Olympic
COMMUNITY of HEALTH

November 20, 2015

Mr. Chase Napier
Community Transformation Manager
Office of Health Innovation and Reform
Washington State Health Care Authority
P.O. Box 42710
Olympia, WA 98504-5502

Dear Mr. Napier:

On behalf of the Olympic Community of Health, it is our pleasure to submit the enclosed Accountable Community of Health (ACH) Readiness Proposal in response to the Framework for the ACH Readiness Proposal document dated June 15, 2015. Both our governing body, the OCH Interim Leadership Council, and our backbone organization, the Kitsap Public Health District, have reviewed and approved the submittal documents put forward to demonstrate our readiness and our request for designation as an Accountable Community of Health for the Olympic Region.

Documents for your review include the following:

- Table of Contents
- Category 1: Governance Structure
  - ✓ Demonstration of interim operational structure
  - ✓ Plan for testing and adjustment
- Category 2: Governing Body Membership
  - ✓ Reflects balanced, multi-sector engagement
  - ✓ Process for adjustments to changing environment
- Category 3: Community Engagement
  - ✓ Activities underway and planned
- Category 4: Backbone Functions
  - ✓ Fiscal and administrative functions established
  - ✓ Demonstrate accountability to ACH
  - ✓ Process for evaluation and confirmation of backbone
- Category 5: Approach to Regional Health Improvement Plan
  - ✓ Priority areas and strengths identified as part of regional needs inventory and assessment development
  - ✓ Initial regional health improvement plan process identified
- Category 6: Budget and Sustainability
  - ✓ 2016 operating budget established
  - ✓ Sustainability planning strategy documented
- Summative Narrative

Questions regarding this application may be directed to: Scott Daniels, Administrator, Kitsap Public Health District: scott.daniels@kitsappublichealth.org, 360-337-5287.

We believe the Olympic Community of Health has created a strong foundation for collaboration on regional health improvement in partnership with the State. We thank you for consideration of our request for designation as the Olympic Community of Health.

Sincerely,

Scott Daniels	Rochelle Doan	Barbara P. Malich
OCH Grant Administrator	OCH Project Manager	OCH Project Manager

Olympic COMMUNITY of HEALTH

Accountable Community of Health Readiness Proposal

Regional Vision, Local Action

Better Health. Better Care. Lower Cost.

Table of Contents

Narrative

The following is a description of the various documents that make up the Readiness Proposal for the Olympic Community of Health (OCH). Each category included is introduced with a summary explaining the manner in which our region has met the minimum requirements as described in each category. Supporting documents follow the summary, and each document is briefly introduced to clarify the relationship of the document to its respective category. For a complete listing of all supporting documents, please refer to the Table of Contents.

Category 1: Governance Structure

Demonstration of operational governance structure, interim or otherwise, includes a plan for testing/adjustment.

The individuals involved in the initial formation of an Olympic Community of Health have worked diligently for 16 months in bringing Clallam, Jefferson and Kitsap stakeholders together to create a three-county Accountable Community of Health (ACH). Since its conceptualization in July 2014, a group of nine individuals representing eight agencies participated in monthly planning calls to set the stage for the first tri-county stakeholder meeting and what would soon become known as the Olympic Community of Health (see document 1.7., OCH Organizing Steering Committee). This first gathering of the OCH, held November 7, 2014 in Port Townsend, Jefferson County, engaged multiple sectors and organizations represented by over 40 leaders across the three counties. Laying the foundation for future conversations, Dale Jarvis of Dale Jarvis and Associates introduced ACH concepts, Washington State's Innovation Plan, the Collective Impact model, and the current state of health care reform. Siri Kushner, Epidemiologist, Kitsap Public Health District, provided data and information regarding the Community Health Improvement Priorities in each of the three counties, noting regional consistencies in priorities. Following discussion, participants agreed that Kitsap Public Health District, with stakeholder group assistance, would submit an ACH Design Grant application to the Washington State Health Care Authority (HCA) and serve as the virtual backbone organization to begin the formation of an Olympic Community of Health.

From January through September 2015, the original planners, joined by additional agencies, served as an informal steering committee, which met monthly to set in place processes and next steps necessary to launch a fully functioning ACH. Following receipt of the Design Grant contract in March 2015, a Project Consultant was hired and began to engage additional stakeholders identified as crucial to the emerging OCH. In June 2015, five steering committee members stepped forward to craft an initial governance structure for review by the full Steering Committee, informed by review of emerging ACH governance structures throughout the State. In July 2015, a second Stakeholder gathering occurred in Port Gamble, Kitsap County. Over 50 stakeholders jointly reviewed and provided input to further develop the governance charter for an Interim Leadership Council (ILC), met in stakeholder groups by sectors, and identified their sector representatives to the newly forming ILC which was scheduled to convene September 2015. Using the input provided by stakeholders, the Governance Subcommittee completed a final draft ILC Charter. Following Steering Committee approval September 23, 2015,

the Charter now serves as the foundation for an interim governance structure that guides the functioning of the OCH (see documents 1.1 – 1.6).

The Charter identifies the OCH's commitment to *Regional Vision, Local Action*, improving the health of our communities by focusing on population health outcomes, providing a unified voice, collaborating across systems, utilizing a collaborative infrastructure, delivering culturally competent services, and driving action oriented measureable outcomes. Stakeholders agreed to focus on areas related to Access to Care, Population Health Improvements, Access to Whole Person Support, and Data Management/ Region-wide Infrastructure, and to use a set of Guiding Principles to accomplish the OCH's collective vision and goals. The result is an interim governance structure built on a balanced, shared, geographically diverse, broad-based community and multi-sector approach to OCH leadership and the health transformation priorities and actions that together can be leveraged to more effectively meet the Triple Aim locally, regionally, and in congruence with the State. For additional details, see document 1.2, Visual Governance Structure Representation and 1.9 OCH Governance Subcommittee Meeting Summaries.

At this time, under ILC oversight, the Governance Subcommittee is drafting a governance structure that will replace the ILC with a Governing Board, expected to be in place no later than March 2016 (see document 1.6 Annual Governance Structure Review Policy). The Governance Subcommittee is additionally identifying the advantages and disadvantages of the various legal entities under which a neutral, effective backbone organization would best sustain the OCH though time. The period between formation of the ILC and the institution of a Governing Board allows us to finesse our design and test our governance structure to ensure its inclusivity, effectiveness in meeting the purposes of the OCH, and ability to leverage the broad-based multi-sector community and stakeholder engagement necessary to design and meet a common action agenda. The consensus-based decision making process as described in the ILC Charter has been successfully practiced thus far in both ILC and subcommittee meetings (see document 1.4, OCH Decision Making Process).

Building on existing community structures, in particular the Community Health Improvement Plan process with the breadth of community voice it brings to inform health planning locally and across the region, is key to our shared learning, voluntary collaboration, and thoughtful decision-making to work together on regional priorities most effective in improving population health, quality of care, and in reducing cost of care. The ILC monthly meetings and those of its subcommittees are providing a learning laboratory to discern if the decision-making approach facilitates effective dialogue and subsequent decisions, and if the guiding principles we are operating under are serving us well. It will also tell us if we have been inclusive enough of stakeholder sectors and if not, how to continue to grow the stakeholder voice while maintaining a viable governance structure, and if there are concerns or issues we had not previously considered and if so, which ones will require addressing in the evolving OCH governance structure.

The Interim Leadership Council is supported in its decision making role (see 1.3 OCH Council and Backbone Support Responsibilities) by Project Managers and the Kitsap Public Health District as the *Virtual Backbone Organization*. The ILC Subcommittees (sustainability, community assessment and planning, governance) are also supported by the Project Managers who ensure information necessary to carry out each subcommittee's charge is readily available to subcommittee participants for consideration, and that subsequent subcommittee recommendations are brought back to the ILC. They also ensure that stakeholder meetings are places where information and shared learning effectively takes place, and stakeholder input is valued and incorporated into the OCH's endeavors. The Kitsap Public Health District, the OCH backbone organization since February 2015,

serves as a conduit for information flow from the HCA to the OCH ILC and Project Managers, and as fiscal agent for the OCH. The roles and responsibilities of the backbone organization have been delineated in documents 1.3 and 4.1, OCH Council and Backbone Support Responsibilities. Still, the Olympic Community of Health is young, and as the ILC is newly formed, it is this December in process of determining a Chair to guide the Project Managers in setting agendas and the direction for the overall work of the ILC and its subcommittees. Lastly, as seen in document 1.6, a process for an annual governance structure review is in place, although this annual review will not be initiated until February 2016.

True collaboration is built on trust and a shared vision. This is what is being developed within the framework of the Interim Leadership Council Governance Charter (see document 1.5 OCH Conflict of Interest Policy) to ensure a culture of openness and trust. Stakeholders in their respective sectors have elected their representative voices to the Council, and stakeholder organization representatives are immersed in the work of subcommittees (see 1.8, OCH ILC, Governing Body Membership). The OCH is refining its governance structure, developing a strategy and mechanisms for shared community planning, priority setting and regional action, and setting forth an operating budget and sustainability plan for the near and long term future of the OCH (see Category 2 Governing Body Membership, Category 3 Community Engagement, Category 5 Priority Areas and Regional Health Improvement Plan and Category 6 Operating Budget and Sustainability Pathway). Our collaborative work in based on the collective impact model and its five conditions: a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone support. The OCH is well supported in this endeavor by the Virtual Backbone Organization (Kitsap Public Health District and the OCH Project Managers) and the remarkable commitment of the OCH Interim Leadership Council and the many OCH participating stakeholders. As the Olympic Community of Health, we express our gratitude to the pioneering path laid for us by other Accountable Communities of Health throughout the State from which we have learned much as we develop our own ACH, and for the technical assistance and consultation provided through our association with the Washington State Health Care Authority Community Transformation Team. At end of Year One of our ACH Design Grant, we have created a clear pathway to a fully operational Olympic Community of Health.

A brief introduction is included for each document included in the ACH Readiness Proposal Portfolio, in support of Category 1.

ACH Readiness Proposal Category 1.1

INTERIM LEADERSHIP COUNCIL CHARTER

Better Health. Better Care. Lower Cost.

1.1.1 History and Purpose of this Charter

The purpose of this Olympic Community of Health (OCH) Interim Leadership Charter is to support the formation of an Accountable Community of Health (ACH) and its desired future formal ACH designation in 2016 by the Washington State Health Care Authority (HCA) for the Olympic region consisting of Clallam, Jefferson, and Kitsap counties. The Charter was developed by the Governance Subcommittee of the initiating OCH Steering Committee with the intent to move our region's ACH to its next stage of development, and to document the work to date to create and implement a regional health improvement plan. The Charter was prepared based on review of existing HCA guidance and other regional ACH governance documents, and widely shared with stakeholders for comment in summer 2015. This Charter for the Interim Leadership Council has been reviewed and approved by the initiating OCH Steering Committee so as to provide guidance for the OCH Interim Leadership Council as it met this October, was subsequently approved by the OCH Interim Leadership Council October 19, 2015, and is recommended for adoption by OCH stakeholders as a whole November 2, 2015.

The charter is a work in progress, and is not yet inclusive of all elements we may choose to address in the future. It is intended to establish a basis by which an OCH Interim Leadership Council (ILC) can readily meet its primary objectives to prepare for official designation as an ACH by November 30, 2015, and make recommendation by year end to the OCH stakeholders for adoption of a more permanent governance structure in which oversight will be provided through an OCH Governing Board. The Interim Leadership Council began meeting fall 2015 and as frequently thereafter as necessary to fulfill its responsibilities. The OCH Governing Board will replace the ILC and will take on leadership of the Olympic Community of Health no later than February 2016.

The Interim Leadership Council consists of a multi-sector group of leaders necessary to rapidly build on the work accomplished through prior OCH planning conversations. Driven in part by a short timeline and by the deliverables included in HCA's ACH Design Grant to the region, certain agreements will need to be reached by late 2015 regarding the functions and governance of the OCH moving forward, and what stakeholders and/or sectors will play which roles in the future to effectively mobilize the region around real health improvement. This leadership council is an "interim" one because its work will include recommending, by end of 2015, an ongoing governance structure. In order to assure testing and adjustment of the governance structure for the Olympic Community of Health, the Governance Subcommittee of the OCH will focus on continued review and revision to the structure during 2016, and as necessary thereafter.

1.1.2 Olympic Community of Health (OCH) Purpose and Rationale

The purpose of the Olympic Community of Health is to improve the health of our communities in Clallam, Jefferson, and Kitsap Counties through achievement of the *Triple Aim*:

- Improving patient care, including quality and satisfaction;
- Reducing the *per-capita* cost of health care; and
- Improving the health of the population.

Major changes are coming to our health care system, and it is critical for our communities to have a strong voice in that process. The OCH is the primary vehicle through which our communities can be heard and can participate in the process of change.

1.1.3 *"Regional Vision, Local Action":* The Motto of Olympic Community of Health

The motto of the Olympic Community of Health is "Regional Vision, Local Action". The OCH agrees that it is critical to have a regional vision and take local action to improve the health of our communities by:

- **Focusing on improving health outcomes across the population**, not simply improving the health care system.
- **Sharing a unified, regional voice** for the Olympic region regarding health priorities.
- **Collaborating across systems** to improve our community safety and well-being.
- **Utilizing a collaborative infrastructure** that creates efficiency and scale.
- **Delivering culturally competent services**, which include language access.
- **Driving action oriented measureable outcomes** through the use of data and local voice.

Additionally, we agree on the following broad areas of focus:

Access to Care

- Increase the number of insured individuals in our region.
- Increase network adequacy for Primary Care Providers, Specialty Care Providers, Behavioral Health Services Providers and Oral Care Providers.

Population Health Improvements

- Ensure every county has a plan to increase population health with a specific focus on reducing the prevalence of diabetes, high blood pressure, obesity, child and vulnerable adult abuse and neglect, mental illnesses, and substance abuse.
- Ensure every county has a plan to address key areas that effect overall health, including affordable and adequate housing, education, economic and food security, employment, health workforce development, crime, transportation, and environment.
- Participate in selecting and piloting regional and state innovations.

Access to "Whole Person" Support

- Increase affordable housing options and food security throughout the region.

- Increase the number of individuals who have Medical Health Homes and integrated behavioral health and oral health services.
- Increase knowledge of, and integrate service delivery to address, Social Determinants of Health and Adverse Childhood Experiences.
- Increase care coordination and utilize social services support.
- Increase supports for age friendly communities, aging in place, in particular options for dementia and palliative care.

Data Management/Region-Wide Infrastructure

- Promote region-wide data sharing and infrastructure to increase measurement, accountability, and coordination of care.

1.1.4 Olympic Community of Health Guiding Principles

1. To achieve the changes needed for improvement in the health and health care of our communities, purposeful collaboration between health care, public health, social services, local and Tribal government, education, business, community-based sectors, health care consumers and their family caregivers and advocates, is required. To be successful, communities must be engaged to shape their goals and strategies for community health improvement.

2. Reform efforts will present serious challenges, and in some cases even survival threats, to health care organizations in this region. Providers in rural areas face challenges different from those seen in more densely populated areas. An important purpose of OCH is to assure that rural providers and health care organizations in this region have a voice in upcoming health system changes, and that the needs of rural communities are recognized as state, regional and local health care system decisions are made.

3. To improve overall community health, we need to address upstream determinants of health and health disparities, and strengthen the system of home and community-based supports that can stabilize the health of our most vulnerable community members of all ages.

4. A substantial percentage of savings from population health improvement and health care delivery system improvement should be reinvested through gain sharing in effective community-based prevention programs and initiatives identified at the local level through community health improvement plans and related efforts.

5. Improved data on health and health care is a critical tool informing our decisions and will empower us to leverage best and promising practices. Each county conducts a Community Health Improvement Process (CHIP) that engages local stakeholders to identify local health priorities. As a mechanism for broad community involvement in setting local priorities, results will inform OCH direction and decision-making. Multiple sector specific and related community needs assessment and planning processes which engage the community and utilize sector expertise are also included in OCH' prioritizing and decision making process.

6. It is critical for OCH to operate in a transparent and inclusive manner. Meetings are open to all interested parties to the extent possible, and partners from various sectors are encouraged to attend.

7. OCH leaders are chosen in part because of the organizations, sectors, or communities they represent. It is appropriate for them to assure that the views and interests of those they represent are included in OCH discussions. When making OCH decisions, however, members must consider issues from a regional perspective, rather than from the narrower perspective of their organization, affiliations, or locality.

8. The Interim Leadership Council will allow regular opportunities for public comment at its meetings.

1.1.5 Interim Leadership Council (ILC) Membership

As the Olympic Community of Health, we strive for balance across the region to make equitable policy decisions in which we all have a piece of the vision. Therefore we seek to achieve a balance of representation by each county. Nomination to the ILC is to be made among and by stakeholders of the sector for whom the individual serves as representative. Stakeholders are to be inclusive of their peers within the tri-county region in making the selection for representation, and to inform their representative by meeting regularly and independently of the OCH. Representatives are expected to communicate on behalf of and represent the sector as a whole and to ensure a system for regular communication and feedback within their sector and as a responsibility of their ILC membership. Sector stakeholders may identify an alternate if their representative is unable to attend. Each sector will constitute one "vote" in decision making.

Terms for the Interim Leadership Council will be one year or less, by which time the transition to a Governing Board will be complete and the ILC will disband. Immediate focus for developing the Interim Leadership Council includes Stakeholder Sectors identified by the Cambridge Management Group as representing a Health and Recovery Services focus within a systems framework for health (Formative Focus). Wider representation from the Community Services System Sectors will be sought out and developed late Fall 2015 through Spring 2016. These additional sectors will then be considered for inclusion in the OCH Governing Board which replaces the ILC. After the governance structure is formalized in early 2016, sector membership composition will be reviewed the first quarter of each subsequent year for geographic balance, sector inclusion, community voice, and membership terms.

Interim Leadership Council membership will include one representative for each sector as listed below:

Formative Focus: Health & Recovery Services

- Behavioral Health Organization (Staff, by Executive Committee Appointee)
- Chemical Dependency (Medicaid Provider)
- Chronic Disease Prevention Across the Lifespan
- Community Action Program/Social Service Agency
- Dental Health
- Federally-Qualified Health Clinic

- Private/Not for Profit Hospital
- Housing/Homeless
- Long-Term Care/Area Agency on Aging/Home Health
- Medicaid Managed Care Representative
- Mental Health (Medicaid Provider)
- Primary Care
- Public Health
- Public Hospital
- Rural Health
- Tribes

Total Voting Members: 16

The following sectors are identified as important to be developed and invited for representation on the Interim Leadership Council and/or Governing Board.

Widening Focus: Community Services System

- Economic Development
- Education (early learning through higher education)
- Law & Justice
- Nutrition & Active Living
- Philanthropy
- Transportation
- Workforce Development
- Other sectors yet to be identified

1.1.6 Functioning of the OCH Interim Leadership Council

The Governance Subcommittee is recommending to the existing Steering Committee and OCH stakeholders as a whole that an Interim Leadership Council be established to serve in a transitional role prior to adopting a more permanent Governing Board structure in early 2016. Early planning for the OCH has continued through existing stakeholder interactions, and as the ILC takes on its role, the governance structure will become more formalized, although it will continue to evolve as the ILC, supported by the Governance Subcommittee, works to hone a governance model late 2015 through early 2016. The ILC will convene October 2015 and meet at least once monthly to begin its role in moving the OCH to readiness for ACH designation and to ensure the expectations and deliverables associated with being an accountable community of health are underway and ultimately, met. At this juncture, the initiating Steering Committee will cease, and turn its role over to the ILC. Recognizing the need to meet the tight timelines involved in creating a rapidly functioning governance structure, OCH Stakeholders approved the ILC structure in principle at their July 2015 meeting, so that the ILC could begin its initial work in September 2015. OCH Stakeholders will convene in November to review and comment on

progress, and to formally adopt the ILC governance structure. OCH Stakeholders as a whole will convene at least twice annually.

The Interim Leadership Council is convened now for the purpose of supporting Olympic OCH Stakeholders, overseeing the work of OCH 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. In addition to assuring the OCH is focused on regional planning and projects that will substantively meet the Triple Aim, the ILC is expected to assure that the OCH includes as its focus regional health system supports regarding health care financing, practice changes, workforce development, and the regulatory environment. Its work must also develop and begin implementation of a long-term plan for administration, financing and sustainability of the OCH.

1.1.7 Interim Leadership Council Subcommittees

To support the work of the OCH Interim Leadership Council, three subcommittees will be formed. The ILC may also elect to establish other committees or work groups as needed. As with the ILC, these committees disband when the final governance structure is adopted and the Governance Board initiates its first meeting in 2016, or as otherwise determined by the Governance Board.

The three ILC Subcommittees will include 1) Governance, 2) Community Health Assessment and Planning, and 3) Sustainability. The ILC may invite additional OCH stakeholder representatives to participate in subcommittees, however, at least two participants in each subcommittee must be members of the ILC, one of whom will serve as the Subcommittee Chair. Subcommittees are expected to draw upon community health improvement plans and priorities as identified by each county's citizenry and providers, and other available information and data, and to draw upon the expertise of the OCH Stakeholders to most effectively carry out their charge. Recommendations from these subcommittees are then to flow through from each subcommittee via its Chair to the ILC for planning, prioritization, and decision-making.

1. **Governance Subcommittee:** Researches and recommends a governance structure for the OCH, to include decision-making, conflict of interest, and conflict resolution processes. The Governance Subcommittee assembles and reviews existing ACH governance documents, and will prepare an interim governance structure for stakeholders to approve by November 2015. Recommendations on the legal form of the OCH including by-laws and articles of incorporation will be made by end of 2015, and work initiated in 2016 to create a legal ACH entity, if indicated. The work of the Governance Subcommittee is completed when the governance structure, legal entity determination and any associated tasks are completed, and the Governing Board is fully established and operational. At that point, the Governance Subcommittee may be dissolved and other subcommittees may be initiated to support next steps. The Governance Subcommittee consists of 4 – 8 members, and will meet at least monthly.

2. **Community Health Assessment and Planning Subcommittee**: Facilitates the development of a single, cross-sector health data and needs inventory and multi-year regional health improvement plan to consolidate community health planning efforts required by various agencies and funders across the region; works on plan performance measures, and with other ACHs and the State, develops and

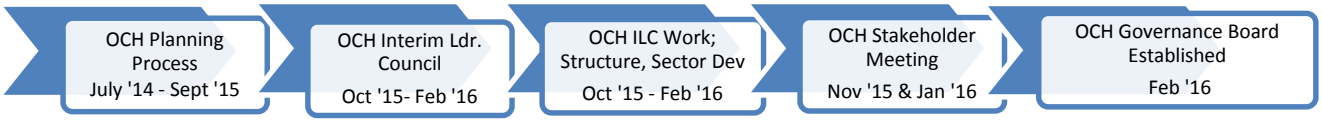
implements a set of statewide performance measures. A collective impact approach to shared priorities, which will involve regionally-aligned voluntary engagement of independent stakeholders from the local level will be applied. The local Community Health Improvement Process (CHIP) and projects in each of the counties will continue to serve as a means to improve the health of the region. Service innovations may also be evaluated and recommended. This work will be ongoing. The Community Health Assessment and Planning subcommittee will consist of 4 – 8 members and meet monthly. The Committee is ongoing and service innovations are likely to be generated, recommended and evaluated by this group.

3. **Sustainability Subcommittee:** Researches potential funders, identifies funding opportunities, and develops a short- and long-term plan to solicit resources in support of the OCH. This *may* include establishment of a Wellness Fund for shared savings, identifying possible revenue sources for the OCH which may include, but may not be limited to, private and public sector funding, membership dues, and in-kind support, and research and support for new health care payment models. The Sustainability Committee will consist of 4 – 8 members and will meet at least monthly. The Committee is ongoing.

1.1.8 Duration of Interim Leadership Council

The OCH Interim Leadership Council agrees to work together from October 2015 until the formation of the Governing Board, expected to be in place by February 2016. In late 2015, as part of an anticipated shift to an ongoing ACH structure, the Interim Leadership Council will develop and execute a plan to transition from an interim to an ongoing structure.

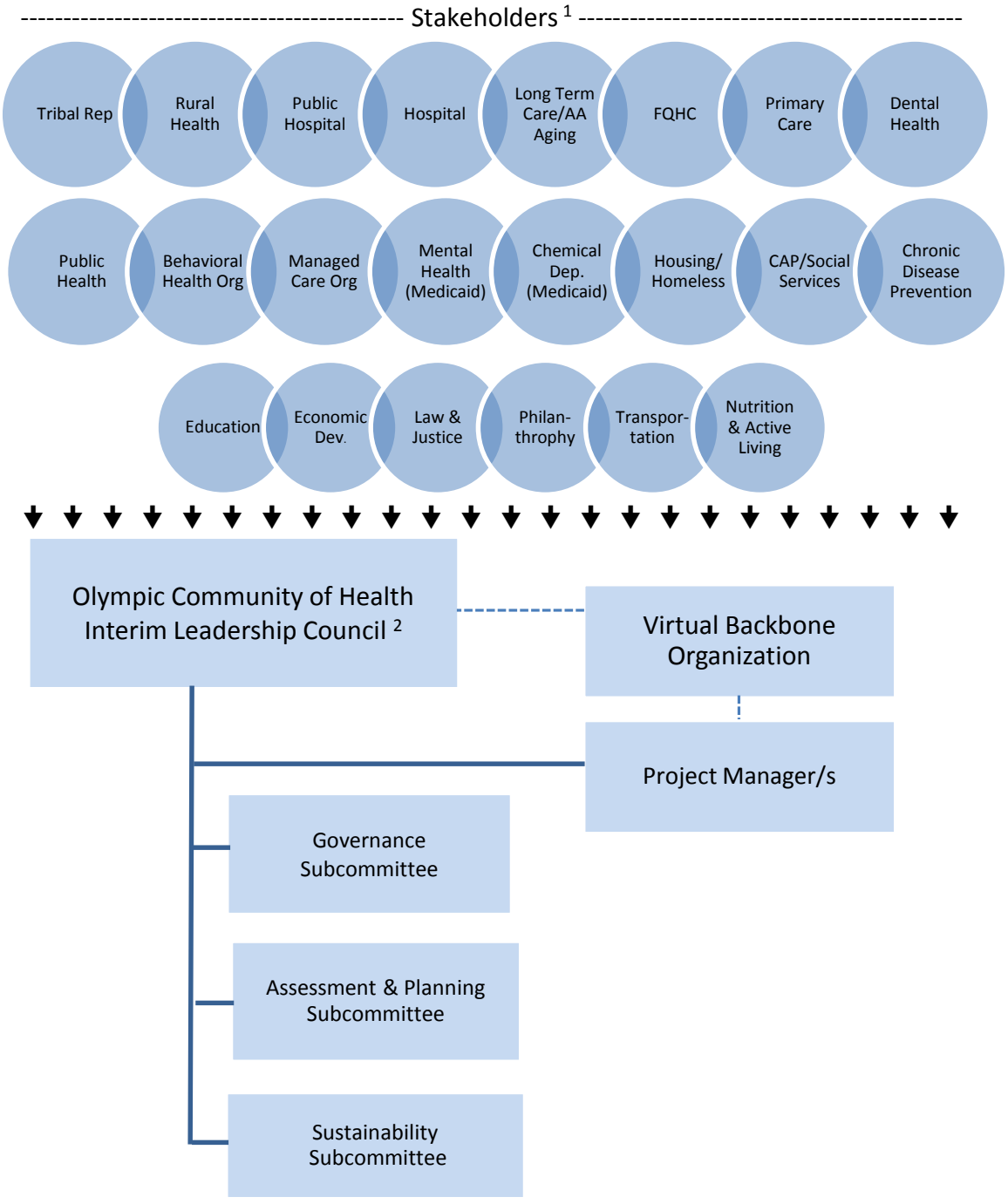
OLYMPIC COMMUNITY OF HEALTH DEVELOPMENT TIMELINE



1.2 Visual Governance Structure Representation

This document is a visual representation of the Olympic Community of Health's (OCH) overall governance structure. It illustrates both the initial and widening stakeholder sectors whose representatives constitute the Interim Leadership Council (ILC), the OCH's current governing body, the relationship of the Virtual Backbone Organization to the ILC, the relationship of the Project Manager to the ILC and its subcommittees, and to the Virtual Backbone Organization.

ACH Readiness Proposal Category 1.2
VISUAL INTERIM GOVERNANCE STRUCTURE REPRESENTATION
Olympic Community of Health Interim Leadership Governance Structure



[1] OCH Stakeholders from all sectors will populate organizational entities.

[2] OCH Interim Leadership Council disbands after ACH design deliverables accomplished and formal governance structure for Governing Board in place.

1.3 OCH Council and Backbone Support Roles and Responsibilities

This document describes the roles and responsibilities of the OCH Interim Leadership Council in eight operational areas, including vision, policy, governance, sustainability, community assessment and planning, regional and local action strategies, project management, and backbone function. It describes the roles and responsibilities of the virtual backbone organization regarding overall project and fiscal management, administrative and clerical support, and communications with the HCA and other ACHs programs.

ACH Readiness Proposal Category 1.3
OCH Interim Leadership Council & Backbone Support Organization Roles & Responsibilities

1.3.1 Roles and Responsibilities of the OCH Interim Leadership Council

- The ILC, with the Project Consultant/s, will prepare for official designation as an Accountable Community of Health from the Washington State Health Care Authority. With support from the Backbone Agency, the Readiness Proposal will be submitted in November 2015. The OCH, ILC and its subcommittees will work accountably with other ACH partnerships and with the State as the role of the ACH in health care redesign continues to evolve.

- With Governance Subcommittee, the ILC will develop a recommended OCH governance structure for stakeholder adoption by November 2015, and implement a transition plan to the more permanent governance structure no later than January 31, 2016. In early 2016, it will establish organizational preparedness, including review of benefits and recommendations for choice of organizational structure, development of bylaws, backbone support needed to support the OCH, its governance structure, and work plan. The Governance Subcommittee, as with the ILC and OCH in its entirety, will work accountably with other ACH partnerships and with the State as the role of the ACH in health care redesign continues to evolve.

- With the Sustainability Subcommittee, the ILC will recommend an initial plan for sustainability, including exploration of shared savings, and alternate forms of payment such as pay for performance, and creation of a Wellness Fund. In addition to assuring the OCH is focused on regional planning and projects that will substantively meet the Triple Aim, the ILC is expected to assure that the OCH includes as its focus regional health system supports regarding health care financing, practice changes, workforce development, and the regulatory environment. Its work must also develop and begin implementation of a long-term plan for administration, financing, and sustainability of the OCH including the backbone support functions. The Sustainability Subcommittee will work accountably with other ACH partnerships and with the State as the role of the ACH in health care redesign continues to evolve.

- With Assessment and Planning Subcommittee, the ILC will assure coherence of regional vision and initiatives, and work to support their success in ways appropriate to each to support a regional health improvement plan, including consideration of information technology infrastructure needs. It will recommend an ongoing regional-level health assessment and how to incorporate the Community Health Improvement Plan process into the OCH structure. This subcommittee may also in the planning process recommend measurable health outcome and evaluation goals. The Assessment and Planning Subcommittee will work accountably with other ACH partnerships and with the State as the role of the ACH in health care redesign continues to evolve.

- The ILC will recommend how administrative, fiscal management, coordination, convening, communication, and data support functions (backbone functions) will be carried out in the future structure and ensure a mechanism is put in place for periodic reaffirmation of the virtual backbone organization in order to allow for adjustments over time, as necessary. The current virtual backbone organization is the Kitsap Public Health District which provides administrative support and fiscal management; web communications support is also currently provided by in-kind support from the Kitsap County Human Services Department. The backbone organization for the immediate future, 2016, will require the ILC to either confirm the current structure and backbone organization, or identify another backbone structure agreed upon by the ILC.

- The ILC will be supported in its processes, business, and in carrying out OCH goals by staff who provide project management. Staff are directed by and accountable to the ILC as the governing body for the OCH.

- The ILC will provide input/recommendations to the State (and to the counties/cities, where appropriate) related to health innovation elements such as physical/behavioral health integration, aspects of Medicaid purchasing, the Healthier Washington Initiative, data analytics, and issues connected to ACH development and functions.

- Recognize and facilitate decision-making about how to respond to new cross-sector health improvement initiatives/opportunities as they arise.

1.3.2 Roles and Responsibilities of the Virtual Backbone Entity

During 2015, at the request of participating OCH Stakeholders, the virtual backbone entity selected to provide administrative support functions, including organizational, logistical, fiscal, and data support, was the Kitsap Public Health District. The Kitsap Public Health District will continue to serve in this role during 2016 if approved by the ILC to do so and if agreed upon by the Health District. Oversight of the Virtual Backbone Entity was initially provided by the OCH Steering Committee, and will subsequently be provided by the Interim Leadership Council and, when in place, the Governing Board.

The virtual backbone entity's role is to:

- Supply overall project and financial management, including serving as fiscal agent for grants and other funds.
- Provide administrative and clerical support necessary to meet grant deliverables including
    - Publications, web postings, and general communications.
    - Assisting in convening meetings and facilitating communications with stakeholders.
    - Recording and distributing minutes for OCH meetings.
    - Limited administrative support for the work of the OCH's various committees and groups.
- Manage associate consultant contracts to meet design grant deliverables including, but not limited to, project consultation, and epidemiology services for assessment and data, including support for development of a regional health improvement plan.

- Keep the OCH informed regarding ACH-related communications from the State, and about efforts statewide to implement the work.

Backbone support is also provided to the Interim Leadership Council, and Subcommittees by Project Managers who with the ILC and Stakeholders, carry out OCH strategies and manage work to meet the specific deliverables, including ACH Design Grant deliverables associated with ACH designation. The Project Consultant/s reports to the Interim Leadership Council and is contracted for services through the fiscal backbone.

The Project Managers ensure connectivity with stakeholder groups to grow the OCH over time and assist the OCH in aligning its members to achieve its goals. Specifically the Project Managers works with the Steering Committee to prepare objectives for various OCH meetings in order to effectively and quickly advance the OCH. Agenda and meeting materials will be distributed at least three (3) business days in advance, no fewer than five (5) business days when a decision-making item is on the ILC agenda. The Project Consultant/s, with backbone entity support staff, will record and distribute meeting summaries to the membership and post these on the OCH website for access by OCH stakeholders and the public. The website is maintained by Kitsap County Human Services Department.

1.4 OCH Decision Making Process

This document describes an approach for coming to agreement using a consensus-based decision making process. It includes a description of how concerns are heard and a way to arrive at a decision where agreement cannot readily be found. This process has been employed during ILC meetings and subcommittees and to date has been found effective in achieving decisions.

ACH Readiness Proposal Category 1.4
OCH Decision Making Approach

Because achieving voluntary agreement and buy-in from different sectors is foundational to the work and success of an ACH, the Interim Leadership Council (ILC) and Governing Board will make decisions and recommendations by consensus. The approach encourages putting the good of the whole above the interests of a single organization, geography or sector, and finding solutions that all parties can support or at least live with. Decisions will be documented in meeting summaries and posted on the OCH website. This process is consistent with true collaboration to produce sustainable agreement. Key decisions will be made in person ILC or Governing Board meetings.

Every effort will be made to determine ILC decisions by consensus. Consensus in this context does not mean 100% agreement on all parts of every issue, but rather that all members review a decision in its entirety and say, "I can live with that." The Council or Board will work to understand and integrate perspectives until a solution is identified that is acceptable to everyone in a reasonable amount of time.

If an ILC or Board member cannot support an emerging agreement of the group, the member is obligated to make his or her concerns known, and the rest of the group is obligated to listen with an interest in resolving these concerns. Members are expected to work to address the concerns, including asking the concerned party to clarify any underlying interests or other dynamics that could be interfering with an agreement. All ILC and Board members are obligated to try to find an alternative that meets the interests of the concerned party as well as their own.

If the ILC makes a good faith effort to achieve consensus but finds that consensus is not possible, the decision will be submitted to a vote of the ILC or Governing Board and decided by a simple majority of members present, provided there is a quorum. Robert's Rules of Order will be used to facilitate ILC or Governing Board decision making.

1.5 OCH Conflict of Interest Policy

This document specifies how OCH Interim Leadership Council representatives are to handle real or perceived conflicts of interest. The document defines conflicts of interest and sets forth a specific process for responsibly and transparently managing any such conflict. This policy was adapted from review of other ACH Charter descriptions of managing potential Conflicts of Interest.

ACH Readiness Proposal Category 1.5
Managing Real or Perceived Conflicts of Interest

Conflict is to some degree inherent and expected in an endeavor that brings different sectors together to work on issues addressed more successfully as a community than by individual sector or organization. The Interim Leadership Council and Governing Board acknowledge that conflicts, real or perceived, may surface in their work. This may occur within and among members of the ILC or Board, its multiple stakeholders, project consultants/staff, and state partners working on the initiative.

The ILC and Board seek to cultivate a culture of openness in talking about conflicts of interest as many of its members as well as those in project staff and facilitation roles may have contractual relationships with one another and/or with the State.

The Interim Leadership Council and Board will be intentional in identifying potential conflicts of interest. Members should raise or ask fellow members about potential conflicts related to the topics under discussion or decision making. Members, staff, and consultants are expected to disclose potentially relevant conflicts, at which time the Interim Leadership Council or Board will collectively decide how to address or manage the potential conflict on an issue-by-issue basis. Identified conflicts will be reflected, including dates on which those conflicts are declared, in meeting summaries.

1.6 OCH Annual Governance Structure Review Policy

The review process recognizes that development of the OCH governance structure is an iterative process and will require finessing and adjustment as the ACH function and our local structure becomes further defined over time. The Virtual Backbone Organization will be reviewed on an annual basis by the governing body (at this time the Interim Leadership Council) which will select or reaffirm the backbone organization, and note as such in the governing body meeting summary. The OCH Interim Leadership Council will review the current structure at least annually, affirming the current composition or when indicated, make adjustments in real time should issues or gaps emerge. These adjustments or the affirmation will be noted in the meeting summary.

ACH Readiness Proposal Category 1.6
Annual Governance Structure Review Policy

1.6.1 Annual Review Policy of the Governance Structure and Backbone Organization

We recognize the need to allow for adjustments to our ACH structure as it becomes more clearly defined in the near and longer term future. Collaboration is an iterative process, for the purposes of arriving at shared outcomes. While the governance structure of the Olympic Community of Health is yet under design and will undergo further review by the Interim Leadership Council, with approval for adoption requested of the OCH stakeholders during January 2016, recommendation of the current governance structure is described in sections 1.6.2 and 1.6.3 below.

1.6.2 Interim Leadership Council (current); Governing Board (February 2016)

On an annual basis, the governing body (Interim Leadership Council or Governing Board) will review the governance structure and affirm the current composition or make adjustments as issues and gaps emerge over time. Adjustments or the affirmation of the recommendation and decision to maintain or change the structure will be noted in summary documentation.

1.6.3 Backbone Organization

On an annual basis, the governing body will select or reaffirm the backbone organization. Such selection or affirmation will be noted in summary documentation.

1.7 OCH Organizing Steering Committee Calls and Meeting Summaries

These meeting agendas and summaries reflect the early, informal organizing structure of the Olympic Community of Health beginning July 2014, the planning and execution of a first Stakeholders gathering in November 2014, and Steering Committee communications until establishment of a guiding Interim Leadership Council in October 2015, at which point the original Steering Committee disbanded. Select Steering Committee summaries are included to demonstrate the commitment of the initial OCH organizers July 2014 – January 2015, and the growth of interest as more organizational entities joined the OCH launch in spring 2015.

8/14/2015 from Doug Washburn: Planning Group Doodle Poll for 3-County ACH Conference Call

Good Afternoon everyone,
Below is the link to the **Doodle poll** to schedule our initial planning group call to discuss the steps that need to be taken should the group wish to move forward with a Three-County ACH. Once we have the date set we can send around the draft agenda and finalize as a group. For the initial call I have the following people on the list; Tom Locke, Scott Daniels, Joe Roszak, Rochelle Doan, Jean Baldwin, Barb Malich, Larry Eyer, Iva Burks, Doug Washburn.
Additional people can easily be added if you would like anyone else on this call. http://doodle.com/9d6vg9c6vig6buy8

Thank you. Doug

Doug Washburn, Director
Kitsap County Department of Human Services
360-337-4526
dwashbur@co.kitsap.wa.us

From: Doug Washburn
Sent: Friday, September 05, 2014 3:40 PM
To: Barbara Malich (bpmalich@pchsweb.org); Scott Daniels; Joe Roszak (joer@kmhs.org); Jean Baldwin (jbaldwin@co.jefferson.wa.us); Rochelle Doan; Larry Eyer (larrye@kcr.org); iburks@co.clallam.wa.us; Tom Locke (TLocke@co.jefferson.wa.us)
Subject: Clallam - Jefferson-Kitsap ACH Planning Conference Call

The planning conference call will be Wednesday, September 10 from 9:00 – 10:00. The people on the call will set the agenda but the initial agenda items I have heard people would like to cover are:

1. Develop a list of invitees to bring into the initial stages of the planning process – by county
2. What are the steps we need to take to move forward – mirror what the ACH planning grant recipients are required to do or chart our own course
3. Who will be the convener for the beginning stages – Sending out agenda, planning meetings, collecting documents, keeping policy makers informed, staff work, etc.
4. Do we want to bring in a consultant to help with the initial planning – if so, whom
5. Timeline

I have attached the Kitsap Public Health resolution supporting the three-county configuration, the signed three county letter to DSHS and HCA and the most recent communication from DSHS and HCA (that I currently have). Also attached is the HCA planning grant we may need to reference for dates and activities and a few slides from HCA and Choice on planning activities. The call in number is: (530) 881-1000
Code: 812029#. Here is the call in number and code: (530)881-1000 Code: 812029#

Regards,
Doug
Doug Washburn, Director
Kitsap County Department of Human Services
360-337-4526

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

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

Letter of Invitation to ACH Stakeholders

We want to share with you recent and important efforts to create a regional **Accountable Community of Health (ACH)** involving Kitsap, Clallam, and Jefferson Counties. Creation of an ACH is in response to Washington State's current development of common Regional Service Areas (RSAs) for Medicaid Purchasing, and the initiation of ACH Regions that have the potential to significantly change and improve the quality of health services we provide, lower the cost of providing our services, and ultimately improve the health of our communities.

More importantly, we are asking you to join us in creating a tri-county ACH structure --- to be called the **Olympic Community of Health** --- that recognizes that health and health care are local, promotes shared accountability, and furthers the existing collaborative endeavors and delivery systems within our counties now and into the future.

Under the Washington State Health Care Innovation Plan, an Accountable Community of Health will have multiple roles in driving health care transformation including:

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

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 ACH designation. The timeline was brief, and none of our three counties submitted a proposal. Our three counties were however included in a proposal made by the CHOICE Regional Health Network for the July – December 2014 planning grant to explore a 10-county regional ACH, called the "Cascade Pacific Action Alliance (CPAA)." Post award, leadership of various health and social service organizations within our three-county region participated in a webcast conversation and additional follow-up discussion with CHOICE/CPAA.

As a result of these conversations among the Clallam, Jefferson and Kitsap county participants, we determined it is of the utmost importance to withdraw participation in the ten-county effort, and instead create a local ACH tri-county structure. This work is critical as the State begins to solidify regionalization areas for state-financed health care, social support and other essential state services. The regional ACH structure has long-term implications for health and human services delivery and accountability, especially for delivery of Medicaid services which include the mental health services managed by the existing Peninsula Regional Support Network and chemical dependency services.

Following discussion with our County Commissioners, a letter dated August 13, 2014, was sent to the Washington State Health Care Authority and to the Washington State Department of Health, stating our three counties' intent and commitment to actively engage in the creation of a local ACH (see attached letter). Our State partners understood the desire for our communities to take a more local approach to setting community health priorities and for the delivery of health and community services. And while we have chosen to maintain a liaison connection to CHOICE to learn from their efforts, it is now up to us to demonstrate that we can deliver an effective regional Accountable Community of Health in our three counties.

That's why we are contacting you today. We believe that by bringing critical stakeholders together soon, and through a conversation facilitated by our consultant, we can arrive at strategies that will effectively move us forward along with other regional initiatives in process across the State.

We have scheduled an initial session with our consultant for Friday, November 7th, 9:30 a.m. to 12:30 p.m. at the Fort Warden State Park Commons building (Room A) in the Port Townsend. We very much hope that you will attend this meeting and participate in this vital conversation. Location and specific agenda will be confirmed shortly.

Any of us as noted below may be contacted for additional questions, but do please let Linda Ward know of your intent to participate so that we may inform you of final details. Linda can be contacted at 360-337-4604 or via email at lward@co.kitsap.wa.us.

For additional information, please contact:

Scott Daniels, Administrator
Kitsap Public Health District
360-337-5287
Scott.Daniels@kitsappublichealth.org

Barbara P. Malich, CEO
Peninsula Community Health Services
360-478-2366
bpmalich@pchsweb.org

Dr. Tom Locke, Health Officer
Clallam and Jefferson County Health Departments
360-417-2437
TLocke@co.clallam.wa.us

Joe Roszak, CEO
Kitsap Mental Health Services
360-373-5422
joer@kmhs.org

Iva Burks, Director
Clallam County Health and Human Services
306-417-2329
IBurks@co.clallam.wa.us

Jean Baldwin, Director
Jefferson County Public Health
360-385-9408
JBaldwin@co.jefferson.wa.us

Larry Eyer, Executive Director
Kitsap Community Resources
360-473-2004
LarryE@kcr.org

Doug Washburn, Director
Kitsap County Human Services
360-337-4526
dwashbud@co.kitsap.wa.us

Olympic Community of Health - Initial Meeting
Friday, November 7, 2014 - 9:30 a.m. to 12:30 p.m.
Fort Worden State Park Commons building (Room A)
200 Battery Way
Port Townsend, WA 98368
Facilitated by Dale Jarvis and Associates Consulting

9:30 Welcome and Introductions
9:50 Plan for the Morning - Why We Are Here?
10:00 An Introduction to Accountable Community of Health Concepts
   a. Just what is an Accountable Community of Health (ACH)?
   b. ACHs and the State Innovation Plan
   c. Health Care Authority Expectations
   d. Tasks to Accomplish and Timeline
10:45 Break
11:00 Health Care Trends in Our Three-County Region – Clallam, Jefferson & Kitsap
   Siri Kushner, Epidemiologist
11:30 Designing a Three-County Regional Collaboration – Full Group Discussion
   a. What types of collaborations are you currently involved with that are helping residents of the region move toward the Triple Aim?
   b. What are the necessary "ingredients" to include in a community-based, health-oriented "ecosystem"?
12:10 Initial Plan of Action and Next Steps
   a. Do you think Jefferson, Clallam and Kitsap Counties should be part of a 3-county ACH or a 10-county ACH?
   b. Based on the answer to the above question, what are key next steps to ensure that Clallam, Kitsap and Jefferson County stakeholders become part of the emerging design?

12:30 - Adjourn

Please contact Linda Ward at 360-337-4604 or via email at lward@co.kitsap.wa.us if you have any questions.

Olympic Steps Planning Meeting Notes, Dale Jarvis 11/7/14 PM

How'd it go this morning?

- Who did attend was the good news
- Who didn't attend that we thought would was another piece of news (no tribal representatives – Neah Bay, Jamestown Clallam Tribe); tribal involvement will be important in this region.
- We have the most developed relationships with tribal governments than anywhere in the state.
- Was at a table of folks who are new to this; is the system even broken? Why are we shifting the risk? Other folks were looking at their mission and how it interfaces with it; we had to go back to where your community is. This type of discussion is our next step.
- Three versus 10 counties is better.
- It was great that Harrison showed up; to hear them say that their interests were very similar to public health's interest was great; they identified their threats and it wasn't insurmountable.
- What about not having any health plans here: it was a good idea the way we were talking about them; the five health plans will join when we want them to.
- What about the ACHs putting together a set of hoops that they have to jump through to participate in the design.
- Toppenish: the ACHs want the state to organize as an ACH like the local ACHs are coming together.
- Managed care has not worked. The real future is in Medicaid ACOs.

Creating the Steering Group

Cover letter: written by the same as white paper.

Include the people already on the group; add missing folks (see below); contact the missing folks directly to ask to have someone assigned (see the list below); include in the letter the question: who else should be on the steering group? Ideally, health departments, tribes, LTC, human services, etc.

White Paper

Rochelle, Siri, Dale, Scott, Jean

Notes from today; Dale's papers

I have 3 of the 7 sets of notes.

Creating a steering group

Letter of Intent

Take the position that the counties and the hospitals have already signed off on this. Tom will be the point person on this.

Funding Proposal

Due January 9th; we think; we will know this afternoon.

Dale will ask SWRHA if he can share what we're writing to help Olympic.

The steering group will be responsible for writing this.

Olympic Steps Planning Meeting Notes, Dale Jarvis 11/7/14 PM

What are your Next Steps?

Typical next steps:

1. Create an inclusive steering group
2. Decide what you want to work on in phase 1 of our evolution
3. Organize workgroups with leads to develop simple workplans and budgets
    a. Governance
    b. Service Innovations
    c. Infrastructure
    d. Funding
4. Compile the workplans and budgets and create an organizational budget, identifying what type of backbone resources are needed to support the phase 1 effort (money and staffing)
5. Go after funding to support phase 1 (Sources: Catholic Health Initiatives; Kitsap Foundation [maybe]; Jefferson Healthcare Foundation; Jefferson Community Foundation is doing collective impact; Olympic has a foundation)
6. Get to work
    a. Get state and foundation funding
    b. Create a nonprofit organization
    c. Begin working on at least one high impact project in each county

Idea: Do a steering committee to create an application:
Idea: Create a separate governance workgroup.
Idea: Write a paper.

From Chase: Letters of intent to go for the next round of funding are due on 11/19.
Who are the existing fiscal agents in the tri-county: Kitsap County Human Services or Kitsap Public Health; Doug and Scott will figure this out.
Who's missing from the steering group?

- Tribes
- The hospitals
- The EMS providers
- Oral health providers (Clallam and Jefferson have the lowest rates of Medicaid use in the state)

HCA Design Application

Note: Subsequent to the November 7, 2014 meeting, the Kitsap Public Health District (KPHD) was determined to be the entity to serve as fiscal agent for an OCH Design application. A workgroup consisting of Kitsap Public Health District (Scott Daniels, Katie Eilers), Kitsap Mental Health Services (Rochelle Doan), Jefferson Public Health (Jean Baldwin) and Clallam Public Health Department (Tom Locke) prepared the OCH application, with consultation from Dale Jarvis, and final approval from the Steering Committee. The Award was made to the OCH Backbone Organization, KPHD in February and a contract signed March 27, 2015. A Project Manager/Consultant was hired May 2015 to move the OCH to its next stage.

Olympic Community of Health
Steering Committee Meeting
February 6, 2015

MEETING MINUTES

Attending: Scott Daniels, Kitsap Public Health District (Facilitator); Monica Bernhard, Kitsap Community Resources; Iva Burks, Clallam County Health and Human Services; Rochelle Doan, Kitsap Mental Health Services; Katie Eilers, Kitsap Public Health District; Ford Kessler, Safe Harbor Recovery Center; Jeanne Librec, Clallam County Health and Human Services Board; Tom Locke, Jefferson Public Health Department; Barb Malich, Peninsula Community Health Services; Judith McCrudden, Olympic Educational Service District 114; Joe Roszak, Kitsap Mental Health Services

1. **Update on HCA ACH Design Grant**
   - **Design Funding and Period of Performance**
     Scott Daniels explained that the Grant Award Announcement originally listed a period of performance starting on February 2, 2015. Due to the prior-approval process for these Design contracts, the likely award date and starting point for the period of performance is likely closer to the end of February. This later start date will result in pushing back the dates on some of the grant deliverables and may compress the overall work timeline.
   - **Technical Assistance Categories**
     Under SIM Round 2, the Washington State Health Care Authority has funding to provide technical assistance to the grantees to assist with Accountable Community of Health (ACH) development. The Committee discussed whether this will affect the need to contract with Dale Jarvis. Scott Daniels will contact HCA to determine the scope of the technical assistance and whether it has any bearing on the Dale Jarvis contract.
   - **HCA ACH Website Updated to Reflect Regional Contact Information**
     Scott Daniels mentioned that the HCA's ACH website has been updated. He mentioned it's a good resource especially for contact information for the other ACH regions across the State. This website will be a good resource to direct partners to for updates regarding statewide efforts.

2. **Review of Design Grant Work Plan Deliverables**
   - Scott Daniels reminded the Steering Committee of the deliverables contained in the grant Work Plan. After some discussion, it was decided to form the Governance Subcommittee now in order to have that recommendation ready for the next full Olympic COH Stakeholder meeting. Volunteers for this subcommittee were Scott Daniels, Rochelle Doan, Judith McCrudden, and Barb Malich.
   - **Project Manager Recruitment**
     Scott Daniels mentioned he has discussed the Project Manager position with two interested candidates, Peter Browning, former Skagit County Health Department Director, and David Mitchell, a healthcare consultant in Kitsap County. Scott mentioned he has also discussed the position with Mary McClure, Director of the Kitsap Regional Coordinating Council, who may also be interested in the opening. Scott mentioned that recruitment for this position is one of the critical path activities for the Olympic COH.
   - After some discussion, the Committee decided to form a Project Manager Recruitment Subcommittee to put together the job posting, screen applicants and conduct the interviews. The Health District will prepare a draft position description for the Subcommittee's review, and post the position when the job description is ready. Volunteers for the Recruitment Subcommittee were Scott Daniels, Jeanne Librecque, Barb Malich, and Joe Roszak.

3. **Work Underway to Support Project Manager**
   - Scott Daniels mentioned that District staff have started to compile documents developed by the ten preliminary planning grant ACHs (accessing their websites and the HCA ACH website) to assist the yet-to-be recruited Project Manager to help them hit the ground running.

4. **ACH Implementation Consultant Contract (Dale Jarvis)**
   - The Committee supported moving forward with this contract, but only after a report back from Scott Daniels on the scope of the technical assistance to be provided for this work by HCA.

5. **Stakeholder Engagement and Communication / Stakeholder Meeting**
   - After some discussion, the Committee decided that a full Stakeholder meeting will be scheduled after the Project Manager is hired and the governance recommendations have been prepared.

6. **Next Steps**
   - The Health District will write the Project Manager position description, obtain Recruitment Subcommittee approval, and then post for the position. After that, the Recruitment Subcommittee will screen applicants, conduct interviews, and hire.
   - The Health District will assemble governance documents for the other ACHs, and then schedule a Governance Subcommittee meeting to discuss and decide on the preferred option(s).
   - The Health District will negotiate the final ACH design grant with HCA. The Health District will also research the scope of HCA's offer of technical assistance.

Olympic Community of Health
Steering Committee Meeting
May 13, 2015

MEETING MINUTES

Attending: Scott Daniels, Kitsap Public Health District (Facilitator); Jennifer Acuna, Olympic Educational Service District 114; Jean Baldwin, Jefferson Public Health Department; Peter Browning, Browning Solutions; Iva Burks, Clallam County Health and Human Services; Rochelle Doan, Kitsap Mental Health Services; Jeanne LaBrecque, Clallam County Health and Human Services Board; Barb Malich, Peninsula Community Health Services; Judith McCrudden, Olympic Educational Service District 114; Cristina Moyer, CHI-Franciscan Health; Joe Roszak, Kitsap Mental Health Services; Doug Washburn, Kitsap County Human Services Department

1. **Introduction of Peter Browning, Browning Solutions**
   Scott Daniels introduced Peter Browning as new Project Manager for the Olympic Community of Health (OCOH). Peter is a subcontractor to the Kitsap Public Health District under the HCA ACH Design Grant, and serves as Project Manager for the entire ACH. Peter said he is excited to be part of this project and looks forward to getting started. [Note: Peter will take over for Scott Daniels in organizing and facilitating future Steering Committee meetings].

2. **Report Back from Statewide ACH Convening Meeting**
   Barb Malich, Jean Baldwin, and Scott Daniels attended a statewide convening of the state's Accountable Communities of Health in SeaTac on April 30. The meeting was organized by the Washington State Health Care Authority (HCA) and paid for by the Federal Reserve Bank of San Francisco. Barb said a lot of the discussion centered on the role of the ACHs and said it appears HCA will continue as the purchasing agent working with payers who will assume most of the risk. She also said that the Washington State Department of Health sees themselves as the data gatherers and providers of technical support on practice reform etc. Scott said the challenges that the ACHs expressed at the meeting was "the plane (the ACH) they are currently flying is still being built by HCA".

3. **Full OCOH Stakeholder Meeting Agenda and Logistics:**
   Rochelle Doan said that, prior to the next full stakeholder meeting, it would be beneficial to dialogue with folks who are not currently involved with the ACH effort about why they might want to, or should be, involved. She suggested having a full meeting in mid-summer after some of those discussions have occurred. She said the full meeting will need to look at a governance model and developing that will take some dedicated work time on our part. Peter agreed and said he was ready to get out and start having those discussions. He asked the group for feedback on who that should be including contact information. He also invited Steering Committee members to participate in those meetings with him. Rochelle also mentioned a one-page briefing paper describing the goals and the work ahead for the ACH (was previously discussed by the Steering Committee) and having that available for these visits.

   Jean Baldwin mentioned she had recently met with the three hospitals in Jefferson and Clallam Counties (predominantly Medicaid) and said they were ready to be more involved. She said the hospitals were really concerned because they are not hearing much from our region, but are hearing a lot regarding what's happening in other regions around the state. She said they are concerned about insurance reform and the Medicaid waiver in process, and because they have community health plans in place in their counties they want to know how their plans will fit in with a regional plan. They also want to get Tribes involved. She said the three hospitals are also in conversation with Harrison Medical Center about how the hospitals will work with the ACH.

The group then discussed the ideal of first having "specialty meetings" with the healthcare sector and meeting later with those less involved. Joe Roszak said he liked this idea, and he, and others, suggested that those conversations include like FQHCs, rural health clinics, mental health, substance abuse, BHOs, HCA, Tribes, and other healthcare service providers. Joe suggested not including the MCOs in these first meetings. Jeanne LaBrecque recommended including the new community health center in Port Angeles, and making sure to include the largest practices that serve Medicaid, and just the largest practices in general. The group suggested that at these meetings stakeholders provide feedback on possible governance options including the option of forming a 501(c)3 non-profit to serve as backbone entity. Peter requested specific direct feedback from members of the Steering Committee regarding who he should meet with, and to let him know if anyone would be interested in attending any meetings with him.

The group agreed that the next full OCOH meeting occur sometime in mid to late July if possible.

4. **Ongoing Stakeholder Meeting Logistics**

The following venues were mentioned as possible venues for the second full OCOH meeting: Jamestown S'Klallam Casino and Conference Center, Port Ludlow Conference Center, and Fort Worden State Park Conference Center. Peter said he would work with Jean Baldwin to determine venue logistics and availability. Scott mentioned that Craig Nolte from the Federal Reserve Bank of San Francisco has offered to pay for meeting costs as they have done for other ACHs around the state, and for HCA. Joe recommended exercising caution in having them do this for us because of what they might want in return.

5. **Governance Subcommittee**

This item was not discussed.

6. **Other Issues**

Joe mentioned that we should consider having the OCOH incorporate as 501(c)3 as soon as possible.

June 9, 2015

Steering Committee Conference Call (11:00 a.m. to 12:00 p.m.)

In Attendance: Peter Browning, Adam Marquis, Barbara Malich, Rochelle Doan, Doug Washburn, Jeanne Librecque, Joe Roszak, Susan Turner, Scott Daniels, Larry Eyer, Dale Jarvis, Judith McCurdden, Jean Baldwin

1. Meetings with Healthcare Authority
2. Medicaid Waiver
3. Large Group Meeting in July
4. Communications

July 10, 2015

Steering Committee Conference Call (9:00 a.m. to 10:30 a.m.)

In Attendance: Peter Browning, Adam Marquis, Barbara Malich, Rochelle Doan, Doug Washburn, Jeanne Librecque, Joe Roszak, Susan Turner, Scott Daniels, Larry Eyer, Dale Jarvis, Judith McCurdden, Jean Baldwin

1. ACH Governance Structure
    a. Governance Model
    b. Role of Local Community Forums
    c. Role of MCOs
2. July 29th Stakeholder Meeting
3. ACH Technical Assistance Needs
4. Communication Tool Update

August 31, 2015

Steering Committee Conference Call (10:30 a.m. to 12:00 p.m.)

In Attendance: Scott Daniels, Barbara Malich, Joe Roszak, Doug Washburn, Judith McCrudden, Susan Turner, Peter Browning, Larry Eyer, Jennifer Kreidler-Moss, Darryl Wolfe, Hilary Whittington

1. ACH Governance Subcommittee Status
2. Interim Governance Board
3. Steering Committee Membership
4. OCH Website
5. Report Back from HCA ACH Summit
6. HCA and DOH Technical Support
7. Stand Steering Committee Meeting Dates
8. Dates for Stakeholder Meeting

September 23, 2015

Steering Committee Conference Call (1:00 p.m. – 2:30 p.m.)

In Attendance: Scott Daniels, Iva Burks, Jean Baldwin, Doug Washburn, Adam Marquis, Susan Turner, Rochelle Doan, Siri Kushner, Peter Browning, Larry Eyer, Kayla Down, Hilary Whittington

1. Project Manager Update
2. Recruitment Plans
3. Approve ILC Governance Charter
4. Interim Leadership Council Meetings
5. Website and Logo
6. Agenda for November 2nd Stakeholder Meeting

1.8 OCH Interim Leadership Council

These documents reflect the ILC sector representatives and ILC subcommittee members to date. The number and constituency of ILC sector representatives and subcommittee members are expected to evolve prior to establishment of a Governance Board by March 2016. Minutes of the ILC, which met for the first time October 19, 2015 and again on November 2, 2015 are included for review. The ILC will review and approve the Readiness Proposal November 18, 2015 prior to submission; monthly meetings will occur thereafter until the Governance Board is established.

Olympic COMMUNITY of HEALTH

OCH Interim Leadership Council 2015 (11/15/2015)

Name and Affiliation	County	Service Area	Sector (s)
Doug Washburn Director Kitsap County Human Services	Kitsap	Clallam Jefferson Kitsap	**Behavioral Health Organization** Staff, by BHO Executive Committee appointment
Robin O'Grady Executive Director Westsound Treatment Center	Kitsap	Kitsap	**Chemical Dependency** (Medicaid Provider)
Katie Eilers Assistant Director, Community Health Kitsap Public Health District	Kitsap	Clallam Jefferson Kitsap	**Chronic Disease Prevention** Across the Lifespan
Larry Eyer Executive Director Kitsap Community Resources	Kitsap	Kitsap	**Community Action Program/ Social Service Agency**
Tom Locke	Clallam	Statewide	**Dental Health** (State Rep)
Barbara Malich PCHS Consultant Peninsula Community Health Services	Kitsap	Kitsap	**Federally Qualified Health Clinic**
Michael Anderson Chief Medical Officer Harrison Medical Center	Kitsap	Clallam Jefferson Kitsap	**Private/Not for Profit Hospital**
Kurt Wiest Executive Director Bremerton Housing Authority	Kitsap	Kitsap	**Housing/Homeless**
Roy Walker Executive Director Olympic Area on Aging	Clallam Jefferson	Clallam Jefferson	**Long Term Care/Area Agency on Aging/ Home Health**
Erin Hafer Director, Network Development Community Health Plan of WA	Statewide	Statewide	**Medicaid Managed Care** **TBD by MCOs**
Peter Casey Executive Director Peninsula Behavioral Health	Clallam	Clallam	**Mental Health** **(Medicaid Provider)**
Justin Sivill Director, Operations Harrison Health Partners	Kitsap	Clallam Jefferson Kitsap	**Primary Care**

Jean Baldwin Director Jefferson County Public Health	**Jefferson**	**Clallam**	Public Health
Eric Lewis Chief Executive Officer Olympic Medical Center	Clallam	Clallam	**Public Hospital**
Hilary Whittington Chief Financial Officer Jefferson Healthcare			**Rural Health**
TBD			**Tribal Representative/s** Under discussion, to be determined

Olympic COMMUNITY of HEALTH

ILC Subcommittees 11-15-2015

Community Assessment & Planning Subcommittee

Michael Anderson	Kitsap	Hospital
Jean Baldwin	Jefferson	Public Health
Rochelle Doan	Kitsap	Project Manager
Larry Eyer	Kitsap	Community Action Program
Siri Kushner	Kitsap	Epidemiologist, Public Health
Gay Neal	Kitsap	Behavioral Health
Roy Walker	Clallam	Aging & LTC
Kurt Wiest	Kitsap	Housing/Homelessness

Governance Subcommittee

Rochelle Doan	Kitsap	Project Manager
Mike Glen	Jefferson	Public Hospital
Barbara Malich	Kitsap	Project Manager
Adam Marquis	Jefferson	Mental Health
Peter Casey	Clallam	Mental Health
Iva Burks	Clallam	Social Services
Jeanne LaBrecque	Clallam	Community Member
Doug Washburn	Tri County	Behavioral Health Organization
Eric Lewis	Clallam	Public Hospital

Sustainability Subcommittee

Rochelle Doan	Kitsap	Mental Health
Katie Eilers	Kitsap	Public Health
Barbara Malich	Kitsap	Project Manager
Hilary Whittington	Jefferson	Rural Health
Joe Roszak	Kitsap	Mental Health
Jennifer Kreidler-Moss	Kitsap	FQHC
Jody Moss	Clallam	Philanthropy
Kirsten Jewell	Kitsap	Housing/Homelessness

From: "Kathy Greco" <kathy.greco@kitsappublichealth.org>
To: "Barbara Malich (malich.messages@gmail.com)" <malich.messages@gmail.com>, "David Schultz, CEO" <david.schultz@harrisonmedical.org>, "Doug Washburn" <dwashbur@co.kitsap.wa.us>, "Erik Lewis" <elewis@olympicmedical.org>, "Jean Baldwin" <jbaldwin@co.jefferson.wa.us>, "Justin Sivill (Justin.sivill@harrisonmedical.org)" <Justin.sivill@harrisonmedical.org>, "Katie Eilers" <katie.eilers@kitsappublichealth.org>, "Kurt Wiest" <kwiest@bremertonhousing.org>, "Larry Eyler" <larrye@kcr.org>, "Peter Casey" <peterc@peninsulabehavioral.org>, "Robin O'Grady" <westsound1@wavecable.com>, "Rochelle Doan" <rdoan1@q.com>, "Roy Walker" <walkerb@dshs.wa.gov>, "Siri Kushner" <siri.kushner@kitsappublichealth.org>, "Tom Locke (Jefferson)" <tlocke@co.jefferson.wa.us>
Sent: Friday, October 16, 2015 2:21:20 PM
Subject: OCH Interim Leadership Council Meeting 10/19/15

Good afternoon!

Just a reminder that the first OCH Interim Leadership Council meeting takes place this Monday, October 19th, 2:30 - 5:00 PM at the Silverdale Hotel. The Meeting Agenda, ILC Roster, and the ILC Charter is attached for your review.

While the formative work for the Olympic Community of Health was initiated in July 2014, we recognize representatives comprising the Interim Leadership Council have each had varying levels of involvement in this endeavor to create the Olympic Community of Health. Since July 2014, informal steering committee calls with interested individuals committed to launching the OCH have taken place monthly, resulting in two large gatherings of stakeholders during November 2014 and again this July 2014. Five steering committee participants then met this summer to create the Interim Leadership Council Charter, approved by the larger steering committee this fall, so that we could move to the more formal ILC structure that will guide the further development of our OCH, as well as the process of preparing a Readiness Proposal to be submitted by November 30, 2015. The Readiness Proposal will reflect the history of our OCH development, our accomplishments to date, and our detailed plans over the months ahead to better the health of the people and communities across our region.

To this end, you will notice the agenda for Monday is ambitious, but we believe it is doable, and we look forward to supporting you, the OCH ILC and the many stakeholders developing the Olympic Community of Health. Please do not hesitate to contact us for questions and information as we begin this journey with you!

Our best,

Barb Malich
253-312-7508
malich.messages@gmail.com

Rochelle Doan
253-405-0972
rdoan1@q.com

OCH Project Managers

OLYMPIC COMMUNITY OF HEALTH

Interim Leadership Council Agenda

October 19, 2015

2:30-5:00 p.m.

Location: Best Western Silverdale Beach Hotel
(Anchor Room)

Facilitators: Barbara Malich, Rochelle Doan

1.	Welcome and Introductions	15 min
2.	Charge of Interim Leadership Council	10 min
3.	Governance Structure: Charter Review Discussion	30 min
4.	Moving Forward:	
	a. Update on ACH Expectation and Support to Regional ACH's	10 min
	b. Subcommittee Formation	20 min
	c. Preparing Readiness Proposal by 11/30 for ACH Designation	10 min
	d. Timelines	10 min
	e. Stakeholder Engagement: Setting the November Agenda	20 min
	f. OCH Logo	10 min
5.	Other Discussion Items	15 min

Handouts: Quick Glance
Invest in Your Community
Coordinated Statewide Measurement Strategy

QUICK GLANCE

Olympic Community of Health Development 10/8/15 – 1/31/16

"Regional Vision, Local Action"

CREATION OF THE OCH INTERIM LEADERSHIP COUNCIL

9/15 ILC Charter document completed by Governance subcommittee

9/22 Steering Committee approves ILC Charter, directs OCH consultant to convene ILC sector stakeholders identified at the July 22, 2015 Stakeholder meeting. Further directed to continue discussion to secure yet unidentified stakeholder representation, include Tribal, rural health, private/not for profit hospital, chemical dependency.

10/1 ILC meeting scheduled for 10/19. Steering committee to disband 10/19/15 as ILC takes on governance role.

OCH INTERIM LEADERSHIP COUNCIL

CHARGE: Support formation of an Olympic (Accountable) Community of Health and its future designation, serving in a transitional role October 2015 – February 2016 until a yet more formal Governing Board with additional sectors and deeper representation is in place. Provide 1-2 ILC members each subcommittee to chair and report back to ILC.

- Create a regional pathway to improving patient care, reducing the per-capita cost of health care and improving health of the population.
- Guide a regional vision by bringing the voice of sectors and the stakeholders they represent to the table to work collectively toward common areas of focus: access to care, population health improvements, access to "Whole Person" Support and promoting data sharing and a region-wide infrastructure. Collaborate across systems to improve our community safety and well being. Adhere to the OCH Guiding Principles.
- Intentionally work now to deepen stakeholder participation 1) within each sector so that representation on the Governing Board is rich with the experience and voice and 2) bring additional sectors and representation yet to be identified from Community Services System.

MEETING:

1st	October 19	2:30 pm – 5:00 pm	Silverdale
2nd	November 2	1:00 pm – 4:00 pm	Port Gamble
3rd	December 7	1:00 pm – 4:00 pm	TBD
4th	January 11	1:00 pm – 4:00 pm	TBD

SUSTAINABILITY SUBCOMMITTEE

CHARGE: Research and recommend OCH sustainability plan and health care payment models.

MEETING: 1st October 27 2nd Nov 1 – 15

Monthly thereafter

STAKEHOLDERS

GOVERNANCE SUBCOMMITTEE

CHARGE: Research/recommend evolving governance structure for OCH. Research/recommend legal form of OCH to ILC including bylaws. Act on legal form if indicated.

MEETING: 1st October 20-31
2nd TBD Nov/Dec
3rd TBD January

COMMUNITY HEALTH ASSESSMENT & PLANNING

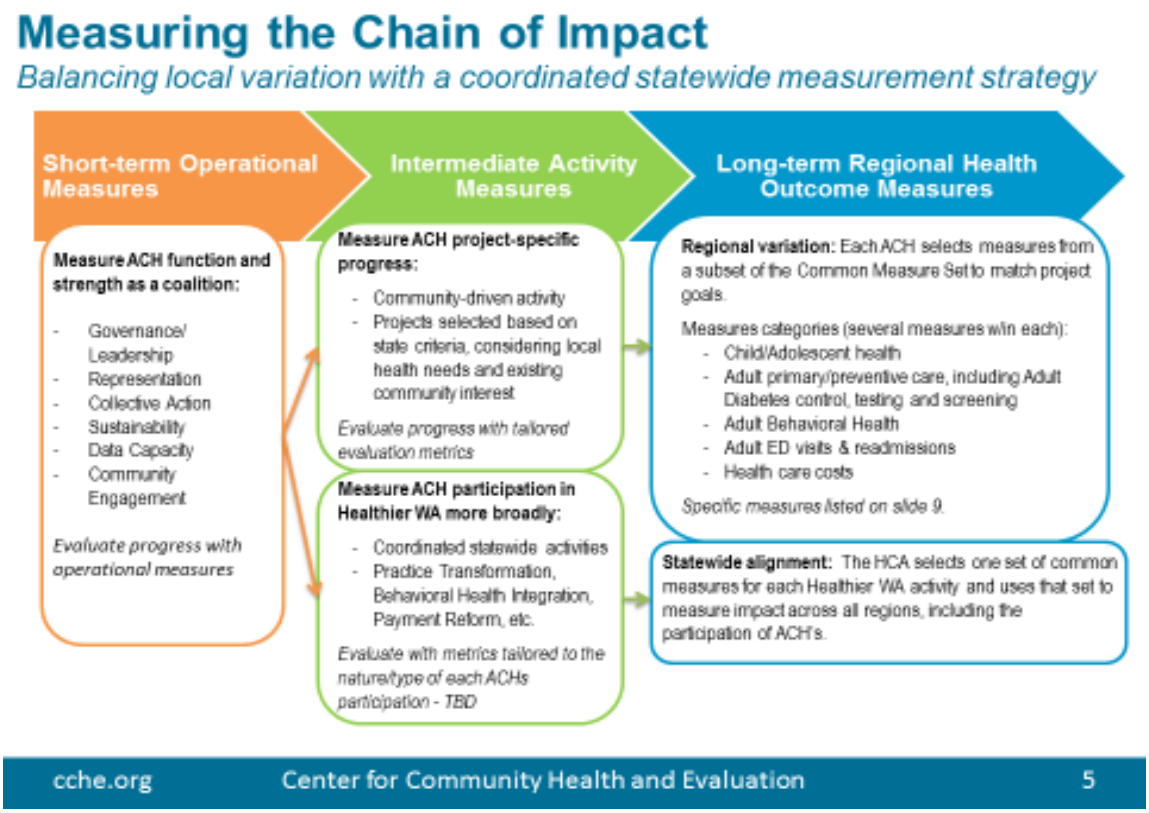
CHARGE: Facilitate service gap analysis, priority setting; CHIP; develop approach for Regional Health Improvement Plan by 11/15; performance measures, recommend innovations. Carry out RHIP via collective impact.

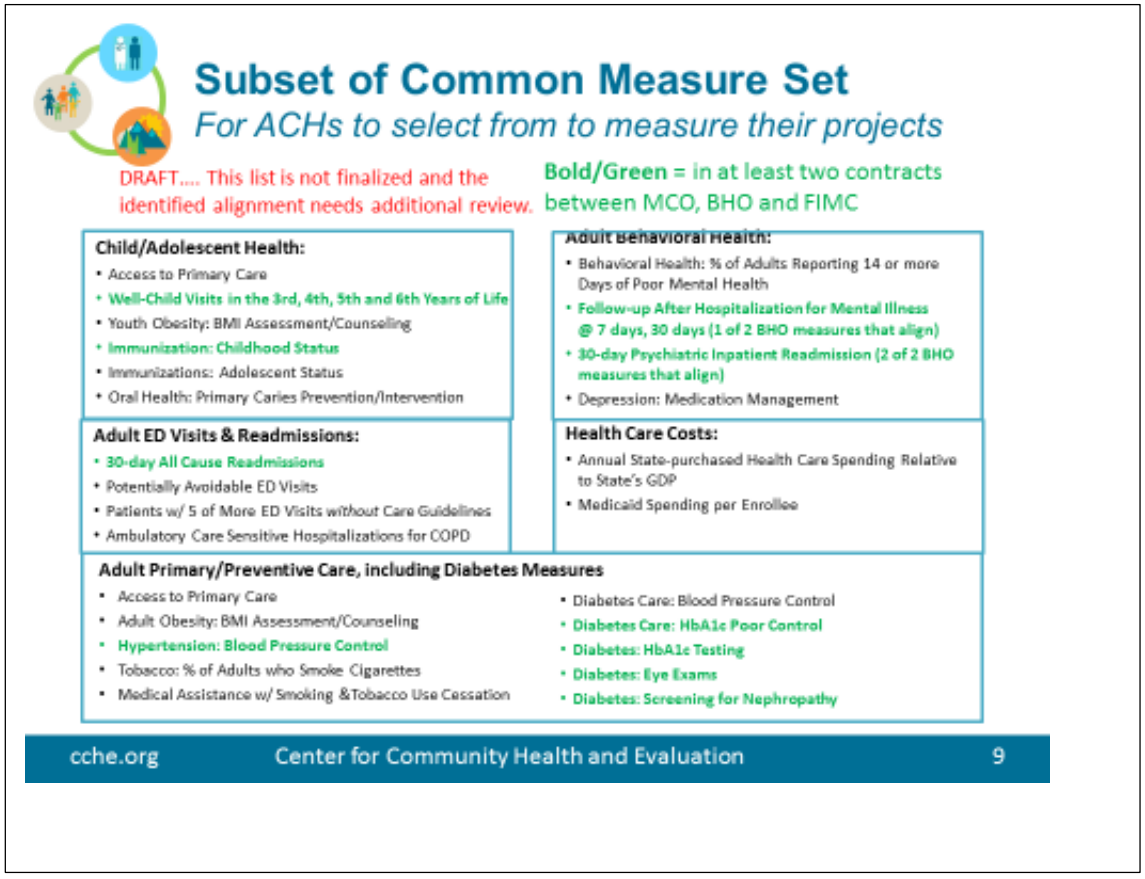
MEETING: 1st TBD Oct 20 - 31
2nd TBD Oct 26-Nov 5
3RD TBD Nov 5-Nov 15
Monthly thereafter

STAKEHOLDER MEETINGS

1st November 2014
2nd July 2015
3rd November 2 2015
4th January 26, 2016

Better Health. Better Care, Lower Cost.



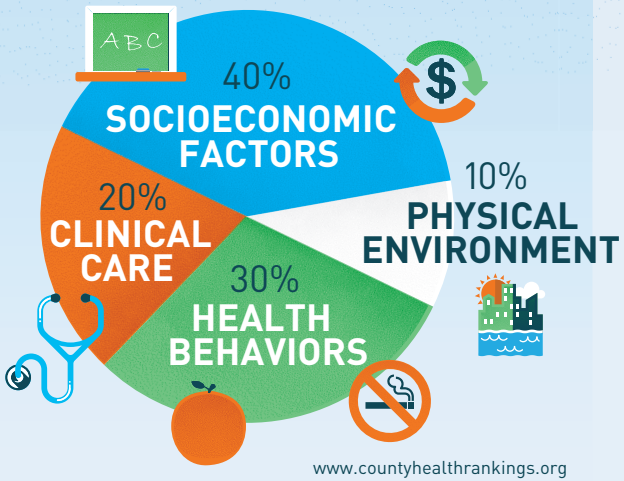


Note: ACH Framework for Statewide measures introduced at ILC meeting 10-19-15 and again at Stakeholders meeting 11-2-15; in use by Community Assessment & Planning Committee Subcommittee for Regional Health Improvement Plan approach.

INVEST IN YOUR COMMUNITY

4 Considerations to Improve Health & Well-Being *for All*

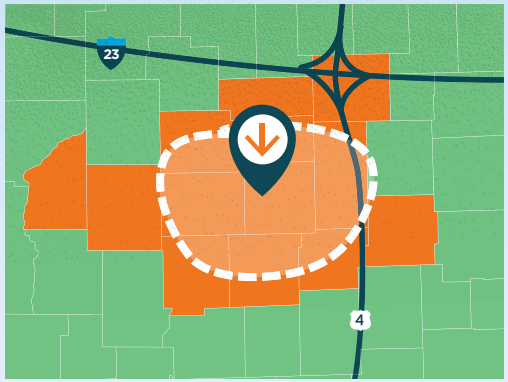
WHAT — Know What Affects Health



www.countyhealthrankings.org

WHERE — Focus on Areas of Greatest Need

Your zip code can be more important than your genetic code. Profound health disparities exist depending on where you live.



WHO — Collaborate with Others to Maximize Efforts

HOW — Use a Balanced Portfolio of Interventions for Greatest Impact

- Action in one area may produce positive outcomes in another.
- Start by using interventions that work across all four action areas.
- Over time, increase investment in socioeconomic factors for the greatest impact on health and well-being for all.

Four ACTION Areas

VISIT **www.cdc.gov/CHInav** FOR TOOLS AND RESOURCES TO IMPROVE YOUR COMMUNITY'S HEALTH AND WELL-BEING

CDC Centers for Disease Control and Prevention

NPS NATIONAL PREVENTION STRATEGY

Robert Wood Johnson Foundation

MARCH 2015

OLYMPIC COMMUNITY OF HEALTH

Olympic Community of Health
Interim Leadership Council Meeting
October 19, 2015

Date: 10/19/2015	**Time: 3:30 – 5:00 p.m.**	**Location:** Silverdale Beach Hotel, Anchor Rm., Silverdale, WA

Meeting Scribe: Kathy Greco

Attendees: **Rochelle Doan, Barbara Malich, Doug Washburn, Larry Eyer, Scott Daniels, Kurt Wiest, Peter Casey, Jean Baldwin, Eric Lewis, Katie Eilers, Michael Anderson (for David Schultz), Hilary Whittington, Mike Glen, Siri Kushner, Adam Marquis, Roy Walker, and Kathy Greco**

Person Responsible for Topic	Agenda Topic	Discussion/Outcome	Action/Results
Rochelle Barbara	Welcome and Introductions	Program Managers , Rochelle and Barbara thanked everybody for their time and commitment to the OCH Interim Leadership Council (ILC). Introductions, with sector affiliation, were made. Barbara stated that she and Rochelle have other community affiliations, Barbara with Peninsula Community Health and Rochelle with Kitsap Mental Health Services. She asked the Council if there are any concerns from them with regards to conflict of interest in their Project Manager role. There were no concerns and there were no objections voiced.	Barbara and Rochelle stated if there are any concerns regarding conflict of interest that the Council can bring them to Scott Daniels attention.
Rochelle	Charge of Interim Leadership Council	The purpose of the OCH Interim Leadership Council (ILC) is to support the formation of an Accountable Community of Health and its desired future ACH designation in 2016 by the Washington State Healthcare Authority (ACH). The ILC is tasked to work together until the formation of a new entity (possibly a non-profit organization) and a Governing Board is established (no sooner than February, 2016 and possibly later). The Accountable Community of Health (ACH) Readiness Proposal is due to Scott on 11/15/15. It is due to the State of WA on 11/30/15.	

		Kitsap Public Health District is the administrator for the Health Care Authority (HCA) Grant. Scott and Kathy represent the backbone organization that will provide administrative support to the OCH.	
Rochelle	Governance Structure: Charter Review and Discussion	Rochelle led the Council through a review of the, Draft ACH Readiness Proposal Category, Interim Leadership Council Charter. This will be an evolving document until a new organization and its Governing Board is formed. After full review of the Charter, the Council approved moving forward on the ILC Charter after incorporating the following changes: <u>Page 3, Section 1.1.3 (Access to "Whole Person" Support):</u> • Add Health Disparity Equity • Add Aging/Elderly Care (dementia/palliative care), vulnerable adults <u>Page 3, Section 1.1.4 (OCH Guiding Principles), #4</u> • Savings Reinvestment, "Gain-sharing" vs. "rationing of care" <u>Page 3, Section 1.1.4 (OCH Guiding Principles), #5</u> • It was noted that the all three county Community Health Needs Assessments are excellent resources for data and should be utilized. • <u>Page 9, 1.3.1 (ILC & Backbone Support Organization Roles and Responsibilities)</u> • Add: Reporting Role of Project Managers to ILC. • Clarify Relationship of the OCH and HCA/state Jean moved and Michael seconded the motion to approve the ACH Readiness Proposal, Interim Leadership Council Charter (to include the above changes). The motion was approved unanimously.	Rochelle will update the Charter and email to ILC members for final review. Scott will email a copy of the ACH contract to Committee members. Time will be allotted at the November 2, 2015 Stakeholder Meeting to discuss #4 on page 3, the "Savings Reinvestment" Rochelle will update the Charter and highlight the changes incorporated. She will email to ILC members for final review before presenting to the Stakeholder meeting on 11/02.

Barb	**Moving Forward:** a. Update on ACH Expectation and Support to Regional ACH's	Each sector is expected to determine what type of communication plan they will use to communicate within their group. For Example: Barb is working on communications with all Tribes and two Federally Qualified Health Centers.	Council members will identify their contacts and send them to Kathy at Kathy.greco@kitsappublichealth.olrg who will keep a master list. This will help identity who is missing and any overlaps.
Barb	b. Sub Committee (SECTOR) Formation	It is time in the process for the ILC to form three Sub-Committees. Barb reviewed the charge and responsibility for each Sub-committee. The Sub-Committees and those that volunteered are: **Governance Committee – Barbara Malich** • Eric Lewis • Doug Washburn • Adam Marquis • Rochelle Doan **Sustainability Committee – Barbara Malich** • Hilary Whittington • Katie Eilers **Planning and Assessment – Rochelle Doan** • Jean Baldwin • Roy Walker • Katie Eilers • Larry Eyer • Michael Anderson • Kurt Weist • Siri Kushner • Gay Neal	The ILC will meet monthly The Governance, Community Health Assessment and Planning and Sustainability Sub committees will meet on a need by basis.
Barb	c. Preparing Readiness Proposal by 11/30 for ACH Designation d. Timelines	Barb reviewed the Readiness Proposal expectations and deadlines.	The Readiness Proposal is due to Scott by November 15, 2015 and due to the state on November 30, 2015.

Rochelle Barbara & Council	e. Stakeholder Engagement: Setting the November 2, 2015 Agenda	The November Stakeholder Meeting was discussed and several possible agenda topics discussed. • Service Gaps • Big Picture, "Where are we Going • Hear the Stressors and struggles learned by Cascade Pacific through their process. • Panel discussion • Community Engagement (Energize and excite the Stakeholders) • ACH/ACO – What is the Difference? • Develop a one page Q&A flyer • ILC Charter Update • Assessment (of work so far) In order to meet the immediate deadlines for the Readiness Proposal, the Council will focus on three agenda topics at the Stakeholder meeting: • Community Engagement (energize and excite the Stakeholders • ILC Charter Update • Assessment (of work so far) A suggestion was made to create a Q&A flyer that could be used as a resource to the Stakeholders.	The meeting on November 2, 2015 will be as follows: 1:00-4:00 p.m. Stakeholder Meeting 4:00-5:00 p.m. ILC Meeting.
Council Barb	f. OCH Logo g. Close	The Council discussed the many options for a new logo. Kitsap Public Health is working with a Design Consultant who will provide samples for the ILC review. Also, Jefferson Hospital of drafting a few logos for ILC review. We went around the table and identified this work is important and why each is committing time and talent.	Use current logo until final decision made. Once the draft logos are ready they will be emailed out to the ILC for review and feedback. Repeat this exercise in an abbreviated way at Stakeholders.
Rochelle	Other	There being no further business the meeting was adjourned at 5:00p.m.	

1.9 OCH ILC Governance Subcommittee Meeting Summaries

The document “A Pathway to Governance Decision Making” reflects the thinking of the ILC Governance subcommittee participants to date, shared at the November 2 Interim Leadership Council meeting. Minutes of the ILC Governance Subcommittee are also included for review.

OLYMPIC COMMUNITY OF HEALTH

AGENDA
OCH Governance Committee
Friday - October 30, 2015
2:00-3:30 p.m.

Conference Call Phone Number: 866-730-7515
Conference Call PIN: 883040#
Facilitator: Barbara Malich

Committee Members: Eric Lewis, CEO Olympic Medical Center; Doug Washburn, Director, Kitsap County Human Services; Adam Marquis, Executive Director, Jefferson Mental Health

1. **Member Introductions**

2. **Ground Rules for Teleconference Participation:**
Identify yourself before you speak (at least until we learn each other's voices), don't speak over each other, and allow for courtesy to rule. We will set up a cue if needed depending on the number of participants. There is a clear expectation that all members will participate!

3. **Review Charge -** (Quick Glance), attached.

4. **Review Proposed Language** (Governance Next Steps), attached.

5. **The Bigger Picture (Group Discussion):** What do we want to be when the OCH becomes a "real" entity? A non- profit (independent) with hired staff/independent board of directors/ capacity for membership relationship or charitable purpose? Perhaps a Government program imbedded within a larger structure (Public Health Program manager for OCH), or even an LLC (independent business created to build capacity with an expectation of partners, shareholders, etc. in the future)?

6. **Technical Assistance** to proceed or are we ready to make recommendation?

7. **Next Meeting**

OLYMPIC COMMUNITY OF HEALTH

Governance Subcommittee– Meeting Notes

October 30, 2015

Present: Doug Washburn, Adam Marquis, Barbara Malich Absent: Eric Lewis

Member Introductions: It was suggested to reach out to Mike Glenn, Jefferson Health Care, to add to committee. The committee will continue to consider expanding to a larger size. Announcement of both subcommittees and the opportunity to get more involved was suggested for the Stakeholder meeting on Monday, November 2.	Barbara Malich will reach out to Mike Glenn to see if he is interested and available for the next meeting.
Review Charge: no changes	
Review "The Pathway to Governance Decision-Making" Approved with no changes. Note: The document will be included as part of the Readiness Proposal to demonstrate the work of the Governance Committee. The Interim Leadership Council Charter will also be included (recommended by Governance Committee, approved by Steering Committee, then confirmation of approval by ILC. Earlier Governance Committee meetings were not recorded, but the work has been on-going July-October and will continue into the next phase of OCH development.	
The Bigger Picture: Discussion followed around the approach to pursue re next steps. It was recommended that Barbara Malich prepare a document for the next meeting demonstrating the pros/cons of the various organizational models to be considered by the Committee. It was suggested starting with non-profit, engage with sponsoring organization (non-profit), and for profit (LLC or similar) be the initial options to pursue. It was noted it is difficult to support within a government entity, given part of the future role will potentially involve advocacy and fund development. The burdensome nature of the backbone organization role was also briefly discussed.	
Technical Assistance: It was decided no request for Technical Assistance will be made at this time.	Barbara Malich will prepare review document for next meeting as described.
Next Meeting: No meeting is needed in November unless additional work is generated by either the Stakeholders or the ILC. The next meeting will be arranged in conjunction with the ILC meeting currently planned for December 7.	Barbara Malich will coordinate next meeting and communicate with the committee.

OLYMPIC COMMUNITY OF HEALTH

"The Pathway to Governance Decision-Making"

10-22-2015 ILC Governance Subcommittee (Reviewed 11-2-2015 ILC)

Current Governance Position

The initial organizing steps have been completed, but are characterized as "interim". OCH has now adopted a "start-up" model that includes the seating of an Interim Leadership Council to provide an authorizing role and planning/decision-making function until the next steps in governance are identified and implemented. There is no set time frame for this work, but it is hoped that the work can be expedited and completed over the next 6-8 months.

Next Steps

Review and consider multiple organizational structures to support the role of the OCH. These options include (but are not limited to):

- Continue as a Multi-Partner Collaborative with a Financial/Administrative partner (backbone organization) to manage the business and deliver the work.
- Seek an existing Nonprofit or Government Agency to "take the lead" on the work as a managing partner---structure would defer to the host structure and the OCH would essentially just be a program within the host organization.
- Create a new, Integrated Legal Entity (Non-profit, Government, or For Profit) There are multiple options within each of these categories!

Core Principles

- **Accountability** that reflects - Transparency, Community Representation, Strategic Planning and Goals and Commitments
- **Neutrality –** balancing the three county model, large v. smaller partners, urban v. rural, and committing to growing the partnership/collaboration
- **Flexibility –** As a "start-up" we have no restrictions at present on our choices. The more defined the state expectations become, this flexibility may change
- **Sound Governance –** whatever the pathway, the commitment to excellence in the face of a changing environment must be a primary consideration for the partners/stakeholders

Key Elements for Consideration

- ACHs are emerging, evolving and experimental
- Collaboration/Collective Impact work is challenging, hard, and potentially rewarding
- OCH presents a real opportunity for:
  - Holistic Problem Solving
  - Alignment and Empowerment
  - Building New Relationships
  - Improving Communication
  - Realizing the goals of better health, better care and lower cost

1. An opportunity to do this work closer to home where we can be directly engaged in the pathways to progress, but recognize we must step up to the opportunity by commitment of time, resources, and reflect a willingness to embrace change.

TABLE 1. GUIDING PRINCIPLES OF AN ACH

	NEUTRAL	FLEXIBLE	ACCOUNTABLE	SOUND GOVERNANCE
NONPROFIT	A nonprofit organization is capable of being a neutral body within a community. Because nonprofit organizations are permitted to have a variety of stakeholders, members, and board members, a nonprofit organization can sufficiently represent various groups and act independently of other major institutions.	As a public benefit corporation, a nonprofit can engage in many different types of transactions to further its charitable purpose and mission, including grant-making, loans, joint ventures, program-related investments, and other financial transactions. Nonprofits are constrained by their charitable purpose, so for-profit activities unrelated to a charitable purpose are potentially subject to taxation.	A nonprofit organization can be directly accountable to a community through its form, mission and/or activities. Some nonprofit organizations have community members sit on their board of directors, such as federally qualified health centers. Nonprofits may focus their mission on assisting a specific community or addressing a particular issue within a community.	A nonprofit organization can provide sound governance under California law and develop additional policies or procedures to ensure accountability.
GOVERNMENT	In most circumstances, it will be very difficult for a government entity to maintain neutrality within a community. The nature of politics will generally influence major financial decisions related to the Wellness Fund, and most elected and appointed officials are influenced by the overall dynamics of the government and any related special interests. The potential exception is the creation of a special purpose district (e.g., health care district) or joint powers authority that may not be directly subject to the local politics of a city or county.	Government entities have some flexibility to engage in innovative projects, though have less flexibility than nonprofit and for-profit entities. Governments may set up enterprise funds to provide certain services to the public, such as water and sewage facilities, airports, and convention centers. A Wellness Fund can be established as an enterprise fund, but it would be subject to control by the elected body of government.	A government's board is usually composed of a limited number of elected or appointed individuals. While it is possible to have a board or commission composed of stakeholders or community members, ultimate authority still resides with the political body (i.e., city council, county board of supervisors, etc.). Thus, a government enterprise cannot fully delegate control and decision-making authority to a separate governing body. The only exception is a voter-approved initiative that fundamentally alters a government.	Government agencies have established governance procedures that are prescribed by law (either state or local). An ACH would not need to create new governance rules, but it would not have the flexibility to change the governance rules.
FOR-PROFIT	A for-profit organization is considered a single purpose entity. Its primary purpose is to earn profit for its owners. In this sense, a for-profit organization can be neutral if it focuses on one goal. However, power by owners can be shifted through acquisitions of additional ownership shares.	For-profit organizations have the greatest flexibility to engage in many different types of transactions. However, they typically engage in profit-driven business transactions, and generally do not distribute funding through grants. Similarly, it is highly unusual for a for-profit organization to be eligible for government or philanthropic grants.	While there are no restrictions on forming a for-profit organization, a for-profit organization is generally accountable to its owners, not a community. Because its primary purpose is to generate profit, conflicts may arise between the profit-making purpose of the entity and the interests of the community.	A for-profit organization can provide sound governance under California law and develop additional policies or procedures to ensure accountability.

Category 2: Governing Body Membership

Governing body membership reflects balanced, multi-sector engagement. At a minimum, a balanced engagement refers to the participation of key community partners that represent systems that include health: public health, the health care system, and systems that influence the Social Determinants of Health (SDOH), with the recognition that this includes different spheres of influence. The governance model should also include a process for adjusting as the environment changes.

From its initial conception, the Olympic Community of Health (OCH) has sought regional inclusivity and a growing multi-sector approach. The originating organizers represented local public health jurisdictions and county health and human services organizations in each of the three Counties, a Federally Qualified Health Center, a designated community mental health center, and a community action program. The first Stakeholder meeting in November 2014 quickly captured the interest of other sector voices and they began to participate with enthusiasm in the creation of the Olympic Community of Health and a shared multi-faceted regional vision to meet the Triple Aim across the region. In July 2015, participants in the second stakeholder meeting selected their sector representatives to the OCH Interim Leadership Council. The formative focus for the OCH is on sector representatives with a health and recovery services mission, to identify areas where sectors involved in driving effective population health strategies in concert with sectors addressing the social determinants can hone in rapidly on activities that meet and support the Triple Aim. Looking ahead to 2016, attention will quickly shift to broadening the sector voices at the table, while balancing the challenge of maintaining a group size that can work within a consensus framework.

Each stakeholder sector holds a single seat on the Council (see document 2.1 OCH Interim Leadership Council Composition). The Council strives to maintain balance across the region to make equitable policy decisions in which all participants hold a piece of the vision, bringing a diversity of perspectives to the health improvements we seek to make. Therefore we seek to achieve a balance of representation by each county. Nomination to the ILC is made among and by stakeholders of the sector for whom the individual serves as representative. Stakeholders are expected to be inclusive of their peers within the tri-county region in making the selection for representation, and to inform their representative by meeting regularly and independently of the OCH. Representatives are expected to communicate on behalf of and represent the sector as a whole and to ensure a system for regular communication and feedback within their sector and as a responsibility of their ILC membership. Sector stakeholders may identify an alternate if their representative is unable to attend. Each sector constitutes one “vote” in decision making.

Terms for the Interim Leadership Council are one year or less, by which time the transition to a Governing Board will be complete and the ILC will disband. The ILC Governance Subcommittee is charged in part with discerning how to add additional community sector voices while maintaining the integrity of a well-functioning governance structure. This is an illustration of the recognition and expectation that the current OCH governance structure is in a state of evolution. Forthcoming governance structure changes or additions can be made on an iterative basis, and are to be anticipated as we become clearer about our OCH identity and that of the ACH’s as a whole. Annual review of the governing council or board as well as that of the backbone organization is expected and facilitated by our governance structure guidance (see document 2.2 Annual Structure Governance Review Policy).

2.1 OCH Interim Leadership Council Composition

This document describes the formative, multi-sector composition of the OCH Interim Leadership Council. Each stakeholder sector holds a single seat on the Council. The Council strives to maintain balance across the region to make equitable policy decisions in which all hold a piece of the vision. Terms for the Interim Leadership Council will be one year or less, by which time the transition to a Governing Board will be complete and the ILC will disband.

Approved OCH Interim Leadership Council Governance Structure Membership Composition

Demonstrates regional, wide representation from multiple sectors with one representative each from the following sectors:

FORMATIVE FOCUS: HEALTH & RECOVERY SERVICES

Early Establishment of ILC October 2015-January 2016

- Behavioral Health Organization (Staff, by Executive Committee Appointment)
- Chemical Dependency (Medicaid Provider)
- Chronic Disease Prevention Across the Lifespan
- Community Action Program/Social Service Agency
- Dental Health
- Federally-Qualified Health Clinic
- Private/Not for Profit Hospital
- Housing/Homeless
- Long-Term Care/Area Agency on Aging/Home Health
- Medicaid Managed Care Representative
- Mental Health (Medicaid Provider)
- Primary Care
- Public Health
- Public Hospital
- Rural Health
- Tribes

Total Voting Members: 16

WIDENING FOCUS: COMMUNITY SERVICES SYSTEM

January 2016 and ongoing

The following sectors are identified as important to be developed and invited for representation on the OCH Interim Leadership Council and/or Governing Board.

- Economic Development
- Education (early learning through higher education)
- Law & Justice
- Nutrition & Active Living
- Philanthropy
- Transportation
- Workforce Development
- Other sectors yet to be identified

Terms for the Interim Leadership Council are one year or less, by which time the transition to a Governing Board will be complete and the ILC will disband. Formative focus sector representation will be followed by wider representation from the Community Services System Sectors, to be sought out and developed winter 2016, with additional sectors considered for inclusion in the OCH Governing Board.

OF NOTE:

Tribal Representation has yet to be determined**.** The Olympic Community of Health is dedicated to reflecting the entire community in our three county region. The diversity of our population and communities is rich in history and most significantly includes seven tribal nations. These sovereign nations continue to negotiate with the State for full autonomy as a statewide Accountable Community of Health, however in the meantime we are engaging with the tribes as vital components of our governance structure. All are invited to participate as Stakeholders and each will likely have a seat on the governing board as it evolves with the creation of an independent organization. At this time, with the creation of an Interim Leadership Council we encourage Tribal participation.

Managed Care Organization representation has yet to be finalized. The Olympic Community of Health is currently governed by an Interim Leadership Council dedicated to building a strong, viable, sustainable organization. The work of defining this governance structure falls initially to the Governance Subcommittee of the ILC. At this time all five managed care organizations serving in one or more counties in the three region area are encouraged to participate in all Stakeholder meetings and to attend the ILC. Although most decisions are reached by consensus, should a vote be taken, the MCOs have agreed to consolidate and speak through a single voting member of the ILC. They are requesting some flexibility in this role with the option that their voting member may rotate within the five companies. We are testing this model in the ILC. If successful the model will continue within the permanent governance model of an independent OCH.

2.2 OCH Annual Governance Structure Review Policy

This policy ensures that the OCH Interim Leadership Council or Governing Board will conduct a formal review of the OCH governance structure annually, allowing the OCH to plan for, test, and adjust to environmental changes. This includes the composition of the governing body, whose membership may be adjusted more frequently as additional sector representation can be brought to the table. Additionally, the policy ensures the ILC or Governing Board conducts a formal review of the backbone organization on an annual basis.

Annual Review Policy of the Interim Leadership Council and Virtual Backbone Organization

This process is established and documented to allow for adjustments to the ACH structure as concerns or additional governance structure needed will evolve over time. The review process recognizes that development of the OCH governance structure is an iterative process and will require finessing and adjustment as the ACH function and our local structure becomes further defined.

Interim Leadership Council/Governing Board

The OCH Interim Leadership Council will review the current governance structure as a whole at least annually, affirming the current composition or when indicated, make adjustments in real time should issues or gaps emerge. These adjustments or the affirmation will be noted in the meeting summary.

Virtual Backbone Organization

The Virtual Backbone Organization will be reviewed on an annual basis by the governing body (at this time the Interim Leadership Council, at a future time, a Governing Board) which will select or reaffirm the backbone organization, and note as such in the governing body meeting summary.

Category 3: Community Engagement

Community engagement activities are underway and additional community engagement activities are planned, in addition to engagement that occurs through the governance structure (e.g., ACH governing body and committee meetings).

The Olympic Community of Health's (OCH) commitment to community engagement evolves from understanding that the capacity to be a trusted partner in regional health improvements only comes about from a willingness to invite, involve, listen and act through the voices of the people in the communities we serve. Our communities and our counties have a long history of working closely together to solve problems and support healthy environments for the individuals, families, and places in which we live, work, and play. To this end, our originating conveners and most recently, our Interim Leadership Council (ILC) as the OCH's governing body, have taken responsibility for representing the sector voices of their organizations and geographic regions. Members in ILC workgroups are instrumental in providing insight from their knowledge and experience. As we create health priority strategies, we anticipate that additional stakeholder voices will be invited and present to share their knowledge, experience, and organizational perspectives.

Community engagement in the OCH began with the inception of our first stakeholder meeting in November 2014. Key leaders across the region in the 16 sectors now represented on the ILC, plus leaders from education, political office, justice, transportation, and others sectors, were invited to attend and learn about the vision and steps needed to form a local Accountable Community of Health (see document 3.2, Stakeholder Engagement and Development of Regional Health Priorities). Stakeholders also reviewed 2014 Community Health Improvement Plan (CHIP) findings from each of the three counties to develop a shared understanding of what regional priorities might be chosen for action planning together. The three counties share the same CHIP approach and utilize support from the same Kitsap Public Health District epidemiologist, creating a quality of information flow, planning guidance, and connectedness for future priority setting, regional planning, and local and regional action. In our community assessment and planning efforts, we have also recognized many existing opportunities for community engagement and action strategies. By considering these plans, which generally involve issue specific and/or community-specific input, and which have engaged large numbers of participants through forums, surveys, and task groups, we are able to incorporate additional community voices into our regional planning. During the completion of our regional health improvement plan process we will continue to engage additional stakeholders.

The OCH stakeholder invitation list has been expanded through review by sector representatives and stakeholder meeting attendees and has generated between 45 – 80 participants at each of three Stakeholder meetings. The second and third stakeholder meetings have been well balanced geographically and have included a wide range of health, human services, housing, non-profit and governmental agency, MCO, tribal, community, and other participants. The OCH stakeholders are active participants, and the perspectives shared by this wide range of partners is of great value. Discussions are currently on-going about the Tribal role in governance activities. It is likely all Tribes will be seated at the governing table when the OCH moves to the next stage of development and a more permanent model is finalized for the OCH. Lastly, we have initiated an audience specific communications strategy as included below, and are committed to maintaining current information on the OCH website (http://www.olympiccommunityofhealth.org/Pages/Welcome.aspx) for organizations or individuals interested in the work of the OCH (see document 3.1 OCH Communication and Community Engagement Framework). Meetings have been and will continue to be open to any interested attendees.

3.1 OCH Communications and Community Engagement Framework

This document reflects our philosophy and approach to our communications strategy and community engagement. It discusses content specific to the purpose, audience, and dissemination of our communications and community engagement framework.

OCH Pathway to Effective Communication and Community Engagement

November, 2015

Introduction: The focus for effective communication and collaboration within the stakeholder group at the regional level and subsequently in communities served by the Olympic Community of Health (OCH) is built on a foundation of trust. This foundational basis for all communication is forged by the emerging trusting relationship and the stakeholders' confidence that the integrity of the work being undertaken is valid and has at its core the desire to improve the health of local communities. In building the trusting relationship, target audience/stakeholders will be specifically identified and communications tools developed to support the engagement of the various groups. This conceptual framework is intended only as a starting point for communications planning to be developed in the future.

Purpose: The Communications and Community Engagement Pathway is to serve as a roadmap for effective communication and collaboration between stakeholders in participating local communities. The intent is to provide timely information, updates and an avenue for feedback. Communication must be consistent, clear, and encourage discussion and the exchange of ideas.

We acknowledge the value of the work of the international Association for Public Participation, introduced through the ACH Peer Learning Collaborative and we embrace these "IAP2 Spectrum" precepts:

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives and/or solutions	To obtain public feedback on analysis, alternatives and/or decision.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision-making in the hands of the public.
PROMISE TO THE PUBLIC	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We implement what you decide.

Based on the understanding that no single individual, organization or program can effectively solve complex problems alone, the OCH uses the collective impact model as the guiding framework to collaborate and support our health improvements: a common agenda, shared measurement, mutually reinforcing activities, continuous communication and backbone support. Both a Project Manager and Backbone organization staff have participated in a weeklong Collective Impact summit (October 2015), and many of the OCH participating stakeholders have previously been introduced to this approach to community engagement and action through shared learnings opportunities. The Community Health Improvement Plan processes held throughout our region have included education regarding the underpinnings of collective impact.

Audience: OCH brings many stakeholders from diverse sectors and communities to the table. Different groups may have different communication norms and preferences. The goal is to build communication platforms that can be used effectively across multiple stakeholders and communities. At this time, the following primary audiences are:

The Interim Leadership Council and its subcommittees, currently comprised of 15 representative voices who can speak to health and human services in the OCH region; there are seven area Sovereign Tribal Nations who will either share a single sector voice, or will each have a vote at the ILC; a determination we expect will be made by the Tribes prior to establishment of the OCH Governing Board in 2016. Additional sectors will likely emerge at the Interim Leadership Council/Governing Board over the course of 2016 as the OCH moves from its formation stage into a broader sector focus.

Stakeholders who are interested in improving population health, including the social determinants of health, in the Olympic region consisting of Clallam, Jefferson and Kitsap Counties through collective action and who are active participants in the OCH stakeholder convening's held three times yearly. Much of the work and engagement potential in the OCH is predicated on the strategies focused on, and encouraging involvement in ILC subcommittees and workgroups which may be identified in the future to support this RHIP, including engagement with community members and geographies especially impacted by health disparities.

Communications tools: OCH will employ diverse tools to build trust and community engagement. These tools will include, but are not limited to: In-person Meetings (including both training and shared learning), phone calls, website, email, press, and social media.

Communications Tools

TOOLS	AUDIENCE	FREQUENCY
In-person meetings	Interim Leadership Council Stakeholders ILC Subcommittees & workgroups Community members & potential stakeholders	Monthly 3 times annually Monthly or as needed As needed/requested
Phone calls	Council, Stakeholders, subcommittees community members	As needed
Website	Interested stakeholders & community members	Updated as new info occurs
Email	Interim Leadership Council Stakeholders Subcommittees	Monthly and as needed As needed Monthly and as needed
Press	Community members	As needed
Organization communications	Extension of stakeholders sector audience Outreach to community members	As appropriate to sector communication vehicle As needed
Social Media	Stakeholders Community members	As needed As needed

Continuous Improvement: Effective communication is a two-way process. Evaluation of tools employed, planning and strategic development will be conducted on an ongoing basis. Feedback from target groups will be analyzed and used as a means to continually improve communications and ensure accountability to and engagement within our communities.

3.2 OCH Stakeholder Engagement & Development of Regional Health Priorities

These documents reflect the participation by stakeholders throughout the OCH region. It includes a roster of participants by county, sector, and role, record of the inaugural OCH meeting in November 2014 with presentation materials and participant discussion of next steps in forming an ACH, and record of the July and November 2015 stakeholder meetings and presentation materials.

2014-2015 OCH Stakeholder Roster Attendees = red Black, possible attendee

SECTOR	COUNTY	ORGANIZATION	PERSON	ROLE
BEHAVIORAL HEALTH ORG *Medicaid MH & CD*	**Tri County**	**Kitsap County Human Services**	**Doug Washburn**	**Director**
	Tri County	Penin. Regional Support Network	Anders Edgerton	Administrator
	Tri County	BHO	Kathleen Kier	Chair, Executive Comm.
CHEMICAL DEPENDENCY *Medicaid Provider*	**Kitsap**	**Westsound Treatment Center**	Robin O'Grady	**Executive Director**
	Clallam	Local Provider	Gill Orr	Provide
	Jefferson	Safe Harbor Recovery Center	Ford Kessler	Director
	Jefferson	Jefferson SA Advisory Board	Kathryn Robbins	Human Services Planner
	Kitsap	Kitsap County Behavioral Health	Gay Neal	Citizen Advisory Board
	Kitsap	Kitsap County SA Advisory Board	Jeannie Screws	
CHRONIC DISEASE PREVENTION THROUGH THE LIFE SPAN	**Kitsap**	**Kitsap Public Health District**	**Katie Eilers**	**Assistant Director , CH**
	Clallam	Prevention Works!		
	Clallam	Planned Parenthood		
	Clallam	First Step Family Resource	Nita Lynn	
COMMUNITY ACTION PROGRAM/ SOCIAL SERVICE	**Kitsap**	**Kitsap Community Resources**	**Larry Eyer**	**Executive Director**
	Clallam	Clallam Co Health & Human Serv	Iva Burkes	Director
	Clall/Jeff	Clallam/Jefrson Comm Resources	Dale Wilson	Executive Director
	Kitsap	Kitsap Community Resources	Monica Bernhard	Dir Hous/Comm Support
DENTAL HEALTH *Medicaid Provider*	State Wide	Clallam	**Tom Locke**	State Dental Association
	King	WA Dental Service Foundation	Chad Lennox	Program Manager
FEDERALLY QUALIFIED HEALTH CLINIC	**Kitsap**	**Peninsula Community Health Services**	**Barbara Malich**	**PCHS Consultant**
	Clallam	No Olympic Healthcare Network	Michael Maxwell	Chief Executive Officer
	Kitsap	Peninsula Comm Health	J. Kreidler Moss	Chief Executive Officer
PRIVATE NPO HOSPITAL	**Kitsap**	**CHI/Harrison Medical Center**	**Mike Anderson**	**Chief Medical Officer**
	Kitsap	CHI/Harrison Medical Center	Christina Moyer	Executive Director
	Kitsap	Franciscan Health System	Dianna Killian	Senior VP of Mission
	Kitsap	Franciscan Health System	Charlie Aleshire	Ex Dir Emerg/Urgent
	Kitsap	CHI/Harrison Medical Center	Lori Kerr	Care Dir Case Mgmt
HOUSING/HOMELESS	**Kitsap**	**Bremerton Housing Authority**	**Kurt Wiest**	**Executive Director**
	Clall/Jeff	Peninsula Housing Authority	Kay Kassinger	Director
	Clall/Jeff	Peninsula Housing Authority	Sarah Martinez	Dir Asset Management
	Kitsap	Kitsap Continuum of Care/KCR	Monica Bernhard	Housing Director
	Kitsap	Housing Kitsap	Stuart Grogan	Executive Director
	Kitsap	Bremerton Housing Authority	Sarah Van Cleve	Director of Housing
	Kitsap	Bremerton Housing Authority	Debra Gallagher	
	Kitsap	Bremerton Housing Authority	Samantha Seuls	
	Kitsap	Kitsap Co HS Hous/Homeless	Kirsten Jewell	Human Services Planner
LONG TERM CARE/AAA/ HOME HEALTH	**Clallam/ Jefferson**	**Olympic Area on Aging**	**Roy Walker**	**Executive Director**
	Clall/Jeff	Olympic Area on Aging	Barbie Rasmussen	Planning Director
	Kitsap	Kitsap Co Aging & LTC	Stacey Smith	Administrator

MEDICAID MANAGED CARE ORGANIZATION	**Tri County**	TBD	TBD	
		Amerigroup Washington Inc	Kris Lee	External Affairs, Director
		CHPW	Erin Hafer	
		CHPW	Dorothy Hardin	
		Coordinated Care	Caitlin Safford	Mgr, External Relations
		Coordinated Care	Andrea Tull	
		Molina Healthcare	Jorge Rvera	Director, Cmty Engemnt
		Molina Healthcare	Laurel A Lee	VP/ Community Engage
		Molina	Carlos Meija	
		Molina Healthcare	Lisa Anderson	Exec Asst/Laurel Lee
		United Health Care	Amina Suchoski	
		United Health Care	Allan Fisher	
MENTAL HEALTH *Medicaid Provider*	**Clallam**	**Peninsula Behavioral Health**	**Peter Casey**	**Executive Director**
	Clallam	Westend Outreach Services	Pam Brown	Executive Director
	Jefferson	Jefferson Mental Health	Adam Marquis	Executive Director
	Jefferson	Jefferson Mental Health	Chuck Henry	President, JMH
	Kitsap	Kitsap Mental Health Services	Joe Roszak	Chief Executive Officer
	Kitsap	Kitsap Mental Health Services	Rochelle Doan	Chief Adv. Officer
	Tri County	Peninsula 211/Crisis Clinic	Kelly Schwab	Supervisor
PRIMARY CARE *Medicaid Provider*	**Tri County**	**Harrison Health Partners**	**Justin Sevill**	**Director Operations**
	Tri County	Harrison Health Partners	Gary Kriedberg	Manager of Operations
PUBLIC HEALTH	**Jefferson**	**Jefferson County Health District**	**Jean Baldwin**	**Director**
	Clallam	Clallam Health & Human Services	Iva Burkes	Director
	Clallam	Clallam Health & Human Services	Chris Brink	Health Officer
	Jefferson	Jefferson County Health District	Tom Locke	Health Officer
	Kitsap	Kitsap Public Health District	Scott Daniels	Administrator
	Kitsap	Kitsap Public Health District	Susan Turner	Health Officer
	Kitsap	Kitsap Public Health District	Siri Kushner	Epidemiologist
	Clallam	Elwha Health Department	Sher Carlson	
PUBLIC HOSPITAL	**Clallam**	**Olympic Medical Center**	**Eric Lewis**	**Chief Executive Officer**
	Clallam	Olympic Medical Center	Darryl Wolf	Director, Administration
	Clallam	Olympic Medical Center	Bobby Beeman	Communications
	Clallam	Olympic Medical Center	Jennifer Burkhart	Manager
	Clallam	Forks Hospital	David Selman	
	Clallam	Forks Hospital	Jim Chaney	Chief Executive Officer
	State	Assoc WA Public Hospital Districts	Ben Lindekugel	Chief Financial Officer
RURAL HEALTH	**Jefferson**	**Jefferson Health Care**	**Hilary Whittington**	**Chief Financial Officer**
	Jefferson	Jefferson Health Care	Mike Glenn	Chief Executive Officer
TRIBAL NATIONS & Associated	TBD	Hoh	Maria Lopez	Chairwoman
		Lower Elwha S'Klallam	Francis G Charles	Chairwoman
		Jamestown S'Klallam	Cindy Lowe	Deputy Director, Health
		Jamestown S'Klallam	Bruce Simcosky	
		Port Gamble S'Klallam	Jeromy Sullivan	Tribal Council Chairman
		Port Gamble S'Klallam	Ed Fox	
		Suquamish Tribe	Leonard Forsman	Tribal Council Chairman
		Suquamish Tribe	Leslie Wosnig	Health Administrator
		Quileute – Health Center	Andrew Shogren	Health Director
		Quileute – Health Center	Sarah Hanson	
		Sophie Trettevick Indian Health-Makah	Betsy Buckingham	Director

2016 DEVELOPING SECTORS

Economic Development	Tri County	Craft 3 Community Development Financial Institution	Erika Lindholm	
Education				
	Clall/Jeff	Peninsula College		
	Kitsap	WSU Extension	Renee Overath	Director
	Tri County	Olympic College	David Mitchell	President
	Tri County	Olympic Educational Service District	Judith McCrudden	Nurse ProgSpecialist
	Tri County	Olympic Educational Service District	Jennifer Acuna	
Law & Justice				
	Clallam	Drug Court		Coordinator
	Clallam	Prosecutors Office	Mark Nichols	Prosecuting Attorney
	Clallam	City of Pt Angeles, Police Dept	Terry Gallagher	Chief of Police
	Clallam	Juvenile Services	Pete Peterson	Director
	Kitsap	Prosecutors Office	Tina Robinson	Prosecuting Attorney
		Juvenile Services		
Philanthropy				
	Jefferson	United Way	Carla Caldwell	Executive Director
	Clallam	United Way of Clallam County	Jody Moss	Executive Dir (Ret)

ADDITIONAL ATTENDEES

State Government affiliated	State	Health Care Authority	Chaise Napier	Cmty Transformation Mgr
	State	Health Care Authority	Kayla Down	Cmty Transformation Spec
	State	CCHE	Lisa Schafer	CCHE Evaluator
	State	CCHE	Lauren Baba	CCHE Evaluator
	State	Lifelong	Mark Baker	Consultant
	State	DSHS	Glenn Baldwin	Evaluator
Board of Health Elected Officials or Affiliated	Clallam	Clallam Co Board of Commissioners	Jim McEntire	Commissioner, Chair
	Clallam	Clallam County Board of Health	Jeanne LaBrecque	Board Member
	Jefferson	Jefferson Co Board of Commissioners	Kathleen Kier	Commissioner
	Kitsap	Kitsap Board of Commissioners-BOH	Robert Gelder	Chair
	Kitsap	Kitsap Board of Commissioners-BOH	Charlotte Garrido	Commissioner
	Kitsap	Kitsap Board of Commissioners-BOH	Ed Wolfe	Commissioner
	Kitsap	Kitsap Regional Coordinating Council		
	Kitsap	City of Bainbridge – Kitsap BOH	Sarah Blossom	Councilperson
	Kitsap	City of Bremerton-Kitsap BOH	Patty Lent	Mayor
	Kitsap	City of Port Orchard-Kitsap BOH	Tim Matthes	Mayor
	Kitsap	City of Poulsbo – Kitsap BOH	Becky Erickson	Mayor
Other Medical	Kitsap	Group Health Cooperative, Silverdale	Tricia Hamill	Administrator
	Kitsap	Group Health Medical Centers	Redge Campbell	Medical Cnts Administr
	Kitsap	The Doctors Clinic		
	Kitsap	Bremerton Fire Department	Doug Baier	Medical Officer
	Clallam	Volunteers in Med/Olympics Clinics	Zoe Apisdorf	Developmt Coordinator
Private Insurers	Clallam	Caskell Insurance		
Community Members	Clallam	League of Women Voters		Health Care Subcomm
	Clallam	Access to Health Care	Florence Bucierka	

Olympic Community of Health - Initial Meeting

Friday, November 7, 2014 - 9:30 a.m. to 12:30 p.m.

Fort Worden State Park Commons building (Room A)
200 Battery Way
Port Townsend, WA 98368

Facilitated by Dale Jarvis and Associates Consulting

9:30 Welcome and Introductions

9:50 Plan for the Morning - Why We Are Here?

10:00 An Introduction to Accountable Community of Health Concepts

a. Just what is an Accountable Community of Health (ACH)?
b. ACHs and the State Innovation Plan
c. Health Care Authority Expectations
d. Tasks to Accomplish and Timeline

10:45 Break

11:00 Health Care Trends in Our Three-County Region – Clallam, Jefferson & Kitsap

Siri Kushner, Epidemiologist

11:30 Designing a Three-County Regional Collaboration – Full Group Discussion

a. What types of collaborations are you currently involved with that are helping residents of the region move toward the Triple Aim?
b. What are the necessary "ingredients" to include in a community-based, health-oriented "ecosystem"?

12:10 Initial Plan of Action and Next Steps

a. Do you think Jefferson, Clallam and Kitsap Counties should be part of a 3-county ACH or a 10-county ACH?
b. Based on the answer to the above question, what are key next steps to ensure that Clallam, Kitsap and Jefferson County stakeholders become part of the emerging design?

12:30 - Adjourn

Please contact Linda Ward at 360-337-4604 or via email at lward@co.kitsap.wa.us if you have any questions.

Olympic Community of Health
Initial Meeting
11/7/2014

Welcome

Who's here today?

The Morning's Agenda

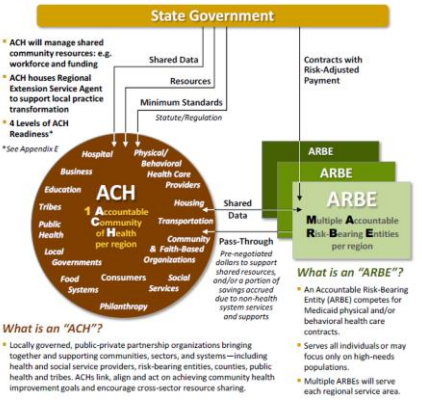
- 9:30 Welcome, Introductions, Agenda Review
- 9:50 Plan for the Morning: Why are we here?
- 10:00 Accountable Community of Health Overview
- 10:45 Break
- 11:00 Health Trends in Our Three County Region
- 11:30 Designing a 3-County Regional Collaboration
- 12:10 Initial Plan of Action and Next Steps

Why Are We Here?

- To have a rich and meaningful discussion about our future.
- To answer a simple question at 12:10pm:
  - Do you think Jefferson, Clallam and Kitsap Counties should be part of a 3-county ACH or a 10-county ACH?
- And to decide what next steps we want to take as a community about health reform in Washington State.

Accountable Communities of Health

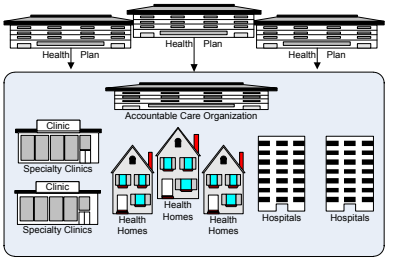
- Just what is an Accountable Community of Health (ACH)?
- ACHs and the State Innovation Plan
- Health Care Authority Expectations
- Tasks to Accomplish and Timeline



Some Say It Started with a Discussion in Southwest Washington in 2010

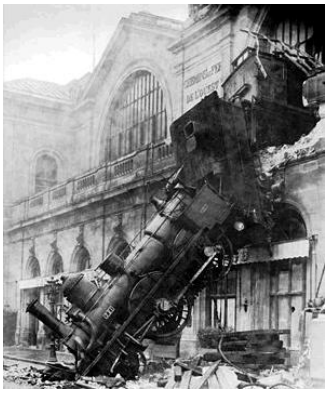
We already know how to fix the healthcare system:

- Medical Homes and
- Accountable Care Organizations
- Supported by Payment Reforms



But what about folks in the Safety Net?

- For many children, families, and adults in the safety net, good healthcare is not enough
- Consider a mom with depression and diabetes
- Add to this scenario the facts that she is the head of household of a family of three, has lost her job, is experiencing domestic violence and she and her children are on the brink of homelessness

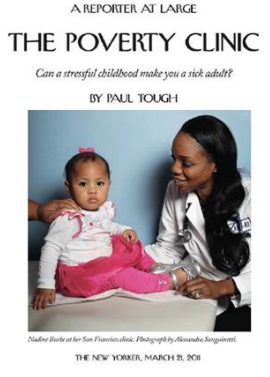


A Key Part of the Equation: Addressing the Social Determinants of Health

- There is a distinct relationship between an individual's health status and the social and environmental conditions in which he or she lives
- The US healthcare system is not currently structured to address these problems, separating ***health*** from ***human services***

Social Determinants of Health

Socio-economic status	Education
Transportation	Violence
Housing	Income
Access to services	Social gradient
Social or environmental stressors	Norms
Policies and laws	Social networks
Social support	Culture
Social capital	Racism / discrimination
Transportation	Neighborhood characteristics
Physical living conditions	



A REPORTER AT LARGE

THE POVERTY CLINIC

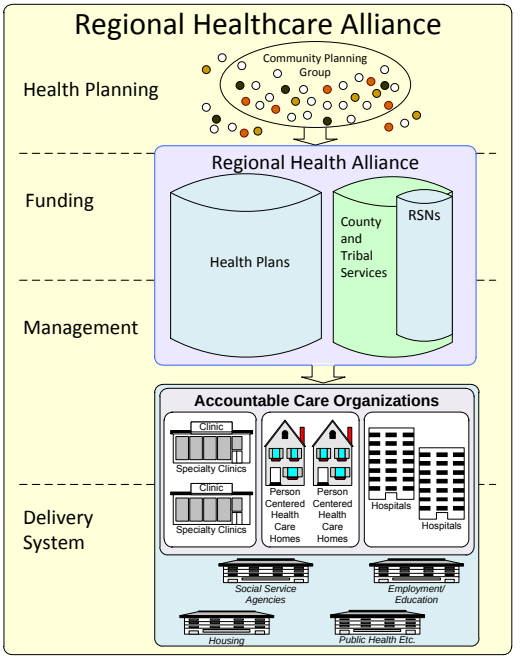
Can a stressful childhood make you a sick adult?

BY PAUL TOUGH

Nadine Burke at her San Francisco clinic. Photograph by Alexandra Sanguinetti.

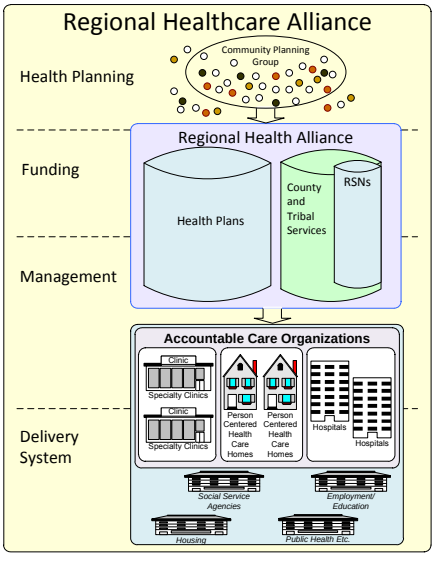
THE NEW YORKER, MARCH 21, 2011

- Two-Part Idea:
  - A Regional Health Alliance to organize the payors/funders to create a supportive payment and regulatory system
  - In order to support organizing the delivery system into accountable systems of care



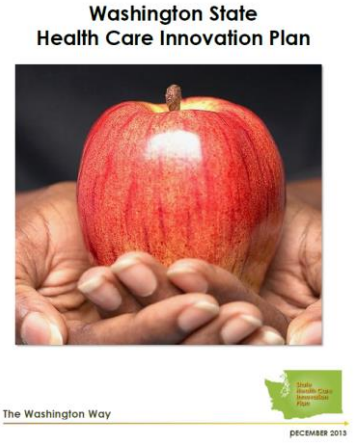
Key RHA Tasks

1. Community-wide needs assessment and improvement plan
2. Multi-Payer "virtual" budget development
3. Community health improvement projects/hot spotting
4. Multi-Payer payment, contracting, and performance measure models
5. Person-Centered Healthcare Home development support
6. Local ACO development support
7. Support Patient Registry, EHR, Health Information Exchange development
8. Community-wide performance measurement

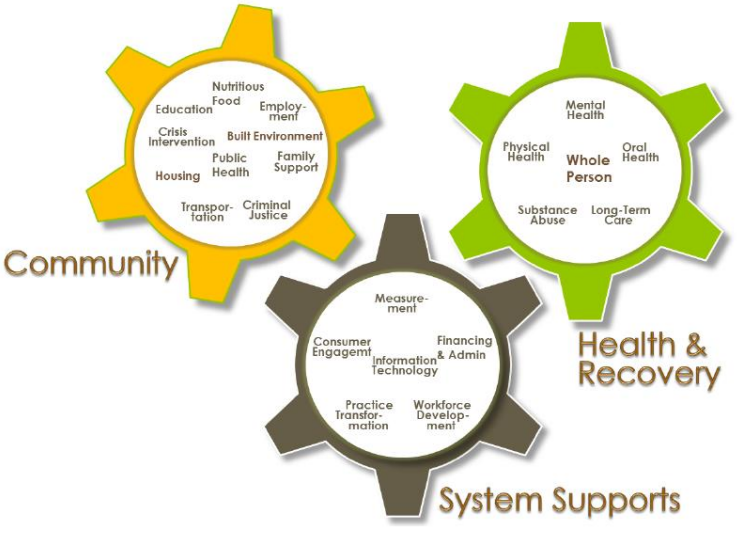


Washington's Medicaid Reform

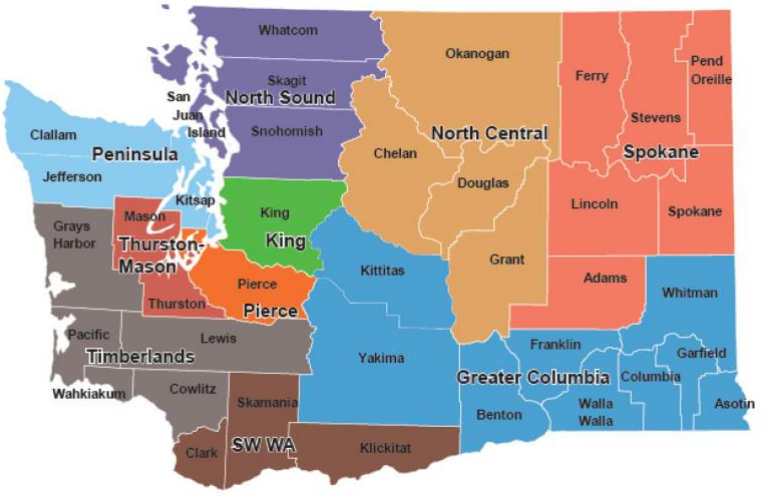
- Design came out of the CMMI funded State Innovation Planning Grant Process



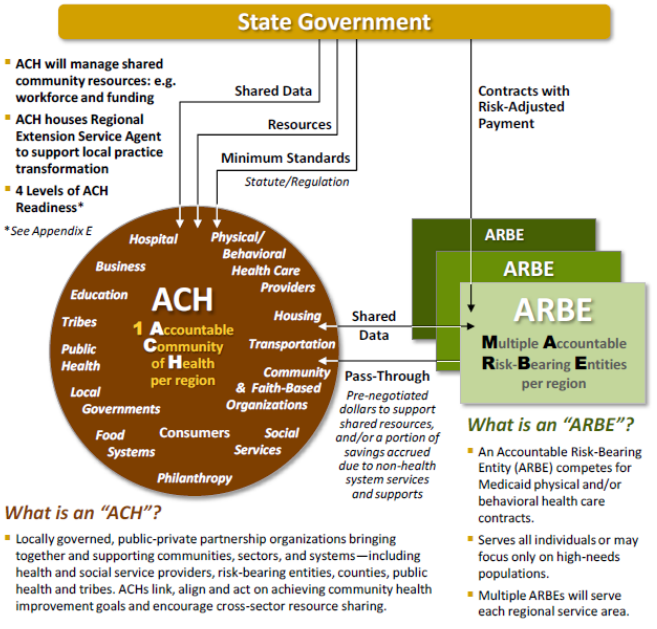
Whole Health Silo Busting



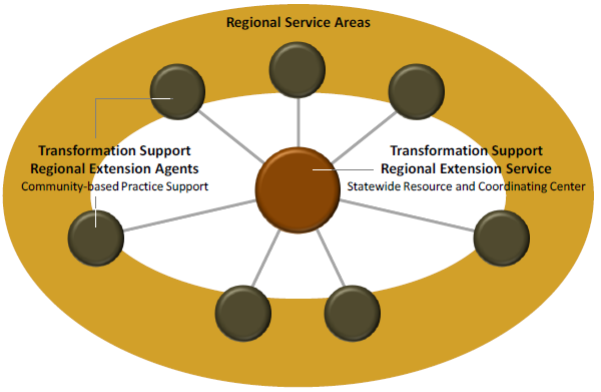
Organized on a Regional Basis



Inside Each Region



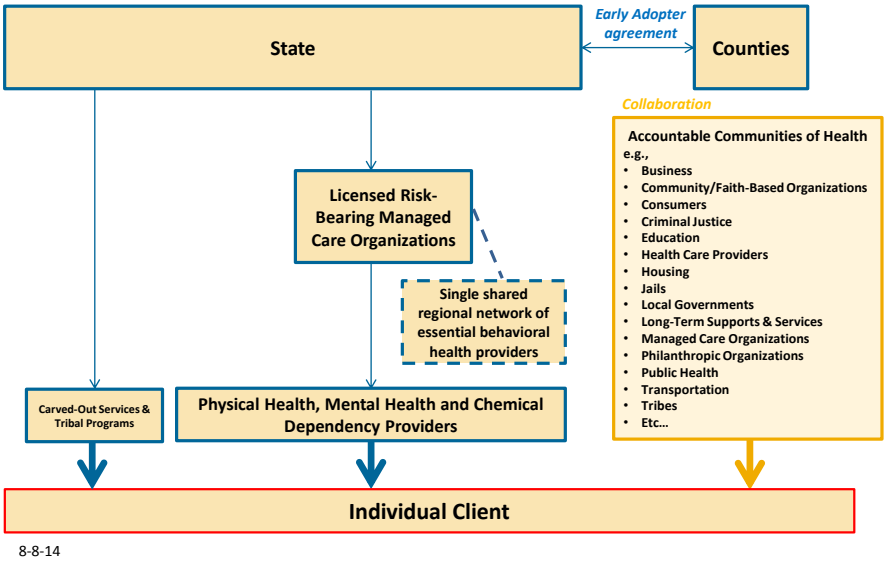
Transformation Support
Regional Extension Service



Data & Metrics Support
Separate function informing Regional Extension Service. Extension Service and Agents serve supportive role in clinical achievement of performance measure targets.

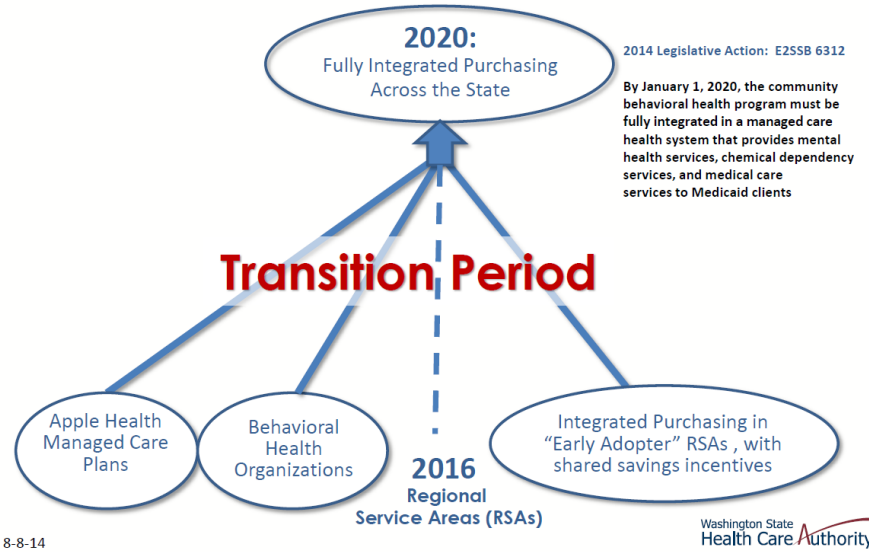
Early Adopter Regions: Fully Integrated Physical & Behavioral Health Purchasing
Single Shared Regional Behavioral Health Network

DRAFT DRAFT



8-8-14

Parallel Paths to Purchasing Transformation



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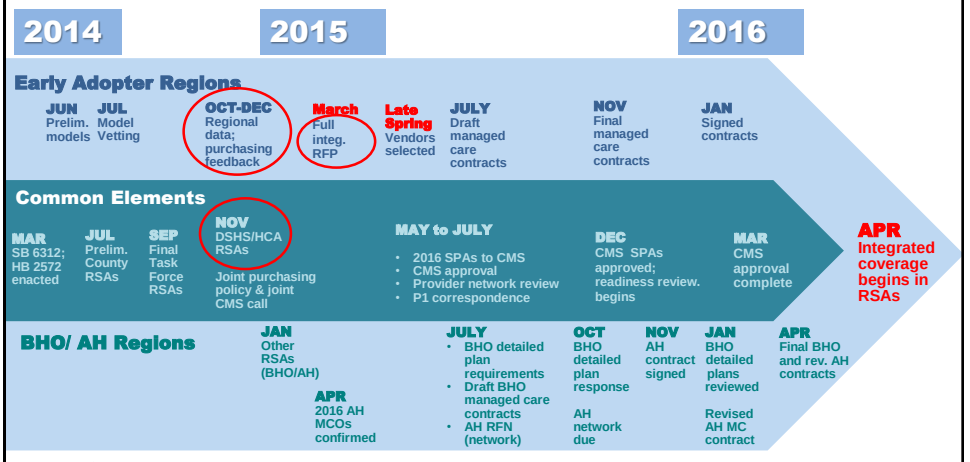
Washington State Health Care Authority

Health Care Authority ACH Expectations: The Planning Grant

1. Engage broad range of stakeholders and government entities in the planning process.
2. Partner with the State to further identify opportunities for alignment, barriers to achieving shared aims, and barrier resolution strategies.
3. Identify shared community health and health care priorities that align with State transformation priorities as outlined in the State Health Care Innovation Plan and related transformation efforts.
4. Consider and articulate potential roles in driving community and State transformation.
5. Develop a pathway to achieve community aims through plan of action, building upon existing community priorities and efforts.
6. Develop a community backbone organization, including its governance, structure, shared measurement mechanisms, communication framework, and sustainability.
7. For all elements, consider specific engagement and inclusion strategies for underrepresented populations, geographies, and consumers and families.

Medicaid Integration Timeline – for Early Adopter Discussion



RSA – Regional service areas
MCO – Managed Care Organization
BHO – Behavioral Health Organization
AH – Apple Health (medical managed care)
SPA – Medicaid State Plan amendment
CMS – Centers for Medicare and Medicaid Services
Early Adopter Regions: Fully integrated purchasing
BHO/AH Regions: Separate managed care arrangements for physical and behavioral health care
September 15, 2014

Questions and Comments before the Break?

Health Trends in Our 3 County Region

- Siri Kushner, Epidemiologist

Designing the 3-County Collaboration

- Two Round Robin Questions
  - What types of collaborations are you currently involved with that are helping residents of the region move toward the Triple Aim?
  - What are the necessary “ingredients” to include in a community-based, health-oriented “ecosystem”?

Initial Action Plan and Next Steps

- Two Questions:
  - Do you think Jefferson, Clallam and Kitsap Counties should be part of a 3-county ACH or a 10-county ACH?
  - Based on the answer to the above question, what are key next steps to ensure that Clallam, Kitsap and Jefferson County stakeholders become part of the emerging design?

Final Questions and Comments before we Adjourn

OCH: Small Group Break-out Meeting Notes for Next Steps - November 7, 2014

2 Questions Posed:

1. What roles/tasks must ACHs take on to support
2. What are the barriers

Group 1 *(Katie Eilers: 360-337-5224)*

- Make a statement of what the health priorities are for the region (common agenda)
- Make recommendations on payment reform – need more transparency like Massachusetts
- Need health plans at the table. Plans should shift what they cover to include prevention.
- EHR sharing! Interoperability of health systems. Where is the HIE??!
- Ability to indicate what cost savings are over time as we transition what is being paid for.
- Redefine what prevention means (broaden it)
- Envision true warm handover process from birth to death
- How can we incentivize the consumer to keep ourselves/kids healthy? (Cash fund transfer models)
- Given that the payment system will change, plan for how hospitals engage on the prevention side. Or should hospitals even go beyond acute care?
- Place providers at the school

Group 2 *(Rochelle Doan: 360-415-5871)*

Goal: Establish and maintain a separate, neutral entity committed to the goals of an ACH

1) Key Tasks

1) ID Key stakeholders/convene in conversation, layout timeframe for ACH development
2) Define success and goals; further develop trust/relationships,
3) Set timeline/methods for continued conversations, working simultaneously on key tasks outlined herein and determining decision making process for immediate movement forward

4) Research existing successful models or seek consulting, educating ourselves on ACH/State plan
5) Seek temporary housing/umbrella for fiscal entity initially needed to successfully seek/be accountable for financial support
6) Create NPO
   - Governance structure
     - Discuss role of elected official in relation to ACH
   - Seek neutral leadership staff for NPO
     i. Leadership capabilities
        - Consultant/model neutrality
        - Credibility across regions and stakeholders
        - Must understand risk bearing, how and $ flow in health care systems, insurers role and $, how to change paradigm, buy into public health, social determinants of health
7) ID funding; grant applications – soon

2) Barriers

- Time and energy
- Agency agendas
- Regulatory environment

3) Note:

- Keep concept of risk bearing on table
- Need people involved and experienced in organizational dynamics

Group 3 *(Tom Locke)*

1) **Key Tasks**
   - 3 county improved local control
   - Allowing broader stakeholder involvement
   - Economic interaction (Jefferson/Kitsap/Clallam)
   - Engaging consumer – why does it matter?
2) **Barriers**
   - Empowering leaders within at-risk communities
   - Need open channels of communication
   - "Sick care" system tends to dominate discussion
   - How can we change incentives to create systems of wellness and address SCH. If not engaged, will oppose.
   - System changes will cause major changes in jobs/organizational workforce
   - For profit system at odds with system goals ("Maytag Man")
   - Payment driver
   - Value needs to be defined. Purchaser? Consumer?
   - Need to promote social connectiveness – how to invest dollars to promote is crucial
   - Role of Health Plan
   - Ultimately how to incentivize – Plans, hospitals, providers

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Group 4 *(Barbie Rasmusen, Olympic AAA: 360-379-5064)*

1) **Key Tasks**
   - Inform state about what is unique about our region
   - Invite/engage the folks who are not at this meeting; EMS, hospital, tribes, transportation entities.
   - Do we need more data/info on regional dynamics, i.e. hospital affiliations, eg. Jefferson healthcare, Olympic Medical Center & Swedish
   - Need to understand what state wants to buy
   - Need MCO's at ACH level
   - How to capture individual perspective, i.e. how can individual affect own health outcome
   - Need consumer role function in developing service delivery that has import

2) **Barriers**
   - Agencies themselves don't share info about what they do. Need to understand all parts of the elephant.
   - Redundancy not as big a problem as fragmentation
   - Creating uniform vision in complex environment. Danger of diluting some key elements that could factor in successful outcome.
   - Vast majority of health care is performed by unpaid family members – for kids, elders, etc. How mobilize this into better service delivery/coordination and better health outcomes.
   - Major barrier = ignoring the potential of consumer engagement to impact
   - Need to work on changing "health environment" we live in, e.g. unhealthy behaviors. The choice to smoke, drink, eat unhealthy food – that now supports unhealthy behaviors.
   - How change expectation that "I can drink, smoke, overeat myself into a chronic condition and the state will take care of me."
   - More personal responsibility
   - Need to align ourselves with "marketing" entities
   - May need to pick "something", not do the entire bucket

Group 4: ***(****Gay Neal: 360-337-4879)*

1) **Key Tasks**
    - Legislative advocacy
    - Break down the funding silo's
    - Invite union to the table
    - Analyzing where the money goes
    - Create community support
    - Integrated approach – Prevention (to) long term care
    - Need to build something flexible, but sustainable
    - Community Education – health and preventions
    - Reach out to plans
    - Work with plans, legislators and develop a $ plan for at least 2-3 years
    - Get the tribes on board
    - Collect evidence based reason why this approach is best
    - Evidence based practice – funded at the local level
    - Trust building
2) **Barriers**
    - Breaking down the silo's
    - Union involvement and support
    - Care providers have a stake in the status quo
    - Economic realities of the health care costs
        - Lack of control over other costs
    - Incentive for the health plans
    - Outside economic realities of prevention. Example: Hospital opening a gym for prevention (Swallowing the Little Guy)
    - Hospital challenges – look to us for the $
    - Access to health care for all?
    - Dental Health separated from Health Care
    - Associations – Dr's., dental, etc.
    - Competing health systems in the room
    - Political parties
    - Social belief, moral compass

Group 6: ***(****BoCC only reference?)*

1) **Key Tasks**
    - are we broken? Before we do this fix, is it broken?
    - ACH 2 coordinators (?)
    - $$
    - Non-profit, really, how

2) **Barriers**
    - Shift/risk/transfer, from state to who
    - Reorganizing state before we are all clear

OLYMPIC COMMUNITY OF HEALTH

AGENDA

Olympic Community of Health Stakeholder Meeting
July 29, 2015, 1:00–4:00 p.m.
Hood Canal Vista Pavilion
4740 View Drive
Port Gamble, WA

1:00 **Welcome & Introductions**
Peter Browning, OCOH Manager

1:20 **Today's Agenda**
Peter Browning, OCOH Manager

1:30 **Introduction to Accountable Communities of Health (ACH/Handouts)**
Kayla Down, Washington State Health Care Authority

2:00 **Requirements for ACH Designation**
Scott Daniels, Kitsap Public Health District, OCOH Steering Committee

2:15 **Proposed Governance Structure**
Rochelle Doan, Kitsap Mental Health Services, OCH Steering Committee
Barbara Malich, Peninsula Community Health Services, OCOH Steering Committee
Peter Browning, OCOH Manager

2:45 **Current Cross-County Shared Collaborations**
Barbara Malich, Peninsula Community Health Services, OCOH Steering Committee

3:00 **Break-Out Session Discussions**

Tables Facilitated by OCOH Steering Committee Members

- Who is Here and Who is Missing
- How Interim Council Members Should Communicate within the Group

3:30 **Stay at Your Table & Talk about How & Why You / They Should be Involved**

3:40 **Table Reports**

Peter Browning, OCOH Manager

3:55 **Wrap up**

HANDOUTS

- ACH Facts
- Healthier Washington
- Medicaid Waiver Comment Opportunity

OLYMPIC COMMUNITY OF HEALTH

GOVERNANCE CHARTER

BETTER HEALTH. BETTER CARE. LOWER COST.

Developing the OCH Charter

- **Purpose of This Charter**
- **Why is an OCH Interim Leadership Council forming?**
- **History and Background**
- **OCH Purpose and Rationale**
  - Improving patient care, including quality and satisfaction;
  - Reducing the *per-capita* cost of health care, and;
  - Improving the health of the population.

Regional Vision, Local Action

- **Focus on improving health outcomes**
- **Share a unified, regional voice**
- **Collaborate across systems**
- **Utilize a collaborative infrastructure**
- **Deliver culturally competent services**
- **Drive action oriented measureable outcomes**

Broad Areas Of Focus

✓**Access to care:** Increase the number of insured individuals. Increase network adequacy.

✓**Population Health Improvements:** every county has a plan to address diabetes, high blood pressure, obesity, and substance abuse, and key areas that effect overall health – affordable and adequate housing, education, poverty, employment, health workforce development, crime, transportation, and environment.

✓**Access to "whole person" support:** Increase affordable housing options and food security; individuals have Medical Health Homes, integrated behavioral health and oral health services; Increase knowledge and integration of Adverse Childhood Experiences and Social Determinants of Health in service delivery; Increase Care Coordination, utilize social services support

✓**Data Management/region wide infrastructure:** Promote region wide data sharing and infrastructure to increase measurement, accountability, and coordination of care.

Guiding Principles

- Purposeful collaboration between health care, social service, government, education, business and community-based sectors.
- Assure rural providers and health care organizations have a voice in upcoming health system changes, and the needs of rural communities are represented.
- Address upstream determinants of health and health disparities, and strengthen the system of home and community based supports for our most vulnerable community members.
- Savings from population health improvement and health care delivery system improvement are reinvested in effective community-based prevention programs and initiatives.
- Data on health and health care will be a critical tool informing our decisions and best practices.
- Operate in a transparent and inclusive manner. Meetings are open.
- OCH leaders are chosen because of the organizations, sectors or communities they represent. Members must consider issues from a regional perspective, rather than from the narrower perspective of their organization, affiliations or localities
- Interim leadership council will allow regular opportunities for public comment at its meetings

Interim Leadership Council Membership

Stage One: *Formative*

- ❑ Behavioral Health Organization Executive Committee
- ❑ Chemical Dependency (Medicaid Provider)
- ❑ Federally Qualified Health Clinic
- ❑ Mental Health (Medicaid Provider)
- ❑ Hospital
- ❑ Long Term Care/Area Agency on Aging
- ❑ Medicaid Managed Care Organization
- ❑ Private Practice/Primary Care
- ❑ Public Health
- ❑ Public Hospital
- ❑ Rural Health Clinic
- ❑ Tribal Representative

TOTAL: 12

Interim Leadership Council Membership
Stage Two

- ❑Community Action Program/Housing
- ❑Education
- ❑Economic Development
- ❑Elected Officials
- ❑Philanthropy

Total Voting Members: 17

Decision Making Approach

- ❖Decisions and recommendations by consensus.
- ❖Putting the good of the whole above the interests of a single organization, geography or sector.
- ❖Finding solutions that all parties can support or at least live with.
- ❖Decisions will be documented in meeting summaries, posted on OCH website.
- ❖Consistent with true collaboration to produce sustainable agreement.
- ❖Key decisions will be made in person at leadership council meetings.

Proposed roles of Interim Leadership Council

- develop a recommended OCH governance model by end 2015
- Develop an initial plan for sustainability, including shared savings
- Assure coherence of regional vision and initiatives, and work to support their success
- Recommend how administrative, coordination, convening, communication, and data support functions (backbone functions) will be carried out
- Recommend an ongoing regional-level health assessment process
- Provide input/recommendations to the state (and to the county/cities, where appropriate) related to health innovation elements
- Recognize and facilitate decision-making about how to respond to new cross-sector health improvement initiatives/opportunities
- Prepare the ACH Readiness Proposal by the December 2015 for ACH designation approval
- work August 2015 until governance group formed develop and execute a plan to transition from interim to ongoing structure

SHARING SUCCESSFUL LOCAL AND REGIONAL COLLABORATIONS

KITSAP COUNTY

Agency: Kitsap Public Health District

HEALTHY COMMUNITIES OBESITY, DIABETES, HEART DISEASE, & STROKE PREVENTION PROJECT (1422 GRANT): This year the Kitsap Public Health District received a four-year grant from the Washington State Department of Health, with funding provided by CDC, to implement a multi-county (Clallam, Jefferson, Kitsap), multi-sector *Healthy Communities Obesity, Diabetes, Heart Disease and Stroke Prevention Project*. The Community Health Action Network, the coalition formed with this funding, is focused on preventing the costly care of diabetes and cardiovascular disease by expanding early screenings for diabetes and hypertension, diversifying aggressive disease management services, facilitating improved usage of electronic health records to promote patient centered care, and creating environmental and systems changes that make healthy living the easy choice. This project sets the foundation for the type of work that can be done across sectors to reach the Triple Aim, and involves a wide variety of partners, including Tribes, hospitals, local public health, and non-profit organizations. Partners include: Jefferson, Clallam, and Kitsap county public health jurisdictions; YMCA of Pierce/Kitsap County; Bremerton Housing Authority; Dungeness Health Clinic; Volunteers in Medicine of the Olympic Health Clinic; Peninsula Community Health Services; Kitsap Mental Health Services; CHI Franciscan/Harrison Medical Center; and the Tribal Health Clinics of Lower Elwha, Port Gamble S'Klallam, Suquamish, Makah, Quileute, and Jamestown S'Klallam.

PROJECT ACCESS: During the 2011 Kitsap Community Health Improvement Process, participants identified as a top priority that "all residents have access to quality and affordable care." The community determined to specifically address the gap in access to quality specialty care for low-income, particularly uninsured, families. In response, Harrison Medical Center, United Way, and the Kitsap Public Health District supported the expansion of Project Access --- a non-profit organization committed to reducing financial and logistical barriers to care for poor communities --- into Kitsap County. Project Access coordinates patient care with volunteer specialists in the area.

ACES PARTNERSHIP: Through our Kitsap Community Health Assessment and Improvement Process, which recently identified "Preventing and Reducing the Impact of Adverse Childhood Experiences" as the top health priority in the County, the KPHD has partnered with the Kitsap Community Foundation, the Suquamish Tribe, and the United Way to fund a Project Director position to develop a cross-sector collective impact approach to preventing and reducing childhood trauma. Steering committee leadership includes representatives from military, education, social services, primary care, tribal, and faith community sectors. One objective of this project is to support the integration of trauma-informed care within all key service sectors such that organizational policies and service practices are founded in the NEAR (neuroscience, epigenetic, adverse childhood experiences and resiliency) sciences. The goal is to help reduce the burden of chronic disease and substance use disorders in the community.

PERINATAL TASK FORCE: The Kitsap Public Health District has convened the Perinatal Task Force, a multi-disciplinary group of clinicians, lay leaders, public health nurse home visitors, administrators, lactation specialists, and perinatal service providers learning together and developing solutions to promote better holistic outcomes among women and babies in our community. This coalition works to identify, assess, and address quality of care and health care access issues for pregnant and post-partum women, and their young children. Over the past year, the group has collectively supported the development of the Applewood Open Access Perinatal Care Clinic at the Health District's office in Bremerton, an urban area where access to perinatal care has been a challenge.

Agency: Peninsula Community Health Services (PCHS) – SBIRT

The project: PCHS, through funding provided by the 1/10th of 1% MH/Therapeutic Court Sales Tax, was given the opportunity to implement screening for substance abuse and chemical dependency for our patients. The collaboration between Kitsap County (the funder), care teams (PCHS) and providers in the community (community collaborators) allowed for identification and appropriate intervention targeting patients ready to engage in care to enhance their capacity for long-term improved health outcomes. The SBIRT (Screening, Brief Intervention, and Referral for Treatment) is an evidence based model of care. We were supported in our implementation efforts by our local mental health and substance abuse care network. The triple aim: **Better health, Better outcomes, Lower cost** was met on all three levels for those patients engaging in care! This model can be replicated across all three counties for improved outcomes and lower costs but primarily for improved health.

Agencies: Kitsap Mental Health Services and Peninsula Community Health Services

Integration of Primary Care/Behavioral Health Services (two models): KMHS in part through a CMMI Innovation Award completed this June, has for the past three years been moving toward full integration of mental health, co-occurring substance use disorders, patient management of chronic disease, and provision of primary care into their site as well as supporting community access to expanded BH services. For the community this has included psychiatric consultation for all primary care providers, and in collaboration with Harrison Health Partners (HHP) placement of a Behavioral Health Professional in 4 HHP clinics. For KMHS clients, in this bi-directional model, an HHP provider was "in clinic" weekly at KMHS to provide primary care services and medications management to those KMHS patients best served in the community mental health setting. Partners also included Harrison Medical Center for ED data, Public Health for epidemiology and evaluation, and multiple PCP offices for patient care coordination. The "bi-directional care integration project is complex and a great deal of data is available.

PCHS through federal Social Innovation Fund dollars awarded through the John A. Hartford Foundation with matching funds provided by the Margaret A. Cargill Foundation, was able to use the IMPACT model of integration of BH services into the primary care setting. The focus for this three year project was to screen all PCHS patients to identify emerging depression and other anxiety disorders for brief/early intervention in conjunction with a primary care visit. Recognizing the issues with those patients experiencing more substantial BH concerns, an ARNP-Psych and part time psychiatrist were also added to the team in addition to BH providers in each PCHS clinic site full time. PCHS has experienced considerable success with this model and extensive reporting is available.

With the conclusion of the separate funding streams, KMHS and PCHS are currently working toward bi-directional support to continue both models for the residents of Kitsap County with expansion of PCHS primary care staff at KMHS, and out-stationing KMHS staff at PCHS Port Orchard site later this fall. KMHS and PCHS are also working with the State "One HealthPort" HIE to integrate/share records of patients in common. No date of completion is set on this component of the collaboration.

JEFFERSON COUNTY

Agency: Jefferson Mental Health Services (JMHS)

Project: Joint business venture with Jefferson Healthcare (JHC), a local hospital with primary care clinics in East Jefferson County, have teamed up to provide Psychiatric Services together through a 50/50 split with a MD/Psychiatrist starting in June 2015. The goal is to layer on more and more bridges between JHC and JMHS to eventually include shared OICSW and Physical Health practitioner TBD.

CLALLAM COUNTY

Agency: Peninsula Behavioral Health

Project: Integrated Primary and Behavioral Healthcare in Clallam County:

A. We have a Behavioral Health Specialist (Advanced Registered Nurse Practitioner) working in three Olympic Medical Physician Clinic, 2 in Port Angeles and 1 in Sequim.
B. We will have a full-time Licensed Independent Clinical Social Worker located with the North Olympic Health Network, the FQHC for Clallam County that will open on September 1st.

Project: Health Homes: Through a partnership with Behavioral Health Northwest, we provide care management services to OPTUM and Molina patients with chronic health conditions throughout Clallam and Jefferson Counties**.**

Olympic Community of Health Stakeholder Meeting
July 29, 2015 1:00-4:00 p.m.
Meeting Notes

Olympic Community of Health - PLAN by 1/31/16

09/08/15 Governance Structure Draft Plan
- Input today (7/29/15)
- Governance Draft Group Meeting, 8/13/15
- Copy to Stakeholders for comment
- Complete by 8/31/15

08/31/15 Sectors Nominate Representative, 8/31/15

09/01/15 Interim Leadership Council Meets
- Adopts Governance Structure
- Meets September thru December

WHAT DO YOU WANT TO ACCOMPLISH IN TODAY'S MEETING?

- Where are we going?
- Understand the process
- Appropriate use of Emergency Room
- Address healthcare needs of students
- Better understanding of ACH
- A road map
- How do plans fit and how do we make them work?
- How does housing fit?
- How will this help people with disabilities?
- What will benefit everyone?
- Have a conversation
- Where do non-profits fit in?
- How do we get more effective healthcare
- How do we improve accessibility
- How to partner with Healthier Communities
- Want to know others perspective
- What about the Waiver?
- Where do seniors fit and how do we keep them in their homes?

ADDITIONAL POTENTIAL STAKEHOLDERS WERE IDENTIFIED

- Oral Health
- Informal Supports
- Economic development – Workforce Development
- Home Healthcare Providers
- Olympic Community Action
- Nutrition – outdoor activity
- Transportation (EMS & Transit)
- Schools
- Patient Voice
- Faith Communities
- Military
- Military-VA
- Sexual abuse
- Neurodevelopmental CTRS/DD
- Pharmacies
- Local police and EMS

HOPES AND FEARS WERE IDENTIFIED

HOPES	FEARS
▪ How do we get authentic community engagement?	▪ Complex infrastructure developed
▪ Waiver will force us to design what Medicaid Purchasing/ACH role is	▪ Move at a pace that moves us all effectively
▪ Don't break up things that work well	▪ What will be controlling, ACH Medicaid Purchasing?
▪ Disciplines shifting ground	▪ What role will Medicaid Managed Care play?

SECTOR REPRESENTATIVES IDENTIFIED

Behavioral Health Organization (BHO) Executive Committee Appointed

Chemical Dependency (CD)
- Safe Harbor
- Clallam County
- KRC

Federally Qualified health Clinic (FQHC)
- Barb Malich with cross discipline representatives

Long Term Care (LTC), Area Agency on Aging (AAA)
- Roy Walker, Olympic Area Agency in Aging

Medicaid Managed Care
- Will identify after their working group meets

Rural Health Clinics
- Jefferson

Mental Health
- Peter Casey, Peninsula Behavioral Health

Hospital and Public Hospital
- Hilary Whittington, Jefferson Health Care
- Darryl Wolfe, Olympic Medical Center

LTC/AAA
- Roy Walker, Olympic Area Agency in Aging

DENTAL
- Tom Locke

PRIVATE PRACTICE/PCP
- Harrison Health Partners (HHP) (Justin Sivill)

Note: HHP asked to use the term, "Outpatient Primary Care", rather than, "private practice/primary care".

Tribal
- Will determine

OTHER COMMENTS AND FEEDBACK:

Vital to gather public comment, not only in a public forum, but in stakeholder Board meetings.

OLYMPIC COMMUNITY OF HEALTH

Olympic Community of Health
Stakeholder Meeting
November 2, 2015
Port Gamble, Hood Canal Vista Room
1:00 – 4:00 p.m.
Agenda

Regional Vision, Local Action

1:00 p.m. Welcome & Opening – Why Does The OCH Matter?
Tom Locke, MD, MPH

1:30 p.m. The Charge for Stakeholders & Interim OCH Structure
Barbara Malich, OCH Program Manager

1:50 p.m. OCH Stakeholder Conversation: Assets, Gaps & Priorities
Siri Kushner, KPHD Epidemiologist
Community Assessment & Planning Subcommittee Members

3:40 p.m. ACH Evaluation Process
Lisa Schaefer, CHEC

3:45 p.m. Growing the OCH Sector Participant Voice & Next Steps
Rochelle Doan, OCH Program Manager

Attachments:

- OCH Fall 2015
- Quick Glance: the ILC and OCH Stakeholders
- Interim Leadership Charter
- Sector and Representative Stakeholder Roster (group verify roster, add if appropriate)

Better Health, Better Care, Lower Cost

Olympic Community of Health Overview *Fall 2015*

Healthier Washington and the Development of Accountable Communities of Health (ACH's)

In 2014 a five year roadmap for transforming health and health care in Washington State was created to achieve better care for individuals, better health for our population, and do so at lower costs. A $65 million federal grant to carry out elements of *Healthier Washington* now supports communities in working together to improve the public health, so that the health care delivery system realizes better services, lower costs and greater access to community resources that result in better health and wellness for everyone - individuals and communities alike.

ACH's bring community, social service & public health strategies together for shared health goals

ACH Regional collaboratives are building blocks where public and private entities together work on shared health goals, dedicated to whole person care, and creating a foundation for lasting change that offers better health for all. To bring clinical and community partners together to plan and carry out health improvement across systems of care and align to leverage shared results, nine regionally based Accountable Communities of Health are being created across our state. ACH's are engaging the many sectors affecting health, from public health, health care providers including behavioral health, social services and community organizations, housing, economic and workforce development, to education, health care payers, philanthropy, governmental entities, and Tribes. The state is partnering with regions to invest in development of the ACH's that can demonstrate concept and proof of design that will assure a sound foundation of governance and administrative infrastructure to be effective in this health transformation.

What affects our overall health and well-being?

40% socio-economic factors

30% health behaviors

10 % physical environment

20% clinical care

Regional Designations by County

Specifically, ACHs:

- Establish collaborative decision-making on a regional basis to improve health and health systems, focusing on social determinants of health, clinical-community linkages, and whole person care.
- Bring together all sectors that contribute to health to develop shared priorities and strategies for population health, including improved delivery systems, coordinated initiatives, and value based payment models.
- Drive physical and behavioral health care integration by making financing and delivery system adjustments, starting with Medicaid.[1]

1 Healthier Washington. The FACTS. Accountable Communities of Health, Washington State Health Care Authority, July 2015

Olympic Community of Health forms through local and regional planning, sector collaboration

In August 2014, in keeping with the vision of Healthier Washington, leaders representing voices of primary care, community behavioral health, public health, public hospital, social services and governmental entities began initial formation of an Olympic Community of Health (OCH) consisting of Clallam, Jefferson and Kitsap Counties. A history of cross system collaboration and partnerships to accomplish shared purposes resulted in a November 2014 gathering of 50+ leaders to explore together becoming the OCH. Participants were educated on current Health Care System Transformation and reviewed each counties Community Health Improvement Plan (CHIP), including shared priorities for future action. At this meeting, participants decided to come together as local drivers of our State's health system transformation, and requested the Kitsap Public Health District (KPHD) apply on the OCH's behalf for a 2015 design grant. Subsequently awarded, the KPHD currently serves as OCH backbone agency.

OCH Milestones

July 2014 – Oct 2015	Steering Committee	Plans monthly for actions needed to launch OCH
November 7, 2014	Stakeholder Meeting	Health Care System Transformation, Dale Jarvis, Consultant Local & regional CHIP priorities, Siri Kushner, Epidemiologist Decision to apply for HCA ACH Design Grant
Nov - Dec 2014	Design Writing Team	Kitsap Public Health District to serve as virtual backbone
Jan – April 2015	Kitsap Public Health District	Design Grant awarded, contracts initiated
May 2015	KPHD, Steering Committee	Project Manager hired
May – Oct 2015	Project Manager	Develops Stakeholder, Sector relationships
June – Aug 2015	Governance workgroup	Drafts Interim Leadership Council (ILC) Charter
July 29, 2015	Stakeholder Meeting	Discussion Governance/Charter Identification of Sector Representation for ILC, who is missing
October, 2015	Project Management	New Project Managers engaged
October 19, 2015	Interim Leadership Council	Approves Charter, appoints subcommittees, plans 11/2/15
Oct –Jan 2015	Subcommittees	Meetings and planning begins – Sustainability on 10/27/15 Community Assessment/Plan 10/29 Governance 10/30/15
November 2, 2015	Stakeholder Meeting	Community Assessment/Plan, Deepen Sector Participation
July 2014 to date	KPHD & Stakeholders	Participation in HCA & ACH communications and activities

The Role of the OCH Interim Leadership Council (ILC)

The ILC is guiding further development of the structures and the engagement needed to facilitates cross-sector health improvement. The ILC, with Project Management support, is preparing a Readiness Proposal portfolio for ACH designation so as to continue with ongoing ACH health transformation strategies. The ILC subcommittee for community assessment and planning is using existing assessments and plans from all three counties, local and regional CHIP priorities and data to hold a November 2, 2015 stakeholder discussion of service gaps, assets, and further define priorities. This will inform the development of the ILC's Regional Health Improvement Plan approach, and use of the approach to complete the RHIP in early 2016. The ILC, with its Community Assessment/Planning Subcommittee and OCH stakeholders, will discern how best to align with Healthier Washington's statewide common performance measures, use the information and technical assistance available through Healthier Washington, and continue to learn from other ACH's across the State. Deliverables for 2015 include the ACH Readiness Proposal to be submitted to the Washington State Health Care Authority November 30, 2015 for ACH designation. The proposal will include plans for approaches to the future Regional Health Improvement Plan, governance and administrative functions, and sustainability planning.

For more Information

- Visit the Olympic Community of Health website at: **http://www/Olympic community of care.org**
- Visit the Healthier Washington ACH website: **http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx**

QUICK GLANCE

Olympic Community of Health Development 10/8/15 – 1/31/16

"Regional Vision, Local Action"

CREATION OF THE OCH INTERIM LEADERSHIP COUNCIL

9/15 ILC Charter document completed by Governance subcommittee

9/22 Steering Committee approves ILC Charter, directs OCH consultant to convene ILC sector stakeholders identified at the July 22, 2015 Stakeholder meeting. Further directed to continue discussion to secure yet unidentified stakeholder representation, include Tribal, rural health, private/not for profit hospital, chemical dependency.

10/1 ILC meeting scheduled for 10/19. Steering committee to disband 10/19/15 as ILC takes on governance role.

OCH INTERIM LEADERSHIP COUNCIL

CHARGE: Support formation of an Olympic (Accountable) Community of Health and its future designation, serving in a transitional role October 2015 – February 2016 until a yet more formal Governing Board with additional sectors and deeper representation is in place. Provide 1-2 ILC members each subcommittee to chair and report back to ILC.

- Create a regional pathway to improving patient care, reducing the per-capita cost of health care and improving health of the population.
- Guide a regional vision by bringing the voice of sectors and the stakeholders they represent to the table to work collectively toward common areas of focus: access to care, population health improvements, access to "Whole Person" Support and promoting data sharing and a region-wide infrastructure. Collaborate across systems to improve our community safety and well being. Adhere to the OCH Guiding Principles.
- Intentionally work now to deepen stakeholder participation 1) within each sector so that representation on the Governing Board is rich with the experience and voice and 2) bring additional sectors and representation yet to be identified from Community Services System.

MEETING:

1st	October 19	2:30 pm – 5:00 pm	Silverdale
2nd	November 2	1:00 pm – 4:00 pm	Port Gamble
3rd	December 7	1:00 pm – 4:00 pm	TBD
4th	January 11	1:00 pm – 4:00 pm	TBD

SUSTAINABILITY SUBCOMMITTEE

CHARGE: Research and recommend OCH sustainability plan and health care payment models.

MEETING: 1st October 27 2nd Nov 1 – 15

Monthly thereafter

STAKEHOLDERS

GOVERNANCE SUBCOMMITTEE

CHARGE: Research/recommend evolving governance structure for OCH. Research/recommend legal form of OCH to ILC including bylaws. Act on legal form if indicated.

MEETING: 1st October 20-31
2nd TBD Nov/Dec
3rd TBD January

COMMUNITY HEALTH ASSESSMENT & PLANNING

CHARGE: Facilitate service gap analysis, priority setting; CHIP; develop approach for Regional Health Improvement Plan by 11/15; performance measures, recommend innovations. Carry out RHIP via collective impact.

MEETING: 1st TBD Oct 20 - 31
2nd TBD Oct 26-Nov 5
3RD TBD Nov 5-Nov 15
Monthly thereafter

STAKEHOLDER MEETINGS

1st November 2014
2nd July 2015
3rd November 2 2015
4th January 26, 2016

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QUICK GLANCE

Olympic Community of Health Development 10/8/15 – 1/31/16

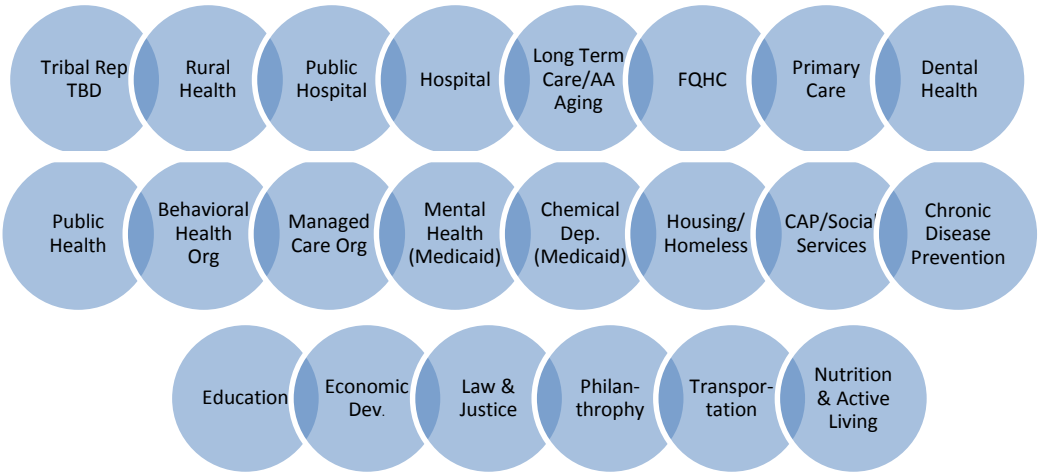
"Regional Vision, Local Action"

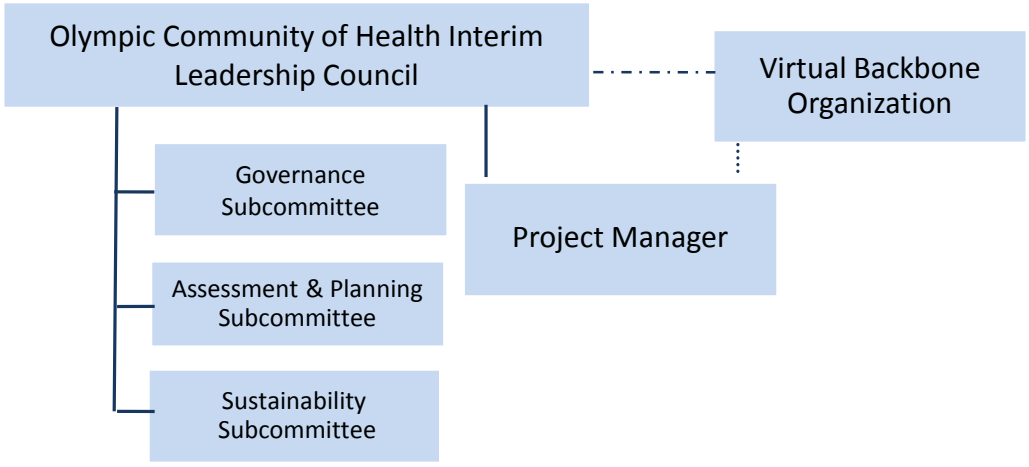
OCH STAKEHOLDERS

Represent a group of people in Clallam, Jefferson and Kitsap Counties who represent entities from a variety of different sectors with a common interest in improving health.

CHARGE: Through diverse multi-sector partnerships, ACHs are an integral part of the Healthier Washington initiative. The Olympic Community of Health will:

- Establish collaborative decision-making on a regional basis to improve health and health systems, focusing on social determinants of health, clinical-community linkages, and whole person care.
- Bring together all sectors that contribute to health to develop shared priorities and strategies for population health, including improved delivery systems, coordinated initiatives, and value based payment models.
- Drive physical and behavioral health care integration by making financing and delivery system adjustments, starting with Medicaid.





Accountable Communities of Health (ACHs) are where public and private entities come together to work on shared health goals. ACHs address health needs where they occur – at the local level. ACHS are based on the notion that health is more than health care, and will focus on issues that affect health, such as education, income, housing, and access to care, in order to address the needs of the whole person, and integrating purchasing on a regional basis to bring down costs and pay for value. *Adapted from WA State Health Care Authority ACH Fact Sheet July 2015*

Better Health. Better Care, Lower Cost.

http://www.olympiccommunityofhealth.org/

11-2-15 STAKEHOLDER BRAINSTORM OF ASSETS, GAPS, PRIORITIES LOCALLY & REGIONALLY

County_____

PART 1: In the work you do, what are key assets & gaps? Please note the sector this asset or gap relates to.				
SECTOR	**Perceived Assets**		**SECTOR**	**Perceived Gaps**

PART 2: Describe opportunities for cross sector collaboration. Identify which collaborations can affect Triple Aim.	
Cross-Sector Opportunities	**Affect Triple Aim?**

Mixed Sector Discussion

1. **Note cross sector collaboration opportunities most important in meeting Triple Aim, note accordingly. May range from complex endeavor to specific action strategy on shared issue.**
2. **If time allows note which sectors are needed to accomplish purpose**
3. **Note if regional, or if county specific, which county.**

Cross-Sector Opportunities	**Which Sectors needed to accomplish**	**Regional?**	**County?**
MH/CD/TC tax			

Olympic Community of Health Stakeholder Meeting November 2, 2015			
Date: 11-02-2015	**Time: 1:00 – 4:00 p.m.**	**Location:** Port Gamble, WA - Hood Canal Vista Room	
Attendees: See attached sign in sheets. Kathy Greco (scribe).			
Person Responsible for Topic	**Topic**	**Discussion/Outcome**	**Action/Results**
Tom Locke, MD	Welcome and Opening	Dr. Tom Locke began the meeting by welcoming everybody and thanking them for their continued support of this important endeavor. He talked about the importance of the three-county alliance and the collaborative work being done to create foundations for lasting change and better health for all.	
Barbara	The Charge for Stakeholders & Interim OCH Structure	Barbara Malich gave an overview of Healthier Washington and the Development of the Accountable Communities of Health (ACH). In 2014 a five year roadmap for transforming health and health care in WA State was created to achieve better care for individuals, better health care for our population, and lower costs. She briefly reviewed the map of WA State regional designation, by county. She then referred to the handout, "Quick Glance" and reviewed the charge of the Interim Leadership Council (ICL), Stakeholders and subcommittees (Governance, Community Health Assessment & Planning, and Sustainability). She spoke to the progress of each of these committees and reviewed the Olympic Community of Health (OCH) Readiness Proposal timelines and past and future meeting dates. The "Quick Glance" document will be modified as the OCH moves forward. She made an open invitation to all Stakeholders to join any one of the committees. Next, Barbara reviewed the ILC Charter. She encouraged the Stakeholders to take the time to read thoroughly through the Charter to see if how their organization can be globally involved. Barbara briefly reviewed through the remainder of the documents in the Packet: 1) CDC tools and resources: Invest in Your Community – 4 considerations to improve health and well-being for *All* 2) Stakeholder Roster broken out by sector.	Stakeholders are informed of most recent ACH developments. Stakeholders have an overview of the current status of our Olympic Community of Health and its Governance Structure. Interested Stakeholders were invited to join ILC subcommittees. Stakeholders reflected on what actually affects health (socioeconomic, clinical care, physical environment, health behaviors); and current Stakeholder engagement by Sector.

Siri	OCH Stakeholder Conversation: Assets, Gaps, & Priorities	Siri Kushner, KPHD epidemiologist and member of the Community Assessment & Planning Subcommittee, gave a presentation on the Regional Health Improvement Plan (RHIP). She explained that the plan identifies and drives action for projects that address priority areas for health improvements throughout the service area, including the social determinants of health. In order to capture the collective knowledge she asked the Stakeholders to break into sectors by county and identify the key assets and gaps and potential opportunities within the OCH areas of focus that could be implemented collectively to accomplish the Triple Aim. Each of the 5 brainstorming groups identified and presented the outcome of their thinking. Stakeholders then broke into mixed sector groups to identify local and regional cross sector collaboration opportunities. Again, each group presented the outcome of their work.	Stakeholders reviewed what is the RHIP, the Triple Aim and OCH areas of focus, the Assessment and Plan Inventory, local and regional CHIP priorities, other ACH initiatives, and provided stakeholder input to the RHIP process. The Community Assessment and Planning Sub Committee will collect all the feedback and summarize the information shared today to use in developing regional health improvement plan priorities.
Lisa	ACH Evaluation Process	Lisa Schaefer, thanked everybody for their participation in the Accountable Communities of Health (ACH) survey that was sent out regarding their opinion on the progress made to date in the OCH.	
Rochelle	Growing the OCH Sector Participant Voice and Next Steps	Rochelle requested that stakeholders review the stakeholder roster by sector listing to identify if there are additional stakeholders who should be added to the current list for future engagement. She noted the items and activities on today's agenda were planned to accomplish several things – ensure everyone is knowledgeable about the current status of our OCH, its new Interim Leadership Council Charter and governance structure, have substantive opportunity to continue to be engaged in the discussions that will ultimately lead to a regional health improvement plan and priority initiatives and projects, and be aware of the progress toward submission of our OCH Readiness Proposal to be submitted to the Health Care Authority by November 30, 2015.	Organization and individuals names were collected to add to the potential Stakeholder list.
Rochelle Barbara		There being no questions or further input, the meeting was adjourned at 4:00 p.m.	Next meeting: January 26, 1 PM – 4 PM.

CATEGORY 4: Backbone Organization Support

Established backbone functions to perform financial and administrative functions. These functions can be performed by one or more organization, interim or otherwise, and must demonstrate accountability to the ACH. There must be a process for ongoing evaluation and confirmation of the backbone organization(s).

The Kitsap Public Health District (KPHD), as the Olympic Community of Health (OCH) backbone organization, has been one of the organizations collaborating to create the OCH since July 2014. In November 2014, at the request of OCH Stakeholders, the virtual backbone entity selected to provide administrative support functions, including organizational, logistical, fiscal, and data support, was KPHD. This selection was a logical choice given KPHD's public health role in developing all three counties community health improvement plans and their relationship with Clallam and Jefferson County public health officials. Subsequently, an ACH Design Grant application was made and awarded by the Washington State Health Care Authority (HCA), and by end of March 2015, a contract was in place for KPHD to proceed in carrying out its responsibilities as the OCH backbone organization.

The KPHD Administrator has maintained strong connections with the Health Care Authority, with frequent communications, attendance at ACH organizational and informational meetings, and OCH leadership and stakeholder meetings (see document 4.2, Connection with HCA/ACH). KPHD has contracted with the Project Managers (see document 4.3 OCH Project Management), and has maintained budget and fiscal accountability. KPHD epidemiology staff have been assigned to the work of the OCH and have been instrumental in furthering the assessment and planning processes associated with the Regional Health Improvement Plan. KPHD has provided consistent executive level clerical support for the work of the OCH, including record keeping, regular communications with stakeholders and the Interim Leadership Council (ILC) and its subcommittees, and web postings via the Kitsap County Department of Human Services. The scope of KPHD's responsibilities is detailed in document 4.1, OCH Interim Leadership Council and Backbone Support Roles and Responsibilities.

KPHD will continue to serve in this role of Virtual Backbone Support in 2016. Oversight of the Virtual Backbone Entity is provided by the ILC and by spring 2016, when in place, the Governing Board. KPHD reports out to the ILC regarding its administrative and fiscal performance. The OCH ILC will review and evaluate the performance of the KPHD this March 2016, and make a determination regarding its continuance of provision of backbone responsibilities starting in January 2017, consistent with the ILC Charter annual review policy to assess performance of the backbone support organization, confirm the backbone support organization, or select a new one (see document 4.4, OCH Annual Governance Structure and Backbone Organization Review Policy).

4.1 OCH Interim Leadership Council and Backbone Support Roles and Responsibilities

This document details the OCH backbone support functions in ten arenas. It was developed based on the ILC Charter detailing the roles and responsibilities of the ILC as governing body and the backbone organization as administrative and fiscal lead. It details the distinct roles both in current practice, and anticipated roles as the OCH evolves over the course of 2016.

Olympic COMMUNITY of HEALTH

OCH Interim Council and Backbone Support Roles and Responsibilities

FUNCTION	OCH ILC COUNCIL	BACKBONE ORGANIZATION
Administration	▪ Annually review support organization performance	▪ Prepare reports to ILC & HCA to demonstrate performance ▪ Contract management ▪ Backbone organization staff management
Communications	▪ Review and approve regional communications plan and performance annually ▪ Develop and approve key messaging ▪ As sector representatives, provide lateral and vertical communication from and to sector/ILC re ACH associated issues ▪ Represent OCH in statewide meetings, committees, shared learnings ▪ Receive regular updates from project staff and communicate information as needed to HCA, stakeholders ▪ Direct stakeholder agenda, including shared learning opportunities and opportunity to provide comment to HCA, others as appropriate	▪ Project Managers to prepare regional communications plan, develop key messaging, implement communications plan ▪ Represent OCH in statewide meetings of ACH, committees, Peer Collaborative, shared learnings, other as needed ▪ Serve as liaison between OCH and State/partner agencies i.e., ACH Development Council calls ▪ Prepare publications, web postings (with Kitsap County Human Services for web management), and communications identified in ILC communications plan
Community Engagement	▪ Plan agenda for and host Stakeholder meetings ▪ Determine additional stakeholders/sectors to be engaged and take action to engage ▪ Determine avenues to engage specific communities for inclusion in planning and implementation of ACH efforts, especially where health disparities are high	▪ Prepare for and coordinate stakeholder meetings ▪ Support ILC in outreach to additional sectors, stakeholders, communities
Data & Evaluation	▪ Maintain active assessment and planning subcommittee to: ▪ Provide guidance for and engage stakeholders in assessment process ▪ Review data, determine performance metrics, review and approve regional dashboard, consider and approve baselines for key metrics ▪ Prepare prioritization information for ILC and stakeholder consideration ▪ Monitor regional performance toward achievement of shared regional goals & successful implementation of RHIP ▪ Monitor fulfillment of stakeholder commitments ▪ Review data and performance reports ▪ Use data to inform recommendations for action to ILC ▪ ILC to review and approve subcommittee prioritization of RHIP	▪ Ensure provision of epidemiology support for community assessment and planning subcommittee ○ community assessment, ○ data analysis ○ prioritization process ○ evaluation ○ report preparation including regional dashboard ○ attendance/presentation at committee, ILC and stakeholder meetings ○ monitor and use available HCA/ACH TA for setting measures and gathering data

	▪ ILC to review, approve subcommittee reports, recommend further action	
Finance	▪ Determine program of work for budget cycle and communicate to backbone organization ▪ Approve budget ▪ Oversee management of funds including review of financial reports	▪ Develop budget to support OCH program of work ▪ Receive and manage funds ▪ Provide quarterly financial reports to Council
Governance	▪ Governance subcommittee to research and recommend sustainable OCH structure ▪ Annually review governance model including governing body composition ▪ Adjust governance model as needed ▪ Review and approve governance policies	▪ Support ILC in annual governance review ▪ With Governance Subcommittee support continued development of governance structure, policies and develop bylaws if needed
Implementation	▪ Form workgroups to advance RHIP strategies as needed ▪ Act collectively on strategies requiring region-wide aligned action at ILC level i.e., policy advocacy, opportunities to comment ▪ Evaluate & report on RHIP implementation	▪ Support workgroups with planning, logistics, facilitation, meeting summaries, reports, records and communications ▪ Provide process leadership as needed and/or desired ▪ Support regional action planning
Planning	▪ With consideration of Planning and Assessment subcommittee recommendations, develop RHIP including: o Setting shared regional health priorities o Determining shared regional strategies for aligned action o Identify supporting actions support strategies implementation o Determine and support lead implementation agencies as appropriate	▪ With RHIP leads, develop Driver diagrams, goals, measures ▪ Support ILC and stakeholders in regional action planning by: o Organizing, coordinating and recording meetings o Providing thought and process leadership o Facilitating meetings o Recording & distributing meeting summaries o Preparing RHIP based on ILC content decisions ▪ Support OCH/ILC annual RHIP review
Policy	▪ Develop and approve shared regional policies, including policies related to State action on Medicaid financing and health care services delivery ▪ Advocate for shared regional policies	▪ Support ILC in policy development ▪ Communicate ILC approved shared regional policies
Sustainability & Resource Development	▪ Sustainability Subcommittee to develop, implement sustainability plan with ILC and stakeholders ▪ Sustainability Subcommittee to implement sustainability plan with ILC /stakeholders ▪ Design shared savings and reinvestment mechanism, model, possible wellness fund over time ▪ Sustainability Subcommittee to review and make recommendations to ILC annually for sustainability plan pathway ▪ Jointly, Sustainability and Governance Subcommittees to make recommendations to ILC regarding governance structure, including consideration of forming non-profit entity as OCH future becomes clear.	▪ Project Managers and ACH TA support Sustainability Subcommittee through research, contacts, thought leadership, grant prospecting and requests, liaison and acknowledgments, grants management. ▪ Project Managers and ACH TA creatively support Sustainability Subcommittee through research, identification and development of shared savings, reinvestment mechanisms, and wellness fund where opportunity arises. Research & prepare benefits of types of legal entity for review.

4.2 Connection with State HCA/ACH

This document denotes the level of lateral and horizontal communications and engagement between the backbone entity, the OCH and the HCA/ACH structure. It illustrates the consistency of participation of the backbone organization administrator, project managers, and stakeholders to ensure the OCH maintains its accountability to the ACH model for health improvements.

OCH Communications and Engagement - Backbone Entity and Stakeholders Meeting Participation

Partial list of meetings attended by backbone administrator, facilitated by OCH Project Manager/s, recorded and communicated out to stakeholders by backbone clerical support, attended by HCA/ACH staff.

A. OCH Stakeholder Meetings:

- November 7, 2014, Port Townsend, WA
- July 26, 2015, Port Gamble, WA
- November 2, 2015, Port Gamble, WA

OCH Steering Committee Meetings:

- November 7, 2014, Port Townsend, WA
- February 2, 2015 (phone conference)
- May 13, 2015 (phone conference)
- June 9, 2015 (phone conference)
- July 10, 2015 (phone conference)
- July 15, 2015 (phone conference)
- August 31, 2015 (phone conference)
- September 23, 2015 (phone conference)

OCH Interim Leadership Council (ILC) Meetings:

- October 19, 2015, Silverdale, WA
- November 2, 2015 Port Gamble, WA

ILC Subcommittee Meetings:

- October 19, 2015, Silverdale, WA
- November 2, 2015, Port Gamble, WA

B. OCH Project Manager Interviews (Administrator/stakeholders):

- April 27, 2015, Bremerton, WA
- August 8. 2015 Bremerton, WA
- October 8, 2015 Bremerton, WA

C. ACH Meetings with the Washington State Health Care Authority (HCA):
Administrator attendance except where otherwise noted.

- **ACH Planning Grantee Statewide Meeting**
  November 5, 2014, Toppenish, WA
- **ACH Design Grant Kick-Off Webinar**
  March 23, 2015
- **ACH Convening Statewide Meeting**
  April 30, 2015, SeaTac, WA
- **ACH TA Call - Larry Thompson (HCA Contractor)**
  July 22, 2015 (phone conference)
- **ACH Evaluation Call - Lisa Schafer (HCA Contractor)**
  August 19, 2015 (phone conference)
- **ACH Medicaid Transformation & Coordinating Entity Workgroup Meeting** *(Project Manager)*
  October 14, 2015, Olympia, WA
- **ACH Development Council Meetings (HCA, All ACHs Participating)** *(Administrator/Project Manager)*
  October 19, 2015 (phone conference)
- **ACH Collaborative Leadership Statewide Summit**
  August 24, 2015, SeaTac, WA
  August 25, 2015, SeaTac, WA
- **Collective Impact Summit**
  (Administrator/Project Manager)
  September 28, 2015, Richmond, BC, Canada - October 1, 2015, Richmond, BC, Canada
- **Peer Learning Collaborative Participation**
  (Project Manager)

Other ACH Meetings:

- **King County ACH Legal Seminar- ChangeLab Solutions** *(Administrator/Program Manager, ILC Members)*
  August 21, 2015, Seattle, WA
- **ACH "Backbone Huddles"**
  October 14, 2015 (phone conference)
  October 21, 2015 (phone conference)

4.3 OCH Project Management

Background documentation is included regarding the hiring of an OCH Project Manager (Consultant Peter Browning in May 2015) by the OCH Backbone Agency, Kitsap Public Health District and OCH Steering Committee members, as well as the Consultant's departure as of October 8, 2015. New Project Management were then retained (Consultants Barbara Malich and Rochelle Doan) as of October 10, 2015. Ms. Doan, at the existing Governance Committee's request, had previously been retained to draft the Interim Council Leadership Charter during August 2015. This new consultation team, together with a highly committed OCH Interim Leadership Council and ILC subcommittee participants, have invigorated and intensified development of the Olympic Community of Health and its purposes.

E-mail of 5-5-2015 To OCH Steering Committee Re: OCH Consultant

I wanted to announce that our Recruitment Committee has selected Peter Browning, MA, of Browning Solutions, as our first Olympic Community of Health (OCOH) Project Manager. Peter has accepted our offer and we are now in the process of finalizing the professional services agreement for this work under our ACH Design Grant. The term of the agreement will end when the grant wraps up on January 31, 2016. Congratulations Peter, we commit to helping you make our ACH a reality and wish you great success!

On a related note, later today we'll be sending out a Doodle Poll for our next OCOH Steering Committee meeting. We'll welcome Peter to this call, and we'll discuss next steps in the ACH development work.

Let me know if you have any questions. Thanks again for your participation.

Scott Daniels, MS, RS
Administrator
Kitsap Public Health District
345 6th Street, Suite 300 Bremerton, WA 98337-1866
360-337-5287 Office 360-620-3704 Cell 360-475-9287 Fax kitsappublichealth.org

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E-mail of 5-27-2015 To Chase Napier, HCA Re: OCH HCA Representative

Chase, I wanted to let you know that Peter Browning will now be our primary Olympic Community of Health lead working with HCA and stakeholders. He will serve as our representative on the ACH Advisory Committee and will participate on Friday's committee call. He should also be listed as the lead for our ACH on HCA's ACH web page. He's cc'd. His phone number is 360-770-4321.

Because the Kitsap Public Health District is the contractor for the ACH design grant, please continue to keep me in the loop on all matters related to the grant. As you know, Peter is a subcontractor to the District (and the OCOH) under the grant. Let me know if you have any questions, thanks.

Scott Daniels, MS
Administrator
Kitsap Public Health District
kitsappublichealth.org

From Kathy Greco, KPHD, 9-15-2015 to all OCH Stakeholders via e-mail:

September 15, 2015

To all of my Olympic Community of Health friends and compatriots,

The work we are doing is possibly some of the most important work we have done in years. I have been excited about having the opportunity to fundamentally change the way healthcare is being delivered in our communities. The people we work with in this three county community are very positive and engaged. It is for these reasons I am sad to tell you that I am leaving OCH in early October. I have been offered the opportunity to work in British Columbia with the Bands (tribes) living around the area where the new Natural Gas pipeline will be constructed. I will be responsible for making sure that as many indigenous people are trained and employed as is possible.

Our ACH is off to a good start and I am confident we will have great success in meeting the Triple Aim. I am convinced our ACH will have real positive results from working together in a cooperative/collaborative way. I am comfortable that our region will stand out based on the commitment of the people involved. I will always be available for questions or assistance. Thank you for welcoming me into your communities, I feel privileged to have had the opportunity to work with all of you.

Peter Browning

From Kathy Greco on behalf of Scott Daniels, KPHD, 10-15-2015 to all OCH Stakeholders via e-mail:
October 15, 2015

Subject: Olympic Community of Health Update

Olympic Community of Health Stakeholders:

I wanted to take this opportunity to update everyone on the status of the Olympic Community of Health (OCH), the Accountable Community of Health (ACH) forming in Clallam, Jefferson, and Kitsap counties to address Healthier Washington's Triple Aim of health reform: better health, better care, and lower costs.

1. Project Management

Our previous OCH Project Manager Peter Browning resigned effective October 6th to pursue employment opportunities outside our region. In response, the Kitsap Public Health District (KPHD), who is currently contracted with the Washington State Health Care Authority (HCA) as the backbone agency for the OCH work, is subcontracting project management work through January 31, 2016, with **Barbara Malich** and **Rochelle Doan** who are operating as licensed independent businesses for this work.

Barbara will be primarily responsible for communications with regional stakeholders regarding the work of the OCH, and meeting facilitation. Meetings she will be facilitating include the newly formed OCH Interim Leadership Council (ILC, the OCH's interim governing body), OCH Stakeholder Meetings (all stakeholders), the Governance Subcommittee, and the Sustainability Subcommittee (not yet formed).

Rochelle will be primarily responsible for developing activities and drafting documents necessary to demonstrate our region's commitment to being formally designated as an Accountable Community of Health by the State. Rochelle will also work in tandem with Barbara to co-facilitate the ILC and Stakeholder meetings, as well as facilitate the Planning and Assessment Subcommittee.

KPHD's **Kathy Greco** will continue to provide administrative support to both Barbara and Rochelle for this work, and I will continue to manage our ACH Design Grant.

Thanks to Barbara and Rochelle for agreeing to take on these tasks under extremely demanding timeframes and working in the short-term, and over the long-term, to improve the health of our communities.

2. ACH Readiness Proposal

The project subcontractors will be working with KPHD to draft and submit documentation needed to complete an **ACH Readiness Proposal**, due November 30, 2015. The ACH Readiness Proposal is the portfolio required by HCA, under KPHD's ACH Design Grant, to receive formal designation as an ACH. The ACH Readiness Proposal reflects the work of the OCH to date, and future plans of the OCH, and includes, in part, the following:

- Governance Documents including the Interim Leadership Council (ILC) Charter.
- Regional Health Needs Inventory which will be developed in conjunction with all three county Community Health Priorities (CHP) and other assessment data, which describes both regional health needs *and* resources. The CHP process was accomplished with assistance from KPHD's epidemiology staff, and they will continue to offer their expertise to the Assessment and Planning Subcommittee.
- Engagement Plan which will focus primarily during this shortened timeline on filling vacant positions on the ILC and developing the community and stakeholder engagement approach moving forward.
- Sustainability Plan, to be developed by the new Sustainability Subcommittee, which will focus on the importance of diversified funding if/when the Washington State Medicaid Waiver is approved by the federal government and the exact function of the ACHs is better defined. This work also directly relates to the ultimate governance model approved by the ILC.

3. Contact Information

Barbara Malich
Email: malich.messages@gmail.com
Phone: (253) 312-7508

Rochelle Doan
Email: rdoan1@q.com
Phone: (253) 405-0972

Kathy Greco, Administrative Support
Email: kathy.greco@kitsappublichealth.org
Phone: (360) 337-5216

Scott Daniels, ACH Design Grant Administrator
Email: scott.daniels@kitsappublichealth.org
Phone: (360) 337-5287

4. Upcoming OCH Meetings

Upcoming OCH meetings include:
OCH Interim Leadership Council (first meeting)
Monday October 19, 2015
2:30 - 5:00 p.m.
Best Western Silverdale Beach Hotel, Anchor Room
3073 NW Bucklin Hill Road
Silverdale, WA
Agenda to be distributed soon

OCH Full Stakeholder Meeting (third meeting)
Monday November 2, 2015
1:00 - 4:30 p.m.
Port Gamble Events Center, Vista Pavilion
4740 View Drive
Port Gamble, WA

Agenda to be distributed soon

Formation of the OCH's Assessment and Planning Subcommittee will also be occurring soon. This subcommittee will be discussed at next Monday's Interim Leadership Council meeting. The Assessment and Planning Subcommittee will be tasked with developing the Regional Health Needs Inventory.

Let me know if you have any questions or concerns, and thanks again for your commitment to the work of the Olympic Community of Health.

Scott Daniels, MS | **Administrator**
Kitsap Public Health District
345 6th Street, Suite 300
Bremerton, WA 98337-1866
360-337-5287 Office | 360-620-3704 Cell | 360-475-9287 Fax
kitsappublichealth.org

4.4 OCH Annual Governance Structure and Backbone Organization Review Policy

This policy ensures that the OCH Interim Leadership Council or Governing Board will conduct a formal review of the OCH governance structure annually, allowing the OCH to plan for, test, and adjust to environmental changes. This includes the composition of the governing body, whose membership may be adjusted more frequently as additional sector representation can be brought to the table. Additionally, the policy ensures the ILC or Governing Board conducts a formal review of the backbone organization on an annual basis.

Annual Review Policy of the Interim Leadership Council and Virtual Backbone Organization

This process is established and documented to allow for adjustments to the ACH structure as concerns or additional governance structure needed will evolve over time. The review process recognizes that development of the OCH governance structure is an iterative process and will require finessing and adjustment as the ACH function and our local structure becomes further defined. Note: The OCH Virtual Backbone Organization KPHD formally began its role March 27, 2015 following signed contract award under HCA for KPHD services. The OCH ILC will review the KPHD at completion of its year one contract and make recommendation to reaffirm or discontinue the relationship based on performance review and evolving OCH governance structure needs.

Interim Leadership Council/Governing Board

The OCH Interim Leadership Council will review the current governance structure as a whole at least annually, affirming the current composition or when indicated, make adjustments in real time should issues or gaps emerge. These adjustments or the affirmation will be noted in the meeting summary.

Virtual Backbone Organization

The Virtual Backbone Organization will be reviewed on an annual basis by the governing body (at this time the Interim Leadership Council, at a future time, a Governing Board) which will select or reaffirm the backbone organization, and note as such in the governing body meeting summary.

CATEGORY 5: Regional Health Improvement Plan

Initial priority areas (service gaps and/or health priorities) and strengths identified as part of ongoing regional needs inventory and assessment development. Initial regional health improvement project(s) or plan identified with a plan in place to continue this development in alignment with forthcoming ACH technical assistance opportunities (i.e., framework for regional initiatives inventory and priority identification).

The foundation for development for an Olympic Community of Health (OCH) Regional Health Improvement Plan (RHIP) has been well established through completion of a Community Health Improvement Plan (CHIP) process by each of our three counties within the past few years, supported by the Epidemiology Program staff of the Kitsap Public Health District (KPHD). Within each county, the CHIP process facilitated identification of shared health priorities. We cross-walked those priorities to identify overlap across our region and reviewed them at the initial OCH stakeholder meeting in November 2014. Further, within the OCH region, a wide range of community and agency-level needs assessments, gap analyses, strategic plans, and priority-setting plans and processes already exist. Some are broad, covering a range of topics, while others cover specific population groups or issues. At this time, no single document of cross-sector needs and associated shared priorities exists; the OCH Regional Health Needs Inventory and Priorities (RHNIP) will be the inaugural compilation of both.

A Community Assessment and Planning Subcommittee, formed under the direction of our Interim Leadership Council (ILC) and together with the KPHD epidemiologist, has initiated steps toward a RHIP by:

- Reviewing the regional CHIP priorities cross-walk (see document 5.6 Local and Regional CHIP and other Data). This document identifies initial county and regional shared priorities.
- Reviewing existing county and regional assessments and plans and marking priorities in a matrix to identify overlap (see document 5.4, Matrix of Community Assessment & Plan Priorities).
- Securing additional data including the CHIP process data, such as health shortage designation areas, with additional data to be secured as the need arises (see documents 3.2 and 5.6 as above).
- Engaging stakeholders in identifying assets/gaps and cross sector opportunities and reviewing results (see document 5.3, OCH Stakeholder Asset Gap and Priorities Report Out).
- Soliciting and compiling regional input into an inventory of existing local and regional health initiatives (see document 5.5, list of current health initiatives).
- Reviewing Core Performance Measures to date (see document 3.2, OCH Stakeholder Engagement & Development of Regional Health Priorities). *Note: We anticipate Core Performance Measures to be further informed through State Technical Assistance, Providence Core. The Subcommittee will be monitoring these developments and will incorporate measures into our RHIP process.*
- Developing initial documentation of our approach to the OCH RHIP (see document 5.1, OCH Regional Health Improvement Plan Approach).

The Community Assessment and Planning Subcommittee membership consists of highly skilled individuals from throughout our region familiar with diverse assessment and planning processes. Together they bring sector representation from: public health, hospital, primary care, housing and homelessness, human services including youth development, prevention and substance abuse treatment, behavioral health, and community action/social services. The planning processes that they themselves have completed have involved working with community members, affected population groups, in person key informant interviews, on line surveys, advisory boards, and task groups. They have a depth of understanding of the value of planning processes and community engagement and a commitment to service delivery that improves population health and meets the Triple Aim.

The Regional Health Improvement Plan approach was created from this basis of understanding and expertise. Immediate next steps in December 2015 will be to review the community assessment/plan matrix, inventory of existing initiatives, and the Washington State Common Measure Set for Health Care Quality and Costto be released by the Washington State Health Care Authority on December 8, 2015. Following this, the

Subcommittee will synthesize all of these findings and prepare a slate of potential priorities, cross-walked to the four areas of priority focus identified in the OCH Interim Leadership Council Charter:

1. **Access to Care (coverage and capacity)**
   - Increase the number of insured individuals in our region.
   - Increase network adequacy for Primary Care Providers, Specialty Care Providers, Behavioral Health Services Providers and Oral Care Providers.
2. **Population Health Improvements**
   - Ensure every county has a plan to increase population health with a specific focus on reducing the prevalence of diabetes, high blood pressure, obesity, child and vulnerable adult abuse and neglect, mental illnesses, and substance abuse.
   - Ensure every county has a plan to address key areas that effect overall health, including affordable and adequate housing, education, economic and food security, employment, health workforce development, crime, transportation, and environment.
   - Participate in selecting and piloting regional and state innovations.
3. **Access to "Whole Person" Support (clinical coordination and integration)**
   - Increase affordable housing options and food security throughout the region.
   - Increase the number of individuals who have Medical Health Homes and integrated behavioral health and oral health services.
   - Increase knowledge of, and integrate service delivery to address, Social Determinants of Health and Adverse Childhood Experiences.
   - Increase care coordination and utilize social services support.
   - Increase supports for age friendly communities, aging in place, in particular options for dementia and palliative care.
4. **Data Management/Region-Wide Infrastructure**
   - Promote region-wide data sharing and infrastructure to increase measurement, accountability, and coordination of care.

There are already multiple initiatives, task groups, and collaborations related to these priority areas and the OCH will build on these existing efforts where possible, or may initiate new collaborative endeavors where none exist. Accomplishing objectives within each of these broad areas of focus will require prioritized strategies with accompanying timelines, milestones, and measurements.

The Regional Health Improvement Plan approach is described below and includes these documents as follows:

- Assessment & Planning Subcommittee Meeting Minutes (see document 5.2)
- Early Community Assessment/Planning Committee Pathway as of October 29, 2015 (see document 5.2)
- November 2, 2015 Stakeholder Brainstorm Results (see document 5.3)
- DRAFT Assessment & Plans Matrix (see document 5.4)
- DRAFT Health Initiative Inventory (see document 5.5)
- Local and Regional CHIP and Other Data Inputs, including HPSA (see document 5.6)

5.1 OCH Regional Health Improvement Plan Approach

These documents set forth the strategies, timeline, current state of completion, and parties responsible for carrying out specific portions of the Regional Health Improvement Plan (RHIP) process. The approach to the RHIP process has been developed by the ILC Assessment and Planning Subcommittee, with support of the KPHD epidemiologist and OCH program manager. Together the Subcommittee and OCH Interim Leadership Council participates in, monitors and reviews the evolving RHIP process.

OCH Regional Health Improvement Plan Approach

Table 1: Strategies and activities, timeline target, and current state of completion of the RHIP process.

STRATEGY/ACTIVITY	TARGET DATE	COMPLETED
1. Current local (3 county) and regional Community Health Improvement Plan findings and priorities shared with stakeholders.	11-2014	✓
	11-2015	✓
2. Community Needs Assessments/Plans gathered for review by subcommittee.	10-2015	✓
3. Community Needs Assessments/Plan holders requested to inform subcommittee of priorities if not clearly stated in document.	10-2015	In process
4. Community Needs Assessments/Plan priorities charted in matrix to identify shared priorities across issue/across sector/across region.	10-2015	In process
5. OCH Stakeholders engage in assets/gaps/cross-sector opportunities brainstorm, results shared with subcommittee.	11-2015	✓
6. Current health initiatives inventory by county/region or issue based on key informant and OCH stakeholder input.	12-2015	In process
7. Additional data inputs identified and gathered for review (ie hotspot maps, healthcare professional shortage designations, State identified performance measures, etc.).	12-2015	In process
8. As HCA TA including Providence Core and Performance Measure expectations are ready, utilize assistance and support as/when available.	TBD	
9. Subcommittee to review synthesis of findings (Assessment/Plan matrix; Stakeholder brainstorm results; health initiatives inventory; additional data inputs) and develop preliminary priorities.	1-2016	
10. Subcommittee to report findings/preliminary priorities to ILC and stakeholder process to determine final shared regional health priorities.	1-2016	
11. Stakeholders will determine final shared regional priorities.	1-2016	
12. Identify key measures (process and/or outcome) for monitoring shared regional health priorities. Ensure any required measures are included.	2-2016	
13. Identify and prioritize key strategies to address shared regional priorities. These should include strategies by existing groups.	3-2016	
14. Determine leads and supports for each prioritized strategy.	3-2016	
15. Develop implementation timeline, driver diagram, milestones and measures for the prioritized strategies.	4-2016	
16. Develop regional dashboard with key metrics for progress monitoring.	4-2016	
17. Begin implementation of prioritized strategies.	5-2016	
18. Quarterly progress reports to subcommittee, ILC and Stakeholders.	quarterly	
19. Publish dashboard quarterly to monitor progress. Use continuous quality review quarterly to finesse strategies as needed.	8-2016	
20. Regional Health Improvement Plan reviewed annually to monitor progress and identify additional priorities.	ongoing	

Table 2: OCH RHIP Steps Stakeholder Timeline

OCH RHIP Steps Timeline						version 11/12/15
	FOUR INPUTS					
	Community Assessment/ Plan Inventory	**Health Initiatives Inventory**	**Stakeholder brainstorm**	**Other Data inputs**	**CORE measures from state**	**Synthesis = Findings x-walk to ILC Broad Areas/ Objectives**
Subcommittee	review mid dec 2015	review mid dec 2015	review 11/13/15	review mid dec 2015	review mid dec 2015	review first week of jan 2016
ILC	n/a	n/a	n/a	n/a		review second week of jan 2016 (anything missing)
Stakeholder	11/2/2015 mtg asked for additional plans	electronic review early dec 2015	*review only as inputs on 1/26*	*review only as inputs on 1/26*	*review only as inputs on 1/26*	**review on 1/26/16**

5.2 ILC Assessment and Planning Subcommittee Meetings

These documents reflect the discussion and minutes of the ILC Assessment and Planning Subcommittee meetings as they determine and review the necessary data, stakeholder inputs, current initiatives, to support the development of priorities and a regional health improvement plan.

OLYMPIC COMMUNITY OF HEALTH

AGENDA

OCH Planning & Assessment Committee
October 29, 2015
9:00 – 10:00 am

Thu, Oct 29, 2015 9:00 AM - 10:00 AM Pacific Daylight Time, at Kitsap Public Health District, Norm Dicks Bldg 4th Floor Sinclair Room OR Please join my meeting from your computer, tablet or smartphone.
https://global.gotomeeting.com/join/307244045. **You can also dial in using your phone.**: +1 (872) 240-3412

Facilitators: Rochelle Doan and Siri Kushner
Committee Members: Jean Baldwin, Director, Jefferson County Health Department; Roy Walker, Executive Director, Olympic Area Agency on Aging; Michael Anderson, Chief Medical Officer, CHI Harrison Medical Center; Kurt Wiest, Executive Director Bremerton Housing Authority; Siri Kushner, Epidemiologist, Kitsap County Health District; Gay Neal, Human Services Planner, Kitsap County Human Services; Larry Eyer, Executive Director, Kitsap Community Resources.

1. **Member Introductions**

2. **Review Charge –**
   - Develop Asset and Gap Assessment
   - Develop an Approach to a Regional Health Improvement Plan

3. **Develop process for stakeholder engagement in Asset and Gap Assessment**
   - Review of possible process approach documents

4. **Discussion of Regional Health Improvement Plan Process**

5. **Next Meeting**

OLYMPIC COMMUNITY OF HEALTH
Community Assessment & Planning Minutes Subcommittee– Meeting Notes
October 29, 2015

P	Jean Baldwin	P	Gay Neal	A	Kurt Wiest
P	Rochelle Doan	P	Justin Seville	A	
P	Larry Eyer	P	Roy Walker		
P	Siri Kushner	P			

Recorder: Rochelle Doan/Siri Kushner	
Topics	**Tasks/Decisions**
Introductions: All committee members at location or on GotoMeeting. 1. **Member Introductions.** a. Roy said he represents both Clallam and Jefferson AAA in his agency and he will read the Kitsap plan to be able to represent all three counties b. Larry said his agency produces a Community Assessment every three years that is "all things poverty" they also participate in a Head Start/ECEAP annual assessment. His agency is human services, housing, WIC and he serves on the 3-county workforce development board. c. Katie works on the CHIP process for Kitsap.	

2. Review charge Rochelle reviewed the role of the committee to create and guide the process of reviewing assessments/plans to develop priorities for a regional health improvement plan (RHIP). First work product due with Readiness Assessment 11/15/15. "Initial priority areas (service gaps and/or health priorities) and strengths identified as part of ongoing regional needs inventory and assessment development. Initial regional health improvement project(s) or plan identified with a plan in place to continue this development in alignment with forthcoming ACH technical assistance opportunities." Our Regional Health Improvement Plan approach will be informed by the local CHIP process and shared regional priorities identified in 2014, with all three counties benefiting by use of KPHD Epidemiologist Siri Kushner (use shared regional priority slide from the November 2014 Stakeholder meeting as a reminder). It will also be informed by creating a matrix of priorities from the multiple community assessment and planning documents created by the various sectors in the conduct of their work. We will identify key areas that show up consistently in plans that we review, we will consider these as we identify emerging themes and priorities which may include major system issues such as care coordination.	Use existing local and regional CHIP priorities as well as community assessment and planning documents produced through the region's stakeholders to inform the OCH RHIP.
3. Develop process for stakeholder engagement in Asset and Gap Assessment. Agenda facilitates stakeholder engagement in Charge 1 from 1:50 – 3:40 – subcommittee discerned best approach using Community Assessment & Planning Draft to guide discussion. Committee members will be facilitators on 11/2 and reviewed the following documents: • template for Assessment/Plan review for input into Inventory Matrix • draft template for Asset/ Gap Assessment input 11/2 Stakeholder meeting Discussion: • Roy suggested we might try to obtain data to understand what's actually occurring in our communities based on where $ (claims) is being spent • Larry likes the matrix to easily see where there are key overlapping areas that 11/2 groups can validate in discussion – he said that in the process "I want to feel like I'm being heard" • Justin suggested we need to have a prioritization method and scope to our work – identify the 2 issues we can impact the most? Can we find major systems issues out of the literature in addition to those we identify with inventory matrix and qualitative input on 11/2 • Would be helpful to see priorities/work areas put forward by other ACH's for inspiration – Rochelle will put together a matrix with these • Katie suggested the other ACH work would be a good introduction and we should frame our work within the elements of the Triple Aim Group landed on: • 2 rounds stakeholder input: 1) by county; 2) mixed by county & sector. • Table to capture discussion has columns for: Assets, Gaps and Cross-system Opportunities Subcommittee members will serve as table facilitators, selecting a scribe to capture the discussion points. Facilitators will have a guide, instructions will be given verbally and be posted at tables for participants. Discussion to be scoped by Triple Aim and OCH focus areas as described in the ILC Leadership Charter document, to be placed at each table for easy viewing. We are seeking to identify assets, gaps by county and region, and areas for cross sector collaboration – instructions will facilitate this aim.	Plan for participatory stakeholder process to identify assets and gaps by county, and then across region with multiple sectors developed. Plan in place for participatory stakeholder process to identify cross system collaborations that will benefit meeting triple aim, using experience and reflecting on OCH focus areas as noted in governance documents. Siri/Rochelle to draft PP, generate support materials and discussion guide for facilitators. Subcommittee members will facilitate table discussions and appoint a scribe to capture the information.
4. Next Steps: Subcommittee to set date to reconvene prior to November 15 to review the approach to a regional health improvement plan draft that builds on the discussion draft reviewed at the October 29th meeting. Date/time TBD at ILC 11/2.	Approach to a Regional Health Improvement Plan Draft to be included in Readiness Proposal will be reviewed by Nov 15.

For discussion: Community Assessment/Planning Committee Pathway as of October 29, 2015

Proposed path to initial assessment/ planning that informs our approach to a Regional Health Improvement Plan, for discussion and review Oct. 29 2015:

1. **Review of existing county and regional plans.** Each of these plans represents the thoughtful work of widely diverse community members, organizations, and service providers. The methods of securing data and information, provision of feedback loops and community member input, with subsequent group assessment, recommendations and priority setting have provided multiple opportunities for community voice, engagement and investment. Existing plans are being identified and their recommendations and priorities catalogued to provide a brief but rich snapshot for OCH stakeholders to consider in our Regional Health Improvement Plan process. Task completed during October 2015. (see Matrix)

2. **Matrix of Assessments/Plans:** An at-a-glance catalogue of results from the review, shared at the Stakeholders November 2 meeting. The matrix also includes the county Health Improvement Plans and the Regional shared priorities emerging from these plans. Note: Include narrative on timing of reports (CHIPs in particular) and ACA Medicaid expansion since we do not know but expect population level impact in access to care.

3. **Community Engagement: Stakeholder Asset/Gap Identification.** Stakeholders as identified in the Interim Leadership Council Charter, and other interested community members will briefly review the matrix of assessment plans. The Stakeholder conversations that follow are not expected to result in actual adoption of OCH priorities yet, they are designed to **create community engagement and input in what priorities may emerge for consideration early in 2016**. This is the beginning of our process
   - **Round 1:** Stakeholders meet in County with these tasks:
     - Review DRAFT Assessment inventory list – see what we have, what are we missing?
     - Review what other ACHs have identified as priorities
     - In your sector, what are the key assets and gaps?
     - In your sector, provide 1-3 areas that could benefit from cross-system collaboration
     - Identify which cross-system collaborations will affect the Triple Aim
     - Break into multiple county groups depending on number of participants
     - ILC Assessment sub-committee members facilitate discussion within groups; identify a notetaker

   COUNTY:

SECTOR	Perceived Assets	Perceived Gaps	Cross-System Opportunities
	MH/CD/TC tax		

- **Round 2:** Reconvene full Stakeholder group and share which can be addressed by cross-sector evaluation
    - Stakeholders meet by mixed sectors, discuss which cross-sector collaborations among the most important in meeting Triple Aim and note accordingly. May range from a complex endeavor, to a very explicit action strategy on a shared issue.
    - ILC Assessment sub-committee members facilitate discussion in groups; identify a notetaker

REGIONAL:

Perceived Assets	Perceived Gaps	Other Passionate Discussion
Shared epidemiologist, data formatting and tracking		

- Reconvene full Stakeholder group, and share observations. Identify if any of these cross system/Triple Aim observations reach across the full Region.

Community Assessment & Planning Minutes Subcommittee – Meeting Notes

November 13, 2015, 3 PM – 4 PM

P	Michael Anderson	P	Roy Walker	A	Jean Baldwin
P	Rochelle Doan	P	Kurt Wiest	A	Gay Neal
P	Larry Eyer	P			
P	Siri Kushner	P			
Recorder: Rochelle Doan/Siri Kushner					

Topics	**Tasks/Decisions**
Introductions: All committee members at on GotoMeeting. Agenda was reviewed with no additions for today's discussion. Siri began by reviewing through the data compiled from the Stakeholder Meeting on November 2, 2015. The first breakdown of data reflected the member participation by sector and county, with reminder that the Stakeholder meeting was broken into two-parts. First the Stakeholders broke into groups by county and identified access and gaps. Secondly, the groups identified cross sector collaboration. The comments collected were very interesting and rich in content. Siri worked the data into several categories and reviewed all the breakdown. • The top assets were identified as: behavioral health and healthcare resources. • The top gaps were identified as: housing, behavioral health and healthcare. Next she presented the detailed data of the assets and gaps, including notes from each groups with review of the cross-sector opportunities reflected in the data: Collaboration, mostly with behavioral health, was a common theme. Other opportunities identified were cost savings, data & information sharing, dental. A question about how affordable housing is linked to the data was asked. It was clarified to be a very important link as 80% of social determinants of health impact health status. Often people with unstable housing have difficulty maintaining medication and treatment regime. It is a direct impact on health status, especially in the behavioral health population where maintaining stable housing is marker of maintaining stability in mental health. Siri reviewed the results of the cross-sector collaboration opportunities that are most important in meeting the Triple Aim. This data also identifies the results mapped to OCH broad focus areas as outlined in the ILC Charter. The data reflected top themes of: collaborations, Information and data sharing, coordination of care, integrated care, access to services, and housing. Rochelle reviewed the timelines for the RHIP. Ultimately it will result in this group identifying explicit strategies, whether local or regional, that are above and beyond what is already happening, and/or link to existing initiatives. It is an ambitious timeline that will require monthly meetings between now and March, 2016. The group supported this timeline. Information as noted in the RHIP will continue to be gathered for committee review and recommendations for priority setting. The group reviewed Category 5 of the RHIP and clarified the difference between, "access to care" and "access to whole person care". **Access to care** is about capacity and coverage	The documents presented today will be synthesized into the Regional Health Improvement Plan (RHIP). This subcommittee will continue to work with these documents to help shape their recommendations. Siri/Rochelle to continue and complete the assessment of current plans, matrix of priorities, inventory of current initiatives and other data as needed for sub-committee analysis December 11th or 18th. The Regional Health Improvement Plan Approach is recommended for inclusion in the Readiness Proposal with Rochelle

rather than clinical work and **whole person care** is the provision of clinical care, including the integration of primary care and behavioral health. Additional data has been gathered, and the group reviewed definitions and maps from the Department of Health that shows regional designation by primary care, dental care, mental health care and medical underserved designation. Dr. Anderson stated that Harrison Medical Center has plans to start a family practice residency that will supply primary care providers throughout all counties for long-term. This will be a huge asset to the primary care workforce gap. Lastly, Siri referred to the Health Initiative Inventory that identifies what is already happening and where some of the current efforts already are. This will be helpful in determining strategies for health priorities. <u>Next Steps</u>: Subcommittee to set date to reconvene either December 11 or 18th to analyze the growing information available to support development of RHIP priorities. Fridays at 3 – 4 PM are generally good times for conference calls. We will need to meet face to face, probably in January for a longer time period to hone in the health priorities and prepare recommendations to the ILC by their January meeting (TBD).	to note clarification regarding these two focus area differences. Request if the anticipated HMC family practice residency program may be included in the inventory of current initiatives. Kathy Greco to conduct doodle poll for December 11 or 18 call. All information to be reviewed to be sent at least 3 business days prior to meeting.

5.3 OCH Stakeholder Asset, Gap & Priorities Report Out

The results included here are the analysis of Stakeholder input on the assets, gaps, priorities, and potential cross system collaborative opportunities to consider in setting the Regional Health Improvement Plan priorities January/February 2016. This input was collected from small group discussion at the November 2, 2015 Stakeholder brainstorming session.

November 2, 2015 OCH Stakeholder Convening: Participation

SECTOR	# participants
Tribal Nations	5
Medicaid MCOs	4
CAP/Social Service	3
Housing/Homeless	3
Primary Care	3
Public Hospital	3
BH Organization	2
LTC/AAA/Home Health	2
Mental Health	2
Other Medical	4
Private NPO Hospital	2
Public Health	2
Rural health	2
Board of Health/Elected	1
Ch Dz Prevention thru the Life Span	1
Chemical Dependency	1
Dental Health	1
FQHC	1
Philanthropy	1
State	1
None of the above	1
TOTAL*	**45**

COUNTY	# participants
Clallam	13
Jefferson	4
Kitsap	19
Clallam/Jefferson	1
Clallam/Jeff/Kitsap	1
State	7
TOTAL*	**45**

*Does not include facilitators who represent: FQHC, MH, PH or State Evaluators (2)

November 2, 2015 OCH Stakeholder Convening

COUNTY DISCUSSION RESULTS SUMMARY, THEMES RANKED BY FREQUENCY:

Part 1: In the work you do, what are the assets & gaps?

Frequency	# Counties	Asset Theme
20	3	Behavioral Health
19	3	Health Care Resources
10	3	Community
6	2	Housing
4	2	Early Intervention
3	2	Data
3	1	Education
2	1	Oral Health

Frequency	# Counties	Gap Theme
12	3	Housing
11	3	Behavioral Health
10	3	Health Care
8	2	Data
7	1	Care Coordination
6	3	Aging
6	3	Dental
5	2	Funding
3	1	Community
3	2	Education
3	1	Health risk
3	2	Transportation
2	2	Economy

Part 2: Opportunities for cross-sector collaboration

Frequency	# Counties	Opportunity Theme
13	3	Collaboration
13	2	Data/Information Sharing
5	2	Community
5	2	Dental
5	1	Workforce
4	2	Cost Savings
4	2	Housing
3	2	Health Care Model
2	2	Justice

November 2, 2015 OCH Stakeholder Convening: Discussion by County

RESULTS: Key assets

Group instructions were not followed for identifying related sectors.

COUNTY	ASSET	THEME	CATEGORY
Clallam	regional mh	BH	BEHAVIORAL HEALTH
Kitsap	looking at the greater good	BH	
Kitsap	we are responsive	BH	
Jefferson	chemical dependency & behavioral health: the key players are committed to collaborate	BH: collaboration	
Kitsap	collaboration, work to resolve issues	BH: collaboration	
Kitsap	KMHS has brought many resources to other partners in community	BH: collaboration	
Clallam	PBH in Helen Haller & Crescent	BH: collaboration	
Kitsap	KMHP, data to support coordinated care	BH: coordinated care	
Kitsap	important programs meet Kitsap needs	BH: health care resources	
Kitsap	stable MH provider	BH: health care resources	
Clallam	crisis/detox/resident	BH: health care resources	
Clallam	7 CD treatment providers	BH: health care resources	
Clallam	Juvenlie CD treatment	BH: health care resources	
Clallam	2 public MH providers	BH: health care resources	
Kitsap	Peninsula CHS & KMH both integrated medical care, chemical dependency & mental health care	BH: integration	
Kitsap	some examples of medical/behavioral health integration	BH: integration	
Clallam	(PA) interventions court	BH: justice	
Clallam	case mgmt in jail	BH: justice	
Clallam	MH court, drug court, family therapeutic court	BH: justice	
Clallam	needle exchange	BH: needle exchange	
Clallam	collaborative spirit	community	COMMUNITY
Clallam	Growth of Growing Healthy	community	
Jefferson	population is predisposed to living a health & active lifestyle	community	
Kitsap	a will to work together, few terf wars	community	
Clallam	PACan & revitalize Port Angeles - community engagement	community	
Clallam	Discovery Trail	community	
Clallam	tribes "taking care of own"	tribes: community	
Kitsap	Solely concerned with tribal membership.	tribes: community	
Jefferson	Lack of complexity; size of regional make agencies more aware of each other and our residents needs	community	
Jefferson	volunteers are available	community	

November 2, 2015 OCH Stakeholder Convening: Discussion by County

RESULTS: Key assets

Group instructions were not followed for identifying related sectors.

COUNTY	ASSET	THEME	CATEGORY
Clallam	EPIC E HR is getting better	data	DATA
Clallam	strong data sets: CD, Youth survey	data	
Kitsap	KMHP, data to support coordinated care	data	
Kitsap	strong perinatal home visiting	early intervention	EARLY INTERVENTION
Kitsap	strong early childhood programs (prevention)	early intervention	
Kitsap	strong WIC programs (tribes, KCR, Navy)	early intervention	
Clallam	New Family Service	early intervention	
Clallam	Peninsula College	education	EDUCATION
Clallam	Collaboration with schools, public	education	
Clallam	regional & local early learning coalition	education	
Kitsap	good intentions	FQHC: health care resources	HEALTH CARE RESOURCES
Clallam	FQHC (2)	FQHC: health care resources	
Jefferson	People are used to going out of town as their expectations are to leave for care	health care resources	
Clallam	public hospitals	health care resources	
Clallam	Trauma level 3 asset	health care resources	
Clallam	specialists	health care resources	
Clallam	2 public hospitals	health care resources	
Clallam	VIMO & DVHWC & Urgent Care	health care resources	
Clallam	Hospital Navigators	health care resources	
Clallam	SBIRT	health care resources	
Kitsap	EMS visits could provide early warning of drug abuse/manufacturing	health care resources	
Clallam	a health care coalition	health care: collaboration	
Clallam	integrated care with NOHN & 3 ONP clinics	health care: collaboratoin	
Jefferson	Integrated medical care system; public health dept. integrates with other agencies	health care: integration	
Kitsap	working with UW to do residency program	PC: health care resources	
Clallam	two FQHC/tribal clinics	tribes: health care resources	
Clallam	multiple tribal health providing care to non-tribal	tribes: health care resources	
Kitsap	-they purchase health	tribes: health care resources	
Kitsap	-direct BH service, housing, prevention	tribes: whole person care	

November 2, 2015 OCH Stakeholder Convening: Discussion by County

RESULTS: Key assets

Group instructions were not followed for identifying related sectors.

COUNTY	ASSET	THEME	CATEGORY
Kitsap	900 low income units	housing	HOUSING
Kitsap	home ownership program	housing	
Clallam	housing taskforce	housing	
Clallam	strong housing authority	housing	
Kitsap	coordinated housing	housing	
Kitsap	coordinated community of providers	housing: coordinated providers	
Clallam	fluoride in 2 out of 3 communities	oral health	ORAL HEALTH
Clallam	ABCD	oral health	
Kitsap	2 strong models of cost saving preventive measures	cost savings models	OTHER
Clallam	Strong Human Service agencies	human services	
Clallam	Great Criminal Justice collaboration	justice collaboration	
Kitsap	strong coalition of long term care providers	LTC/seniors: coalition of providers	
Clallam	% persons with DD - employed	employment	
Clallam	Grant writing - bringing outside funds	grant writing	
Clallam	veterans services	veterans	
Clallam	reponsive state & fed legis connectedness	state and fed connection	
Kitsap	statewide managed presence	MCO	
Kitsap	good representation from the county. Good coverage. Growing		
Kitsap	*Need to look beyond Medicaid clients		
Clallam	HRC's for everything		

November 2, 2015 OCH Stakeholder Convening: Discussion by County

RESULTS: Key gaps

Group instructions were not followed for identifying related sectors.

COUNTY	SECTOR	GAP	THEME	CATEGORY
Kitsap		baby bomers lacking over and aging sooner than	aging	AGING
Clallam		Medicare access	aging	
Clallam		Looming Alzheimers	aging	
Clallam		Aging DD care giver	aging	
Jefferson		very few senior activities	aging	
Jefferson		technology gap: seniors don't know how to access tools that may relieve feelings of alienation	aging	
Clallam		counterproductive/competing initiatives for mental health	BH	BEHAVIORAL HEALTH
Kitsap		transition to BHO	BH	
Jefferson		chemical dependnecy & behavioral health systems aren't built	BH	
Kitsap		disparate behavioral health providers (many hand-offs)	BH	
Kitsap		lack of access to behavioral health services - high & low acuity - this jepordizes housing	BH access	
Clallam		No inpatient unit	BH infrastructure	
Kitsap		no inpatient acute psychiatric care	BH infrastructure	
Clallam		mental health professionals	BH workforce	
Kitsap		lack of physician comfort with mgmt of behavioral health, mental health & addiction	BH workforce	
Kitsap		workforce shortage	BH workforce	
Kitsap	MH	KMHS 51 openings	BH workforce	
Kitsap		transitions and handoffs	care coordination	CARE COORDINATIO
Kitsap		hospital to BH	care coordination	
Kitsap	FQHC	care coordination	care coordination	
Kitsap		transition to care	care coordination	
Kitsap		communication at the time of care	care coordination	
Kitsap		have trouble linking folks up	care coordination	
Kitsap		better coordination with healthcare	care coordination	
Jefferson		we are a rural area who identifies more with urban	community	COMMUNI
Jefferson		bimodal nature/demographics are split	community	
Jefferson		areas are intrisically located	community	
Clallam		E HR struggles	data	DATA
Clallam		Lack of data / real-time data / infrastructure	data	
Kitsap		doing a needs assessment	data	
Kitsap		E HR coordination	data	
Kitsap		no share info	data	
Kitsap		state driven data management	data	
Kitsap		lack an __ Sound assessment of needed services	data	
Clallam		Lack of data for MH	data	

November 2, 2015 OCH Stakeholder Convening: Discussion by County

RESULTS: Key gaps

Group instructions were not followed for identifying related sectors.

COUNTY	SECTOR	GAP	THEME	CATEGORY
Clallam		Dental access/Medicaid/uninsured	dental	DENTAL
Clallam		dental care space	dental	
Clallam		Dental - no access for adult Medicaid	dental	
Clallam		high anti-fluoride consipracy	oral health	
Kitsap		Oral healthcare access	oral health	
Jefferson		enormous gap in dental care; few/none accept Medicaid. 7% of adults access dental care; lowest in the state	dental	
Clallam		Limited family wage jobs	economy	ECONOMY
Jefferson		limited economy; few employers with full insurance/ a lot of self-employed	economy	
Clallam		gaps in other schools	education	EDUCATIO
Clallam		Minimal nursing in schools	education	
Kitsap		parenting education	education	
Clallam		risk - are we big enough for capitation	funding	FUNDING
Kitsap		billing	funding	
Clallam	HHS	funding in proportion to need/population	funding	
Clallam		gaps in funding for public hospitals	funding	
Kitsap	Tribe	need more $ to increase services	funding: tribe	
Kitsap	MC	agree w/ gaps - need members to get access to care	health care access	HEALTH CARE
Jefferson		we have a lot of assets but none are connected to the triple aim -> healthcare has virtually been left to the hospitals & public health dept	healthcare access	
Kitsap		resource for those eligible for resources not wanting to use them; non-cooperative user in & out of hospital	healthcare access	
Kitsap		no system to improve frequent utilization of ED by "frequent flyers"	healthcare access	
Clallam		lack of providers - dental, BH & medical	health care workforce	
Clallam		primary care providers - recruitment and retention	health care workforce	
Clallam		specialists recruitment and retention	health care workforce	
Clallam		primary care loan repayment	health care workforce	
Kitsap	PC	availability of PC providers	health care workforce	
Kitsap		low rate band - impacts recruitment	health care workforce	
Clallam		pervasive CD	health risk	HEALTH RISK
Clallam		High ACEs	health risk	
Clallam		low immunization rate	health risk	

November 2, 2015 OCH Stakeholder Convening: Discussion by County

RESULTS: Key gaps

Group instructions were not followed for identifying related sectors.

COUNTY	SECTOR	GAP	THEME	CATEGORY
Kitsap	housing	when folks reach out for support	housing	HOUSING
Kitsap		1 person to support housing people	housing	
Kitsap	BHO	housing staff supported	housing	
Kitsap	housing	not enough affordable housing	housing	
Kitsap		gap in serving chronically homeless	housing	
Kitsap		limited shelter	housing	
Kitsap		housing first	housing	
Kitsap		supportive housing	housing	
Clallam		Affordable housing, accessible	housing	
Clallam		Deterioirating housing stock	housing	
Jefferson		housing is limited	housing	
Kitsap		affordable housing lack units	housing	
Clallam		transportation	transportation	TRANSPORTATION
Clallam		Transportation	transportation	
Jefferson		transportation: not enough	transportation	
Clallam		global warming	environment	OTHER
Clallam		Insufficient police & EMS	first responders	
Kitsap		EMS systems incompatible	first responders	
Clallam		Inadequate nursing homes/Medicaid	LTC	
Clallam		veterans services	veterans	
Kitsap		MAT		
Kitsap		need access		

November 2, 2015 OCH Stakeholder Convening: Discussion by County

RESULTS: Cross-Sector Opportunities

Group instructions were not uniformaly followed for identifying if opporunity affects triple aim

COUNTY	CROSS-SECTOR OPPORTUNITY	THEME	CATEGORY
Jefferson	-potentially join with nursing homes, tribes, FQHCs or schools to fund the projects in conjunction with non-profit organizations	collaboration	COLLABORATION
Kitsap	collaboration across sectors	collaboration	
Kitsap	Harrison collaboration w/ KMH on CMS grant. BH specialist at Harrison	collaboration: BH	
Kitsap	PC provider on site at KMH 1 day a week to meet primary care needs	collaboration: BH	
Kitsap	PCHS works collaboratively with MH/KMHS	collaboration: BH	
Clallam	regional county MH	collaboration: BH	
Jefferson	hospital & health department & metnal health have joined forces for psych care & other projects	collaboration: BH	
Clallam	Hospital & PBH	collaboration: BH	
Kitsap	healthcare-EMS/Fire models - referrals to EMS/Fire who does assessment (FD cares) & post-discharge care "hook and ladder" program & funding/reimbursement "pre-emptive visits"	collaboration: EMS	
Kitsap	-overall saves $ partnership between healthcare and housing	collaboration: housing	
Kitsap	Navy-Kitsap resource sharing	collaboration: navy	
Clallam	Collaborate with schools for improvements = recruitment and retention	collaboration: schools	
Kitsap	tribal-kitsap county health resources for tribal members outside the two recognized tribes	collaboration: tribes	
Clallam	care giver support	community	COMMUNITY
Clallam	Enhancing community policing	community	
Clallam	Trauma informed community - ACEs	community	
Jefferson	community health needs assessment responses involve a lot of agencies	community	
Jefferson	Community groups need the ability to fund projects & spend money differently to move the dial.	community	
Kitsap	where is the cost savings and how do we capture it and reinvest into Health Care	cost savings	COST SAVINGS
Kitsap	Emergency Department - savings could occur through reduced ED use	cost savings	
Kitsap	savings - pre authorizations for Medicaid, Standards, % denials takes times, slam dunk list -	cost savings	
Clallam	identify high users of services & id (families, across systems)	cost savings	
Clallam	EPIC - hospital, health care, PHB, SNF	data/information sharing	DATA/INFORMATION SHARING
Clallam	Information sharing	data/information sharing	
Kitsap	Info sharing - info sharing agreement - multi-sector collective release	data/information sharing	
Kitsap	global release	data/information sharing	
Kitsap	housing does have a data sharing system	data/information sharing	
Clallam	information sharing - creating network across sectors	data/information sharing	
Clallam	addressing confidentiality HIPPA	data/information sharing	
Clallam	creating a broad resource database	data/information sharing	
Clallam	data sharing form insurers	data/information sharing	
Clallam	social media for health care	data/information sharing	
Clallam	same e-records share by Clallam and Jefferson OMC	data/information sharing	
Kitsap	*cross-sectoral health information exchange & WA (health) Connection could feed registration information *	data/information sharing	
Kitsap	streamlining forms opportunity to reduce waste	data/information sharing	

November 2, 2015 OCH Stakeholder Convening: Discussion by County

RESULTS: Cross-Sector Opportunities

Group instructions were not uniformaly followed for identifying if opporunity affects triple aim

COUNTY	CROSS-SECTOR OPPORTUNITY	THEME	CATEGORY
Kitsap	dental network is closed	dental	DENTAL
Jefferson	very LEAN not for profit dental clinics. Partner w/ dentists, public health, payers, hospital	dental	
Jefferson	Schools & dental program collaboration to start kids early with brushing etc.	dental	
Jefferson	Collaborate re; Smile Mobile	dental	
Kitsap	Tribal/state partnerships - collaboration & options to work w/ tribal	dental	
Clallam	community health center model	health care model	HEALTH CARE MODEL
Clallam	equalize state's need to lower cost, with patient-centered care	health care model	
Kitsap	Develop a sound actuary sound payment system. Work w/ managed care plan	health care model	
Kitsap	Create permanent supportive housing initiatives	housing	HOUSING
Kitsap	SB Housing Bill - local housing sales tax - political collaboration	housing	
Clallam	housing	housing	
Kitsap	EMS notify housingt authorities if suspicious activity going on?	housing	
Clallam	training for law enforcement for mental health	justice	JUSTICE
Kitsap	(King County law enforcement gets a call & send RN, BH specialist to do in-home asessment & prevent ED)	justice	
Clallam	Hospital/primary care FQHC/Tribal: collaboration & recruitment	workforce	WORKFORC
Clallam	close urban vs. rural gap for providers	workforce	
Clallam	training in best practices	workforce	
Clallam	community health workers partnerships	workforce	
Clallam	use of technology distant visits	workforce	

November 2, 2015 OCH Stakeholder Convening: Mixed Sector Discussion

RESULTS: cross-sector collaboration opportunitites most important in meeting the triple aim

Group instructions were not followed for identifying which opportuntites could affect triple aim, which sectors needed, and regional vs. county-specific.

Frequency	# Groups	Theme	Quotes	RESULTS MAPPED TO OCH FOCUS AREAS: Access to Care	Population Health Improvements	Access to "Whole Person" Support	Data Management/ Region-wide Infrastructure
6	3	**health, BH, social services collaboration**	medical/dental collaboration	■	■	■	■
			collaboration to look at whole person	■	■	■	■
			Health care set up business agreements with non-health care (housing/social)	■	■	■	■
			RSN, MCO's, BHO collaboration, FQHC	■	■	■	■
			social services - cross state platform - BHO	■	■	■	■
			BHO/Managed Care Plans/Medical Providers	■	■	■	■
6	4	**data/ information sharing**	HIE - Health Information Exchange - overall health; how to take large network & communicate (social services; medical services; focus upstream)				■
			agency information sharing				■
			Data sharing agreements within sectors: better data = better resources				■
			Data sharing agreements between sectors: better data = better resources				■
			prescription addiction/pain mgmt/system provider treating - tracked system, get pt's info				■
			cross-training on best practice				■
5	4	**coordination of care**	Improving "hand offs" between agencies: coordination of care; access to services; agency information sharing	■	■	■	■
			prescription addiction/pain mgmt/system provider treating - tracked system, get pt's info	■	■	■	■
			clinic/hospital warm handovers to services that actually prevent health complications	■	■	■	■
			people are between systems - public practicioners included	■	■	■	■
			platform for cooperation - ID high utilizer *baseline & measure success	■	■	■	■
5	4	**whole person/ integrated care**	overall health	■	■	■	
			ACEs platform, creating platform and collaboration to look a whole person	■	■	■	
			medical, accupuncture, MH, CD counselor, massage therapy - integrated - one stop shop -> make access easy	■	■	■	
			how to get general health connected in	■	■	■	
			Group appointments	■	■	■	
3	2	**access to services/ primary, med home, mh home**	Improving "hand offs" between agencies: coordination of care; access to services; agency information sharing	■		■	■
			Create adequate primary care access - focus on medical home	■		■	■
			Dental, primary care, mental health home	■		■	■

RESULTS: cross-sector collaboration opportunitites most important in meeting the triple aim

Group instructions were not followed for identifying which opportuntites could affect triple aim, which sectors needed, and regional vs. county-specific.

Frequency	# Groups	Theme	Quotes	Access to Care	Population Health Improvements	Access to "Whole Person" Support	Data Management/ Region-wide Infrastructure
3	2	housing	access to stable and affordable housing				
			Respite homes, development of appropriate housing types				
			Transitional shelter with appropriate care				
3	3	oral health/ dental	Dental, primary care, mental health home - collaborate on recruitment				
			oral health access - medical/dental collaboration				
			dental				
3	2	ACEs/ trauma informed	ACEs platform, creating platform and collaboration to look a whole person and improve - collaborative agreement				
			cross-training on best practices, trauma informed, CMEs, available services, medical assisted services				
			trauma informed community development; schools, MH policing, employers, health care, policing				
3	1	addiction plan/ services	medical assisted services				
			Develop a comprehensive plan to address addiction (simliar to homeless plan)				
			treatment - need good med assisted treatment				
2	1	prevention/ public health	looking at prevention planning				
			enhanced role of public health - develop a sustainable plan across 3 counties - would need to be addressed legislatively - OCH becomes public health agency				
2	2	workforce development	workforce development council				
			Dental, primary care, mental health home - collaborate on recruitment				
1	1	coordination of MH/CD funding	multicounty coordination of MH/CD funding (1/10th of 1% sales tax)				
1	1	redirect ED funding	Redirect ER funding				
1	1	aging	social isolation related to aging - hospital overutilization; inability to work				
1	1	high utilizers	ID high utilizer *baseline & measure success				
1	1	bend the cost curve	Bend the Cost Curve - identify successful models				
1	1	telehealth	telehealth? Technology info shared				

5.4 Matrix of Community Assessment & Plan Priorities

These documents illustrate the process underway to capture the priorities noted in existing community assessment and planning processes conducted by organizations, counties, regionally, and/or by issue specific purposes.

DRAFT UNDER DEVELOPMENT: As of 11/19/15

PLAN BY CONCERN	Clallam	Jefferson	Kitsap
Area Agency on Aging	FINAL DRAFT O3A Area Plan 2016 – 2019.docx		http://www.kitsapgov.com/altc/ http://www.kitsapgov.com/altc/pdf/Area%20Plan/20162019%20Aging%20Area%20Plan_Signed.pdf
Behavioral Health	SA Prevention Plan (.docx) SA Treatment Plan (.docx)	SA Prevention Plan (.docx) SA Treatment Plan (.docx)	http://www.kitsapgov.com/hs/substanceabuse/saabstrategicplan.htm http://www.kitsapgov.com/hs/mhsa/DOCUMENTS/2014_Behavioral_Health_Strategic_Plan_021014%20FINAL.pdf
Community Action Program	http://olycap.org/get-informed/strategic-directions http://olycap.org/get-informed/community-needs-summary		2014-2017 Kitsap County Community Needs Assessment.pdf
Community Block Grant Assessment			http://www.kitsapgov.com/hs/block_grant_program/Plans.htm
Community Health Assessment/ Community Health Improvement Plan (CHA/CHIP)	CCHHS & Olympic Medical Center http://www.clallam.net/HHS/	JCPH & Jefferson Health Care http://www.jeffersoncountypublichealth.org/index.php?publications-data-resources	KPHD, Harrison Medical Center, United Way, Kitsap Community Foundation, Kitsap County Dept. of Human Services http://www.kitsapchp.com/CHAR_data.html
Community Health Needs Assessment (CHNA)	http://www.olympicmedical.org/pdfs/2013%20OMC%20Community%20Health%20Needs%20Assessment.pdf	See CHA	See CHA
County Comprehensive Plan with Health included		Under revision. https://www.ezview.wa.gov/site/alias__1912/overview/36467/overview.aspx	Under revision. http://compplan.kitsapgov.com
Early Learning	http://www.okpelc.org/docs/CM-2013-Action-Plan%20.pdf		
Head Start			Available at: http://www.kitsapcountyhealth.com/information/files/CommunityAssessmentKICC_Annual.pdf
Health Professional Shortage	WA State Department of Health http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/RuralHealth/DataandOtherResources/HealthProfessionalShortageAreas; HRSA: http://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx		
Health Rankings	http://www.countyhealthrankings.org/		
Homeless & Housing	http://peninsulapha.org/wp-content/uploads/2013/07/TenYearPlan.pdf	http://peninsulapha.org/wp-content/uploads/2013/07/Jefferson-County-Ten-Year-Homelessness-Plan.pdf	http://www.kitsapgov.com/hs/housing/Documents/Housing%20&%20Homelessness%20Overview/2015%20HH%20Plan%20DRAFT%2009%2023%2015%20for%20Public%20Comment.pdf
Transportation	http://www.clallamtransit.com/images/downloads/2014-2020%20tdp%20final%20pdf.pdf	http://jeffersontransit.com/transit-development-plan/	http://www.kitsaptransit.org/uploads/pdf/2015-2020-tdp-plan.pdf steffanil@kitsaptransit.com.
United Way	see CHA/CHIP	see CHA/CHIP	see CHA/CHIP
Workforce Development Plan	http://www.kitsapgov.com/hs/olympdev/workforceplan.htm		
County Vision			
Dental Plan			
Developmental Disabilities			
Education			
FQHC/Rural Health Plan			
Tribes			
Veterans			
WSU Extension			

PRIORITIES BY PLAN (document in process)

	Clallam CHIP	Jefferson CHIP	Kitsap CHIP	Health Professional Shortage Areas	Early Childhood A	Early Childhood B	Aging/ Long Term Care	Tribal Plan/s	Veteran's	Physical Health/ Dental	Behavioral Health	Sub Abuse Prevention	Sub Abuse Treatment	Housing	Transportation	Economic	Law & Justice	County Vision priorities	Early Childhood A	Early Childhood B	TOTAL	TOTAL CATEGORY
YEAR PUBLISHED	2013	2014	2014																			
AGING POPULATION																						
Access to chronic care management																						
Age-friendly communities																						
Falls & Injury Prevention																						
Housing																						
Aging in place																						
Care giver supports																						
CHILDREN & YOUTH																						
Adverse Childhood Experiences (ACEs)			X																			
Early parent support, home visits, education																						
Early childhood education/school enrollment	X																					
School graduation/drop-out rates																						
Mental Health & Substance use treatment																						
Developmental disability services																						
Healthy parenting skills	X																					
COMMUNITY DEVELOPMENT																						
Community & Public Safety																						
Livability & Sustainability																						
Economic Vitality																						
EQUITY, SOCIAL DETERMINANTS HEALTH																						
Poverty & Health disparities																						
Adverse childhood experiences mitigation			X																			
Food Insecurity																						
Access to living wage jobs																						
Access to employment training																						
High quality education																						
Language access																						
Criminal justice																						
Food Insecurity																						
HEALTH CARE DELIVERY SYSTEM																						
Access to preventative services																						
Access to specialty care																						
Access to continuum of mental health services	X	X	X																			
Access to chemical dependency services		X																				
Access to prenatal care																						
Early childhood screenings																						
Integrated physical & behavioral health care																						
Full continuum of health care in community – preventative, emergent, sub-acute, crisis/acute																						
Programs/services support "high utilizers"																						
"High utilizer"/BH /jail intersection																						
Care coordination																						
Respite																						
Hospice/end of life care																						
Sufficient, well trained workforce																						
Culturally competent workforce																						
Incentives for cross system care/gain-sharing																						
Health & Housing intersection																						
Chronic Disease prevention	X	X	X																			
Chronic Disease management	X																					
Access to primary care providers/med home	X																					

Oral health and dental access	X																				
Access to care		X																			
HOUSING																					
Affordability – preserve, expand inventory			X																		
Affordable housing policy, regional planning																					
Expand options, ie rapid rehousing, permanent supportive housing, respite, housing first																					
Supportive services, case management, especially at risk of or chronically homeless																					
Indoor air quality/home environment healthy																					
Housing & Health Intersection																					
Make homelessness a one-time event			X																		
PREVENTABLE CAUSES OF MORBIDITY AND MORTALITY																					
Obesity			X																		
Tobacco Use	X																				
Drug Overdose																					
Suicide																					
Access to affordable, healthy food																					
Access to physical activity opportunities																					
Substance Abuse	X																				
Immunizations		X																			
TRANSPORTATION																					
Access to safe, efficient types of public transit																					
Safe pedestrian and bike pathways																					

5.5 List of Current Health Initiatives

This document reflects current health initiatives across the region. It is a compilation of input obtained by request from ILC members. We expect to continue to add to this document through January 2016 as the ILC Community Assessment and Planning subcommittee continues its RHIP process.

Olympic Community of Health
HEALTH INITIATIVE INVENTORY

DRAFT -

UNDER DEVELOPMENT

as of 11/18/15

County (ies)	Initiative Name	Brief Description including patient population	Goal	Year started	Lead Org	Partner Orgs	Access	BH Integration	Care Transitions	Case Management	ED Diversion	End of Life	Prev/ Early Intervention	Referral Mgmt	Other
Kitsap, some Mason & Jefferson	Outreach & Enrollment Navigators	Provide Medicaid Enrollment and HealthPlanFinder Assisters to enroll residents in health care coverage.	Help the uninsured get and keep health coverage and understand their benefits	2013	KPHD	PCHS, HMC, KCR	X								
Kitsap	Project Access Northwest	Project Access Northwest screens all patient referrals to ensure that appropriate tests and paperwork are completed BEFORE the patient sees a specialist. By arranging for the necessary laboratory and imaging services as well as qualified interpreters, we remove the barriers that prevent patients from keeping their appointments with medical or dental specialists. More than 95% of Project Access Northwest patients keep their appointments, compared to fewer than 70% in typical uninsured populations.	For Project Access Northwest, opening doors means removing the logistical and financial barriers to specialty medical and dental care for patients and their health care providers.	2011	PANW	HMC, PCHS, TDC, HHP,	X		X	X	X			X	
Kitsap	5-2-1-0	Ready, Set, Go! 5210 Kitsap is a countywide initiative to increase physical activity and healthy eating to reduce obesity in Kitsap County.	Increase physical activity and healthy eating to reduce obesity in Kitsap County.	2011	KPHD	KPHD, HMC, YMCA, KCU, Suquamish Tribe, Pt. Gamble S'Klallam Tribe, Bremerton Schools, CK Schools, KMHS, Bremerton Farmers Market							X		X
Kitsap	Mental Health, Chemical Dependency and Therapeutic Tax Fund (1 10th of 1%)	Local sales tax of one-tenth of one percent to augment state funding of mental health and chemical dependency programs and services, and for the operation or delivery of therapeutic court programs or services. Programs funded include Kitsap Mental Health Services, Olympic Educational Service District 114, Peninsula Community Health Services, Bremerton Police Department, Juvenile Department, Superior Court, Martha & Mary Health Services, West Sound Treatment Center, WSU Extension and the City of Poulsbo.	The purpose of the tax is to fund a county-wide infrastructure for behavioral health treatment programs and services that benefits Kitsap County youth and adults who are impacted by chemical dependency and mental illness.	2013	Kitsap County Human Services	Board of Commissioners	X	X	X	X	X	X	X	X	
Kitsap	Kitsap ACEs Partnership	Partnership established to educate the community on Adverse Childhood Experiences (ACEs), assets, and building resiliency.	Expand the partnership and build community infrastructure to support resiliency, and creating a compassionate community.	2012	Kitsap County Commission on Children and Youth	Kitsap Mental Health, Kitsap Public Health, Olympic Educational Service District							X		

Kitsap	Kitsap County Commission on Children and Youth	Appointed Advisory Board to the Kitsap County Board of Commissioners whose mission is to advocate or a healthy environment for kids in Kitsap County.	Supports activities that increase the capacity of the community to build Developmental Assets among youth.	1988	Kitsap County Commission on Children and Youth	Kitsap Mental Health, Kitsap Public Health, Olympic Educational Service District							X			
Clallam, Jefferson, Kitsap	1422 Heart, Stroke Prevention, Diabetes and Obesity Prevention	Diverse clinical, public health, and non-profit stakeholders engage 15 different strategies to promote environmental, systems, and policy changes to lead to improved health among low-income populations, AIANs, and persons with behavioral health issues	Heart, Stroke Prevention, Diabetes and Obesity Prevention	2015	Kitsap Public Health	KMHS, PCHS, HMC, BHA, CCHHS, JCPH, KPHD, VIMO, Dungeness Valley Medical Center, Makah Tribe, Quileute Nation, Jamestown S'Klallam Tribe, Port Gamble S'Klallam Tribe, Suquamish Tribe	X			X				X	X	
Jefferson, Kitsap, Port Gamble S'Klallam Tribe	Nurse Family Partnership	Intensive nurse home visitation program for first time pregnant women/mothers prenatal to age 2	Improve birth outcomes, prevent child abuse and neglect, ensure developmental milestones met, primary care/behavioral health linkages, client education. Regional approach to share staff and save money.	Jefferson 2008; rest 2010	JCPH	KPHD, JCPH, Port Gamble S'Klallam Tribe	x	x	x	x			x	x	x	*
Kitsap, some Mason & Jefferson	PCHS Dental - now 2 sites	Adult and pediatric dental preventative and basic dental services for the underserved Medicaid population.	Provide oral health care access.	Sixth St. many years, Port Orchard opened 8/2015	PCHS		X				X		X			
Kitsap, some Mason & Jefferson	PCHS Medical - 4 sites	Comprehensive outpatient primary care services with on site lab services and Class A Pharmacies	Affordable high quality healthcare		PCHS	LabCorps	X	X	X	X	X	X	X	X		
Kitsap, some Mason & Jefferson	PCHS Pharmacy DSME	Diabetes Self-Management Education accredited by AADE provided to patients by a Clinical Pharmacist.	Improve Diabetes Self-Management		PCHS		X			X			X			
Kitsap, some Mason & Jefferson	PCHS Pharmacy Anticoagulation	Manage patients needing anticoagulation	Therapeutic treatment		PCHS					X						
Kitsap, some Mason & Jefferson	PCHS Pharmacy HTN Care	Partner with PCP in managing HTN control.	Achieve HTN control (BP <140/90)	2015	PCHS	1422			X	X			X			
Kitsap, some Mason & Jefferson	PCHS Integrated Behavioral Health	Screen for depression using PHQ-2 and PHQ-9 and provide counseling services at each site and access to Psych Med prescribers.	Mental Health Integration		PCHS		X	X	X	X	X		X	X		
Kitsap, some Mason & Jefferson	PCHS/KMHS Care Co-Location	Provide primary care medical services to our shared patients at Kitsap Mental Health services' facility	Provision of primary and preventative health services to shared patients	2016	PCHS & KMHS	HHP	X	X	X	X	X		X	X		

Kitsap, some Mason & Jefferson	HealthCare Specialists	Dedicated FTE at each clinic site who handles ED and Hospital transitions, case management of patients, transportation experts, provides fundus photography, provides patient education, and more!	Provision of high quality patient-centered medical home		PCHS		X	X	X	X	X	X	X	X		
Kitsap, some Mason & Jefferson	SBIRT & Substance Abuse Coordination	Screen adults for substance abuse and intervene when screened positive. Coordinate connecting patients to substance abuse treatment.	Behavioral Health Integration	2014	PCHS	Multiple	X	X	X	X	X		X	X		
Kitsap, some Mason & Jefferson	Vaccinators	Provide immunizations at each clinic site and support the VFC program.	Vaccinate patients		PCHS	DOH	X						X			
Kitsap, some Mason & Jefferson	Preventative Care Task Force	Staff-level committee working to increase cancer screening	Increase cervical, colon, and breast cancer screening		PCHS		X						X			
Kitsap, some Mason & Jefferson	Referrals Specialists	Process and track referred care and diagnostic studies ordered by PCHS providers.	Provision of high quality patient-centered medical home				X		X	X				X		
Kitsap	Integrated Care	Kitsap Mental Health Services has co-located primary care physician from Harrison Health Partners to serve BH clients onsite at KMHS.	Provide whole person care, at the right place, right time.	2012	KMHS	HHP	X		X	X	X		X	X		
Kitsap	Psychiatric Consultation	Kitsap Mental Health Services Behavioral Health ARNP available 24/7 to support community physicians with BH patient needs.	Provide whole person care, at the right place, right time.	2012	KMHS	community providers	X	X	X		X			X		
Kitsap	Psychiatric Consultation	Kitsap Mental Health Services Behavioral Health Professional onsite at 4 Harrison Health Partners clinics to support providers BH care and patient BH needs.	Provide whole person care, at the right place, right time.	2012	KMHS	HHP	X	X	X		X		X	X		
Clallam	Naloxone Distribution	OD Prevention Medication to SSP Clients	Prevent Heroin Overdoses	2015	Clallam Co. HHS								X			
Clallam	Comm. Health. Imp. Plan	Reduce Substance Abuse--focus on Opioids in Community	Provider and Community Education	2014	Clallam Co. HHS	Olympic Medical Ctr.							X			
Clallam	Case Manager in CCHHS Syringe Services Program	Motivational Interviewing with SSP Population	Referral to Treatment and Other Needs	2015	Clallam Co.-- Local Sales Tax	Peninsula Behavioral Health	X			X						
Clallam	Case Manager in Clallam Co. Jail	Motivational Interviewing with Jail Population	Referral to Treatment and Other Needs	2015	Clallam Co.-- Local Sales Tax	Peninsula Behavioral Health	X			X				X		
Clallam	Parents as Teachers Program	Home Visiting to Low Income Parents of Young Children	Increase Parenting Skills and Community Connection	2011	Clallam Co.-- Local Sales Tax	First Step Family Support Center	X						X			

Clallam	Behavioral Health Services for Juveniles	Mental Health & Case Mgmt. to Youth in Juvenile Court System	Address MH, CD and Comm. Referral Needs of Population and Their Families	2009	Clallam Co.--Local Sales Tax	CCJuvenile and Family Svcs, Peninsula Behavioral health, West End Outreach Services		X		X			X		Tx					
Clallam	Co-Occurring Disorders Program	Ind. and Group Therapy & Case Mgmt. for Co-Occurring Population--MH & CD	Promote CD Recovery and Reduce MH Symptoms	2007	Clallam Co.--Local Sales Tax	Klallam Counseling		X							Tx					
Clallam	Clallam County Crisis Respite Unit	Stabilization Program for MH Crisis	Resolve MH Crisis at Comm. Level	2014	Peninsula Behavioral Hlth	Clallam Co.--Local Sales Tax, DBHR	X		X	X					Tx					
Clallam	Living in Families Together (LIFT) Court	Therapeutic Court for Parents Whose Children Have Been Removed by DCFS	Family Reunification; Address Parental MH/CD	2007	Clallam Co.--Local Sales Tax	Courts, CD/MH Agencies				X					Tx					
Jefferson	CHIP Immunization	JC low immunization rates, high vaccine hesitancy population in parents, staff.	Improve immunization rate in children	2015	JCPH/ UW	JHC/Schools	x			x			x	x	x	*				
Jefferson	CHIP Chronic Disease	Whole population - Active living and Healthy eating	Decrease chronic disease, obesity and HBP	2015	JCH	Community/JCPH	x						x	x	x	*				
Jefferson	CHIP Access to Healthcare	Improve access to areas of local need	Dental	2015			x		x				x	x						
Jefferson	CHIP Access to Healthcare	rural access and tobacco services Pregnant women	Prenatal	2015	JCH		x			x			x	x						
Jefferson	CHIP Access to Healthcare	Access to support services and med care	Senior	2015	JHC	O3A, Olycap	x		x	x			x	x						
Jefferson	CHIP MH/CD/tobacco	Whole population needs better access to treatment and prevention services	Improve access in MH/CD treatment and prevention services	2015	JHC/JMH	Community/ police	x	x	x	x	x	x	x	x	x	*				
Jefferson	MH/CD/Sales tax	Improve treatment for individuals and families	Decrease impact on families	2006	JC/BoCC	JCPH/community board	x	x	x	x	x		x	x	x	*				
Jefferson	MH/CD/Sales tax	Jail MH/CD	Transition out of jail to MH/CD care	2008	JCSO jail		x	x	x						x					
Jefferson	MH/CD/Sales tax	Therapeutic courts	MH, Drug, Dependency and Juvenile Justice courts	2008	Courts		x	x	x	x	x	x	x	x	x	*				
Jefferson	MH/CD/Sales tax	MH services in School Based Health Clinics and in all districts	Increase access to MH care to decrease in risks identified in Healthy Youth Survey	2008	JMH	PTSD/CSD/ JCPH	x	x	x	x			x	x	x	*				
Jefferson	MH/CD/Sales tax	MH Kids 0-18	MH community tx to decrease ACEs	2008	Jumping Mouse		x	x	x	x			x		x					
Jefferson	MH/CD/Sales tax	MH/CD treatment	Access to outpatient care for MH and CD	2008	JMH/ Safe Harbor		x	x	x	x				x	x					
Jefferson	School Based Clinics	primary care, reproductive health, MH in Port Townsend School District #50 and Chimacum #49	improve access to care, maintain low teen pregnancy rate	2008	JCPH/ JHC	PTSD & CSD	x	x	x	x			x	x	x	*				

*population education

5.6 Local and Regional CHIP, Other Data

In addition to existing CHIP data and other community assessment information, the Community Assessment & Planning Subcommittee is securing and reviewing data important to priority setting and decision-making. The following documents reflect our 2014 county and reginal CHIP Priorities shared with Stakeholders November, 2014, and our region's Health Service Professional Shortage Designation Areas for primary care, behavioral health and oral health care. Other data will be added as need is determined to support decision making within our four broad areas of focus.

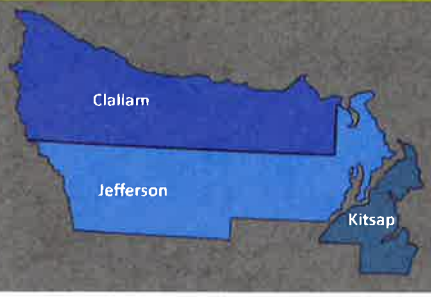
THE HEALTH OF OUR COUNTIES

Olympic Community of Health | Initial Meeting | November 7, 2014

Presented by:

Siri Kushner, Kitsap Public Health District

OUR COUNTIES DEMOGRAPHICS, INCOME & EDUCATION



POPULATION		MEDIAN AGE		MEDIAN INCOME		ADULTS 25+ WITH COLLEGE DEGREE	
Kitsap	255,900	Jefferson	55.5	Kitsap	$58,418	Jefferson	37%
Clallam	72,500	Clallam	49.8	Jefferson	$48,123	Kitsap	30%
Jefferson	30,700	Kitsap	40.8	Clallam	$43,345	Clallam	25%

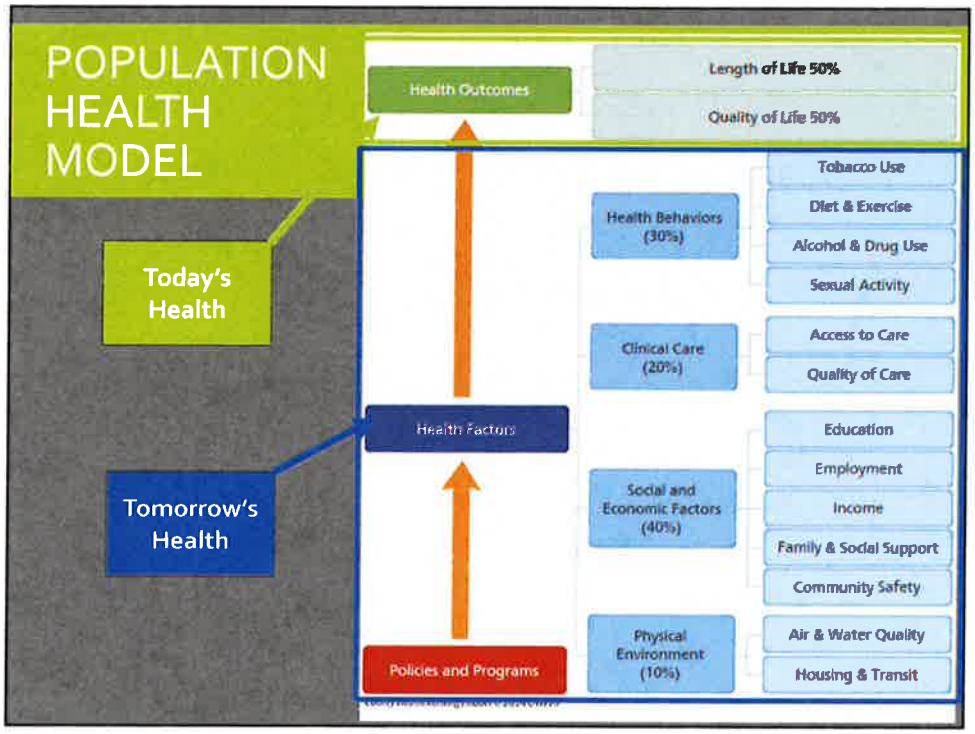
WA State Office of Financial Management: Population, April 1, 2014 estimate; Median Age, 2013 estimate; Median Household Income, 2013 projection; Education, 2011-13 American Community Survey

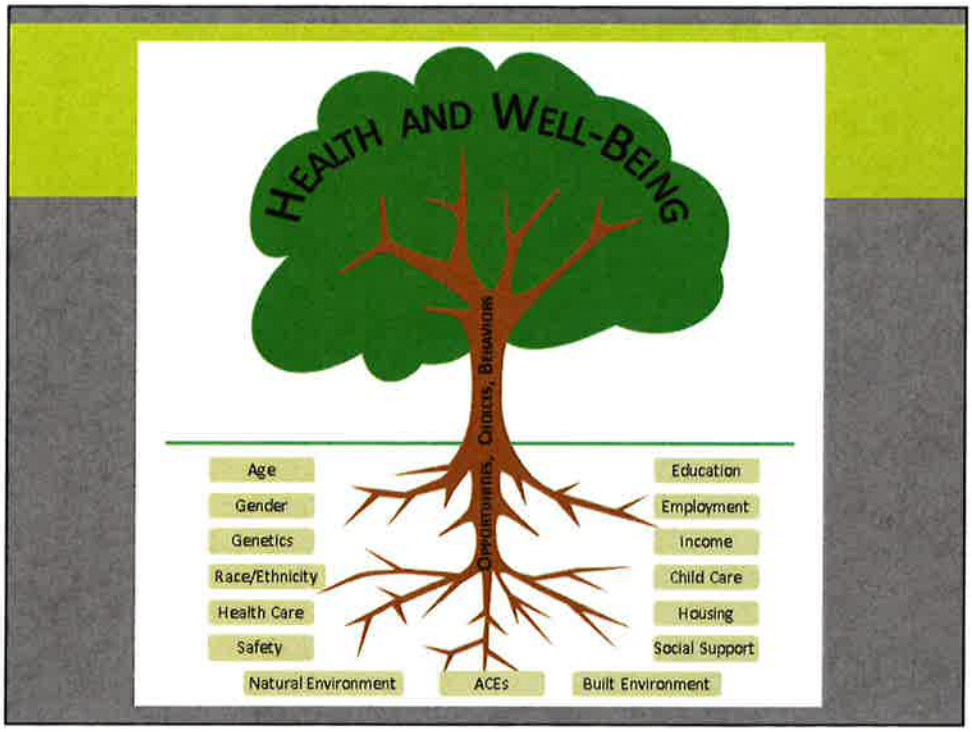
COUNTY HEALTH RANKINGS BACKGROUND

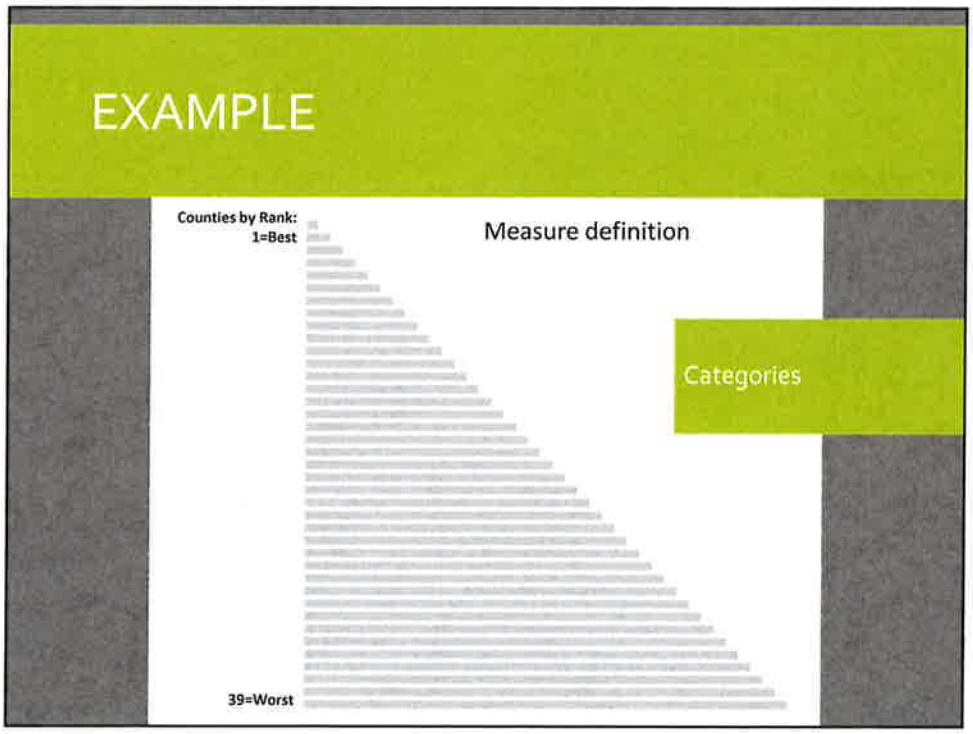
- Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute
- National data for counties across the US
- First release in 2010, released annually
- Two overall categories derived from 36 measures of health:

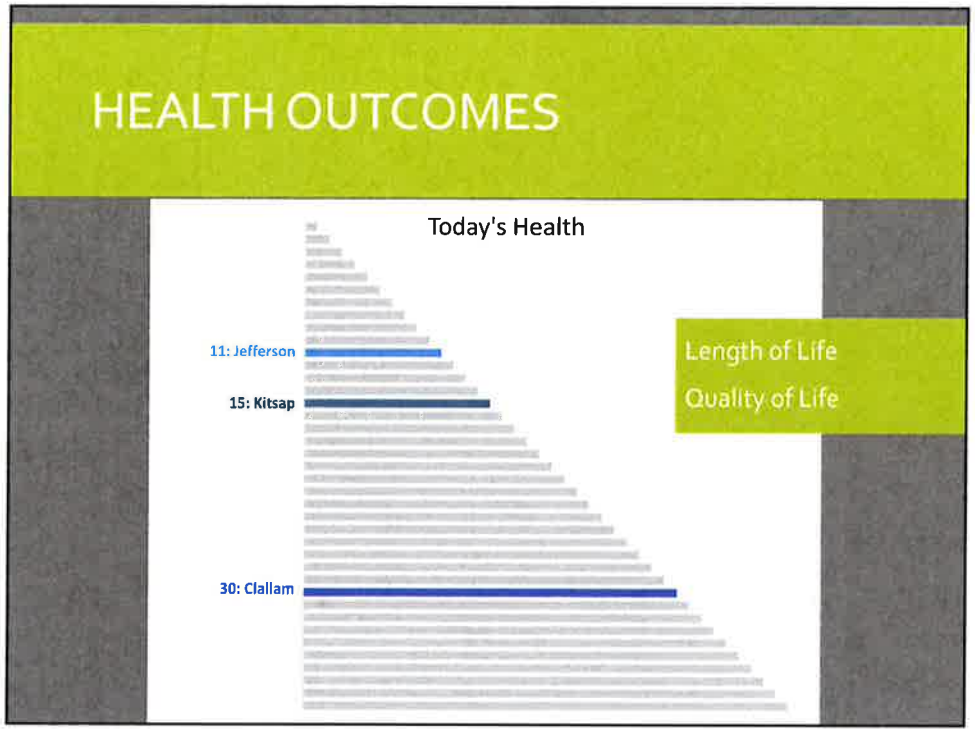
http://www.countyhealthrankings.org/

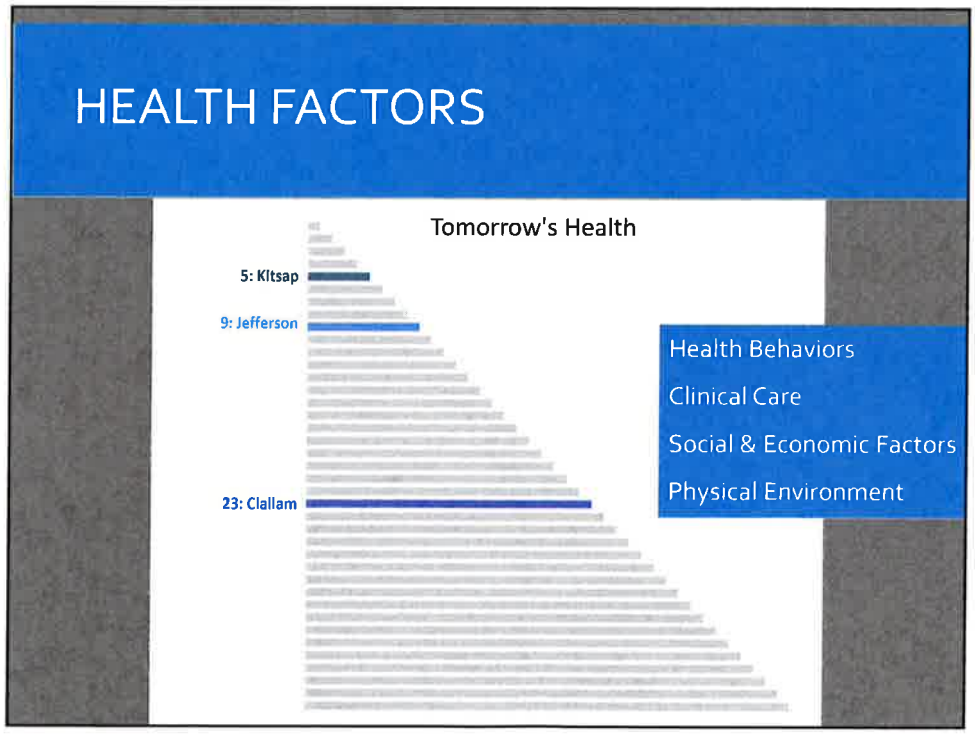
POPULATION HEALTH MODEL



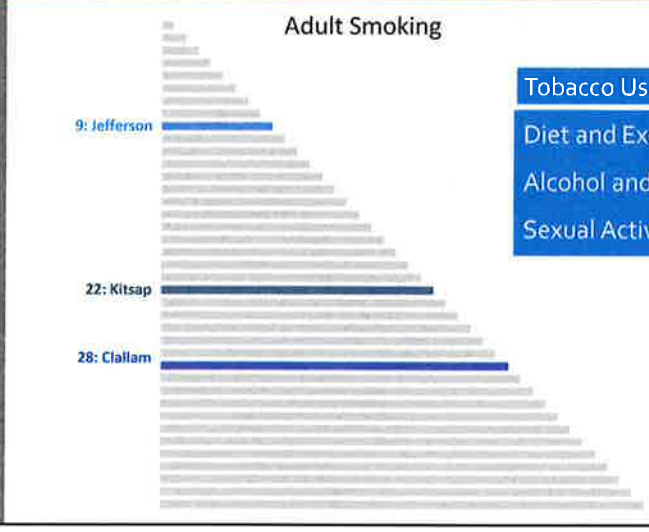

Health and Well-Being
Decisions, Choices, Behavior
Age
Gender
Genetics
Race/Ethnicity
Health Care
Safety
Education
Employment
Income
Child Care
Housing
Social Support
Natural Environment
ACEs
Built Environment


EXAMPLE
Counties by Rank:
1=Best
Measure definition
Categories
39=Worst


HEALTH OUTCOMES
Today's Health
11: Jefferson
15: Kitsap
30: Clallam
Length of Life
Quality of Life

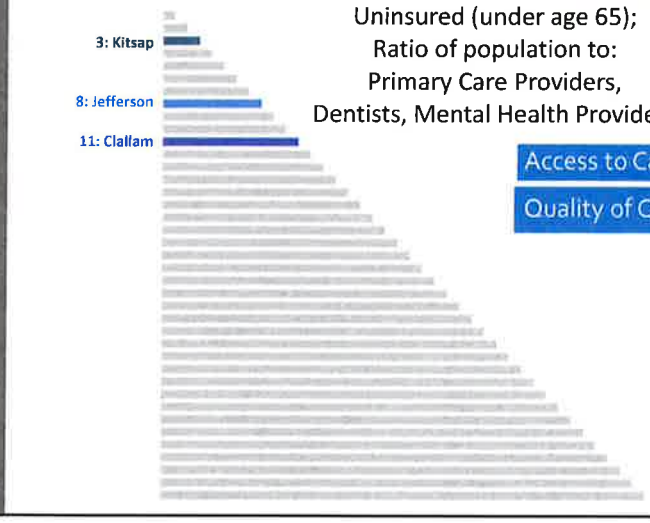

HEALTH FACTORS
Tomorrow's Health
5: Kitsap
9: Jefferson
23: Clallam
Health Behaviors
Clinical Care
Social & Economic Factors
Physical Environment

HEALTH FACTORS: BEHAVIORS



- Tobacco Use
- Diet and Exercise
- Alcohol and Drug Use
- Sexual Activity

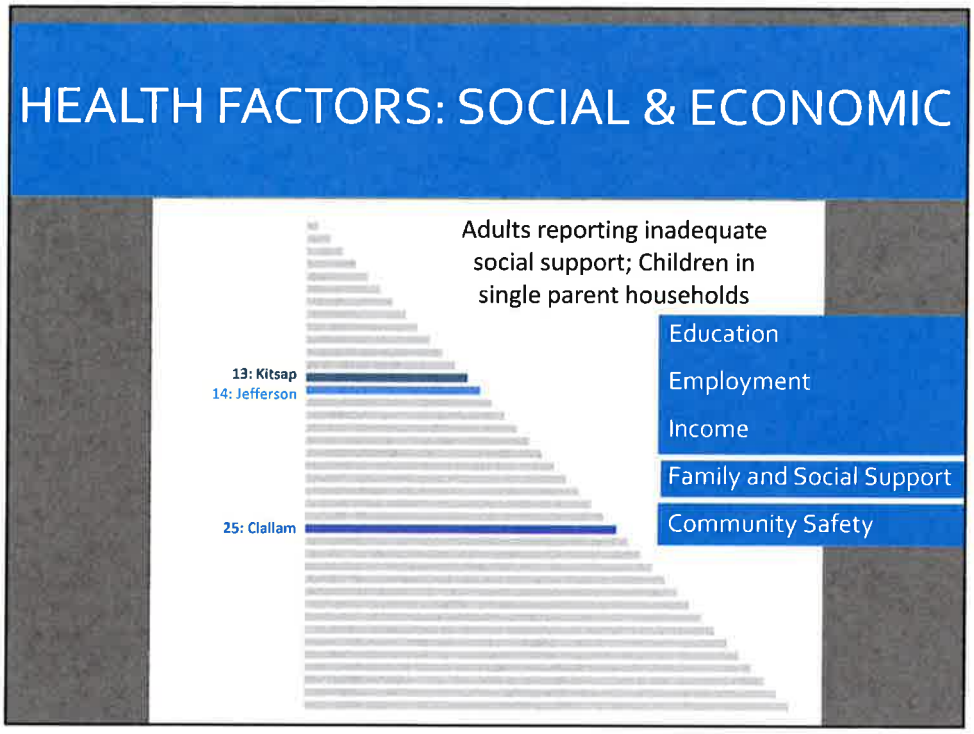
HEALTH FACTORS: CLINICAL CARE



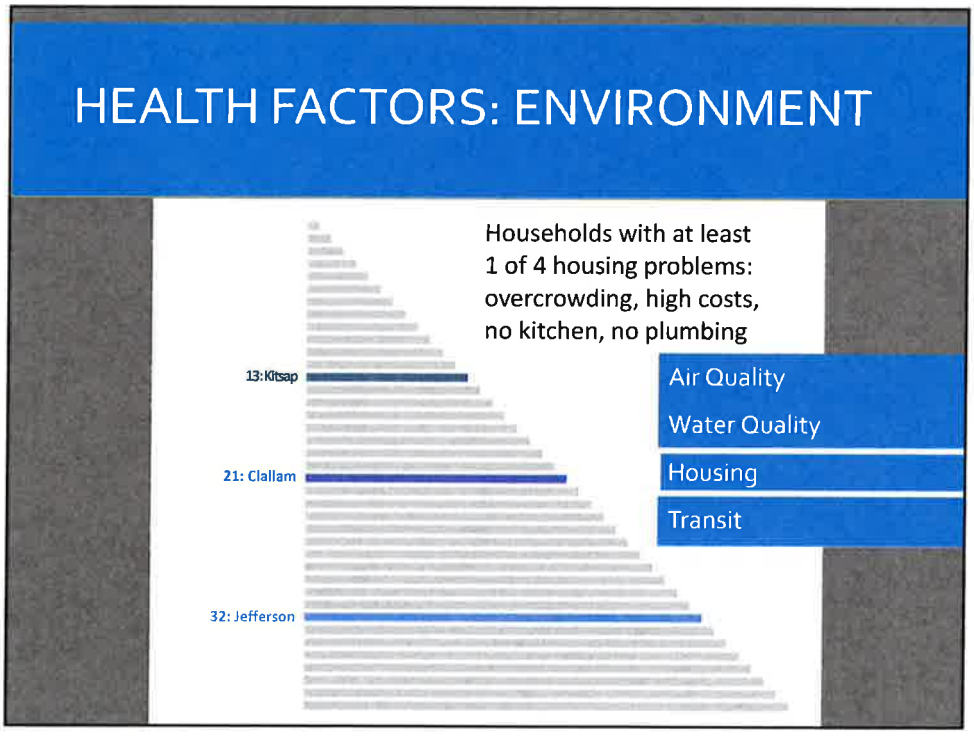
Uninsured (under age 65);
Ratio of population to:
Primary Care Providers,
Dentists, Mental Health Providers

- Access to Care
- Quality of Care

HEALTH FACTORS: SOCIAL & ECONOMIC



HEALTH FACTORS: ENVIRONMENT



COMMUNITY HEALTH PRIORITY PROCESS

- CHIP underway in all 3 counties
- Long term goal of the process is to impact priority issues to improve community health and well-being
- Public Health often leads the process due to their unique role in convening stakeholders and community assessment

CLALLAM COUNTY PROCESS

- WHO:
  - Leadership Group: Clallam County Health & Human Services, Olympic Medical Center and Olympic Medical Physicians
  - Participant Group: Peninsula Behavioral Health, Family Medicine of Port Angeles, Cities of Port Angeles, Forks, Sequim, Board of Health, Volunteers in Medicine of the Olympics, Forks Community Hospital, Crescent and Port Angeles School Districts, United Way, YMCA
- WHAT
  - Modified MAPP – 4 assessments

CLALLAM COUNTY PRIORITIES

Number of Votes per Community Health Issue during Community Meeting Prioritization Exercise	
Early Learning/Healthy Parenting Skills	37
Substance Abuse: Opiate, Alcohol, Tobacco	33
Medical Home/Availability of Primary Care Providers	29
Chronic Disease Prevention/Management	25
Mental Health: Early Identification, Access to Outpatient Services, Crisis Intervention	18
Oral Health and Dental Access	17

- NEXT STEPS:
  - Community groups are meeting to determine and implement strategies to address these six priorities

JEFFERSON COUNTY PROCESS

- WHO:
  - Led by Jefferson Public Health and Jefferson Healthcare
  - Data Review: JPH; JHC: CEO, PIO, medical and quality improvement staff, commissioners; Port Townsend Superintendent
- WHAT: Community Health Status Assessment (quantitative)
- WHEN:

JEFFERSON COUNTY PRIORITIES

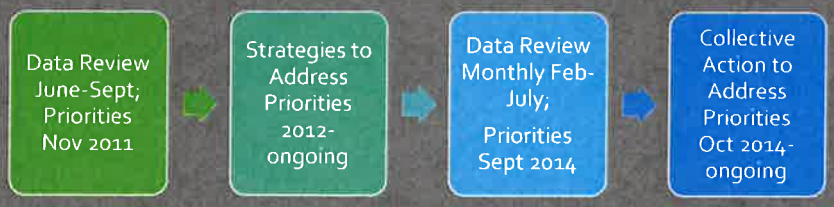
June 13, 2014: FINAL PRIORITIES	TOTAL VOTES
1. Access to mental health and substance abuse care	19
2. Nutrition / Exercise	10
3. Access to Care	9
4. Immunizations	7

Underlying these top issues are the ongoing root causes that impact health. Root causes are academic, economic and housing and must be addressed by the community as a whole.

- NEXT STEPS:
  - Community presentation in January to describe process, present priorities and initiate action teams to address the priorities

KITSAP COUNTY PROCESS

- WHO:
  - Led by Kitsap Public Health District, Harrison Medical Center, United Way, Kitsap Community Foundation, Kitsap County
  - Advisory Group: 47 individuals representing 27 agencies
- WHAT: Four MAPP Assessments (2011); CHSA and Survey (2014)
- WHEN:



KITSAP COUNTY PRIORITIES

2011 FINAL PRIORITIES
Ensure access to affordable medical, behavioral health, and dental care for all residents
Make it easy for all residents to be physically active
Ensure all residents have healthier food options
Promote economic development that provides living wage jobs with benefits
Ensure all children and youth receive the support necessary to be healthy throughout life

2014 KCHP PRIORITIES

RANK	# VOTES	PRIORITY
1	87	Adverse Childhood Experiences
2	46	Mental Health
3	32	Affordable Housing
4	30	Prevent/Reduce Obesity

- NEXT STEPS:
  - Building on collective action to address 2014 priorities and supporting ongoing strategies to address 2011 priorities

PRIORITIES CROSSWALK

	CLALLAM	JEFFERSON	KITSAP
Access to Care; Medical Home	●	●	●
Adverse Childhood Experiences			●
Affordable Housing		*	●
Chronic Disease Prevention/ Mgmt.; Healthy Eating, Active Living; Prevent/Reduce Obesity	●	●	●
Early Learning/Parenting	●		●
Immunizations		●	
Mental Health	●	●	●
Oral Health	●	●	
Substance Abuse	●	●	

*Identified within core community health issues but not selected for health improvement process priority

QUESTIONS?

Siri Kushner
Epidemiologist
siri.kushner@kitsappublichealth.org
360-337-5233

Olympic Community of Health

Health Professional Shortage Areas (HPSA) and Medically Underserved Populations (MUPs)/Areas (MUAs)

CONTENTS

Health Professional Shortage Areas (HPSAs)
Source: http://www.hrsa.gov/shortage/

HSPAs may be designated as having a shortage of primary medical care, dental or mental health providers. They may be urban or rural areas, population groups or medical or other public facilities.

- Primary care HSPAs are based on a physician to population ration of 1:3,500 or more people per primary care physician (does not take into account the availability of Nurse Practitioners and Physician Assistants).
- Dental HPSAs are based on dentist to population ratio of 1:5,000.
- Mental Health HPSAs are based on a psychiatrist to population ratio of 1:30,000 can also be based on "core mental health provider" (psychiatrist, clinical psychologist, clinical social worker, psychiatric nurse specialist, marriage & family therapist) to population ratio.

Medically Underserved Populations (MUPs)/Areas (MUAs)
Source: http://www.hrsa.gov/shortage/mua/index.html

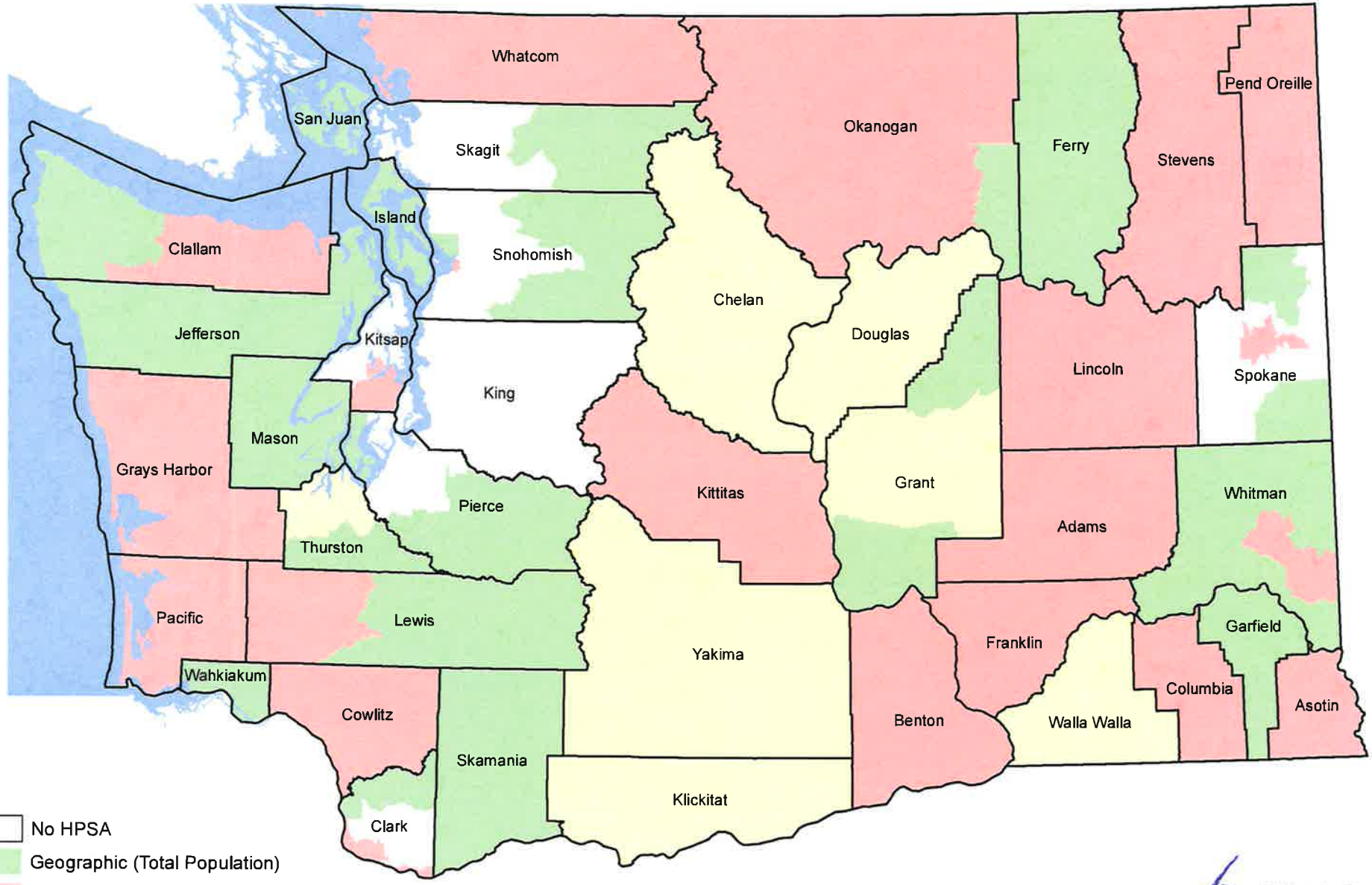
These guidelines are for use in applying the established Criteria for Designation of Medically Underserved Areas (MUAs) and Populations (MUPs), based on the Index of Medical Underservice (IMU), published in the *Federal Register* on October 15, 1976, and in submitting requests for exceptional MUP designations based on the provisions of Public Law 99-280, enacted in 1986.

Three methods for designation:

1. MUA Designation: application of index of Medical Underservice (IMU) to data on a service area to obtain a score for the area. The IMU scale is 0 to 100, 0 is completely underserved, 100 is best served. Each service area with IMU of 62.0 or less qualifies for designation as an MUA. IMU involves four variables: ratio of primary medical care physicians per 1,000 population, infant mortality rate, % of population with income below poverty level and % of population age 65 or over.
2. MUP Designation, using IMU: application of the IMU to data on an underserved population group within an area of resident to obtain a score for the population group. Population groups should be those with economic barriers (low-income or Medicaid-eligible) or cultural and/or linguistic access barriers to primary medical care services. MUP process involves same data as in 1. above but for the population of interest.

3. Exceptional MUP Designation: Under Public law 99-280, enacted in 1986, a population group which does not meet the established criteria of an IMU less than 62.0 can be considered if “unusual local conditions which are a barrier to access to or the availability of personal health services” exist and are documented and such designation is recommended by CEO and local officials of the State.

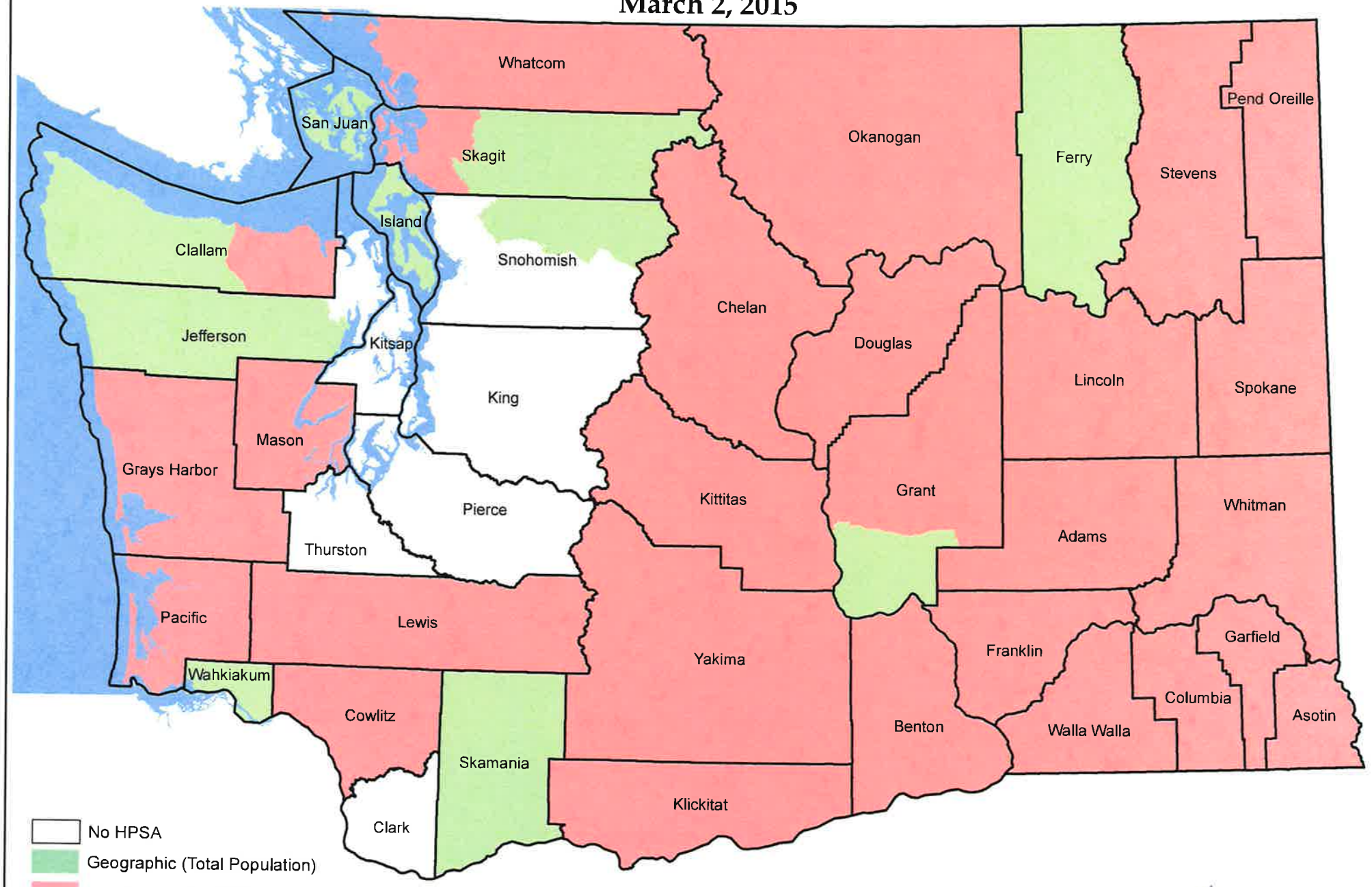
Federally Designated Health Professional Shortage Areas for Primary Care
March 2, 2015



Designation data from the Office of Community and Rural Health.
Designation status changes frequently.
For current information contact Laura Olexa (360) 236-2811.

Washington State Department of Health

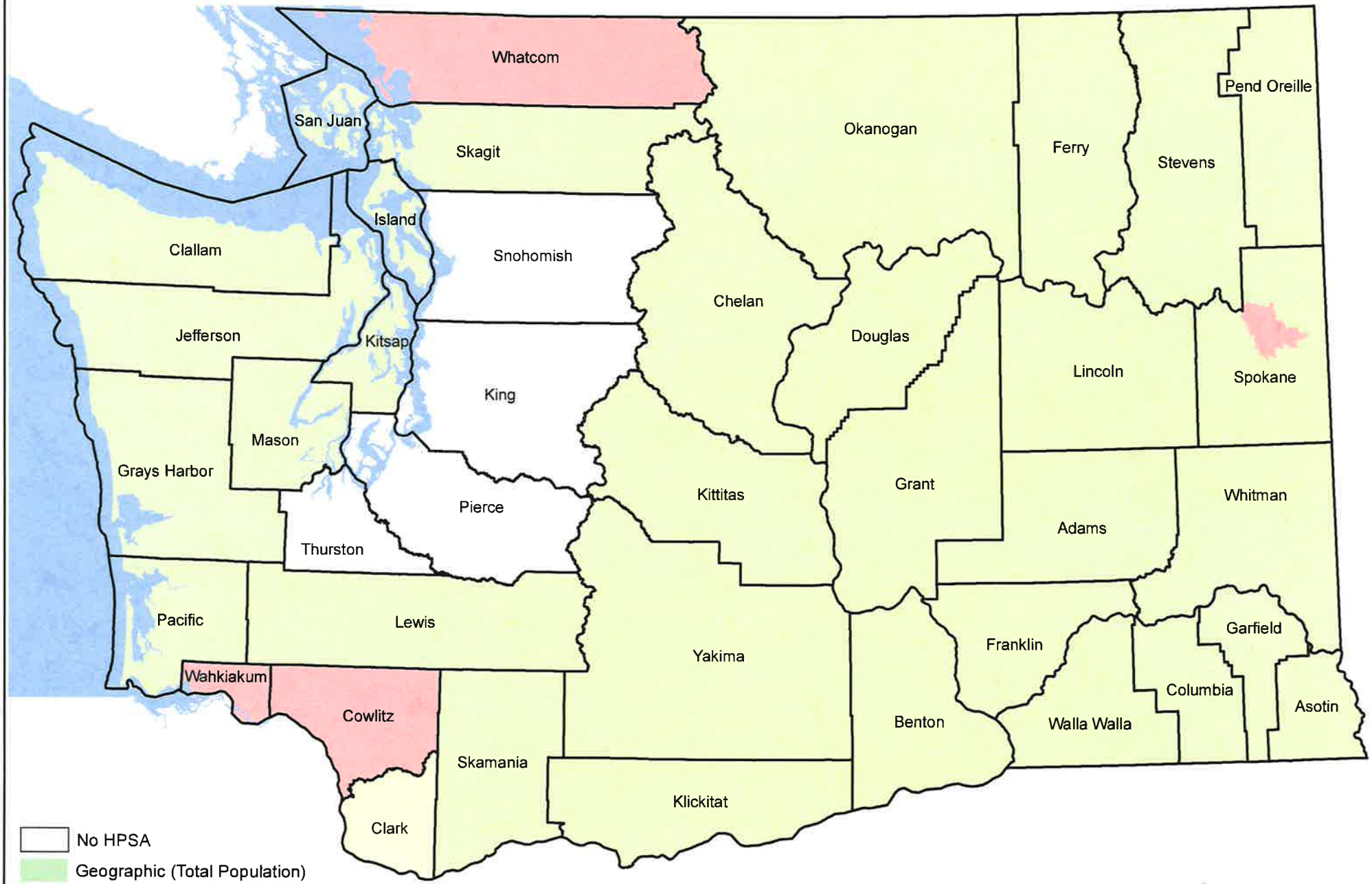
Federally Designated Health Professional Shortage Areas for Dental Care
March 2, 2015



Designation data from the Office of Community and Rural Health.
Designation status changes frequently.
For current information contact Laura Olexa (360) 236-2811.

Washington State Department of Health

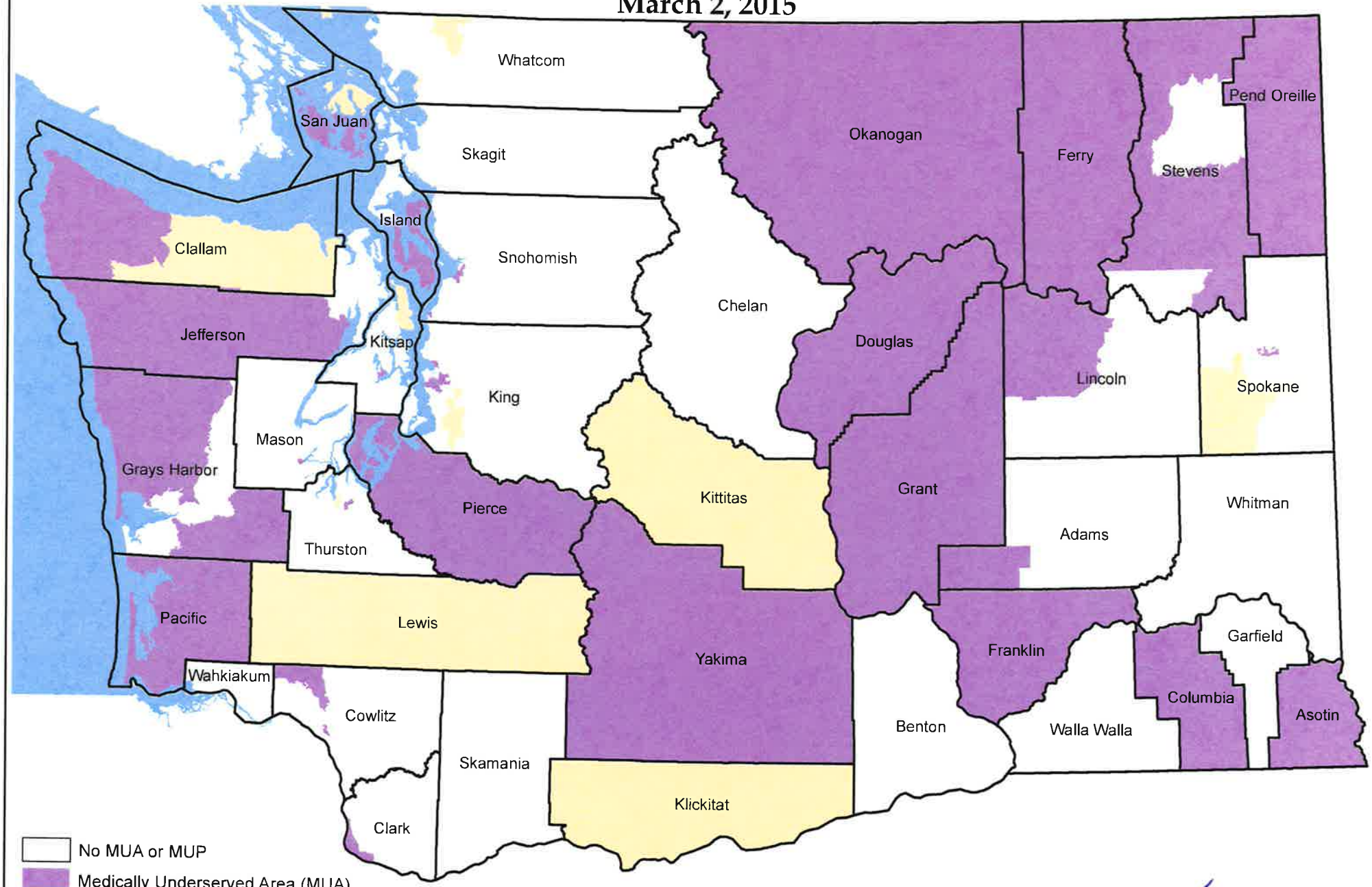
Federally Designated Health Professional Shortage Areas for Mental Care
March 2, 2015



Designation data from the Office of Community and Rural Health.
Designation status changes frequently.
For current information contact Laura Olexa (360) 236-2811.

Washington State Department of Health

Medically Underserved Area & Medically Underserved Population
March 2, 2015



Designation data from the Office of Community and Rural Health.
Designation status changes frequently.
For current information contact Laura Olexa (360) 236-2811.

Washington State Department of Health

CLALLAM COUNTY

HPSA Discipline Class	HPSA Name	Designation Type	HPSA FTE	HPSA Score	HPSA Designation Last Update Date
Dental Health	Jamestown South'Klallam Tribe	Native American Tribal Population		13	10/13/2009
Dental Health	Lower Elwha Klallam Health Clinic	Native American Tribal Population		13	10/13/2009
Dental Health	Makah - Sophie Trettevick Indian Health Center	Native American Tribal Population		16	2/21/2012
Dental Health	Quileute Clinic	Indian Health Service Facility		16	10/26/2002
Dental Health	Peninsula Children's Clinic, Inc.	Rural Health Clinic		0	10/27/2003
Dental Health	West Side Olympic Peninsula	HPSA Geographic	0.00	18	11/19/2013
Dental Health	2	Census Tract			11/19/2013
Dental Health	3	Census Tract			11/19/2013
Dental Health	4	Census Tract			11/19/2013
Dental Health	6	Census Tract			11/19/2013
Dental Health	9400	Census Tract			11/19/2013
Dental Health	Low Income - Port Angeles/Sequim Service Area	HPSA Population	2.00	18	2/22/2011
Dental Health	10	Census Tract			2/22/2011
Dental Health	11	Census Tract			2/22/2011
Dental Health	12	Census Tract			2/22/2011
Dental Health	13	Census Tract			2/22/2011
Dental Health	14	Census Tract			2/22/2011
Dental Health	15	Census Tract			2/22/2011
Dental Health	16	Census Tract			2/22/2011
Dental Health	17	Census Tract			2/22/2011
Dental Health	18	Census Tract			2/22/2011
Dental Health	19	Census Tract			2/22/2011
Dental Health	20	Census Tract			2/22/2011
Dental Health	21	Census Tract			2/22/2011
Dental Health	23	Census Tract			2/22/2011
Dental Health	7	Census Tract			2/22/2011
Dental Health	8	Census Tract			2/22/2011
Dental Health	9	Census Tract			2/22/2011
Dental Health	9901	Census Tract			2/22/2011

HPSA Discipline Class	HPSA Name	Designation Type	HPSA FTE	HPSA Score	HPSA Designation Last Update Date
Dental Health	Clallam Bay Corrections Center	Correctional Facility		21	8/5/2013
Mental Health	Jamestown South'Klallam Tribe	Native American Tribal Population		17	10/13/2009
Mental Health	Lower Elwha Klallam Health Clinic	Native American Tribal Population		12	10/13/2009
Mental Health	Makah - Sophie Trettevick Indian Health Center	Native American Tribal Population		17	2/21/2012
Mental Health	Quileute Clinic	Indian Health Service Facility		16	10/26/2002
Mental Health	Peninsula Children's Clinic, Inc.	Rural Health Clinic		0	10/27/2003
Mental Health	Clallam County	HPSA Geographic	2.00	15	5/19/2014
Mental Health	Clallam	Single County			5/19/2014
Mental Health	Clallam Bay Corrections Center	Correctional Facility		18	8/5/2013
Primary Care	Jamestown South'Klallam Tribe	Native American Tribal Population		15	10/13/2009
Primary Care	Lower Elwha Klallam Health Clinic	Native American Tribal Population		15	10/13/2009
Primary Care	Makah - Sophie Trettevick Indian Health Center	Native American Tribal Population		17	2/21/2012
Primary Care	Quileute Clinic	Indian Health Service Facility		15	10/26/2002
Primary Care	Family Medical Center	Rural Health Clinic		0	11/12/2003
Primary Care	Peninsula Children's Clinic, Inc.	Rural Health Clinic		0	10/27/2003
Primary Care	Clallam Bay Corrections Center	Correctional Facility		9	12/15/2011
Primary Care	Clallam Bay/Neah Bay	HPSA Geographic	3.00	10	5/19/2014
Primary Care	Clallam Bay-Neah Bay	Minor Civil Division			5/19/2014
Primary Care	Forks	Minor Civil Division			5/19/2014
Primary Care	Low Income/Homeless - Port Angeles/Sequim-Elwah	HPSA Population	2.00	13	7/2/2014
Primary Care	10	Census Tract			7/2/2014
Primary Care	11	Census Tract			7/2/2014
Primary Care	12	Census Tract			7/2/2014
Primary Care	13	Census Tract			7/2/2014
Primary Care	14	Census Tract			7/2/2014
Primary Care	15	Census Tract			7/2/2014
Primary Care	16	Census Tract			7/2/2014
Primary Care	17	Census Tract			7/2/2014
Primary Care	18	Census Tract			7/2/2014
Primary Care	19	Census Tract			7/2/2014

HPSA Discipline Class	HPSA Name	Designation Type	HPSA FTE	HPSA Score	HPSA Designation Last Update Date
Primary Care	20	Census Tract			7/2/2014
Primary Care	21	Census Tract			7/2/2014
Primary Care	23	Census Tract			7/2/2014
Primary Care	6	Census Tract			7/2/2014
Primary Care	7	Census Tract			7/2/2014
Primary Care	8	Census Tract			7/2/2014
Primary Care	9	Census Tract			7/2/2014

JEFFERSON COUNTY

HPSA Discipline Class	HPSA Name	Designation Type	HPSA FTE	HPSA Score	HPSA Designation Last Update Date
Dental Health	West Side Olympic Peninsula	HPSA Geographic	0.00	18	11/19/2013
Dental Health	9507.02	Census Tract			11/19/2013
Mental Health	Jefferson County	HPSA Geographic	1.00	15	5/19/2014
Mental Health	Jefferson	Single County			5/19/2014
Primary Care	South County Medical Clinic	Rural Health Clinic		0	10/22/2003
Primary Care	Port Townsend Family Physicians	Rural Health Clinic		0	11/3/2003
Primary Care	Clallam Bay/Neah Bay	HPSA Geographic	3.00	10	5/19/2014
Primary Care	West End	Minor Civil Division			5/19/2014
Primary Care	Port Townsend and Quilcene	HPSA Geographic	7.00	10	8/30/2011
Primary Care	9502.02	Census Tract			8/30/2011
Primary Care	9503	Census Tract			8/30/2011
Primary Care	9504	Census Tract			8/30/2011
Primary Care	9505	Census Tract			8/30/2011
Primary Care	9506.01	Census Tract			8/30/2011
Primary Care	9506.02	Census Tract			8/30/2011
Primary Care	9507.02	Census Tract			8/30/2011

KITSAP COUNTY

HPSA Discipline Class	HPSA Name	Designation Type	HPSA FTE	HPSA Score	HPSA Designation Last Update Date
Dental Health	Suquamish Tribe	Native American Tribal Population		14	10/21/2009
Dental Health	Port Gamble South'Klallam Tribal Clinic	Native American Tribal Population		13	10/14/2009
Dental Health	Peninsula Community Health	Comprehensive Health Center		18	12/27/2013
Mental Health	Suquamish Tribe	Native American Tribal Population		15	10/21/2009
Mental Health	Port Gamble South'Klallam Tribal Clinic	Native American Tribal Population		19	10/14/2009
Mental Health	Peninsula Community Health	Comprehensive Health Center		18	12/27/2013
Mental Health	Kitsap County	HPSA Geographic High Needs	9.00	12	6/19/2013
Mental Health	Kitsap	Single County			6/19/2013
Primary Care	Suquamish Tribe	Native American Tribal Population		16	10/21/2009
Primary Care	Port Gamble South'Klallam Tribal Clinic	Native American Tribal Population		15	10/14/2009
Primary Care	Peninsula Community Clinic	Comprehensive Health Center		13	12/27/2013
Primary Care	Low Income/Migrant Farmworker/Homeless - Bremerton	HPSA Population	4.00	9	5/19/2014
Primary Care	801.01	Census Tract			5/19/2014
Primary Care	801.02	Census Tract			5/19/2014
Primary Care	802	Census Tract			5/19/2014
Primary Care	803	Census Tract			5/19/2014
Primary Care	804	Census Tract			5/19/2014
Primary Care	805	Census Tract			5/19/2014
Primary Care	806	Census Tract			5/19/2014
Primary Care	807	Census Tract			5/19/2014
Primary Care	808	Census Tract			5/19/2014
Primary Care	809	Census Tract			5/19/2014
Primary Care	810	Census Tract			5/19/2014
Primary Care	811	Census Tract			5/19/2014
Primary Care	812	Census Tract			5/19/2014
Primary Care	814	Census Tract			5/19/2014
Primary Care	919	Census Tract			5/19/2014
Primary Care	921	Census Tract			5/19/2014

HPSA Discipline Class	HPSA Name	Designation Type	HPSA FTE	HPSA Score	HPSA Designation Last Update Date
Primary Care	922	Census Tract			5/19/2014
Primary Care	923	Census Tract			5/19/2014
Primary Care	924	Census Tract			5/19/2014
Primary Care	925	Census Tract			5/19/2014
Primary Care	926	Census Tract			5/19/2014
Primary Care	927.01	Census Tract			5/19/2014
Primary Care	927.04	Census Tract			5/19/2014
Primary Care	928.01	Census Tract			5/19/2014
Primary Care	928.02	Census Tract			5/19/2014
Primary Care	928.03	Census Tract			5/19/2014
Primary Care	929.01	Census Tract			5/19/2014
Primary Care	929.02	Census Tract			5/19/2014

CATEGORY 6: Operating Budget and Sustainability Pathway

Our original budget estimate submitted in the Accountable Community of Health (ACH) Design Grant Application reflected in-kind contributions of $51,370, and $100,000 requested in grant funding from the Washington State Health Care Authority (HCA). It was our intent to launch the ACH with the backbone organization operating as fiscal and administrative lead, with contractual services for a consultant program manager budgeted at $72,230, Kitsap Public Health District (KPHD) epidemiology staff budgeted at $15,000 with $4,300 in benefits, Kitsap County communications support staff budgeted at $1,600, and $2,000 allocated for travel. Total direct costs were budgeted at $95,130, with an indirect cost of $4,870 included for KPHD personnel, for a total of $100,000. A balance sheet is included showing ACH Design Grant year-to-date (through November 15, 2015) expenditures and in-kind contributions; also included for review is a proposed 2016 budget (see document 6.1, OCH 2015 Balance Sheet and Proposed 2016 Operating Budget). Our records reflect that we are on track to fully expend ACH Design Grant funds on or before January 31, 2016, and will be likely be slightly less than our estimate for in-kind contributions.

Through November 15, 2015, the following agencies have provided in-kind support to the work under the grant:

Kitsap Public Health District:	$31,193.54
Kitsap County Department of Human Services	$ 1,840.00
TOTAL IN-KIND:	$33,033.54

The Sustainability Subcommittee of the Interim Leadership Council (ILC) has developed a pathway for sustainability, approved by the ILC and included for review below (see document 6.2, OCH ILC Subcommittee Meeting Summaries and Sustainability Pathway). Recently, we have sought HCA Technical Assistance to contract with Dale Jarvis and Associates to provide his considerable expertise in Medicaid financing and sustainability planning to the Sustainability Subcommittee beginning with its third meeting this December. Members of the OCH are familiar with Dale Jarvis, who facilitated our November 2014 OCH Stakeholder meeting in the early planning stages and supported the committee responsible for the 2015 ACH Design Grant submittal.

The Sustainability Subcommittee began meeting in October 2015 and has rapidly gained momentum as more stakeholders have stepped forward to serve. Subcommittee members reflect a balance of geography and sectors, and consist of individuals familiar with financing, resource development, and Medicaid services delivery for multiple organizations, both governmental and not-for-profit. The members acknowledge that as we go into 2016 much is still unknown, including the coordinating role the ACH may play with the yet to be approved 1115 Medicaid Waiver. Therefore, to stabilize the OCH for the short- and mid-term, members are in agreement that sustaining SIM 2 funding will be necessary from the State to support the infrastructure and growth of the ACH. At the same time, the Sustainability Subcommittee will continue its exploration of usual and creative opportunities to move toward a sustainable OCH future.

6.1 OCH 2015 Balance Sheet and Proposed 2016 Operating Budget

The 2015 Balance Sheet is included for review, as is the proposed 2016 Olympic Community of Health (OCH) Operating Budget prepared by the Kitsap Public Health District and approved by the OCH Interim Leadership Council (ILC) as seen below. Following receipt of additional financial guidance from the Washington State Health Care Authority (HCA), the ILC may amend the 2016 Operating Budget prior to final submittal to HCA in 2016.

HEALTH CARE AUTHORITY: ACCOUNTABLE COMMUNITY OF HEALTH DESIGN GRANT

HCA CONTRACT #K1434 TASK BALANCES[1]

Task Elements	Task 1		Task 2		Task 3		Task 4		Task 5		Contract Total	KPHD Contribution
	Establish Capacity and Backbone Support for the ACH	*KPHD Matching Funds*	***Develop Regional Health Needs Inventory***	*KPHD Matching Funds*	***Establish Pathway for Sustainability Planning***	*KPHD Matching Funds*	***Establish ACH Governance Model and Engagment Strategy***	*KPHD Matching Funds*	***Participate in a Statewide ACH Learning Network***	*KPHD Matching Funds*		
Grant Amounts	**$ 50,000.00**		**$ 14,000.00**		**$ 5,000.00**		**$ 23,000.00**		**$ 8,000.00**		**$100,000.00**	
April-15	89.13	1434.34									$ 89.13	$ 1,434.34
May-15	$ -	$ 1,745.40									$ -	$ 1,745.40
June-15	$ 9,750.00	$ 395.68								$ -	$ 9,750.00	$ 395.68
July-15	$ 21,487.50	$ 3,087.61	$ -	$ 134.82	$ 1,500.00	$ -	$ 7,650.00	$ -	$ 4,800.00	$ -	$ 35,437.50	$ 3,222.43
August-15	$ -	$ 3,365.23	$ -	$ -	$ -	$ -	$ -	$ 973.59	$ -	$ -	$ -	$ 4,338.82
September-15	$ 4,446.70	$ 2,407.04	$ -	$ -	$ -	$ -	$ 2,175.00	$ 1,405.74	$ -	$ -	$ 6,621.70	$ 3,812.78
October-15	$ 3,637.50	$ 9,093.48	$ -	$ 1,680.35	$ 450.00	$ -	$ 3,262.50	$ 152.00	$ 300.00	$ -	$ 7,650.00	$ 10,925.83
November-15	$ 3,480.95	$ 2,425.51	$ 3,000.00	$ 2,892.75	$ 1,500.00	$ -	$ 18,150.00	$ -	$ 1,050.00	$ -	$ 27,180.95	$ 5,318.26
December-15											$ -	$ -
January-16											$ -	$ -
Totals to Date	$ 42,891.78	$ 23,954.29	$ 3,000.00	$ 4,707.92	$ 3,450.00	$ -	$ 31,237.50	$ 2,531.33	$ 6,150.00	$ -	$ 86,729.28	**$ 31,193.54**
Grant Balance Remaining	**$ 7,108.22**		**$ 11,000.00**		**$ 1,550.00**		**$ (8,237.50)**		**$ 1,850.00**		**$ 13,270.72**	

Olympic Community of Health Proposed 2016 Operating Budget			
	Year 2 (2016)	**Matching Funds Estimate**	**Total Budget**
Salaries (Internal Staff)	44,190	13,507	57,697
Fringe Benefits (Internal Staff)	21,211	4,490	25,701
External Consultants/Contracts	228,800		228,800
Communications Support	20,000		20,000
Travel	2,000		2,000
Supplies	2,000		2,000
Event Expenses	5,000		5,000
Other	0		0
Total Direct Costs	**323,201**	**17,997**	**341,198**
Indirect Costs	14,741	0	14,741
Total Costs	**337,942**	**17,997**	**355,939**

6.2 OCH ILC Sustainability Subcommittee Meeting Summaries and Sustainability Pathway

The following documents include Subcommittee minutes, including the “Pathway to Sustainability” recommended to and approved by the OCH Interim Leadership Council.

OLYMPIC COMMUNITY OF HEALTH

AGENDA

OCH Sustainability Committee

October 27, 2015
2:30 -3:30p.m.
Kimball Espresso Café, Gig Harbor, WA

Facilitator: Barbara Malich

Committee Members: Katie Eilers, Assistant Director, Community Health Services, Kitsap Public Health; Hilary Whittington, CFO, Jefferson Healthcare.

1. **Member Introductions.**
2. **Review Charge –** (Quick Glance), attached
3. **Develop (at least in concept) Sustainability Pathway for the OCH,** attached
4. **Discussion of Big Picture and TA Request for Dale Jarvis**
5. **Next Meeting**

Handouts:

- At A Glance
- Pathway to Sustainability Planning (Draft)

ACH and Managed Care Health System Meeting

November 3, 2015

SeaTac Conference Center about 60 attendees from state agencies, Managed Care Organizations (MCOs), Behavioral Health Organizations (BHOs), statewide association representatives (WSHA, WSMA, WACMHC, CMHA, and others)

There was at least one personal from each Accountability Community of Health 9 ACH representatives.

Meeting Notes: Barbara Malich, OCH Co-Program Manager,
Attended on behalf of the Olympic Community of Health.

Meeting Objectives:

- Develop a shared understanding of the roles of DSHS and HCA in the context of Medicaid, including the intent behind our managed care health system
- Learn more about how MCOs and BHOs currently operate, and a look ahead, including fully integrated managed care
- Discuss the intent and explore next steps regarding the partner in purchasing and delivery system transformation concept. Hope that next steps from the discussion will inform future regional and statewide discussions

Observations:
Focus on next key date: April, 2016 for transformation/implementation—target BHO/CD
Preston Cody spoke from HCA representing MaryAnn Lindeblad, Medicaid Director, with the HCA over-arching goal to **prevent silos**. HCA is the sole contractor with the Federal CMS. Summary of current enrollment 1.8 million in Medicaid of those, 1.4 million enrolled with an MCO. Last target "high risk" this year including the Blind & Disabled (BD) population in managed care.

Managed care is administered by the state through direct contracts, primarily with the MCOs. The BHOs have a delegated role HCA to DSHS, to a regional approach currently through RSNs but soon to be BHOs. The state apportioned dollars go to the RSN/BHO, they administer contracts primarily to community mental health agencies. Requirements for the BHOs will change to include a mandate for an open and competitive process. DSHS to BHOs is a delegated process. The managed care contracts are direct between HCA and the MCOs. There is an RFP, Stakeholder review submissions/score all 17 contract sections. A primary focus is network adequacy. Next priority area is care coordination/management at the MCO level, and Quality measures including HEDIS CAHPS, non-CAHPS surveys. The state "audit" of the MCO performance is done through a process called "TEAM MONITOR"---plans are also required to participate with the state in monthly operations meetings.

Questions were posed from the group---what will the "reporting lines" be between ACHs and HCA? How can the ACHs influence the contracting between HCA and MCOs if in fact we want to see transformation, this is where it will be defined. Otherwise it will just be a lot of projects without the ability to impact and meet goals of the Triple Aim. How will this happen? Why isn't dental included in this project?

The legislative mandate was for rate-setting and savings (Gain Sharing)---how will this be accrued and how will reinvestment happen is gain-sharing occurs?

Response was that "**rate-setting is perverse**" and that is where the responses stopped.

Virtual panels followed –small room so everyone participated rather extemporaneously. Multiple concerns were expressed:

- Requirement that 86% of cap be spent on patient care
- Align incentives to providers
- Fee-for-service is at core of rate-setting therefore the volume over value will continue
- Care Coordination required of MCOs—not well coordinated with local entities
- Risk is adjusted by county and by plan 2x per year—based on enrollment. A very complex formula administered patient by patient
- How will it be possible for ACHs to work with MCOs on care coordination
- Workforce/salary issues mentioned particularly in BH and CD, also true for some primary care providers (those not hospital based)
- Several constituents that having more control locally will improve performance and outcomes---but who will manage and how funded
- Several expressed concerns about duplication of effort building cost into the system rather than simplifying
- Example of EDIE in the emergency departments cited as a good effort. – could this type of model extend to admissions and discharge---also need to include corrections/jails
- Endorsement of the concept for ACHs---Everything is a health issue—prevention must be a priority---not just discharge from hospital to homelessness.
- Public Health is at high risk. What is expected result for current investment? How do we plan to define what is CORE to public health? Definition of core services should be highest priority for DoH.
- FQHCs as vital providers in the Medicaid program—currently serving 30% of enrollees for primary care, dental and a lesser number for behavioral health. FQHCs have been providing care for 50 years and are a vital part of the safety net.
- Conversation moved to Behavioral Health briefly followed by Southwest Washington as an early adopter, Cascade Pacific as a designee. There were several roles presented—ACHs are designed to provide community/clinical linkages, Partner with Medicaid contractors, develop projects to meet service gaps identified, assist with setting performance targets and metrics, be involved with establishing "contract requirements" (presumably for MCOs with HCA), monitor performance in local region. Provide feedback loop to HCA---regarding such things as network adequacy, rate setting, etc.
- It is imperative that HCA and DOH align their own expectations. This must happen now for ACHs to be able to move ahead.
- Role of hospitals especially public hospital districts also be aligned.
- It was proposed that we end reference to sectors (considered to be silo perpetuation) and move to services and how services will be provided. This was thought to be a more constructive approach for ACHs to take.

- MCOs want to be told what the expectation is---then have everyone (state, region, etc) get out of the way. Give MCOs both authority and accountability.
- Shared and open Health Information Systems must be mandated—this should have been done yesterday! We need to focus on no more than 4-6 key processes
- MCOs want to engage with ACHs in addressing social determinants---less focus on care system and more on support systems
- Duplication represents waste in all systems
- Find a balance---MCOs are afraid of having to respond to everyone differently
- MCOs see role of ACHs as purchasers of value, improve health of the community, developmental assets in children and youth, support local efforts to develop housing and jobs
- Eliminate complexity in the system so it is easier to navigate
- Suggested ACHs choose a few "**uncontroversially positive**" areas of focus
- Requested HCA map ACH/MCO/BHO priorities into common language we all could use
- Align responsibility, accountability, and authority
- Create guiding principle to UNIFY work being done
- Concerns expressed over DSRIPS---need better understanding request TA
- Housing came up several times
- How do we approach the up-coming Legislative session? These are "local/regional" entities now doing a lot of the work of the state. "Who's on first?"
- Health Innovation Leadership Network cited as beneficial for those involved.
- There will likely be on-going training on many of the listed topics---some discussion re a big Statewide summit or series of webinars, or other method for TA
- Last question was wanting more information on HILN Accelerator Committees…no response

It is hoped there will be published notes from HCA Transformation Team and a listing of next steps.

Olympic Community of Health
Sustainability Subcommittee Meeting Notes
November 6, 2015

P	Katie Eilers	P			
P	Hilary Whittington	P			
P	Rochelle Doan				
P	Barbara Malich				
P					

Recorder: Malich

TOPICS	**Tasks/Decisions**
Discussion	
Notes from October 27 meeting were reviewed and accepted as distributed.	
Update on technical assistance request approval for Dale Jarvis, CPA. Dale will provide information on health care financing and the state expectations for sustainability to the subcommittee, the Interim Leadership Council, and the Stakeholders. The terms from the HCA TA folks also included 10 hours for his work on writing a Sustainability Plan. The agreement is from November through the end of January, 2016.	Barb will follow-up with Dale Jarvis on scheduling his time for the TA work.
The Committee discussed the relationship between the work of the Governance and Sustainability Subcommittees. We endorsed the view that if Governance selected a not-for-profit model, that could include a membership structure the Sustainability Subcommittee would develop the membership structure and create a commensurate dues structure. It was expressed that investing in the OCH could include in-kind, cash contributions, as well as "loaned" experts by members.	Barb will share the committee work/discussion with Governance at their Dec 7 meeting.
We reviewed some of the options included by the IRS in the 501 © category and want to clear any membership dues structures with both legal and accounting experts.	
Update was provided on the two "outstanding" membership model issues---representation of managed care organizations (MCOs) and their proposals, as well as Tribal Sovereign Nations. The committee endorses accepting the offer of the Federal Reserve Bank of San Francisco (Craig Nolte)	Barb will follow-up with Craig Nolte.

to facilitate the discussion with the Tribes. Barbara will follow up on getting this scheduled. Observations were shared by other members on the engagement of the Tribes in our region and their willingness to participate. **Barb shared her notes on the ACH/MCO/State Association Meeting with the Committee. It was felt that we need to continue to be present and actively participate in all future meetings.** **New committee members were suggested to enlarge the size/depth of the committee as soon as possible. Names were proposed and Barb will follow-up to gauge interest and seek participants.**	Barb will follow-up with suggested ILC and Stakeholder members re committee membership.
Next Meeting: Pending until timeline with Dale Jarvis is determined. It was requested we identify and select a fixed day/date for meetings and schedule out into 2016. Everyone agreed it would make participation much easier to find a "regular" meeting day/date.	Barb will follow-up and notify committee when dates/options are known.

"The Pathway to Sustainability Planning"

November 2015

The purpose of this document is to further the conversation regarding developing a pathway to sustainability for the Olympic Community of Health (OCH) infrastructure, and later program initiatives. The OCH Sustainability Subcommittee, working together with the Governance Subcommittee, will inform and shape the conversation on sustainability that will then be undertaken by the Interim Leadership Council (ILC). The goals will be to identify necessary next steps to assure a successful organizational launch and subsequently to create stability and infrastructure development. Program initiatives and projects will be identified, but specific funding streams for such will be considered as they are approved. It should be noted that a permanent OCH governance model has not yet been adopted and all governance and sustainability options are under consideration.

The Charge of the Sustainability Subcommittee is to research and recommend an OCH sustainability plan and subsequently, as part of the ongoing work, engage in discussions about the design and implementation of health care payment models.

Currently there are four competing priorities to guide our thinking around sustainability over time:

1. OCH has established existing contracts for the development of deliverables to submit with the ACH Readiness Proposal due November 30, 2015. The current HCA Design Grant that primarily funds Readiness Planning will expire January 31, 2016—with a subsequent final narrative report due by February 29, 2016. One component of the proposal is a discussion regarding sustainability.
2. Following HCA's designation of the OCH as an Accountable Community of Health, the OCH will continue working toward a viable organizational model that will require a firm and diversified financial platform. While it is expected the State of Washington Health Care Authority (HCA) will continue to provide some support for the development of regional ACHs in the short-term with SIM 2 grant dollars, to truly be effective and community based, additional resources will need to be garnered from stakeholders throughout the region.
3. In 2016, the HCA may be awarded 1115 Medicaid Waiver funding that may provide funding to ACHs to develop the infrastructure to become Medicaid Coordinating Entities, and funding for performance-based project work in the OCH region.
4. The "Right" work will be undertaken by the OCH as the organization matures, the health planning and assessment committee will identify targeted opportunities, and then resources will be identified sufficient to impact community health, quality of care, and strive to reduce costs.

The current direction from the Interim Leadership Council is not prescriptive. The Subcommittee is urged to consider the following broad questions: What does it mean to be sustainable? What are we sustaining? How can goals be defined and achieved? Is Sustainability as a concept evolutionary or revolutionary?

We will consider these steps to achieve sustainability — the "Sustainability Pathway":

Step 1. What is the "Value Proposition"? A critical first step in the path to sustainability for OCH infrastructure and activities is to develop a value proposition that resonates with all the partners and stakeholders.

- The OCH is considered to be an "asset" to all involved.
- OCH is a driver in other regional health, including social determinates of health initiatives providing funding or financial resources.
- OCH is one potential avenue for consumer-driven care.
- One goal of the OCH is to reduce administrative complexity for partner organization in the tracking and monitoring of performance/quality measures.
- By centralizing duplicative tasks within the region, could the OCH deliver cost savings to partner organizations?

Step 2. Resources (Identify a list of possible financial resources)

- State and federal funds
- Member fees or dues
- Philanthropic grants, major gifts and donations
- Social impact bonds
- Health plans and hospitals
- City/County funds
- Private business
- In-kind investments
- Venture capital
- Others to be identified

Step 3. Possible mechanisms (Identify a list of possible revenue-generating mechanisms that align with the goals of the OCH)

- We must be accountable in order to expect investments to flow to the OCH.
- Partner with health plans on projects of mutual benefit such as jail/institutional transitions, community health workers, or other strategies to address our regional health needs priorities and in doing so reduce costs and improve care.
- Shape health care purchasing to align with OCH priorities and include specific language related to shared savings for OCH.
- Contracts or fees for services with entities benefiting from such services.
- Engage with Federal Reserve Bank of San Francisco for community building and engagement especially in relationship to engagement with Tribal Nations.
- Leverage membership in the OCH for in-kind donations such as space, equipment, supplies, and personnel. Track these donations.
- Create an OCH membership fee structure.
- Research options through the Practice Transformation Hub and share ideas with other ACHs across the state to identify opportunities for resource development, shared savings, or other value-based reimbursement mechanisms.

Step 4. What are we doing together and what will it cost to sustain?
The concept of the Accountable Communities of Health is new. We do not have any idea about what we want the OCH to ultimately look like. Financial projections for one year is difficult and a five year projection is nearly impossible. The immediate next step is to achieve designation as an ACH and then build the organization to respond to our regional health priorities. Achieving early wins will be optimal and then building on success will foster trust in the partners and in the process. Continuing with contracted staff at least for the short term is optimal. Building an authentic budget process will require time and some determination of programs and opportunities.

Step 5. Continue to expand community engagement by mobilizing stakeholders and generating enthusiasm for the opportunities represented by the creation of the OCH. As the community becomes engaged in the OCH, the desire to sustain it will be generated and resources can be identified sufficient to the tasks.

Step 6. The OCH is evolutionary as it defines goals and opportunities, but the OCH must also be **revolutionary** to secure resources sufficient to impact our regional health priorities.

OCH Summative Narrative

Preparation of the Readiness Portfolio has allowed us to stand back and assess the distance we have traveled since beginning our journey on the Accountable Community of Health in July 2014, to becoming the three-county region Olympic Community of Health we are as of November 2015, and to chart the path ahead to sustain the health and well-being of our residents and communities.

OCH Summative Narrative

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What has happened already?

We have come together as individuals and organizations dedicated to continued health improvements that include the social determinants of health, for all people, and especially for persons who are among the most vulnerable of our populations. We have done this deliberately and consistently over the course of the last sixteen months, gathering the energy of more and more stakeholders as each month has passed, representing organizations who have "come to the table" most often through their in-kind offering of time from the organizations they represent, and with their commitment to *"Regional Vision, Local Action"* in order to ensure better health, better care, at lower cost are available to all people.

We began with an originating group in July 2014 committed to establishing an Olympic Community of Health and who provided the organizational steps to do so. A stakeholders invitation was issued to key leaders representing health, and other sectors contributing to the provision of services related to the Social Determinants of Health. The nearly fifty people who came together in November 2014 and listened to presentations about ACHs and the state of health care (Dale Jarvis, consultant), and to our each of our counties individual and regional shared health priorities (Siri Kushner, KPHD Epidemiologist), thoughtfully decided to move forward in application of an HCA Design Grant, with the Kitsap Public Health District as the "virtual backbone organization".

By end of March 2015, an HCA Design Award contract had been negotiated between the HCA and the KPHD and subsequently a Program Manager (consultant) was hired in May to gather additional stakeholders together for a second OCH Stakeholders meeting (consultant resigned October 2015). During June, a small group of the originating Steering Committee members researched other ACH governance documents, and with gratitude to these ACHs for their pioneering work, drafted an Interim Leadership Council Charter that would facilitate a more formal structure for the OCH. This was then shared in July 2015 with stakeholders for comment and was adopted by the OCH Steering Committee as a whole in September 2015. The Charter provided the guidance for an Interim Leadership Council (ILC) whose inaugural meeting was October 19, 2015. The current ILC is made up of leadership with the commitment, expertise, energy, and wisdom that is rapidly moving our OCH forward.

Since the ILC's inception, with the infusion of energy from two newly contracted Program Managers, and after only two ILC meetings, our OCH has hosted a third Stakeholder meeting, convened three subcommittees --- Community Assessment and Planning, Governance, and Sustainability --- each of which has met twice and produced substantive work. As the governing body, the Interim Leadership Council is rapidly moving our Olympic Community of Health quickly to create a regional health improvement plan, an even more

representative and engaged community voice, and a pathway to explore long term governance and sustainability in order to achieve our vision and purposes.

Why do we care?

What difference does it make, and why, for each of our sector organizations and individual stakeholders, and why is it worth the dedication of time, energy and resources to be present, to participate, and to be in conversation with one another while the sands are shifting so rapidly for organizations involved in health care transformation? These questions were posed by our keynote presenter, Tom Locke, MD, MPH, long time public health officer and medical director, at our November 2, 2015 Stakeholder meeting. It is precisely because we are in the midst of this health care transformation that we are at, and must be at, the table together. None of us can accomplish alone what must be accomplished to preserve and ensure health care for all, including the supportive services and preventative strategies necessary to move toward the vision of better health, better care, and lower cost. The message we are acutely aware of is that we cannot "tinker" with our systems and expect to accomplish the health care transformation we must achieve. We are seeking major change, from population health based approaches, to "whole person care" and payment reform. To do so, we must work together to ensure our health system works, and that it works for all.

What did we learn from what happened that will inform what we do now?

We have learned that it takes a thoughtful, deliberate, strategic approach from, at the very least, a core group of committed individuals to hold the vision for this work and to initiate and implement the action steps it takes to grow an Accountable Community of Health. We also know that it is just the starting point. It takes a structure of accountability and the capacity to manage the administrative and fiscal accountabilities, the communications, the engagement of many stakeholders, and the intentional strategies with committed people behind them, to support and implement the activities that take an organization from vision to action. Our Accountable Community of Health early on had the commitment to move forward, although we lagged at the mid-point due to organizational management challenges. We recouped our effort by October 2015 as our Interim Leadership Council and new project management came on board. The energy to "catch up" has been amazing, a clear demonstration of the dedication and the energy of our governing body and of our stakeholders to make our motto *"Regional Vision, Local Action"* alive and real. We are excited to keep moving forward. Concretely, our ILC will meet December 7, 2015, our subcommittees have scheduled their next meetings to carry out their mutual charges, and our stakeholders have already begun responding favorably to attend a fourth January 26, 2016 gathering. We are bringing our knowledge of Collective Impact to bear on our process, have secured technical assistance for the Sustainability Subcommittee (Dale Jarvis, consultant), are working with Craig Nolte of the Federal Reserve Bank of San Francisco for meeting organization supports, are in attendance at ACH gatherings to stay abreast of health care transformation developments, and are in frequent communication with the Health Care Authority. Our approach to Regional Health Improvement Planning is in full swing, with multiple data collected, stakeholder inputs, and current health initiative inventories under review. Next we will analyze and synthesize our collected information to develop recommendations for priority areas for collaborative endeavors that impact the Triple Aim.

The Olympic Community of Health is ready and looks forward to the next phase of our development as a designated ACH. Moreover, we envision achieving the purposes that have brought us together as an Accountable Community of Health to ensure the health of the people and our communities, locally and regionally.