector is an emerging model based upon partnerships with the chamber of commerce and the small business community for potential for statewide significance. The main focus of the project has been to research and evaluate the opportunities for increasing access to insurance to employees of small businesses.

3. Yakima Valley Farm Workers Clinic Asthma Project has demonstrated potential as an emerging statewide model to address a community need to manage chronic disease through education and collaboration with school districts, community clinics, physicians, and families. The project has adapted best practices from the Master Home Environmentalist training, School Nurse Advisory Committee, and Washington State Asthma Collaborative to low-income, minority populations in rural areas.

4. The Kitsap Partnership for Access to Health Care Services (KPAH) program to integrate primary care and behavioral health is an emerging cross-system model of care. It coordinates administrative, technology, and provider-to-provider communication that coordinates the two disciplines through co-location of services and adherence to a brief treatment model appropriate in a medical setting. It is designed upon research, best practices, and expertise in the integration of primary care provider and behavioral health care.

5. Electronic Medical Records (EMR) can effectively assist in providing early health prevention and identification of treatment, managing chronic disease, applying evidence-based health practices, and improving individual health status. Several of the grant programs have developed, or are in process of developing, systems to track and act on data reports available only through EMR systems. Successes have been demonstrated in preventative health care services for children. Other programs planned results in the second year of funding. The EMR tracking system also has the potential to reduce health disparities through strategies to address chronic care management.

Strategies

1. The Benton-Franklin Access to Care (BFAC) initiative to include patients/clients' investing in a portion of the donated care is worth exploring. This approach has been an effective method in ensuring a higher rate of patients showing up for appointments.

2. Availability of Access Specialist in hospitals; funding Access Specialists in hospitals has been an effective method of reaching the uninsured/underinsured.

3. Education on a local level regarding appropriate use of ED and use of the health care system to ensure a quality experience is an effective strategy for cost and quality.

4. Public Service Announcements to improve Health Literacy is an effective strategy.

5. Translation of health education materials and integrated health education services in clinical model of care are effective strategies in reaching hard-to-reach populations.

6. Use of the Statewide Health Insurance Benefits Advisors (SHIBA) volunteers and AmeriCorps workers promotes quality and is cost effective.

Recommendations

The HCA recommends the following actions:

1. Continue the CHCC Grant Program with sufficient funding for both the grants and program administration.

2. Adjust CHCC Grant Program funding to operate concurrently with the state's biennial budget cycle. Address the funding gap for Cycle 1 grant recipients—the first year of the two-year grant cycle should coincide with the first year of the biennial budget cycle.

3. Continue to provide funding for start-up programs, expansion projects, and programs developing emerging models.

4. Coordinate discussions with CHCC grant-funded programs and state agency partners regarding barriers to program success.

5. Collaborate with Washington Community Connect to coordinate a "best practices" meeting for CHCC grant-funded programs to share program information, discuss suggestions made by grant recipients, standardize performance measures, and share strategies for reduction of inappropriate ED utilization and return on investment throughout the state.

6. Require CHCC grant-funded programs to develop a measure related to long-term sustainability of their program and to report on the measure as part of the quarterly reporting process.

Conclusion

In summary, the Community Health Care Collaborative Grant Program had demonstrated the ability to meet the Legislature's intent to improve access to medical treatment, quality of care, and the effective use of available resources. In the first year of funding, CHCC grants enabled

funded programs to leverage state dollars by an estimated 4.8 to 1 return, coordinate nearly $5 million of volunteer medical services, and help more than 40,000 individuals gain access to health care and medical treatment. Overall, the results demonstrate that the CHCC grant-funded programs have potential beyond what has been accomplished in the first year. It is also clear that it takes time and effort for these programs to effectively establish commitments of funding, resources, time, and the local support necessary for sustainability. There continues to be a role for the state in supporting and sustaining the community-based health care collaboratives.

Appendix A: Engrossed Second Substitute Senate Bill 6459

CERTIFICATION OF ENROLLMENT

ENGROSSED SECOND SUBSTITUTE SENATE BILL 6459

Chapter 67, Laws of 2006

59th Legislature
2006 Regular Session

COMMUNITY HEALTH CARE COLLABORATIVE GRANT PROGRAM

EFFECTIVE DATE: 6/7/06

Passed by the Senate February 13, 2006
YEAS 46 NAYS 1

BRAD OWEN

President of the Senate

Passed by the House March 2, 2006
YEAS 96 NAYS 2

FRANK CHOPP

Speaker of the House of Representatives

Approved March 15, 2006.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SECOND SUBSTITUTE SENATE BILL 6459** as passed by the Senate and the House of Representatives on the dates hereon set forth.

THOMAS HOEMANN

Secretary

FILED

March 15, 2006 - 2:36 p.m.

Secretary of State
State of Washington

ENGROSSED SECOND SUBSTITUTE SENATE BILL 6459

Passed Legislature - 2006 Regular Session

State of Washington 59th Legislature 2006 Regular Session

By Senate Committee on Ways & Means (originally sponsored by Senators Keiser, Brandland, Thibaudeau, Spanel, Rasmussen, Kline, Parlette and Kohl-Welles)

READ FIRST TIME 02/7/06.

AN ACT Relating to community-based health care solutions; creating new sections; and providing an expiration date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** The legislature finds that:

(1) Despite sustained efforts at the federal and state level, too many people in Washington remain without access to appropriate health care. Particularly alarming is the increase in the number of small business employees who are uninsured. Without a health home, many low-income and other vulnerable populations are left to inefficiently navigate a fragmented treatment system that fails to support their long-term well-being.

(2) In recent years, numerous community-based organizations have emerged around the state to address health care concerns at a local level. Through innovation and public/private collaboration, they have demonstrated great success and show even greater promise in improving health care access for local residents. Less remote than state and federal agencies, these organizations have built on local relationships to increase the availability and affordability of services, and

coordinate care, making efficient use of a wide variety of community resources to meet community needs.

(3) Many of these organizations have relied on grants from the healthy communities access program, an initiative of the United States department of health and human services that provided funding and technical assistance to support collaborative efforts at the local level to coordinate and strengthen health services for the uninsured and underinsured. The program, however, was recently discontinued, placing these local efforts at risk.

It is therefore the intent of the legislature to enhance and support the development of collaborative community-based organizations working at the local level to increase access to health care for Washington residents.

NEW SECTION. **Sec. 2.** (1) The community health care collaborative grant program is established to further the efforts of community-based organizations to increase access to appropriate, affordable health care for Washington residents, particularly employed low-income persons who are uninsured and underinsured, through local programs addressing one or more of the following: (a) Access to medical treatment; (b) the efficient use of health care resources; or (c) quality of care.

(2) Grants of up to five hundred thousand dollars per organization shall be awarded pursuant to sections 3 and 4 of this act by the administrator of the health care authority in consultation with the secretary of the department of health, the assistant secretary of the health and recovery services administration within the department of social and health services, and the insurance commissioner.

(3) The health care authority shall provide administrative support for the program.

NEW SECTION. **Sec. 3.** Eligibility for grants shall be limited to nonprofit organizations established to serve a defined substate geographic region and having a formal collaborative governance structure and decision-making process for improving access. The nature and format of the application, and the application procedure, shall be determined by the administrator of the health care authority. At a minimum, each application shall: (1) Identify the geographic region served by the organization; (2) show how the structure and operation of

the organization reflects the interests of, and is accountable to, this region; (3) indicate the size of the grant being requested, and how the money will be spent; and (4) include sufficient information for an evaluation of the application based on the criteria established in section 4 of this act.

NEW SECTION. **Sec. 4.** (1) Grants shall be awarded on a competitive basis based on a determination of which applicant organization will best serve the purposes of the grant program. In making this determination, consideration shall be given to the extent to which:

(a) The programs to be supported by the grant are likely to address, in a measurable fashion, documented health care access needs within the region to be served;

(b) An applicant organization can be expected to successfully implement these programs, including the extent to which the application reflects formal, active collaboration among key community members such as local governments, school districts, large and small businesses, nonprofit organizations, carriers, private health care providers, and public health agencies;

(c) The applicant organization will match the grant with funds from other sources. Grants may be awarded only to organizations providing at least two dollars in matching funds for each grant dollar awarded;

(d) The grant will enhance the long-term capacity of the applicant organization and its partners to serve the region's documented health care access needs, including the sustainability of the programs to be supported by the grant;

(e) The programs to be supported by the grant reflect creative, innovative approaches which complement and enhance existing efforts to address the needs of the uninsured and underinsured and, if successful, could be replicated in other areas of the state; and

(f) The programs to be supported by the grant make efficient and cost-effective use of available funds through administrative simplification and improvements in the structure and operation of the health care delivery system.

(2) The administrator shall endeavor to disburse grant funds throughout the state, supporting organizations and programs of differing sizes and scales, and serving differing populations.

NEW SECTION. **Sec. 5.** One-half the total amount of any award shall be disbursed to an organization upon its selection as a grant recipient. The remaining half shall be disbursed one year later only upon receipt by the administrator of the health care authority of a progress report from the organization, and a determination by the administrator, in consultation with the secretary of the department of health, the assistant secretary of the health and recovery services administration within the department of social and health services, and the insurance commissioner, that the organization is satisfactorily serving the purposes of the grant program and meeting the objectives identified in its application regarding: (1) Access to medical treatment; (2) the efficient use of health care resources; or (3) quality of care.

NEW SECTION. **Sec. 6.** By July 1, 2008, the administrator of the health care authority shall provide the governor and the legislature with an evaluation of the community health care collaborative grant program, describing the organizations and programs funded and the results achieved. Particularly successful programs shall be highlighted with recommendations on whether, and how, the programs could be replicated statewide. The evaluation shall also summarize any recommendations from the participating organizations regarding ways to improve the grant program and for the state to otherwise support community-based organizations working to improve access to health care for Washington residents, including any changes in state statutes or regulations.

NEW SECTION. **Sec. 7.** The health care authority may adopt rules to implement this act.

NEW SECTION. **Sec. 8.** The community health care collaborative account is created in the custody of the state treasurer. Expenditures from the account may be used only for the purposes set forth in this act. Only the administrator of the health care authority or the administrator's designee may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW,

but an appropriation is not required for expenditures.

NEW SECTION. **Sec. 9.** This act expires June 30, 2009.

Passed by the Senate February 13, 2006.
Passed by the House March 2, 2006.
Approved by the Governor March 15, 2006.
Filed in Office of Secretary of State March 15, 2006.

Appendix B: Engrossed Substitute Senate Bill 6386, Section 213(12)

(11) $458,000 of the health services account appropriation, $401,000 of the general fund--federal appropriation, $205,000 of the state health care authority administrative account--state appropriation, and $174,000 of the medical aid account--state appropriation are provided solely for establishment of a centralized evidence-based health technology assessment system as defined in Engrossed Second Substitute House Bill No. 2575 (health technology assessment), for supporting the activities of the health technology clinical committee, or other activities required to implement Engrossed Second Substitute House Bill No. 2575. Participating agencies will be the medical assistance administration in the department of social and health services, the department of labor and industries, the health care authority's uniform medical plan, the department of corrections, and the department of veterans affairs. If the bill is not enacted by June 30, 2006, the amount provided in this subsection shall lapse.

(12) As provided in Engrossed Second Substitute Senate Bill No. 6459 (community-based health care solutions), the authority shall make grants of up to $250,000 from the community health collaborative account to assist community-based organizations increase access to appropriate, affordable health care for Washington residents, particularly low-income working individuals and their families. State grant funds may be used to collect federal matching funds available through medicaid or through the state children's health insurance (SCHIP) program, to the extent allowed by federal rules, and to the extent funds are available in the state's SCHIP allotment in excess of those required for services funded in section 209 of this 2006 act.

(13) $625,000 of the health services account appropriation is provided solely for the implementation of Engrossed Second Substitute House Bill No. 2572 (small business health insurance assistance program). If the bill is not enacted by June 30, 2006, the amount provided in this subsection shall lapse.

(14) $450,000 of the state health care authority administrative account--state appropriation is provided solely for an on-line employee health assessment tool.

(15) $499,000 of the health services account appropriation and $65,000 of the general fund--federal appropriation are provided solely for conducting a study of the employment status of enrollees in the

federal appropriation, and $22,480,000 of the state health care authority administrative account--state appropriation are provided for the development of a new benefits administration and insurance accounting system.

(8) $2,137,000 of the health services account--state appropriation for fiscal year 2008 and $1,000,000 of the health services account--state appropriation for fiscal year 2009 are provided solely for section 5 of Engrossed Second Substitute House Bill No. 1569 (health insurance partnership board) and related provisions of Engrossed Second Substitute Senate Bill No. 5930 (blue ribbon commission on health care).

(9) $664,000 of the health services account--state appropriation for fiscal year 2008 and $664,000 of the health services account--state appropriation for fiscal year 2009 are provided solely for the implementation of the Washington quality forum, pursuant to section 9 of Engrossed Second Substitute Senate Bill No. 5930 (blue ribbon commission). If the section is not enacted by June 2007, the amounts provided in this subsection shall lapse.

(10) $600,000 of the state health care authority administrative account--state appropriation is provided solely for the implementation of the state employee health pilot, pursuant to section 41 of Engrossed Second Substitute Senate Bill No. 5930 (blue ribbon commission). If the section is not enacted by June 2007, the amounts provided in this subsection shall lapse.

(11) $250,000 of the health services account--state appropriation for fiscal year 2008 and $250,000 of the health services account--state appropriation for fiscal year 2009 are provided solely for continuation of the community health collaborative grant program in accordance with chapter 67, Laws of 2006 (E2SSB 6459). The applicant organizations must assure measurable improvements in health access within their service region, demonstrate active collaboration with key community partners, and provide two dollars in matching funds for each grant dollar awarded.

(12) $731,000 of the health services account--state appropriation for fiscal year 2008 and $977,000 of the health services account--state appropriation for fiscal year 2009 are provided solely for the dental residency program, including maintenance of the existing residency

Appendix D: WACs 182-20-600, 182-20-610, and 182-20-620

WAC 182-20-600
Community health care collaborative program.

The community health care collaborative grant program was established July 1, 2006, to develop innovative health care delivery models. The funding covers a two-year cycle; half of the award to be distributed throughout the first year and the final half distributed throughout the second year upon evidence of successful program progress and achieving grant objectives, based upon available funding.

[Statutory Authority: RCW 41.05.160, 41.05.220, 41.05.230, and 2006 c 67. 07-02-055 (Order 06-07), § 182-20-600, filed 12/28/06, effective 1/28/07.]

WAC 182-20-610
Administration.

The authority is responsible for:

(1) Preaward development.

(a) Develop criteria for the selection of community-based organizations to receive grant funding;

(b) Develop equitable standards governing the granting of awards;

(c) Determine nature and format of the application and process.

(2) Award determinations.

(a) Consult with representatives, appointed by the secretary of the department of health, the assistant secretary of health and recovery services administration within the department of social and health services, and the office of the insurance commissioner to make recommendations for final applicant selection and grant determination;

(b) The administrator will review recommendations and make final determination based upon recommendations, funds available and utilization of resources to meet the goals of the program;

(c) Conduct on-site visits to ensure applicant's ability to achieve grant objectives and performance measures identified in the application;

(d) Contract with successful applicants; and

(e) Disburse grant funds according to program policy.

(3) Post-award actions.

(a) Review periodic progress reports from contractors;

(b) Conduct on-site visits of contractors to provide assistance and ensure compliance of grant objectives;

(c) Consult with representatives from department of health, the assistant secretary of health and recovery services administration within the department of social and health services, and office of the insurance commissioner, one year following initial disbursement, to make recommendations to administrator for disbursement of the second half of grant funds, based upon performance measures identified in the application and evidence of successful program progress and achieving grant objectives;

(d) The administrator will review and make final determination for grant disbursements; and

(e) Compile a report to the governor and legislature on July 1, 2008, which:

(i) Describes organizations and programs funded;

(ii) Describes and analyzes results achieved;

(iii) Makes recommendations for improvements to the program; and

(iv) Highlights best practices that can be replicated statewide.

[Statutory Authority: RCW 41.05.160, 41.05.220, 41.05.230, and 2006 c 67. 07-02-055 (Order 06-07), § 182-20-610, filed 12/28/06, effective 1/28/07.]

WAC 182-20-620
Application Process

(1) Eligibility.

(a) Applicants must provide the following in the application format prescribed by the authority:

(i) Evidence of private, nonprofit, tax exempt status incorporated in Washington state or public agency status under the jurisdiction of a local, county, or tribal government;

(ii) Evidence of the specific geographic region served and a formal collaborative governing structure by documentation that may include, but is not limited to:

(A) Bylaws;

(B) Agreements;

(C) Contracts;

(D) Memorandum of understanding;

(E) Minutes;

(F) Letters; or

(G) Other communications;

(iii) Amount of funds requested and how the dollars will be spent;

(iv) Data to evaluate program progress and grant objectives.

(b) Applicants will be evaluated competitively on their ability to:

(i) Address documented health care needs in the specific region served;

(ii) Engage key community members;

(iii) Show evidence of matching funds of at least two dollars for each grant dollar requested. All matching fund contributions, including cash and in-kind, shall meet the criteria determined by the administrator and included in the application guidelines;

(iv) Ability to meet the documented health care needs and address sustainability of programs;

(v) Show innovation in program approaches that could be replicated throughout the state;

(vi) Make efficient and cost-effective use of funds by simplifying administration affecting the health care delivery system;

(vii) Clearly describe size of organization, program objectives, and populations served; and

(viii) Meet the reporting requirements of the authority.

(c) Application access.

(i) The call for grant applications will be made by posting the announcement to the authority's official web site and by notification sent to interested parties.

(ii) To be placed on the interested parties distribution list, send contact information, including mailing and e-mail addresses to community health care collaboration at

Washington State Health Care Authority, P.O. Box 42721, Olympia, Washington 98504-2721.

(2) The guidelines and application forms will be available on the authority's official web site and included with the published guidelines distributed by e-mail to those who request an application. The application will be available in hard copy and sent by United States mail upon request. Applications must be completed and submitted in the format and filed by the deadlines prescribed by the authority and published in the guidelines.

[Statutory Authority: RCW 41.05.160, 41.05.220, 41.05.230, and 2006 c 67. 07-02-055 (Order 06-07), § 182-20-620, filed 12/28/06, effective 1/28/07.]

Appendix E: Grant Application Review Criteria

COMMUNITY HEALTH CARE COLLABORATIVE (CHCC) GRANT PROGRAM
Grant Application Review Criteria
January 2007

Each application was reviewed and scored by four individual review panel members. The review panel consisted of representation from the Department of Health, Health and Recovery Services Administration-Department of Social and Health Services, Office of the Insurance Commissioner, and Community Health Services.

Applications were evaluated competitively on the following criteria:

1. Description of the size of organization, program objectives, and target population;
2. Ability to meet the documented health care needs in a specific region;
3. Engagement of local community, including but not limited to governmental entities, school districts, large and small businesses, nonprofit organizations, carriers, health care providers, and public health agencies;
4. Sustainability and financial viability of the program/project;
5. Methods to streamline administrative practices (administrative simplification) affecting health care delivery;
6. Innovative health care delivery models and potential for replication in other parts of the state; and
7. Performance data sufficient to evaluate program/project progress and meet the requirements of the authority. The measures must:
    a. Address the CHCC program objectives: access to medical treatment, efficient use of health care resources, and improve quality of care;
    b. Address the documented health care needs specific to identified region;
    c. Be qualitative and quantitative;
    d. Be meaningful and measurable;
    e. Include a baseline; and
    f. Serve as a means to determine successful program/project progress.
8. Matching funds of $2.00 for each $1.00 requested are required. Matching funds include cash and in-kind resources. Emphasis will be placed on fund contributions from the local community to show the level of commitment from the community for local programs. For the purposes of this grant opportunity, matching funds must be a direct match, not a duplication or matched to other funds. Additionally, matching funds may include:
    a. Both new and existing funds;
    b. Funding from local governments and the federal government (earmarked for programs aligned with the CHCC's three objectives referenced above);
    c. Local grants such as corporate, community, family or private foundations, or other charitable organizations;
    d. Volunteer services that are documented and furnished by professional and technical personnel, consultants, and other skilled or unskilled labor. Rates for volunteer services must be consistent with those paid for similar work in the labor market;
    e. Donated supplies such as expendable property and office supplies at the market value of the property at the time of the donation; and
    f. Equipment, buildings, or land at the market value of the property at the time of donation;

    Excluded from matching funds are:
    a. Washington State Health Care Authority or other state programs; and
    b. Revenues generated through third-party payers.

Appendix F: May 22, 2007, Press Release

Washington State
Health Care Authority

P.O. Box 42700 • Olympia, Washington 98504-2700
360-923-2820 • FAX 360-923-2606 • TTY 360-923-2701 • www.hca.wa.gov

FOR IMMEDIATE RELEASE: May 22, 2007
CONTACT: Dave Wasser: 360-923-2711

Access to health care increased through state grants

(OLYMPIA) -- Thousands of Washington residents will have increased access to health care, thanks to a series of grant awards announced today. Ten non-profit community-based health care organizations will receive a total of $1.4 million under a new program administered by the Washington State Health Care Authority.

The Community Health Care Collaborative grants were established by the 2006 session of the Washington State Legislature to enhance and support collaborative, community-based efforts to deliver health care. The intent is to support innovative health care delivery systems that can serve as models to other organizations throughout the state.

"Access to health care is one of Governor Chris Gregoire's top priorities," said HCA Administrator Steve Hill. "These grants are intended to improve access for low-income residents who are uninsured or under-insured."

The grant recipients were selected from among 27 applicants based on their abilities to provide access to medical treatment; demonstrate efficient use of health care resources; or improve quality of care. Other state agencies joining the HCA in the selection process were the Health Services recovery Administration within the Department of Social and Health Services; the Office of the Insurance Commissioner; and the Department of Health.

Each recipient organization will receive half of the funding in each year of the two-year grant awards. Funding from the state is to be combined with twice the amount in matching funds, primarily from the communities they serve.

# # #

Appendix F: May 22, 2007, Press Release

Editors: The following is a list of grant recipients, the total amount of their two-year grant, and a description of how the money will be used:

1. Community Health Center of Snohomish County. $75,000 for their Kids Get Care dental program. The program will identify and link families in need of health care with dental and medical health care homes. Emphasis will be given to families that experience barriers because of ethnicity, ancestry, or linguistic isolation. **Contact:** Kenneth Green, Executive Director, 425-789-3750.

2. Free Clinic of Southwest Washington for Clark County. $75,000 to start a Project Access of Clark County. The program will coordinate donated specialty and primary care services to low-income residents. **Contact:** Shirley Gross, Development Director, 360-313-1397

3. International Community Health Services in King County. $100,000 to develop a community collaborative for culturally, linguistically and medically appropriate prevention and self-management of chronic conditions prevalent among Asian-Pacific Islander communities. **Contact:** Michael McKee, Health Education and Grants Manager, 206-788-3660

4. Port Gamble S'Klallam Tribe serving Kitsap County. $100,000 for implementation of digital technologies with focus on electronic medical records and continuity of care. **Contact:** Danette C. Ives, Health Director, 360-297-9664

5. Peninsula Community Health Services. $125,000 for Kitsap Partnership for Access to Health Care Services to integrate primary care and behavioral health and improve access to appropriate care. **Contact:** Barbara Malich, Chief Executive Officer, 360-478-2366

6. Yakima Valley Farm Workers Clinic. $125,000 for the Yakima County Asthma Project (YCAP). The program will provide training, education, health assessments, action plans, emergency care plans, and changes to policies in home and school environments to care for children with asthma. **Contact:** Lisa Campbell-John, Director of Community Health Services, 509-457-6540.

7. Community Choice Physician-Hospital-Community Organization (PHCO) serving Chelan, Douglas, Okanogan, Grant and Adams Counties. $175,000 to expand benefits enrollment services; introduce tele-interpretative services using video-conferencing technology; and a mobile mental health unit to work with primary care providers. **Contact:** Jesus Hernandez, Executive Director, 509-782-5030

8. Spokane County Medical Society Foundation. $175,000 for Project Access Spokane to expand the volunteer network of physicians, hospitals and medical professionals providing total healthcare to the low-income uninsured population in county-wide. **Contact:** John Driscoll, Executive Director, 509-325-5010

9. Whatcom Alliance for Healthcare Access. $200,000 for Project Access Program to add screening and referral program for uninsured people who are referred from the hospital Emergency Department. The grant will also support donated medical care and help develop a small business insurance connector, which will focus on health insurance issues for small business owners and employees. **Contact:** Chris Phillips, Co-Director, 360-715,6548

10. CHOICE Regional Health Network serving Grays Harbor, West Lewis, Mason, Pacific, and Thurston Counties. $250,000 for Project Access Program to implement the Patient Access Link (PAL) initiative, which will integrate the operations of successful existing programs to increase healthcare access and implement a common community case management and information system. **Contact:** Kristen West, Executive Director, 800-981-2123

Appendix G: December 13, 2007, Press Release

Washington State
Health Care Authority

P.O. Box 42700 • Olympia, Washington 98504-2700
360-923-2820 • FAX 360-923-2606 • TTY 360-923-2701 • www.hca.wa.gov

FOR IMMEDIATE RELEASE: December 13, 2007
CONTACT: Dave Wasser (360) 923-2711 (or local contacts listed below)

Health care organizations receive state grants

(OLYMPIA) -- The state of Washington has awarded $500,000 in grants to non-profit community health care organizations in the Tri-Cities, Cowlitz County, Yakima County, and a Spokane-based organization serving 11 Eastern Washington counties.

The Washington State Health Care Authority (HCA) administers the Community Health Care Grant (CHCC) grant program. The agency awarded 10 grants earlier in the year. The grants fund efforts to improve access to health care for low-income Washington residents who are uninsured or underinsured. Each grant funds activities for a two-year period.

The CHCC program was created by the 2007 legislature to help non-profit health care organizations enhance efforts to increase access to appropriate, affordable health care. "Our support of innovative health care delivery systems helps fund programs that can serve as models to other organizations throughout the state," said Loly Reyes-Gonzalez, executive director of HCA's Community Health Services program.

# # #

List of grant recipients and contacts:

1. Benton-Franklin Access to Health. $175,000 to expand existing general and specialty physicians' pro bono network, develop a pharmacy network program, and work with hospitals to reduce the unnecessary use of emergency rooms. Contact: Brooke DuBois, Executive Director, 509-737-8250.

2. Community Health Partners (Cowlitz County), $50,000 to develop a place-based community advocacy program to provide access to health insurance coverage, prescription assistance and other health services. Contact: Paul Youman, Program Coordinator, 360-423-8704.

3. Community Minded Enterprises (Spokane). $175,000 for Health for All to increase access to affordable, appropriate health care services, insurance coverage and reduce the inappropriate use of emergency rooms and uncompensated hospital care. Serves Spokane, Stevens, Pend Oreille, Ferry Lincoln, Grant, Garfield, Whitman, Asotin, Adams, and Columbia Counties. Contact: Ralph DeCristoforo, Project Coordinator, 509-209-2620 or 1-509-444-3088, ext 1020 or Tanya Riordan, Initiative Coordinator, 509-209-2622.

4. Yakima County Department of Community Services. $100,000 for Yakima County Health Care Coalition to help families with children establish medical homes, reduce unnecessary emergency department visits, and assist in accessing insurance coverage. Contact: Rhonda Hauff, 509-574-5552.

Appendix H: Quarterly Reporting Requirements

COMMUNITY HEALTH CARE COLLABORATIVE (CHCC) GRANT PROGRAM
Quarterly Reporting Requirements
January 2007

The CHCC grant-funded programs were required to provide the follow information for each quarter for the first year of the program:

1. Narrative update on changes or revisions to the project, including implementation plans, resources, and goals and objectives, including rationale for changes.

2. Performance measures, including:
    - Quantitative and qualitative outcomes based upon the individualized program performance measures.
    - Strategies and methods used to reduce inappropriate Emergency Department utilization, if relevant to the program.
    - Methodologies used to track Return on Investment (ROI).

3. Clients/patients served, including:
    - Number of clients/patients served, total and unduplicated counts.
    - Total number of clients/patients assisted in obtaining insurance coverage.
    - Total number of clients/patients provided access assistance to health care or services.
    - Number of clients/patients referred for specialty care and associated costs.

4. Client/patient demographics at time of intake, including:
    - Age and gender.
    - Race and ethnicity.
    - Insurance coverage/payer source.
    - Employment status.
    - Income.
    - County of residency.

Appendix I: Survey Results—May 19, 2008

Community Health Care Collaborative Grant Program
Survey Results—May 19, 2008

Question 1: What unanticipated accomplishments have been achieved by your program that may not be reflected in the quarterly reports?	
Respondent 1	As a result of the loss of the program, we are taking a fresh look at developing a system of care for the uninsured in Benton and Franklin Counties.
Respondent 2	1) Support creation and operation of the Mental Health Access Program, a free mental health clinic using donated psychologist time, and integrated its client support with aspects of the Patient Access Links (PAL) initiative (Emergency Department Care Coordination, Project Access and ConneXions client support). 2) Successful bid for a DSHS Patient Navigator contract will enhance the availability of language and culturally appropriate client support in three CHOICE counties. It will integrate through PAL with other aspects of more intensive client support that emerged from the ConneXions part of our work. 3) The ConneXions community partnerships and agreements on vision and common outcomes have had a major impact on a United Way-convened Asset Development Coalition in Thurston County, which has decided to proceed using a multiple "service hub" model that builds directly on ConneXions thought and leverage community effort and potentially other resources for even broader alignment of services around a client-centered, coordinated vision. 4) We found additional sources of funding for prescriptions to supplement the original scope of our Prescription Assistance Program. 5) The unexpected closure of the Refugee and Immigrant Service Center (RISC) in January 2008 left our five county region without a focal point for services for many immigrant groups, especially Southeast Asians. Though it required a financial risk, CHOICE was able to hire a key staff person and pick up some of the services that are most aligned with our mission. The effort to fill emerging service gaps in the Southeast Asian community, in turn, greatly influenced our successful Patient Navigator bid, which will primarily serve Medicaid clients who are Southeast Asian and Hispanic immigrants.
Respondent 3	1) Small Business Health Insurance Connector (SBHIC) - The commitment and enthusiasm of our partners to the success of this program addressing the needs of the small employer uninsured including the Chamber of Commerce, Western Washington University Small Business Development Center, the Whatcom Economic Development Council and the local commercial health insurance broker community. Also there is clarity around the target market for this service which is small employers of 10 employees or less. 2) Emergency Department Project: Successful data collection that results in Whatcom Alliance for Healthcare Access receiving a list daily of any ED patient within the last 24 hours who is uninsured and been referred to a specialist provider. Follow-up on list has resulted in a large % of individuals actually having insurance and that the size of the problem is much more discrete than expected and more manageable to address. There is also a high success rate in getting coverage for these patients.
Respondent 4	We have reduced non-clinical staff, and reallocated resources to increase access and quality.
Respondent 5	What can not be shown in our reports is that we are providing actual medical care to hundreds of people who otherwise would not receive care. Every person counted on our reports is a real person who has experienced a positive outcome due to the program.
Respondent 6	The stimulation for the entire Asthma Home Education project, although the funded project is only located in the Wapato School District. The funding resulted in bringing training to the area; so that benefited all the local partners. Also this training brought in different individuals from the lower valley (Dr. Easton from Sunnyside & now is working with the Sunnyside School nurses) with increases our contracts and possible collaborative partners for future projects. School nurses who attended the training have increased knowledge and confidence in asthma management. All nurses in ESD 105 area have increased knowledge and motivation to use new asthma guidelines. School nurses from other school districts who have heard of the collaborative effort from Wapato are also starting to refer students with asthma to the project.
Respondent 7	The program enabled the collaborative to reach beyond the health care community and connect with educational institutions and social service agencies. By collaborating between these 'service silos' the collaborative was able to efficiently connect children to preventative health care services and optimize use of resources. For example, it is well documented that children with well-child visits are half as likely to have avoidable hospitalizations; in 2007, supported by the Kids Get Care team, Community Health Clinic provided, 7,172 children with well-child visits an increase of 7.1% over the previous year.
Respondent 8	We have increased our capability to reach the Spanish speaking communities. Partially supported by this grant, we have developed a network of affiliate Spanish radio stations that reaches well beyond our initial service area...almost half of the state!
Respondent 9	The level of knowledge with our organizations has been increased, not just among the Access Specialists, but among the people who refer to them.
Respondent 10	Not only are we connecting our Project Access patients with specialist, but we have successfully directed potential patients to other programs for medical help. We directed a patient to the Breast and Cervical Health Program for a breast biopsy. We have successfully sent a patient to Southwest Washington Medical Center for Urology Surgery. They were outside the scope of our Project Access Program, but we were able to help in getting medical help for these people. In our work with Statewide Health Benefits Advocate, we have helped patients find access to other health insurance available to them. Instead of using the Project Access Program, they can use their own, newly found insurance.

Community Health Care Collaborative Grant Program
Survey Results—May 19, 2008

Respondent 11	1) Increased cross-system collaboration administratively, technologically, and provider-to-provider. 2) Acculturation between two disciplines through co-location of services and adherence to a brief treatment model appropriate in a medical setting. 3) Primary Care Provider (PCP) reported increase in productivity. 4) PCP reported increase in confidence for diagnosing & treating Behavioral Health conditions. 5) PCP reported new feeling of being supported in their work to treat patients and better able to respond to patients i.e. "don't know how they practiced without them (BH therapists)." 6) Client perception of change at Peninsula Community Health Services resulting in more comfortable place for Behavioral Health care.
Respondent 12	Thankfulness of the people who are totally unaware of what is available for them, (otherwise). That there is no waiting list for Basic Health and that someone local is able to help them.
Respondent 13	Connection with vocational training and drug rehab programs.
Respondent 14	Translated health education materials. Collaborations with local Community Health Clinic for AmeriCorps. Community support for program: partnered with local libraries, churches/temples, grocery stores, community groups. We have sponsored health fairs, screened individuals for diabetes, cholesterol, and blood pressure. We have sustained community advocacy for the Chinese, Vietnamese, and Filipino communities. We have enhanced outreach to the Samoan/Pacific Islander communities. We continue our efforts to fully integrate health education services into the clinic model of care.
Question 2: At the end of the day, what is different as a result of the Community Health Care Collaborative grant funding?	
Respondent 1	Had we been able to maintain our community funding, the CHCC funding would have made it possible to continue to offer an effective group of access services to the uninsured in our area.
Respondent 2	1) CHOICE might not have survived without this funding, in light of federal funding reductions and delays that directly and indirectly affected our budget. This core support was especially invaluable in moving forward our community development work. 2) During Year 1 of the grant, the PAL partners organized over $1.8 million in donated clinical services and prescription drugs. 3) We proved that targeted low-priced interventions can significantly reduce inappropriate emergency department visits and improve quality. The estimated savings in inappropriate resource use during Year 1, compared to levels prior to clients' involvement in the intervention, totaled about $400,000. 4) The state funding leverages over $900,000 per year in local funds (non-state) deployed towards the objectives in our CHCC grant application.
Respondent 3	Grant dollars have leveraged and attracted other local resources including the City of Bellingham, St. Joseph Hospital, etc. The grant has facilitated a community discussion including the business community, partnerships and commitment to address the needs of the uninsured in the community. Through the ED project we have been able to target individuals who have a likelihood of being eligible for public coverage or eligible for Project Access donated specialty care.
Respondent 3	Grant dollars have leveraged and attracted other local resources including the City of Bellingham, St. Joseph Hospital, etc. The grant has facilitated a community discussion including the business community, partnerships and commitment to address the needs of the uninsured in the community. Through the ED project we have been able to target individuals who have a likelihood of being eligible for public coverage or eligible for Project Access donated specialty care.
Respondent 4	Quality of care has improved.
Respondent 5	Project Access has been able to move towards sustainable funding that will allow us to continue to serve our patients who, without the program would not receive the medical care that they need.
Respondent 6	1) Better trained health care providers in Yakima County because of Asthma Management for Educational Systems, MHE, and Asthma Educator Institute trainings. 2) Students and parents at Wapato School have an opportunity for learning to better manage their asthma. 3) A dedicated Asthma Expert is available to School Nurses in the Wapato School District to help on Asthma Care Plans, track absenteeism and train auxiliary staff to assist students who may by experiencing asthma problems. 4) There are some resources to provide asthma related supplies to project enrollees. This encourages some participants to stay with the project to completion. 5) Students who have asthma under control are able to actively participate in physical education & activities as peers.
Respondent 7	Because of grant funding, Community Health Center of Snohomish County was able to significantly increase the level of health care services for children from low-income families. In particular, preventive health care services were increased. For example, in 2007, Community Health Center provided 4,013 children with DTaP immunizations, an increase of 24.6% over the previous year.
Respondent 8	Greater collaboration among benefit counselors at our various consortium members representing a robust safety net especially in the Wenatchee and Moses Lake regions.

Appendix I: Survey Results—May 19, 2008

Community Health Care Collaborative Grant Program Survey Results—May 19, 2008	
Respondent 9	"Kids Connect" is a known community resource for helping families finds health coverage and medical homes.
Respondent 10	Through the CHCC grant funding, we have Project Access staff, supplies, and administrative support to implement the Project Access Program, directly connecting patients to volunteer specialists. We are helping people get the health care they need. In effect, we now have an operational program.
Respondent 11	1) Renewed and much strengthened relationship between two community agencies serving common clients. 2) Clients getting quality and timely behavioral health intervention/treatment/follow-up. 3) Greater comfort and capacity at community clinic to diagnose, treat, and control behavioral health issues in general patient populations. 4) Clients who would benefit from, but who would not otherwise have access to behavioral health services due to lack of funding, are provided brief treatment.
Respondent 12	Uninsured are gaining access to healthcare and an understanding of what it means to have a medical home. Also, since we are local, the clients have a feeling that the community really does care.
Respondent 13	Reaching population who lack gas money to visit multiple agencies to seek assistance.
Respondent 14	New services for patients are available. Community members support clinic programs. We participate in ongoing dialogue about how to better work together with competing demands on our time.
Question 3: What value has resulted from the connections made from creating/enhancing a collaborative model?	
Respondent 1	The collaborators are already at the table to develop an alternative (and sustainable) system of care model.
Respondent 2	1) All of our unanticipated accomplishments (question 1) emerged from community development work and relationships, rather than simply from CHOICE programs; and we know from experience that community development efforts and relationships will also generate unknown future opportunities to serve the community in coordinated ways consistent with PAL. 2) Ongoing community discussions about further operational consolidation, integration or coordination of major services that are currently underway among CHOICE and partners, which would not be taking place without the core staffing and reputation that CHOICE enjoys as a mature community collaborative. We firmly believe that this trusted role in conversations, convening and negotiations is a key role for collaboratives.
Respondent 3	SBHIC project has resulted in a meaningful partnership with the business community that has resulted in engagement and partnership with WAHA to address other community access needs. ED project has verified the value added of WAHA services to the hospital including quantifying a problem that hasn't been quantified before, insuring of previously uninsured patients that has a direct economic benefit to the hospital and created a value added service to the private specialist community and improved care for the patient.
Respondent 4	Reduced duplication of efforts.
Respondent 5	Collaboration with physicians, hospitals, community health clinics and other entities allows us to enhance the quality and accuracy of medical referrals and strengthens the process of case management.
Respondent 6	1) The Yakima Area Asthma Coalition is more energized due to seeing the results of the project. 2) Having the Asthma Educator Institute in Yakima allowed many health professionals in different settings (physician, school nurses, office staff, respiratory therapists, etc.) to learn together and network. 3) Physician from Sunnyside, Dr. Easton attended the AEI and has gathered a group in Sunnyside consisting of local physicians and school nurses to work on asthma coordination in the lower Yakima Valley. 4) Excellent team-work, collaboration and finding solutions regarding clinic visits and school requirements.
Respondent 7	By removing 'institutional' barriers to care, the collaborative model increased the effectiveness of health care service delivery. The structure of the collaborative model guided staff members in their decision making process to ensure that the agreed upon outcomes remained the program's focus.
Respondent 8	Less people "fall through the cracks" because of gaps in services for benefits counseling and enrollment in benefits.
Respondent 9	There is increased knowledge in the community, and stronger collaboration between primary care, the hospital systems, and the education systems.

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Respondent 10	We in the community and state have come together, identified a need, and are implementing a program to help fill the need. We have collaborated with and formed partnerships with various organizations: the Washington Prescription Drug Program - administered by the Washington State Health Care Authority, Clark Co. Medical Society, Clark Co. Public Health, Columbia United Providers, Kaiser Permanente, Legacy Health System, Project Access of Northwest Oregon & Washington, Pacific Source Health Plan, Portland State University, Providence Medical Group, Retired Senior Volunteer Program, Southwest Washington Medical Center, Statewide Health Insurance Advisors Helpline Program, United Way of the Columbia-Willamette, WA State Health Care Authority Community Health Care Collaborative, Washington State Service Corps, Allergy and Asthma Center of SW WA, Cascade Heart, Columbia Anesthesia Group Dermatology Associates, Ear, Nose, and Throat of SW WA, Family Wellness Clinic, Legacy Clinic Salmon Creek, Legacy Salmon Creek Hospital, New Heights Clinic, Northwest Cancer Specialists, Northwest Surgical Specialists, Pacific Gastroenterology, Pacific Surgery Specialists, Richard Kubiniec, Sea Mar Community Health Center, Southwest WA Medical Center, The Vancouver Clinic, The Women's Clinic, Vancouver Ear Nose and Throat.
Respondent 11	1) Improved quality of patient care. 2) Patients receive one-stop health care that recognizes the relationship between mind and body with well-being and overall improved health as the goal. 3) Improved efficiency in providing patient care--both within community health center and for referrals to KMHS and other community resources. 4) Measured outcomes thru epidemiology evaluation.
Respondent 12	Connectivity within the local community of resources and agencies that normally function along parallel lines but do not intersect on a regular basis.
Respondent 13	Expanded outreach to local agencies serving this patient population.
Respondent 14	Ongoing dialogue about program priorities, community needs, and funding available. There are relationships evolving among and between our community partners. It is a dynamic and changing process.
Question 4: What unique characteristics of your program could be considered for replication throughout the state?	
Respondent 1	The hybrid aspect, i.e. both pro bono and reduced cost care, increased capacity more than just the pro bono approach. The combination of services (connection to insurance, prescriptions and access to primary) as well as specialty care were also successful and worthy of replication.
Respondent 2	1) CHOICE is a regional (multi-county) health collaborative. In addition regional efforts, we support and staff Community Health Task Forces that convene local leaders to focus efforts on prioritized problems and to develop and guide collaborative solutions at the county level. Sponsorship and titles of the Task Forces vary by area but there are many commonalities in approach. 2) CHOICE has developed a philosophy and track record of avoiding competition for funding with collaborating partners. While this is not possible 100% of the time we have shown our willingness to foregoing funding opportunities, as well as forging joint approaches that avoid competitive application 3) We have cultivated a value-based philosophy in seeking funding from members. This includes Return on Investment methods that have continued to evolve with our range of services and community development roles.
Respondent 3	The SBHIC program has provided a model for developing partnerships and implementing a public/private program for targeting small employers with uninsured workers and providing options for coverage. The ED project provides a methodology for data collection and a follow-up process to assist hospitals and local providers better understand uninsured ED users. It also scales the problem in a way that is rarely done.
Respondent 4	Specific protocols, quality assurance audit.
Respondent 5	The Project Access model was build with the intention to be replicated. Our program is already being replicated in other counties such as Whatcom County & King County. Each new Project Access is built individually to accommodate the needs of the community which it serves.
Respondent 6	The Asthma Project components could be replicated at any small to large clinic throughout Washington State. In fact, with a cadre of Certified Asthma Educators available the program could also be available to all health care providers.
Respondent 7	This Kids Get Care program was a collaboration between the local hospital, health district and community health center. Because these organizations exist in most counties, the infrastructure already exists for program development. We found that the Kids Get Care program was a natural extension of the mission of each of the collaborating partners. Cultural diversity and barriers due to linguistic isolation should be embedded into the collaborative. For example, Community Health Center was able to incorporate Hispanic, Russian/Ukrainian and Vietnamese outreach workers into the program. Management from each collaborating partner should provide time for staff members to meet routinely, discuss actions, identify barriers to success, and make change when indicated.

Community Health Care Collaborative Grant Program Survey Results—May 19, 2008	
Respondent 8	The majority of our program practices are replicable. The biggest challenge we face is factors related to the culture of poverty that many of our clients live with regardless of ethnicity or language barriers.
Respondent 9	Our Access Specialists in the ESD has increased the connection with preschool and Head Start programs throughout the valley.
Respondent 10	Project Access Clark County is the 5th Project Model in the state of Washington. We believe, replication of this model in the other Washington Counties would be of great value to low-income uninsured in the state. We believe using the model we are using - of working with SHIBA (Statewide Health Insurance Benefits Advisors) for determining eligibility - while determining if potential patients are qualified for other insurance, is a good way to get more access for health insurance. Lastly, attaching Project Access organizations to a Free Clinic helps with economies of scale - we don't have to recreate Boards and we can optimize funding.
Respondent 11	1) Kitsap Mental Health Service (KMHS) staff (Behavioral Health Therapist/Psych ARNP co-location at community clinic. 2) KMHS ARNP business-hours availability for email/phone consult. 3) KMHS BHT/Psych ARNP participation in Peninsula Community Health Services provider meetings. 4) Ongoing meetings of 3 agency program coordination team: Directors, Medical Directors, Practitioners, Evaluator. 5) Operations functions regarding Electronic Medical Records, shared clients.
Respondent 12	Positive, pro-active outreach: broad brush community approach, such as reaching out to small businesses, working with Employment Security and the Rapid Response Teams when lay-offs occur, training others in organizations where the need is first identified rather than the client being given another number to call, informing and educating key people in small towns, neighborhoods, church groups, etc, on the resources and programs so that community needs are handled at the point of identification.
Respondent 13	Use of AmeriCorps
Respondent 14	Low literacy health education materials available in Chinese, Vietnamese, Korean, and Tagalog. Lessons learned in community outreach to "hard to reach" populations.
Question 5: What recommendations would you make on how the state can support the collaborative grant programs in addition to continuous funding?	
Respondent 1	I would suggest the state look at ways collaboratives can share information about shared clients without violating HIPAA regs.
Respondent 2	1) Technical assistance funding via Communities Connect with purchase of services from more mature collaboratives to help those earlier in the process. 2) Other support to shared infrastructure among collaboratives through Communities Connect. 3) Earlier involvement of grantees and Communities Connect in preparation for value-oriented reports to the Legislature. 4) Formal evaluation (perhaps through the Joint Legislative Audit and Review Committee, or the Washington State Institute for Public Policy).
Respondent 3	Matching funding is key…incentives for local government and others to work collaboratively at the community level. Dollars in are minimal compared to other state health policy initiatives and incubate cost effective community strategies that leverage local resources.
Respondent 4	Share proven models and strategies to increase efficiency, improve quality of care, and maximize access.
Respondent 5	Electronic information sharing with agencies such as DSHS, Medicare & Medicaid would allow us to serve our patients in a timelier manner with a higher degree of accuracy due to the access it would provide us to up to date and complete information.
Respondent 6	Make Asthma Educator services part of the Washington Health Care Authority covered services.
Respondent 7	We found the grant reporting structure to be invaluable. The quarterly reporting was not cumbersome, yet because the outcomes were quantifiable, they helped us focus on our program progress. Sharing the successes and (failures) of other grantees, would allow us to learn from each other, and strengthen future collaborative efforts.
Respondent 8	Collaboratives need a good level of ongoing "base funding" as foundation for continuity of service. Additionally, our ability to engage local funding support for these services from providers in our service area depends on our ability to demonstrate "actual ROI." We need anonymous data from the state on the financial impact of our enrollments to the revenues providers receive as a result of our work. This would compel them to support our Access work more than anything else.
Respondent 9	Help like-projects identify shared outcomes to measure.
Respondent 10	Advocacy for access to health care, offering support in filling gaps in state programs and identifying trends or needs unmet in the community and state that we can help fulfill.
Respondent 11	1) Remove funding barriers to allow for change in RSN/Medicaid rules to allow reimbursement FFS at community health center for behavioral health services. 2) Continue and expand co-location of services.

Community Health Care Collaborative Grant Program Survey Results—May 19, 2008	
Respondent 12	Regularly advertise all of the programs (DSHS programs, HCA programs, etc) because the negative branding over time has led many eligible people to believe that these programs are not for them. In addition to this, use local or regional contacts in the advertising so that potential clients may connect with advocates who are aware of the community situation that people are in and other potential resources.
Respondent 13	No answer.
Respondent 14	Coordinate a "lessons learned" and how to overcome obstacles in collaborations with limited time available.
Question 6: Please rate your level of satisfaction of the service provided by the Health Care Authority's Community Health Care Collaborative grant program staff.	
Respondent 1	Outstanding
Respondent 2	Outstanding
Respondent 3	Outstanding
Respondent 4	Outstanding
Respondent 5	Outstanding
Respondent 6	Outstanding
Respondent 7	Outstanding
Respondent 8	Outstanding
Respondent 9	Outstanding
Respondent 10	Outstanding
Respondent 11	Outstanding
Respondent 12	Outstanding
Respondent 13	Good
Respondent 14	Outstanding
Question 7 (Optional): Organization Name	
Respondent 1	Benton Franklin Community Health Alliance
Respondent 2	CHOICE Regional Network
Respondent 3	Whatcom Alliance for Healthcare Access
Respondent 4	Port Gamble S'Klallam Tribe
Respondent 5	Project Access Spokane
Respondent 6	Yakima Valley Farm Workers Clinic
Respondent 7	Community Health Center of Snohomish County
Respondent 8	Community Choice PHCO
Respondent 9	Yakima Neighborhood Health Services / Yakima Kids Connect
Respondent 10	Free Clinic of SW Washington / Project Access Clark County
Respondent 11	Peninsula Community Health Services
Respondent 12	Community-Minded Enterprises
Respondent 13	Community Health Partners
Respondent 14	No response