State of Washington Health Care Authority
Application for Accountable Community of Health (ACH)
Design Grant, GOA #14-028

Olympic Community of Health

EXHIBIT A
APPLICATION COVERSHEET

1. **Applicant's Organization Name:**

   Kitsap Public Health District on behalf of the Olympic Community of Health.

2. **Applicant's authorized representative for this GOA (this representative shall also be named the authorized representative identified in the Application):**

   Scott Daniels

3. **Title of authorized representative:**

   Administrator, Kitsap Public Health District

4. **Address:**

   Kitsap Public Health District
   345 6th Street, Suite 300
   Bremerton, WA 98337-1866

5. **Telephone numbers:**

   (360) 337-5287 Office
   (360) 620-3704 Cell
   (360) 475-9287 Fax

6. **Email address:**

   scott.daniels@kitsappublichealth.org

7. **A statement of applicant's intent to submit a Grant Application, including intent to apply for a Pilot Grant or Design Grant:**

   This is an application submitted by the Kitsap Public Health District on behalf of the Olympic Community of Health for a Design Grant described in GOA #14-028.

8. The intended RSA served by the applicant and any potential sub-awardees:

The Regional Service Area (RSA) to be served is the Peninsula RSA which includes Kitsap, Clallam, and Jefferson Counties, sharing boundaries with the Sovereign Nations of the Hoh, Quileute, Makah, Lower Elwha Klallam, Jamestown S'Klallam, Port Gamble S'Klallam, and Suquamish Tribes. Within this RSA, a single Accountable Community of Health (ACH), known as the Olympic Community of Health, has been formed. No additional COHs have been formed or are anticipated in this region. No sub-awardees are anticipated.

9. A statement reflecting the applicant's approach to incorporating and/or partnering with an existing COH or other recognized convener within the same RSA, if applicable.

The applicant is a member of the Steering Committee for the Olympic Community of Health. The Olympic Community of Health is the only COH formed, or anticipated to be formed, in the Peninsula RSA serving Kitsap, Clallam, and Jefferson Counties.

10. Please describe how you meet the minimum requirements:

a. Status as an organization or entity with the ability to enable public-private partnership and cross-organizational priority setting. Eligible entities may be engaged in a quasi-governmental arrangement, a 501(c)3 or (c)4 non-profit corporation or cooperative, or another model that enables cross-sector engagement, commitment, and decision making.

The Kitsap Public Health District (KPHD) has a long history of innovative engagement with community health partners at a local and regional level. In all three counties, KPHD facilitated a comprehensive data review process and participated in the selection of highest community health priorities. In Kitsap County, KPHD facilitated the entire community health improvement process (CHIP), most recently engaging 43 partners in data review and priority selection processes. KPHD also created a cross-walk to identify shared health priorities among the three-county region identified through their individual CHIPs. Since 2002, KPHD has also served as the lead county for Public Health Emergency Preparedness and Response Region 2, coordinating a wide and changing range of services for health departments, hospitals, emergency responders, and tribal governments. The three counties and seven tribes have a groundbreaking Mutual Assistance and Collaboration Agreement in effect that has been used as a state and national model for emergency response. Additionally, KPHD was recently awarded a DP14-1422 grant (funded by Centers for Disease Control through the Washington State Department of Health) and will coordinate the efforts of a diverse array of regional partners working to expand chronic disease prevention activities within the three-county region. This partnership includes six tribal clinics, two acute care providers, a housing provider and a social service provider, KMHS, PCHS (our federally-qualified health center), among others. The three health departments and boards of county commissioners also partner on several federal and state projects with the Puget Sound Action Team and Hood Canal Coordinating Council. KPHD is often the fiscal lead on multicounty projects and contracts in the region.

b. Ability to receive and manage funding and learning assistance within the represented RSA.

The Kitsap Public Health District manages an annual budget of $11,175,128 (2015), including grants and contracts, totaling $3,771,540. Learning assistance is a core activity of local public health jurisdictions.

c. Plans to serve an entire RSA and coordinate with existing COHs and other recognized conveners in the RSA, if applicable, to ensure COH plans are authentically incorporated into the regional approach.

The boundaries of the Peninsula RSA and the Olympic COH are the same, encompassing the three counties and seven Tribal Nations in our region. Other recognized conveners for the entire RSA include the Kitsap County Human Services Department (HSD), which has responsibility across the RSA for both the Workforce Development Council and the Peninsula Regional Services Network. The Kitsap County Human Services Department is a member of the Olympic COH Steering Committee and currently maintains the COH's website for communication purposes.

d. Existence of a community partnership.

For purposes of the GOA #14-028 grant application, the relevant partnership is the Olympic COH. Participants currently include local public health jurisdictions, hospitals, behavioral health service providers, county governments, tribal health programs, chemical dependency programs, primary health care providers, housing agencies, and others.

11. If applying for a Pilot Grant, please provide a list of the contacts and email addresses that HCA will use to distribute the survey required as part of the Pilot application (refer to Exhibit E, section 3):

N/A

EXHIBIT B
APPLICATION NARRATIVE

Acronym Key:

ACH:	Affordable Community of Health (synonymous with “Community of Health”)
CBHA:	Community Behavioral Health Agency
CCHHS:	Clallam County Health and Human Services
CHIP:	Community Health Improvement Process
COH:	Community of Health (synonymous with “Accountable Community of Health”)
JCPH:	Jefferson County Public Health
KCHS:	Kitsap County Human Services Department
KCR:	Kitsap Community Resources
KMHS:	Kitsap Mental Health Services
KPHD:	Kitsap Public Health District
PCHS:	Peninsula Community Health Services
PCP:	Primary Care Provider
RSA:	Regional Service Area

1. **Population Served: the Counties/population represented by the community partnership.**

   a. **Please describe the RSA represented by the partnership. If the partnership is proposing any sub-award to facilitate RSA adjustments that impact the ACH design, please describe.**

   The Regional Service Area (RSA) to be served is the Peninsula RSA which includes Clallam, Jefferson, and Kitsap Counties, sharing boundaries with the Sovereign Nations of the Hoh, Quileute, Makah, Lower Elwha Klallam, Jamestown S’Klallam, Port Gamble S’Klallam, and Suquamish Tribes. Within this RSA, a single Accountable Community of Health (ACH), known as the Olympic Community of Health, has been formed. No additional COHs have been formed or are anticipated in this region.

   b. **Please describe any unique challenges or opportunities within the population.**

   Challenges:

   Like many state regions, the Olympic COH geographic area includes both urban and widely dispersed rural populations with differing health challenges. The region is over 5,500 square miles, with the Olympic National Forest contributing to the 1,700 square miles of forested and mountainous land in Clallam County alone, resulting in pockets of isolated populations and provider shortages. Much of Clallam and Jefferson are in the Olympic National Forest and have few roads through the counties.

The regional health system is complex in that it is serviced by five health plans, though not the same plans for each county. The hospitals in the region have different parent/referral organizations, both public and private entities, including Swedish, CHI Franciscan Health, and the U.S. Navy. The region contains one federally-qualified health center (Peninsula Community Health Services in Kitsap County), multiple rural health clinics in Jefferson and Clallam Counties, Veterans Administration community-based outpatient clinics in Bremerton and Port Angeles and three free clinics, including the Volunteers in Medicine of the Olympics and Dungeness Wellness Clinic in Clallam County and the Jefferson County MASH Clinic. In addition, there are seven sovereign tribal nations, six of which operate primary care clinics.

Behavioral health services are provided through non-profit community mental health agencies in Kitsap and Jefferson Counties, and through an affiliation with the Forks Community Hospital in Clallam County, as well as private providers. There are significant gaps in the provision of crisis mental health services, including number of beds available for inpatient psychiatric treatment, and a gap in screening for mental health and substance use among all ages of the population. There are numerous non-profit and for-profit out-patient and inpatient substance abuse treatment providers in the RSA, but a significant lack of early intervention and treatment for substance use services. There is insufficient housing for adults with serious persistent mental illnesses or persons with substance abuse issues, whether pre-treatment or in treatment present challenges to recovery. The three counties face challenges in addressing heroin, methamphetamine and alcohol abuse amidst the struggle to integrate addiction treatment within evolving medical care payment changes.

Within the region, certain sub-populations have markedly disparate chronic disease health outcomes related to cardiovascular disease, stroke, and diabetes. These include Tribal communities, persons with single or multiple co-morbidities including mental illnesses, substance abuse, and a chronic physical health condition, and low-income adults. Cross-cutting health issues in the region include a high prevalence of adult smoking, lack of affordable housing, and prevalence of substandard housing. The region has a distinct military presence, with 5% of the Kitsap County population on active military duty. This has resulted in highly transient sub-populations in certain areas of the county, as well as a relatively high percentage, when compared to Washington State statistics, of youth of a parent in the military or in combat. Clallam and Jefferson Counties have high numbers of military veterans equaling 12% of the population in Clallam and 14.7% of the population in Jefferson. While outpatient facilities are available in Port Angeles and Bremerton, most imaging and specialty services can only be obtained in the Seattle area, resulting in long drives and fragmented care.

Each county has unique health and socioeconomic burdens as well. Clallam County ranks among the lowest counties in the State in relation to length and quality of life, as well as in adoption of health behaviors, access to clinical care, supportive physical environments to health, and positive social and economic factors.

Clallam County occupies the northern portion of the Olympic Peninsula extending nearly 100 miles along the Strait of Juan de Fuca on its north side and more than 35 miles along the Pacific Coast on its west side. There are nearly a million acres of wilderness area in the interior of the Peninsula, including Olympic National Park and the Olympic National Forest. There are four tribes within Clallam County's borders, each with its own health clinic. The county has small towns, and large rural and backwoods areas making it a challenge for service delivery. Median age in Clallam County is 49.5 and percentage of population over age 65 is 26.0%, both much higher than the State average. One in five residents in the west end of the County are American Indian/Alaskan Native and one in seven are Hispanic. Clallam County has a median household income of $41,887 which is lower than the state average. Twenty-one percent of women smoke during pregnancy in the county, and 55% of all drug-related deaths in 2011-13 involved an opioid.

Jefferson County faces unique issues with an aging population, with a median age of 55 and the highest percent of seniors in a Washington State county (30.5%). Citizens there experience economic disparity, as evidenced by the $31,000 annual salary gap between census tracts. Two of every three babies born in Jefferson County are born with Medicaid insurance and 19% of women smoke during pregnancy. Over half of pregnant women are enrolled in the Women, Infants and Children (WIC) Program. One in eight deaths in Jefferson County is related to alcohol and/or drugs.

Kitsap County has high rates of no or late prenatal care access, low birth weight babies, and women with gestational diabetes, hypertension, and smoking during pregnancy. The county is experiencing worsening trends in unemployment rates and increasing prevalence of children living below the federal poverty level. High rates of youth suicidal ideation, attempted suicides, and social isolation are of grave concern to service providers. As with other counties, obesity and physical inactivity are a problem for both youth and adults.

Opportunities:

Several of the key stakeholders within the region have established and meaningful partnerships across county lines, including shared program implementation, collaborative projects, and support through technical expertise. For example, KPHD facilitates the community health improvement process for Clallam, Jefferson, and Kitsap counties. Jefferson Public Health Department (JPHD) collaborates with KPHD to facilitate the Nurse Family Partnership Program in Jefferson and Kitsap Counties and for the Port Gamble S'Klallam Tribe. Public health departments and tribal governments within the tri-county area have developed an unprecedented regional approach to emergency preparedness and management as outlined in the Olympic Regional Tribal Public Health Mutual Aid Agreement. KMHS works in partnership with Clallam and Jefferson community behavioral health providers to manage information technology data reporting systems. KMHS also hosts the Crisis Clinic for the tri-county area.

Stakeholders are invested in thoughtfully approaching the Triple Aim and the mandate for improved regional coordination of health care. This is evidenced by the organic initiative to create a steering committee to explore development of a regional Accountable Community of Health (ACH) with no outside funding source. Recently, 14 cross-sector health care and social service partners from the region, including six sovereign Tribes, were able to quickly mobilize to develop and submit a joint application to the Washington State DOH for a regional approach to chronic disease prevention. These existing strong partnerships provide the necessary foundation for effectively designing the Olympic COH.

A great strength of our Olympic COH is the leadership of providers in the community who have significant expertise with Medicaid financing and caring for vulnerable populations. KMHS operates a capitated behavioral health system, serving 6,000 clients per year. As a federally-qualified health center, Peninsula Community Health Services provides primary care, dental health, and behavioral health services to almost 28,000 Medicaid patients per year. CCHHS contracts with local providers for chemical dependency services: in 2013, there were 1,854 Medicaid patients served, and the estimate for 2014 is 2,600 patients served, a 29% increase.

Finally, Olympic COH members can learn from the expertise of early adopters in integrated health within the region. KMHS is regarded as an innovator in transforming a behavioral health provider system to provide whole person, integrated care in the community behavioral health agency (CBHA) setting and, for the general population, providing psychiatric consultation to primary care providers countywide. KMHS has additionally provided behavioral health care services at four primary care clinics, including PCHS, under a Centers for Medicare and Medicaid Services award. At the CBHA, this integration of mental health, substance abuse treatment and primary care coordination is designed to more effectively prevent or manage co-morbid chronic conditions with Medicaid clients, while in the greater community it is equipping Primary Care Providers (PCPs) to more effectively treat patients with co-morbid behavioral health conditions. This “bi-directional” model creates a more seamless flow between CBHA and PCPs, to provide patients with the right care, at the right time, at the right place for mild to complex conditions.

2. **<u>Governance Structure: the structure and process for decision making, leveraging community and multi-sector stakeholder input.</u>**

   a. **Please describe your partnership's recent efforts to develop or consider the development of a governance structure to leverage broad multi-sector community and stakeholder input toward a common agenda of achievement of better health, better care at a lower cost.**

      In July 2014, KPHD, Kitsap County Human Services Department (KCHS), PCHS (the region's only federally-qualified health center), KMHS, JPHD, and CCHHS convened to form a Steering Committee for the Olympic COH. This Committee determined that it was preferable to pursue a three-county ACH versus a ten-county ACH because of existing partnerships and service delivery alignment with the RSA. The Olympic Medical Center (Clallam County) and Jefferson Healthcare (Jefferson County) supported the tri-county approach to ACH development early in the process. The Committee solicited and received support from the county commissioners of each if the three counties to adopt this tri-county approach. <u>Exhibit G</u> provides a copy of the letter sent by the county commissioners to the Washington State Health Care Authority and the Washington State Department of Health and Human Services urging State support for a three-county Regional Service Area, and the same geographic configuration for the eventual configuration of the region's ACH.

      In November 2014, the Steering Committee convened a formal "launch" of the Olympic COH to an expanded group of key stakeholders, including representatives from housing, behavioral health, chemical dependency, public health, primary care clinics, education, community action agencies, dental clinics, hospitals, long-term care, and tribal councils. The Olympic COH has not yet had the opportunity to discuss governance with the broader coalition. This work will be accomplished during the design grant period.

   b. **Please describe how you have built upon existing community based health improvement coalitions, leveraged and enhanced the existing relationships, commitments and initiatives already in place to ensure a diverse, multi-sector approach to health and health care.**

      In addition to leveraging established regional partnerships, the Steering Committee will draw from each county's Community Health Improvement Process (CHIP) to ensure a diverse approach to health care. All three counties have completed individual CHIPs, each requiring considerable community engagement throughout the data review and health prioritization process. KPHD provided data management and meeting facilitation support to Jefferson and Clallam Counties for their CHIP processes. Each CHIP benefited from multi-sector representation, and dedicated leadership participation from the health system, social services, business, education, and early learning/child care sectors, among others. KPHD, JPHD, and CCHHS will continue to leverage their network of CHIP partners to support engagement in the development of the Olympic COH.

Shared CHIP priorities among the three counties include: 1) improve access to care and having a medical home, 2) chronic disease prevention through nutrition and physical activity promotion, and 3) improved mental health care and access to services. In addition, early child development and substance abuse treatment and prevention were shared priorities in two of the three counties. The Regional Health Needs Assessment will build from these common health priorities, and make every effort to support and enhance existing initiatives to address these common health priorities as appropriate deemed appropriate through the Assessment.

c. Please describe the existing or planned decision-making process for the partnership. Include a description of any existing or planned policies or strategies to address conflicts of interest.

The Olympic COH does not yet have an approved decision-making process for the partnership. This will be developed and approved during the term of the grant. The Olympic COH plans on convening a Governance Subcommittee consisting of key stakeholders to recommend a decision-making process. The Subcommittee will assemble and review governance documents developed by other COHs, then frame up a set of recommended decision-making options to the entire collaborative to approve. The need for such a process was discussed at the Olympic COH's first full meeting on November 7, 2014. The COH will evaluate a range of modified consensus-based decision-making models to ensure greater stakeholder involvement and equality. Such models support the State's mandate that no single entity or sector dominate the COH. Conflict of interest and resolution procedures will also be discussed and developed by the stakeholders early in 2015. The Governance Subcommittee will also evaluate the need for county forums representing the interests in each of the three counties. County forums may be needed to help implement shared regional priorities and other local priorities in each county.

d. Please describe the existing or planned committees/sub-committees and the scope of each.

The Steering Committee will request participating stakeholders to approve an initial governance and committee structure for the COH, including approving the COH's decision-making, conflict resolution, and conflict of interest processes. A broad range of stakeholders will also be encouraged to participate on all committees and sub-committees described below.

1) Board: After the governance and committee structure has been established, the overall direction and governance of the Olympic COH will be the job of the Olympic COH Board. The Board will consist of fewer members who represent individual sectors within the COH, e.g., health care, public health, behavioral health, education, social services, etc. The Board will determine the strategic direction of the COH and lead regional planning efforts including adopting regional action plans. The Board will also serve as a forum for information exchange and shared learning, will review regional data to inform decision-making, and oversee and assist with funding management and acquisition for the COH. The Board will have other responsibilities including ensuring the implementation of action plans, the completion of planning actions necessary to meet plan objectives, and ongoing plan evaluation and revision. Other responsibilities will include advocacy, and communication with state agencies and other partners to respond to information requests and to provide guidance on COH issues and questions.

   Initially in 2015, it is anticipated that the Olympic COH Board will be supported by following committees and subcommittees:

   - Steering Committee
   - Governance Subcommittee
   - Community Health Assessment and Planning Subcommittee
   - Sustainability Subcommittee
   - Ad Hoc Community Advisory Group

2) Steering Committee: In July 2014, a Steering Committee was formed, consisting of the stakeholders who initially came together to form the Olympic COH. Members who have participated, or who have expressed an interest in participating, on the Steering Committee include (listed alphabetically):

   - CHI Franciscan Health Harrison Medical Center
   - Clallam County Health and Human Services
   - Forks Community Hospital
   - Jefferson Health Care
   - Jefferson Mental Health
   - Jefferson Public Health Department
   - Kitsap Community Resources
   - Kitsap County Human Services Department
   - Kitsap Mental Health Services
   - Kitsap Public Health District
   - Olympic Educational Service District 114
   - Olympic Medical Center

- Peninsula Behavioral Health Services
- Peninsula Community Health Services
- Safe Harbor Recovery Center
- West End Outreach Services

These organizations recognized the importance of initiating a formal ACH to create a local community voice for regional planning and population-based service delivery. Without the benefit of a preliminary planning grant from the Washington State Health Care Authority, in July 2014, the Steering Committee began participating in bi-weekly conference calls to discern next steps, later securing the expertise of Dale Jarvis and Associates to assist in strategizing an action plan. Stakeholders were identified based on the HCA ACH guidance, phone calls made, and a letter of invitation sent in October to potential partners to participate in learning more about the ACH's purpose and intent and to explore their interest in participating it the ACH. This meeting, centrally convened in Port Townsend, was facilitated by Dale Jarvis. Subsequent to this meeting, at least 10 organizations indicated they would actively participate, and others are evaluating whether to participate. The Steering Committee identified that they would support the KPHD in this request, including participation in the preparing the ACH design grant application.

Moving forward, the Steering Committee will be comprised of leadership from Olympic COH member organizations. The Steering Committee will initially meet monthly for the purpose of supporting Olympic COH Stakeholders and the Board, overseeing the work of COH staff and consultants, managing the Work Plan and Budget, maintaining project momentum, developing an engagement strategy and community mobilization plan, and resolving problems and issues. Membership on the Steering Committee will be finalized by the Stakeholders early in 2015. The Steering Committee will also support the work of the Governance Subcommittee, the Community Health Assessment and Planning Subcommittee, and the Sustainability Subcommittee.

3) Governance Subcommittee: The Governance Subcommittee will research and recommend a governance structure for the COH, including decision-making, conflict of interest, and conflict resolution processes for the partnership. The Governance Subcommittee will also make recommendations on the legal form of the COH including by-laws and articles of incorporation, if applicable. The Governance Subcommittee will consist of key stakeholders that will assemble and review governance documents developed by other COHs, receive feedback from the Ad Hoc Community Advisory Group and contract staff, and then frame up a set of recommended options for the Stakeholders to approve. We estimate that a governance structure will be developed and approved during the first four months of the grant. We estimate that the formal legal structure of the COH moving forward will be made by the Board in the third quarter of the grant with legal documents

completed in the fourth quarter. Once the work of the Governance Subcommittee is completed in 2015, and the Board is fully established and operational, the Governance Subcommittee may be dissolved and other subcommittees may be initiated to support next steps.

4) Community Health Assessment and Planning Subcommittee: The Community Health Assessment and Planning Subcommittee will facilitate the development of a single, cross-sector health needs inventory and multi-year regional health improvement plan. The goal is to consolidate the many community health planning efforts required by various agencies and funders across the region. This Subcommittee will also work closely on performance measures to be included in the plan, and will work with other COHs and the State to develop and implement a set of statewide performance measures. Individual counties have committed to a collective impact approach to shared priorities, which may involve regionally-aligned voluntary engagement of independent stakeholders from the local level, as a means to improve the health of the region. Service innovations may also be evaluated and recommended by the Subcommittee.

5) Sustainability Subcommittee: This Subcommittee will be developed by Month 6 of the project, and will develop a plan to solicit funds in support of the Olympic COH. The Subcommittee will expand existing research of potential funders and identify priority funding opportunities for the next stages of the COH.

6) Ad Hoc Community Advisory Group: An Ad Hoc Community Advisory Group will be formed by Month 8 to provide feedback to the Board and the Steering Committee on all aspects of the COH's work. The Group will include health care consumers and others with technical expertise in specific health care topic areas.

e. Please describe the existing or planned mediation and conflict resolution strategy that supports the decision making strategy and the ACH's voluntary compact.

The Olympic COH does not yet have an approved mediation or conflict resolution strategy for the partnership. A strategy will be developed by the Governance Subcommittee and approved by Stakeholders during the term of the grant.

f. Please describe additional strengths and/or challenges regarding your existing and/or proposed governance model.

To date, the Olympic COH's Steering Committee has worked well together. The challenge for the COH is the immense scope of the partnership involving many stakeholders and sectors, some of whom have not historically worked together on community health issues.

g. Describe what mechanisms are in place or planned for keeping committees, sub-committees and other involved entities, including the ACH, accountable.

Accountability will be an important topic within our governance model discussions. We will draw from the successes of public health partners in helping to create a culture of accountability for outcome measures as part of their CHIPs, which has included establishing monitoring and evaluation plans, program objective timelines, and routine communication channels.

3. <u>Engagement: representation and participation of community members and multi-sector stakeholders, either as members of the partnership or as informants at the community level.</u>

a. If applicable, please describe your partnership's recent efforts to develop or consider the development of an engagement strategy to increase multi-sector representation and participation.

While the Steering Committee has not yet developed an engagement strategy, the group identified a first round of partners needed for the initial launching of the COH in 2014. Sectors invited to the COH's first meeting on November 7, 2014, included the four main hospitals serving the region (CHI Franciscan Health Harrison Medical Center, Forks Community Hospital, Olympic Medical Center, and Jefferson Healthcare); community action programs for the region; the Olympic Educational Services District 114 representing schools; housing authorities for all three counties; community behavioral health providers (state-designated providers) and chemical dependency service providers for each county; the Boards of Health and Board of County Commissioners for all three counties; primary care providers including Group Health, Doctors Clinic, Volunteers in Medicine of the Olympics Clinic, Harrison Health Partners, and Tribal health clinics; and Tribal Council members. Immediately following the launch, Safe Harbor Recovery Center, Olympic Educational Services District 114, and Jefferson Mental Health, volunteered to serve on the COH Steering Committee.

During the first six months of the grant, the Steering Committee will develop a formal engagement strategy, using HCA's Attachment A: "Potential ACH Partners" as a resource for identifying additional potential sectors.

b. To the extent possible, indicate if there is a sense of urgency in your region around health improvement, including commitment from champions who are willing to make a commitment to addressing the issue. Have you identified any relevant successes or barriers?

Significant transitions in the financing and structure of the health care system stemming from Medicaid expansion, value-based Medicare hospital payments, Health Information Technology for Economic and Clinical Health Act compliance, and the proposed restructuring of Medicaid reimbursement as part of the Washington State Healthcare Innovation Plan have stimulated a sense of urgency to improve health coordination and service in response to these critical changes. Partners share a concern for health improvement among vulnerable populations, particularly in light of ongoing reductions in public health funding including potential additional reduced public health funding pending legislative response to the McCleary decision. Current and proposed changes to the health care system have created both barriers and successes to improving health in our community. Barriers to be addressed to improve health include a shortage of mental health and chemical dependency providers to respond to increased patient loads, limited boarding placements for inpatient psychiatric care, and potential restricted investments in public health preventive care services. Successes and opportunities include effective community engagement in each county's CHIP; overlapping health priorities from the processes across the three counties; a multi-sector commitment among tribal governments, clinics, and public health entities to chronic disease prevention within the region; and the establishment of the tri-county ACH through dedicated champions on the Steering Committee.

c. Please list the sectors and stakeholders currently engaged in your community partnership, including any committees or workgroups they are engaged in.

<u>Steering Committee</u>:

- Public Health and Health/Human Services: Kitsap Public Health District, Kitsap County Human Services Department, Jefferson County Public Health, Clallam County Health and Human Services
- Behavioral Health and Chemical Dependency Providers: Kitsap Mental Health Services, Jefferson Mental Health Services, Safe Harbor Recovery
- Primary Care Providers: Peninsula Community Health Services
- Schools: Olympic Educational Service District 114
- Community Action Programs: Kitsap Community Resources

Other Sectors/Stakeholders Attending Meetings:

- Hospitals and Primary Care: CHI Franciscan Health Harrison Medical Center, Olympic Medical Center, Jefferson Healthcare, Group Health Medical Centers
- Housing: Bremerton Housing Authority, Peninsula Housing Authority
- Aging: Olympic Area Agency on Aging
- Behavioral Health and Chemical Dependency Providers: Peninsula Behavioral Health, Kitsap County Substance Abuse Coalition, West End Outreach Services
- Community Action Programs: Olympic Community Action Programs

d. If not included above, please provide a list of the sectors that are expected to engage in your community partnership in the future. How do you propose to engage them?

Additional sectors whom we would like to engage in the Olympic COH include tribal governments, local and regional food policy councils, free clinics and dental providers, health plans, law enforcement, criminal justice, community wellness programs, home health organizations, long-term care, providers who care for persons with disabilities, early learning providers, faith-based organizations, and community members and consumers. We propose to engage new partners by leveraging our existing relationships and networks in the community, including those established through our community health improvement process networks, agency boards, hospital advisory groups, and local and regional networks and coalitions.

e. Please describe the existing or planned community mobilization plan, including the bidirectional process to inform and learn from activities across the region and in individual communities.

The Steering Committee will develop a community mobilization plan as part of this project. This plan will integrate the expertise of public health partners in mobilizing community responses to priorities identified through CHIPs in all three counties. This work is founded on bidirectional communication between public health and community members.

f. Please describe strategies to engage underserved and underrepresented communities/populations within your region.

Initial engagement of underserved and underrepresented communities within the three-county region will require us to first identify these sectors using health status data, assets mapping, and review of “missing” partners within the Olympic COH. These sectors will be invited to not only become members of the Olympic COH, but to engage in leadership opportunities within the structure. Targeted outreach to underserved and underrepresented communities will likely include: long term care providers, tribal members and health care providers, early learning providers, teachers, and non-profit agencies serving immigrant populations. We will proactively engage consumers in governance and advisory capacities. Our three-county region is uniquely positioned to partner with citizen groups following the very effective implementation of a collaborative “in-person assister” program to enroll community members in health insurance coverage.

g. Please describe strategies you will employ to engage health care consumer populations in your efforts.

The COH will form an Ad Hoc Community Advisory Group to provide feedback on all aspects of the COH’s work. The Community Advisory Group will include health care consumers and others with technical expertise in specific health care topic areas. Over time, the COH may consider utilizing community health workers as staff members of the system to better engage and serve health care consumers, especially those in vulnerable populations. The COH will also leverage existing mechanisms used by sector partners to communicate with their clients, e.g., websites, newsletters, etc., to further engage consumer populations.

h. In light of recently established RSAs (Attachment F), please describe your partnership’s recent efforts to consider or begin the development of a Regional Health Needs Assessment or inventory of existing assessments. Please include a description of the relationship to elements to be included in the Community of Health Plan (if applicable). If you have not begun the effort, describe what your first steps would be.

Each county has completed a CHIP resulting in the identification of health priorities for that county. The first step in the development of a Regional Health Needs Assessment was to identify common priorities and present these to attendees at the Olympic COH launch in November 2014. Shared priorities among the three counties include: improve access to care and having a medical home; chronic disease prevention through nutrition and physical activity promotion; and improved mental health care and access to services. During the grant period, partners will identify how the Regional Health Needs Assessment will develop from these shared priorities.

i. How will you engage existing regional and/or local collaborative efforts within your RSA? If there is an existing COH within your RSA, how will you partner and engage with this entity to promote cross regional collaboration and coordination, including alignment with their COH plan?

The Olympic COH represents the same geographic region as the Peninsula RSA. There is only one RSA in the COH, and only one COH in the RSA. There are a great number of regional and local collaborative efforts across our RSA that further specific issues among multiple partners, such as the Workforce Development Council, Olympic Educational Services District Early Learning Coalition, and many others, as well as county specific partnerships and collaborations. The members, current and future, of the Olympic COH are participants in these various local and regional partnerships, and thus can bring the work of these many collaborations to the attention of the COH Steering Committee and Board for coordination and alignment.

4. **Backbone Support: the necessary administrative and coordinating functions and processes that support the partnership. Refer to Attachment A for additional information.**

   a. **If applicable, please describe your partnership's recent efforts to implement or develop a backbone support function or shared functions, including the relationship with the governance and engagement models.**

   To date, backbone support for the COH has been informal. The COH Steering Committee has set up a web communication tool, and regional stakeholder email and mailing lists. Several Steering Committee members stepped up to organize and accomplish the first meeting of the Olympic COH in Port Townsend on November 7, 2014. KMHS , PCHS, KPHD, KCHS, and KCR agreed to provide preliminary funding for the meeting facilitator and project consultant, Dale Jarvis. The Steering Committee has also discussed recommendations for the planned backbone support functions identified in Exhibit B, Section 4.b.

   b. **Please describe the existing or planned backbone support for the partnership. If these functions are or will be shared or subcontracted, please describe this process and identify the contributing organizations. Washington State Page 23 of 44 GOA #14-028 Health Care Authority**

   The Olympic COH anticipates that the backbone structure identified for the partnership will evolve over time. The backbone entity will provide overall strategic coherence, as well as administrative support functions for the COH, including organizational, logistical, and data support. The backbone entity will supply overall project and financial management, work to produce grant deliverables, work to engage core stakeholders, and convene, facilitate, and record and distribute minutes for COH meetings. The backbone entity will also organize learning events and support the work of the COH's various committees and groups. Over time, the backbone entity will support efforts to acquire additional financial resources for the COH with oversight provided by the COH Board and Steering Committee.

   Additionally, the backbone entity is responsible for communications with stakeholders and the general public. This later function may include maintaining the COH website, preparing and distributing publications regarding the work of the COH, and potentially providing social media communication and engagement opportunities.

The Olympic COH has not yet formally established and operationalized a neutral backbone support structure for the COH. The Steering Committee has identified a Year One backbone structure during the first month of the grant as follows:

- Kitsap Public Health District: Would provide primary backbone support functions including serving as the fiscal agent for the design grant, providing a staff epidemiologist for assessment and data support, in-kind office space for contract staff, in-kind business support for consultant contracting, and other in-kind administrative support as described below.

- Kitsap County Human Services Department: Would provide communications support and planning including website, meeting notices, newsletters, and other communications as needed.

Staffing for the backbone entity will include:

- Project Manager (Contract Staff): Responsible for providing leadership and support for the entire COH collective, overseeing the day-to-day work of the COH, and managing the work of the COH's contractors and staff. The Project Manager will also lead efforts to strengthen stakeholder participation and outreach and serve as the primary liaison between the COH and State partner agencies. Meeting facilitation will also initially be provided by the Project Manager, assisted by staff. The Project Manager will work under a contract administered by the KPHD, and would report preliminarily to the Steering Committee until the Board is established. The Steering Committee will be the recruitment and hiring entity for this position.

- ACH Implementation Consultant (Contract Staff): The COH plans to continue to a sole-source contract with Dale Jarvis for specialized expertise related to the design and implementation of the COH, and for Medicaid expertise. The contract will be administered by the KPHD with contract work managed by the Project Manager.

- Epidemiologist (Kitsap Public Health District Staff): The Epidemiologist is responsible for overseeing monitoring and evaluation functions in support of work plan implementation and modification. This position will provide ongoing data tracking and analysis support required for development of the Regional Health Needs Assessment. The Epidemiologist will provide contract support to the COH, working in collaboration with the Project Manager.

- Administrative Support Staff (Kitsap Public Health District Staff): In-kind clerical and fiscal administrative support will be provided by the KPHD. Staff will work in collaboration with the Project Manager.

c. Please describe the distinction between the backbone support function and the governing body, including safeguards that are in place to protect any organization or sector from dominating the agenda.

Backbone support exists to facilitate administrative, operations, and communication functions that the governing and decision-making body require to achieve its goals. The Olympic COH Board will serve as the governing body for the COH. In developing the governance structure and specific backbone services, the Board will ensure that appropriate safeguards are in place to assure that decision making is broadly representative of the all stakeholders and not dominated by specific sectors. It is initially proposed that the COH Project Manager and project consultants, although potentially housed at the KPHD, will report directly to the Olympic COH Board, not the backbone agency which will either participate as a member of, or be represented on, the Board. It is also proposed that outside consulting support be managed by the Project Manager, not KPHD. Other backbone services and functions provided by KPHD and KCHS will be coordinated directly with the Project Manager, with overall direction provided by the Board.

d. To what extent has the partnership assessed and subsequently tapped the strengths and assets of those partnering entities?

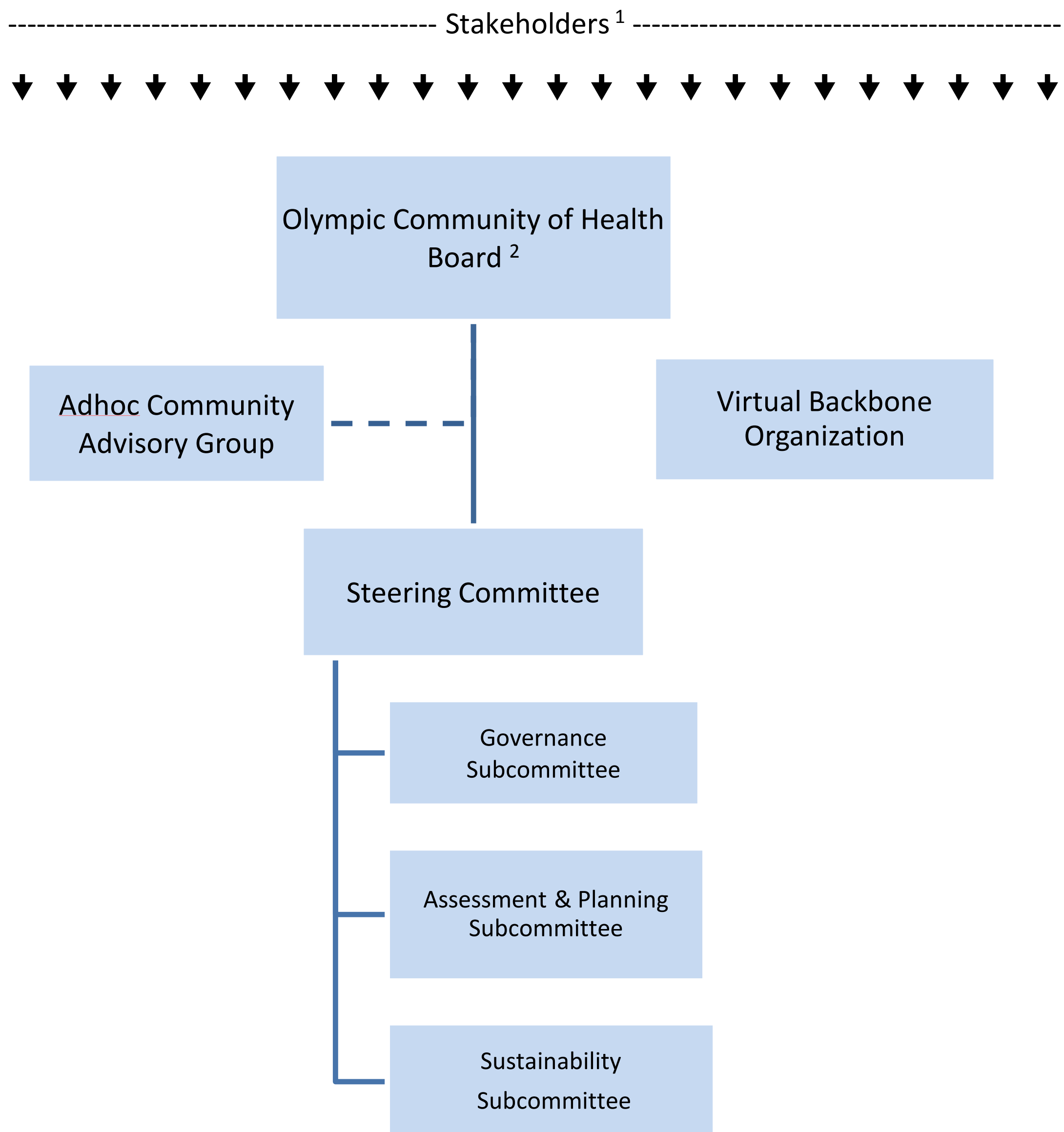
The existing partnership has informally assessed the strengths of its partners and leveraged each partner's expertise to reach this point in development of the Olympic COH. KPHD is a regional public health leader in data management and analysis, capable of handling complex funding opportunities, and is generally viewed as a neutral convener for the next stage of the project. JPHD and CCHHS have robust relational and programmatic ties to Tribal partners, and local hospitals and clinics. KCHS has effectively managed communications for the initial stages of the development of the COH, and along with KMHS and PCHS, brings considerable expertise in understanding the complexities of Medicaid. Kitsap Community Resources (KCR), Kitsap County's Community Action Program, brings an intimate knowledge of issues affecting low-income families, and is seasoned in providing direct service to a broad range of vulnerable sectors. In short, members both individually and collectively recognize that we must rely on each other's expertise and assets in order to move the Olympic COH forward, especially as we begin designing a governance and accountability structure.

5. Governance and Operational Image:

a. **Please provide a visual representation of your community partnership's governance structure and backbone support, and please indicate whether this is an existing or planned structure. This visual should identify the decision-making council or committee, sub-committees, community engagement functions, the operational arm or shared operational functions, etc. Please insert within this section or add as an attachment.**

Provided below (next page) is an operational image of the Olympic Community of Health's planned governance structure and backbone support. Detailed descriptions of the Board, Steering Committee, Ad Hoc Committee Advisory Group and the various subcommittees is provided in Section 2.d., and a description of the backbone support is provided in Section 4.b.

Olympic Community of Health



[1] Olympic Community of Health Stakeholders from all sectors, including consumers, will populate organizational entities.

[2] Olympic Community of Health Stakeholders will initially be tasked with approving the governance structures for the COH. Once that work is completed, the Board will be formed and will serve as the governing entity as described in Exhibit B, Section 2.d.

6. **Sustainability and Support:**

   a. **Please describe the level of existing community support and commitment, inside and outside of the partnership.**

   Steering Committee members have already committed a considerable amount of time, as well as finances to fund technical consultation, to the planning and development of this partnership. With formal backing by the county commissioners from each of the three counties, KPHD, JPHD, CCHHS, KCR, PCHS, KMHS, and KCHS are dedicated to carefully developing and expanding the Olympic COH. A number of additional community partners have indicated an interest in becoming involved in the development of the COH, including but not limited to representatives from education, housing, hospital, community clinic, long-term care, chemical dependency, and behavioral health sectors.

   b. **Please demonstrate how you have sought and captured participant resource commitment.**

   The Steering Committee members to date have responded to fiscal requirements on an as-needed basis, including covering the cost of hiring of a consultant, communications, website development, meeting space and refreshments. Additionally, several agencies have committed considerable staffing time to the development of the COH to date.

   c. **Please describe any in-kind support that is or will be provided, including the types of organizations providing support.**

   Currently, KPHD and KCHS have volunteered to provide a portion of the matching funds needed to support the work of the COH in 2015. Currently, other Steering Committee members are being asked to consider their ability to provide additional matching funds or in-kind to this project necessary to support the proposed 2015 budget. In addition to direct financial support, KPHD will also provide in-kind office space for the Project Manager and in-kind administrative and fiscal support to manage the grant. Half the cost of an Office Specialist to provide ACH communications support will be covered by KCHS. Overall, in 2015, matching funds or in-kind will need to be provided by Steering Committee members or other stakeholders to cover the estimated $5,000 cost for needed supplies and event expenses, a portion of the cost of the Project Manager, and all of the cost for the ACH Implementation Consultant. The estimated total cost for the Project Manager is $108,000 in 2015. Matching funds or in-kind support will be needed to cover an estimated $35,770 of this cost for the Project Manager (approximately 33% of the cost). The estimated cost for the ACH Implementation Consultant in 2015 is $9,000.

d. Please describe the extent to which any discussions or agreements have been sought to share data and/or resources.

KPHD collects all communicable disease data for the tri-counties and facilitates the data analyses and presentations for community health improvement processes in each county. The three public health entities within each county have data sharing agreements between them. Additionally, electronic data sharing agreements exist across counties within behavioral health and primary care sectors.

e. Please describe the level of existing or anticipated community support to promote the partnership (e.g., philanthropy).

The Olympic COH has not solicited funding from philanthropic partners to date, though this will likely be a component of our sustainability plan. Members have identified potential philanthropic partners, including Building Changes, Group Health Foundation, Murdock Foundation, Regence Foundation, Kitsap Community Foundation, Olympic Foundation, Centers for Disease Control, and other federal grants. During the design period, project staff will work with the Steering Committee to further research funding avenues and solicit funds appropriately.

f. Please demonstrate existing involvement of philanthropy within your partnership.

None at this point.

EXHIBIT C.2
WORK PLAN AND TIMELINE

Deliverable	Objectives	Activities	Tracking Methods	Milestones/Timelines
1. ACH governance model that represents the entire RSA	1.1. Adopt governance model to represent the three-county RSA/ACH.	Steering Committee forms Governance Subcommittee and Assessment and Planning Subcommittee.	Steering Committee minutes.	Governance Subcommittee formed in Month 1; Assessment and Planning Subcommittee formed in Month 2.
		Governance Subcommittee identifies and reviews existing governance models.	Governance Subcommittee meeting minutes.	Governance model research and priority identification occurs within Months 1 and 2.
		Governance Subcommittee recommends governance structure to Stakeholders for approval.	Stakeholder meeting minutes.	Stakeholders convened to review governance model recommendations in Month 3.
		Stakeholders approve formal governance structure.	Stakeholder meeting minutes and final COH Governance Structure document.	Final governance structure adopted by Stakeholders in Month 4.
		Stakeholders form Board.	Stakeholder meeting minutes.	Voluntary Board formed in Months 4 and 5.
		Board forms Sustainability Subcommittee.	Subcommittee meeting minutes.	Board forms Sustainability Subcommittee in Month 6.
	1.2. Adopt formal legal documentation to create the ACH.	With input from staff, consultants, and legal counsel, the Governance Subcommittee recommends legal COH structure to Board for discussion.	Board meeting minutes.	Board convened to review governance model recommendations in Month 6.
		Board adopts formal legal structure for the COH.	Board meeting minutes.	Final legal governance structure adopted in Month 8.
		Board develops and adopts formal by-laws and articles of incorporation, if needed.	Board meeting minutes.	Documents completed in Months 10 - 12.

Deliverable	Objectives	Activities	Tracking Methods	Milestones/Timelines
2. ACH Engagement Strategy	2.1 Meaningfully engage a diverse representation of stakeholders in the ACH, including unrepresented and underrepresented stakeholders.	Steering Committee Identifies stakeholders "missing" from the COH Stakeholder list using HCA recommendations as template.	Steering Committee meeting minutes. Recommended participant lists.	Identify missing stakeholders in Months 1 and 2.
		Stakeholders leverage existing relationships to expand outreach to missing stakeholders, including unrepresented and underrepresented stakeholders, not engaged in the COH process.	Meeting sign-ins.	Conduct outreach to unrepresented stakeholders within Months 2 and 3.
		Staff develop accountability structures and engagement plan within COH.	Draft documents completed.	Draft accountability structures and engagement plan completed in Month 3.
		Staff present accountability structures and communication plan to Steering Committee and Board.	Meeting minutes.	Steering Committee and Board review draft accountability structures and engagement plan in Month 4.
		Board approves accountability structures and engagement plan within COH.	Meeting minutes.	Board adopts accountability structures and engagement plan in Month 6.
		Steering Committee makes recommendation to Board on structure for an Ad Hoc Community Advisory Group.	Steering Committee meeting minutes.	Board convened to review Ad Hoc Group recommendations Month 6.
		Board adopts structure for an Ad Hoc Community Advisory Group and forms the Group.	Board meeting minutes.	Final Ad Hoc Group structure adopted by Board in Month 7 and Group formed in Months 8 and 9.

Deliverable	Objectives	Activities	Tracking Methods	Milestones/Timelines
3. Capacity Development, including the backbone support needed for community engagement and community mobilization	3.1. Kitsap County establishes communications support for the COH.	Expand and maintain stakeholder contact lists.	Stakeholder lists completed (and maintained).	Complete in Month 1, with updates ongoing.
		Initiate monthly COH newsletter for stakeholders and others.	Newsletter initiated.	Initiated in Month 2; ongoing.
		Launch community COH website.	Website launched.	Developed in Month 4; ongoing.
		Create inventory of existing stakeholder communications used for consumer outreach.	Inventory completed.	Complete in Month 5.
		Develop more comprehensive COH Communication Plan and present to the Board for approval.	Board meeting minutes.	Complete in Month 5 and 6
		Board adopts COH Communication Plan.	Board meeting minutes.	Complete in Months 7 and 8.
	3.2. Staff and Steering Committee support ongoing shared learning opportunities for the Board.	Schedule and complete regular shared learning opportunities for the Board.	Board meeting minutes.	Ongoing.

Deliverable	Objectives	Activities	Tracking Methods	Milestones/Timelines
4. Development of the backbone support within the ACH, including community support and endorsement	4.1. Establish and operationalize the neutral backbone support structure for the COH.	Steering Committee supports grant-funded epidemiological support services and other services provided by the Health District, and communications support provided by Kitsap County.	Meeting minutes.	Initiate Health District backbone support services in Month 1.
		Kitsap Public Health contracts with Project Manager.	Contract approved.	Steering Committee recruit and contract with Project Manager in Month 2.
		Kitsap Public Health contracts with COH Implementation Consultant.	Contract approved.	Approve consultant contract in Month 2.
		Kitsap Public Health subcontracts with Kitsap County to provide communications support for the COH.	MOU approved.	Approve MOU in Month 2.

Deliverable	Objectives	Activities	Tracking Methods	Milestones/Timelines
5. Regional Health Needs Inventory to reflect the RSA and plans to create a Regional Health Improvement Plan	5.1. Establish a Regional Health Needs Inventory and health prioritization process which builds from individual county Community Health Improvement Processes in all three counties.	Staff research Regional Health Needs Inventory and processes and determine recommendations for approach.	Community Health Improvement Processes in region documented.	Complete report in Month 3.
		Staff present to the Steering Committee and the Board an overview of each county's community health improvement process and common priorities.	Steering Committee meeting minutes. Board meeting minutes.	Recommend Regional Health Needs Inventory process to Steering Committee and Board members and process adopted in Month 4.
		Board approves Regional Health Needs Inventory process which uses shared health priorities by all three counties to inform regional health priorities.	Meeting sign-ins.	Board approval in Month 5.
		Staff conduct Regional Health Needs Inventory.	Regional Health Needs Inventory completed.	Conduct Regional Health Needs Inventory Months 6 – 9 and complete Month 10.
	5.2 Complete Regional Health Improvement Plan.	Identify shared regional priorities and strategies and present to Board.	Board meeting minutes.	Shared regional priorities and strategies presented to Board in Months 10-11.
		Identify regionally-shared actions and present to Board.	Board meeting minutes	Shared regional actions presented to Board in Months 10-11.
		Identify milestones and performance measures for strategies and actions and present to Board.	Board meeting minutes.	Milestones and performance measures for strategies and actions presented to Board in Months 10-11.
		Board approves Regional Health Improvement Plan.	Approved Regional Health Improvement Plan completed.	Regional Health Improvement Plan completed in Month 12.

Deliverable	Objectives	Activities	Tracking Methods	Milestones/Timelines
6. Initial plan for sustainability	6.1 Develop a preliminary COH Sustainability Plan.	Board forms a COH Sustainability Subcommittee.	Board meeting minutes.	Sustainability Subcommittee formed Month 6.
		Use data from the Regional Health Improvement Plan process to identify Triple Aim initiatives that the COH could sponsor through the Backbone Organization.	List of Triple Aim priorities completed.	Identify priorities in Months 7-8.
		Develop a preliminary cost savings analysis based on the initiatives that could support COH sustainability.	Financial analysis completed.	Financial analysis completed in months 8-9.
		Staff and Steering Committee assess stakeholder commitment to provide funding to the COH.	Potential funders list completed.	Identify priority funding opportunities in Month 8.
		Identify priority funders to provide funding support to COH for Years 2 and 3.	Steering Committee meeting minutes.	Priority funders identified in Month 10.
		Pursue outside grant/donation support for the COH.	Grant applications and request for funding letters submitted.	Staff and Steering Committee solicit funding Months 4–12.
		Complete preliminary Sustainability Plan with funders, funding structure, and timelines included.	Preliminary Sustainability Plan adopted by Board.	Preliminary Sustainability Plan Adopted in Month 12.

Deliverable	Objectives	Activities	Tracking Methods	Milestones/Timelines
7. ACH Readiness Proposal	7.1 Identify deliverables necessary to achieve ACH designation for the Olympic COH.	Working with HCA, Steering Committee and staff build from the work plan to identify deliverables necessary to demonstrate ACH functionality.	Meeting minutes and Committee decisions. Preliminary ACH Readiness Proposal completed.	Prepare preliminary ACH Readiness Proposal by Month 8.
	7.2 Complete written ACH Readiness Proposal.	Steering Committee and staff conduct ongoing monitoring and evaluation of progress towards deliverables identified in the work plan necessary to position the Olympic COH as a designated ACH.	Meeting minutes and monitoring reports.	Complete monitoring and evaluation by Month 11.
		Steering Committee and staff complete final ACH Readiness Proposal.	ACH Readiness Proposal completed.	Complete final ACH Readiness Proposal by Month 12.

EXHIBIT D
BUDGET

Budget Line Item	Design Grant Budget	Matching Funds Estimate	Total Budget
1. Personnel *(Internal Staff)*	$ 15,000	$ 0	$ 15,000
2. Fringe Benefits *(Internal Staff)*	$ 4,300	$ 0	$ 4,300
3. External Consultants/Contracts: A. **Project Manager**	$ 72,230	$ 35,770	$ 108,000
B. **ACH Implementation Consultant**	$ 0	$ 9,000	$ 9,000
C. **Office Specialist (Communications)**	$ 1,600	$ 1,600	$ 3,200
4. COH / Backbone Sub-award(s)	$ 0	$ 0	$ 0
5. Travel	$ 2,000	$ 0	$ 2,000
6. Supplies	$ 0	$ 1,000	$ 1,000
7. Event Expenses	$ 0	$ 4,000	$ 4,000
8. Other (e.g., community / regional initiative)	$ 0	$ 0	$ 0
Total Direct Costs	**$ 95,130**	**$ 51,370**	**$ 146,500**
Indirect*	**$ 4,870**	**$ 0**	**$ 4,870**
Total (Direct & Indirect)	**$ 100,000**	**$ 51,370**	**$ 151,370**

* Includes indirect costs for the Epidemiologist (rate applied to salary only). No indirect costs included for external consultants.

Budget Narrative:

The budget narrative should provide clear linkages between the work plan (Exhibit C) and the budget (Exhibit D).

1. **Personnel (Internal Staff)**
   - ***KPHD Epidemiologist*** (Siri Kushner, 0.2 FTE, $15,000): The Epidemiologist will take a key role in development of the regional health needs assessment, building from her previous expertise facilitating the community health improvement process for each county in the region. She will work with core stakeholders to gather, analyze and present data to COH participants as part of the regional health needs assessment, and assist in the health prioritization process for the COH. The personnel cost will be covered by the grant.
   - ***KPHD In-Kind Staff Support:*** will also provide in-kind project support and management for this design grant, contributing in-kind fiscal and administrative support, and office space for the Project Manager. This in-kind cost is <u>not</u> included in the budget.

2. **Fringe Benefits (Internal Staff)**
   - ***KPHD Epidemiologist*** (Siri Kushner, 0.2 FTE, $4,300): Fringe benefits for the KPHD Epidemiologist include health insurance, retirement benefits, and life insurance and are calculated at 28.6% of personnel costs, or $4,300, for the Epidemiologist during for the project period. Cost will be covered by the grant.

3. **External Consultants/Contracts**
   - ***Project Manager*** (20 hours/week @ $150/hour for 9 months = $108,000): Provides leadership and support for the entire COH collective, overseeing the day-to-day work of the COH, and managing the work of the COH's contractors and staff. This position works closely with the Board, Steering Committee, subcommittees, and consultants in the development and implementation of the work plan and community engagement plan, as well as completing grant reporting requirements. This position will provide assistance to the Board and Steering Committee in development of the ACH Readiness Proposal. The Project Manager will also lead efforts to strengthen stakeholder participation and outreach and serve as the primary liaison between the COH and State partner agencies. Meeting facilitation will also initially be provided by the Project Manager, assisted by staff. The Project Manager will work under a contract administered by the KPHD, and will report preliminarily to the Steering Committee, and after that will report to the Board when the Board is established. Consultant cost will be covered partially by the grant and partially by matching funds.

- ***ACH Implementation Consultant**, Dale Jarvis* (40 hours total @ $225/hour = $9,000): The COH Implementation Consultant will provide specialized expertise related to the design and implementation of the COH, and for Medicaid expertise. The contract will be administered by KPHD with contract work managed by the Project Manager. Consultant cost will be covered by matching funds.

- ***Kitsap County Office Specialist, Communications Support*** (10 hours per month for 10 months @ $32/hour = $3,200): The Office Specialist, an employee of Kitsap County, will provide communications support including website development and maintenance, meeting notices, newsletters, and other communications as needed. Half the cost will be covered by the grant and half the cost will be covered by Kitsap County.

4. **COH/Backbone Sub-Award(s)**
   KPHD will provide the backbone support for this grant, and no sub-awards are anticipated.

5. **Travel**
   Travel expenses will be incurred by internal staff and contractors who travel to meetings. Mileage costs will be reimbursed at the IRS rate and are estimated to be $2,000. Cost will be covered by the grant.

6. **Supplies**
   Includes office and meeting supplies based on actual costs. The estimated $1,000 cost will be covered by matching funds.

7. **Event Expenses**
   Costs for meeting space, refreshments, and miscellaneous other event-related expenses for regular monthly Board meetings, and other meetings as needed. The estimated $4,000 cost will be covered by matching funds.

8. **Other**
   N/A

9. **Total Direct Costs**
   Total direct costs for the project period amount to $146,500, with $51,370 covered through matching funds by partners, resulting in a direct costs request of $95,130.

10. **Indirect**
    Indirect costs are calculated at 32.45% of total personnel costs, excluding fringe benefits, for the KPHD Epidemiologist. For the project period, total indirect costs are estimated at $4,870 which will be covered by the grant.

11. Total (Direct & Indirect)

The combined direct and indirect costs of this project for the project period amount to $151,370.

12. Matching Funds Estimate

Matching funds in the amount of $51,370 will be provided by Steering Committee members to cover expenses in excess of the grant funds.

EXHIBIT F
CERTIFICATIONS AND ASSURANCES
GOA #14-028 – ACH Pilot and Design Grants

I/we make the following certifications and assurances as a required element of the Application to which it is attached, understanding that the truthfulness of the facts affirmed here and the continuing compliance with these requirements are conditions precedent to the award or continuation of the related contract(s):

1. I/we declare that all answers and statements made in the Application are true and correct.

2. In preparing this Application, I/we have not been assisted by any current or former employee of the state of Washington whose duties relate (or did relate) to this Application or prospective contract, and who was assisting in other than his or her official, public capacity. Neither does such a person nor any member of his or her immediate family have any financial interest in the outcome of this Application. (Any exceptions to these assurances are described in full detail on a separate page and attached to this document).

3. I/we understand that the HCA will not reimburse me/us for any costs incurred in the preparation of this Application. All Applications become the property of the HCA, and I/we claim no proprietary right to the ideas, writings, items, or samples, unless so stated in this Application.

4. No attempt has been made or will be made by the Applicant to induce any other person or Applicant to submit or not to submit an Application for the purpose of restricting competition.

On behalf of the firm submitting this Application, my name below attests to the accuracy of the above statements.

____
Signature of Applicant

ADMINISTRATOR 1-8-15
____
Title Date

EXHIBIT G

AUGUST 13, 2014 LETTER FROM COUNTY COMMISSIONERS TO HCA AND DSHS IN SUPPORT OF A THREE-COUNTY RSA AND ACH CONFIGURATION

Clallam County
Mike Chapman, Chair
Mike Doherty
Jim McEntire

Jefferson County
John Austin, Chair
Phil Johnson
David Sullivan

Kitsap County
Charlotte Garrido, Chair
Robert Gelder
Linda Streissguth

August 13, 2014

Dorothy Teeter, Director, Washington State Health Care Authority
PO Box 45502
Olympia, WA 98504

Jane Beyer, Assistant Secretary, Washington State Department of Social and Health Services
PO Box 45050
Olympia, WA 98504

Dear Ms. Teeter and Ms. Beyer:

In May 2014, the Washington State Health Care Authority (HCA) announced the availability of planning grants for groups of counties and tribes interested in pursuing Accountable Community of Health (ACH) designation under Washington State's Health Care Innovation Plan. The timeline of these grant applications was exceedingly brief, with one week to submit a letter of intent and less than three weeks to complete a grant application. Jefferson County Public Health submitted a letter of intent for a Jefferson/Clallam ACH with the possible addition of Kitsap County. However, with insufficient time to involve relevant stakeholders, the ACH application was not submitted.

Clallam and Jefferson Counties elected to participate in CHOICE's Cascade Pacific Action Alliance for the planning period July 1, 2014 to December 31, 2014; Kitsap Public Health District indicated they would explore the possibility of involvement. Kitsap, Clallam, and Jefferson Counties viewed this participation as a time-limited community health planning activity carrying no commitment to seek designation as a 10-county ACH. Kitsap, Clallam, and Jefferson Counties never intended this participation as a commitment to join a 10-county ACH.

2SSB 6312, passed by the Washington State Legislature in 2014, calls for the creation of regional service areas within the State for the purchasing of behavioral health and chemical dependency treatment services to be known as Behavioral Health Organizations (BHO), replacing the current system of Regional Support Networks (RSN). The County Commissioners of Clallam, Jefferson, and Kitsap Counties understand the need for the reorganization mandates under 2SSB 6312 and support the formation of "common regional service areas" that would make the geographical

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boundaries of BHOs and ACHs identical. The Boards of County Commissioners of Kitsap, Clallam, and Jefferson Counties oppose creation of either a 10-county ACH or BHO that involves their counties, as do numerous health and social service providers spanning our three county region. We are aware that this July, the Adult Behavioral Health System Task Force voted to adopt the Washington State Association of Counties' (WSAC's) recommendation reaffirming the existing three-county Peninsula Regional Support Network boundary. We applaud adoption of this recommendation, and again affirm our support for a three-county ACH and BHO with the same boundaries of the RSN it is replacing – Kitsap, Clallam, and Jefferson Counties.

We understand the purpose of Regionalization of Medicaid Purchasing and Community Mobilization is to ensure a common regional approach that: 1) aligns state efforts across common regions, 2) recognizes that health and health care is local, 3) promotes shared accountability within each region for the health and well-being of our residents, and 4) empowers local and county entities to develop a "bottom-up" approach to transformation that applies to community priorities and environments. We do not believe a ten-county region can provide for the local priorities setting process and recognition that health and health care is local. We do believe our history of shared networks and formal tri-county councils is consistent with effective regional planning and implementation efforts. Much of our region is rural in nature, posing special challenges associated with health care workforce shortages and populations that are older, sicker, and poorer than their urban counterparts. Kitsap, Clallam, and Jefferson Counties have a long history of working collaboratively on these issues through innovative community health partnerships involving our public health departments, hospitals, Tribal governments, and health care providers. These existing partnerships will prove crucial as we pursue the goals of the Triple Aim throughout our region.

With the stated goal of HCA and DSHS to promote development of regions that contain a sufficient number of "Medicaid covered lives" to allow full financial risk contracting at a recommended minimum of 60,000 Medicaid enrollees per Regional Service Area, our three-county rural and suburban areas combined are sufficient to meet this goal. Ultimately, existing health care delivery systems, established provider networks, referral and travel patterns, and geographic accessibility factors are the most important determinates of a successful regional partnership.

Consistent with our State's vision for health care innovation, we are actively engaging in an ACH planning process for our tri-county area. Should a second round of ACH funding opportunities become available, we will pursue that funding, however, we do not want award of a planning grant to preclude our intent to move forward. As a region, we are committed to convening stakeholders, leading health improvement activities, strengthening partnerships with state and local jurisdictions, acting in alignment with statewide healthcare initiatives, and using collective impact principles to make a three-county ACH successful.

We hereby urge DSHS and HCA to support our decision to form a Kitsap, Clallam, and Jefferson regional service area. Moreover, when the time arrives in 2015 to designate ACH configurations, we also support this three-county configuration as the basis of an ACH for our region.

Sincerely,

Charlotte Garrido, Chair
Kitsap County Board of Commissioners

Michael C. Chapman, Chair
Clallam County Board of Commissioners

John Austin, Chair
Jefferson County Board of Commissioner

cc: Eric Johnson and Abby Murphy - Washington State Association of Counties
Adult Behavioral Health System Taskforce
Nathan Johnson, Washington State Healthcare Authority
MaryAnne Lindeblad, Washington State Healthcare Authority