Olympic COMMUNITY of HEALTH

345 6th Street, Suite 300
Bremerton, WA 98337

CLALLAM • JEFFERSON • KITSAP

July 29, 2016

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 (OCH), it is our pleasure to submit the enclosed deliverables for contract K1434, amendment 2. We included all pertinent OCH developments since our submission of the April 29, 2016 deliverables. Included with this letter is an update within five areas:

1. Three-County Coordinated Opioid Response Project
    a. Project Action Plan
    b. Preliminary data assessments: 1) hospitalizations and death outcomes and 2) birth and maternal diagnosis outcomes
2. Governance
    a. Executive Committee charter
    b. Governance Subcommittee charter
    c. Board of Directors roster and committee membership
3. Communications and engagement
    a. Website and newsletter update
4. Regional Health Needs Assessment and Improvement Plan
    a. Regional Health Assessment and Planning Committee Charter
    b. Revised Regional Health Priorities
    c. Project template
    d. Project scoring criteria

If you require any additional information, please do not hesitate to contact us. As always, thank you for your flexibility, partnership, and continued investment in the OCH.

Sincerely,

Elya Moore, PhD
Director, Olympic Community of Health
Supported by Kitsap Public Health District

Keith Grellner
Administrator, Kitsap Public Health District
Backbone agency to the Olympic Community of Health

Jennifer Kreidler-Moss, PharmD
Vice President, Olympic Community of Health Board of Directors
Chief Executive Officer, Peninsula Community Health Services

Accountable Communities of Health – Regional Health Improvement Project – Action Plan Template

PURPOSE:

This template is a tool for Accountable Communities of Health (ACHs) while selecting, planning, and implementing the regional health improvement project. Completing the template is required for the one project mandated under the SIM grant.

It is a working document that should be revised and updated as your project develops, so it can be used for communication within your ACH and with the Health Care Authority (HCA), Center for Community Health and Evaluation (CCHE), and technical assistance team (TA).

It is meant to facilitate project development and support alignment with state guidelines, but not undermine local project selection and implementation activities.

GUIDELINES:

The HCA has defined an ACH regional health improvement project as having:

- A set of coordinated, multi-sector activities
- A focus on one (or more) regional health priorities
- A design to produce measureable progress toward a health improvement goal

For additional HCA guidance, please see the ACH Health Improvement Project Requirements and Definitions document (see appendix).

SUBMISSION:

The HCA's deadline for ACH project submission is **no later than July 29, 2016, but** ACHs are expected to submit a **draft** version of the action plan template to HCA as soon as a project is identified before the July 29 deadline. This is because ACHs are encouraged to communicate early and often to help staff from HCA, CCHE, and TA provide feedback and resources in a timely manner to support project work.

Please complete the form below with as much information as you have available, while adhering to the instructions about content and length. Refer to the "ACH Action Plan example" document for additional information about how to fill out the form. Questions about completing and submitting the form below can be sent to the Community Empowerment & Accountability Team at HCA: CommunityTransformation@hca.wa.gov

BASIC INFORMATION

This section must be filled out and submitted to HCA before July 29, 2016 for project review and approval.

ACH:

Olympic Community of Health (OCH)

Backbone staff contact (email, phone):

Elya Moore, Director
Office: (360) 337-5289
Mobile: (360) 633-9241
Email: elya.moore@kitsappulichealth.org

Angie Larrabee, Assistant
Office: (360) 337-5216
Email: angie.larrabee@kitsappublichealth.org

Siri Kushner, Epidemiologist
Office: (360) 337-5233
Email: siri.kushner@kitsappublichealth.org

Partner Organization:

Salish Behavioral Health Organization

Partner Organization staff contact (email, phone):

Anders Edgerton, Administrator
Office: (360) 337-4886
Email: aedgerton@co.kitsap.wa.us

Key contact for project-related issues, if different than above (email, phone):

Elya Moore, OCH Director (see above)

Date work plan was last updated:

July 29, 2016

1 – OVERVIEW

This section must be filled out and submitted to HCA before July 29, 2016 for project review and approval.

Project Title:

Olympic Peninsula Coordinated Opioid Response

County or Counties directly served by project:

Kitsap, Clallam and Jefferson counties

Brief description (*3-4 sentences*):

This project is the first phase of a comprehensive initiative to coordinate and implement a community response to the opioid crisis in Kitsap, Jefferson, and Clallam Counties, including the tribal nations within those boundaries. Project personnel, either staffed or through a subcontract, will work under the direction of the Executive Director of the Olympic Community of Health, in close partnership with the Administrator of the Salish Behavioral Health Organization (SBHO). Staff will convene community advisors from multiple sectors across the three counties and tribal nations to address this significant opioid crisis. The project will have multiple phases, beginning with a six-month planning and assessment phase, which is the focus of this proposal.

Goal statement (*1-2 sentences*):

For the purposes of this proposal, the six-month goals are to:

1. Perform a three-county assessment into the scope of the opioid problem including an inventory of the solutions already underway
2. Identify and engage with key stakeholders including payers (SBHO and Medicaid managed care plans (MCO)), mental health providers, substance use treatment providers, public health officers, local health jurisdictions, primary care providers, hospitals, emergency departments, dental providers, FQHCs, first responders (defined as law enforcement, EMTs, paramedics, fire, and others), consumers, and Courts. Staff will also engage with each of the tribal nations.
3. Form a project steering committee
4. Select 3-5 measures to gauge success
5. Hold a three-county Opioid Summit

The long term goals are to:

1. Prevent opioid misuse and abuse through improving prescribing practices
2. Treat opioid dependence through expanding access to treatment
3. Prevent deaths from opioids through distributing naloxone to people who use heroin
4. Use data to monitor and evaluate the first three goals through optimizing and expanding data sources into a shared three-county evaluation hub

Project scope, please describe what part of your regional community the project will serve (e.g. three counties, patients enrolled with two health plans, four primary care clinics, approximate number of individuals served by a social service agency in one city) (*1-2 sentences*):

This project is the first phase of a comprehensive initiative to coordinate and implement a community response to the opioid crisis in Kitsap, Jefferson, and Clallam Counties, including the tribal nations. For the purposes of this proposal, we describe the project scope for the first six months, from August 2016 through January 2017, which we call *the planning phase*. We will use information and community input from the planning phase to inform the implementation phase.

2 – STRATEGIC PLANNING & ALIGNMENT

This section must be filled out and submitted to HCA before July 29, 2016 for project review and approval.

This project is (*check one*): ☒ New ☐ Enhancing an existing project or set of projects

The ACH's "value add" for this project (e.g., What difference does ACH involvement make to the project?) (*2-3 sentences*):

This is a multi-pronged approach to a very intractable and urgent problem which demands a high level of coordination between behavioral health and primary care, other health-related entities as well as law enforcement and local courts. The OCH is uniquely positioned to provide this level of coordination.

Rationale for this project (*up to half a page*), including:

- The regional health need or priority the project addresses, including how the need/priority was identified
- The significance for the region (i.e. how the project contributes to the community in a different way than other, existing programs or resources)
- Any evidence-based interventions, innovative practices, or models that informed the project idea

Regional Health Priority

This project addresses a major public health issue facing our three counties that cuts across all demographic groups: gender, age, ethnicity, and zip code. Within this framework, this project addresses two of the five regional health priorities:

1. Access: A continuum of physical, behavioral, and oral health care services is accessible to people of all ages and care is coordinated across providers.
    a. This priority was identified from a review of local agency assessment and planning documents and input from stakeholder small group discussions where lack of access to providers and health care services as well as a need for better coordination of care across health care, social services, and other service providers were key findings. Across our region we have numerous federally designated health professional shortage areas.
2. Behavioral Health: Individuals with behavioral health conditions receive integrated care in the best setting for recovery.
    a. This priority was most clearly identified in stakeholder small group discussions – not only do our communities need better access to behavioral health care but additionally, we lack settings with integrated care to address the needs of the whole person.

Significance for the region

The data presented below represent a snapshot from two-four years ago. Given the rapid change in opioid use over the past few years, these estimates are likely underestimates. Current syringe exchange data indicate substantial increases in needle exchange. The data presented below represent the most acute presentations of opioid abuse. Data are not currently available to quantify the true public health scale of the problem.

Data from Comprehensive Hospital Abstract Reporting System (CHARS) 2012-2014 on Maternal and Newborn Inpatient Stays with a Substance Use or Use-Related Diagnosis

Birth and Maternal Outcomes

Of multi-county regions in WA State, the Olympic Peninsula (Clallam, Greys Harbor, Jefferson, and Mason Counties) has among the highest rates of maternal stays with opiate-related diagnoses, newborn discharges with drug withdrawal syndrome, maternal stays with amphetamine-related diagnoses, and newborn

discharges with narcotics affecting newborn. The Olympic Community of Health (OCH) region including Clallam, Jefferson and Kitsap Counties has rates statistically higher than the rest of WA State for maternal stays with opiate-related diagnoses and amphetamine-related diagnoses.

Report prepared May 2016

Data from CHARS and Death Certificate Database 2012-2014 on opioid-related hospitalizations and deaths (accidental and intentional)

Clallam County age-adjusted rates are statistically higher for accidental opiate-related hospitalizations and deaths; the crude death rate is statistically the same; Kitsap County age-adjusted rates are statistically lower for opiate-related hospitalizations and deaths while the crude death rate is statistically the same; Jefferson County age-adjusted rates and the crude death rate are statistically the same. Compared to Washington State: age-adjusted accidental opiate-related hospitalization rates were statistically higher in Port Angeles and the West End of Clallam County; and for all sub-county areas, age-adjusted accidental death and crude death rates were statistically the same. While 20% of the OCH region population is in Clallam County, Clallam's share of inpatient hospitalizations and deaths ranged from 30% to 38% of the OCH region events.

Hospitalization and Death Outcomes

Report prepared May 2016

No single sector or county can solve this problem alone. County government has asked the SBHO pursue a coordinated, three-county, multi-sector response. The OCH is well positioned to collaborate with the SBHO to address this complex problem: the OCH board consists of 15 sectors and 4 tribal nations (work is underway to engage all 7 Tribes). We have started a community engagement strategy and each quarter we convene 60-100 community partner around topics relevant to the regional health priorities.

Evidence Base

Attempts to address the opioid crisis have been made by 100 Million Healthier Lives from the Institute for Healthcare Improvement and multiple Washington State Agencies. The Washington State Hospital Association (WSHA) and the Washington State Medical Association (WSMA) have formed a Task Force around this issue. Our regional approach will draw from these efforts to create a road map to guide our own local response, starting with the importance of partner (stakeholder) engagement. The Alcohol and Drug Abuse Institute (ADAI) published a report showing startling increases in opioids in our region. Two of the four long term goals of this project are supported by evidence-based practice: 1) to enhance the availability of Suboxone and 2) Naloxone (ADAI, Info Brief, June 2015; Pierce et. al, *Addiction*, 111, 298-308. 2015).

☒ Check box for TA help identifying resources to inform project strategy/design from the evidence-base/ pool of existing innovative practices.

Sectors and stakeholders engaged, please explain how your project meets the criteria of "a set of coordinated, multi-sector activities" (*2-4 sentences)*:

This crisis cuts across multiple sectors, payers (SBHO and MCOs), mental health, substance use treatment, public health, primary care, hospitals, emergency departments, oral health, FQHCs, first responders, consumers, and criminal justice. It also affects each of the tribal nations. In the *planning phase* we will assess which sectors and Tribes have already started to address this issue and how they have begun to organize themselves around the problem. We do not want to duplicate any existing initiatives. We aim to build from existing momentum and connect efforts into a multi-county, cross-sector approach that also aligns with broader goals to integrate behavioral health and primary care in Washington State.

3 – KEY ACTIVITIES & TIMELINE

Activity	Contributing stakeholders*, their roles & responsibilities	Timeline	TA help?
PLANNING PHASE ACTIVITIES			
Perform a three-county assessment into the scope of the problem and the current solutions already underway	*The OCH will either hire a program coordinator or contract with a coordinator to staff the work of all activities listed in the 'activity' column. The three-county assessment will be overseen by an Epidemiologist employed by Kitsap Public Health District who is also part of the OCH backbone staff team. The OCH Executive Director will oversee all activities in close partnership with the Administrator of the Salish Behavioral Health Organization.* *Partners (stakeholders) will include, at a minimum, representatives from EMS, police, the SBHO, MCOs, substance use treatment, mental health treatment, primary care, hospitals, emergency departments, public health, and possibly other sectors, and also leadership from the tribal nations. Partners (stakeholders) will advise on the selection of measures and phase II of the project.*	Aug to Nov 2016	☒
Identify and engage with key partners (stakeholders)		Aug 2016 onwards	☐
Form a multi-county, cross sector leadership committee to advise the overall project that includes tribal participation		October 2016	☐
Hold a three-county Opioid Summit (NOTE: Timing may change depending on other regional health summits currently being planned)		January 2017	☐
Select 3-5 measures to gauge success		January 2017	☒
Begin work on project implementation plan as consensus builds during the planning phase; develop a visual tool to represent implementation plan.		February 2017	☒
POSSIBLE* **IMPLEMENTATION PHASE ACTIVITIES**			
Formation of task forces around each identified priority	There may be three task forces: 1) Medication-Assisted Treatment Task Force, 2) Naloxone Task Force, 3) Prevention and Education Task Force	March 2017	
Primary care provider qualitative interviews	Identify barriers to Suboxone prescribing; identify what primary care providers need from SU providers to change prescribing practices	March to May 2017	
Substance use provider training	Train SU providers in how to work with primary care providers to treat patients on Suboxone	July to Aug 2017	
First responder* training ** NOTE: "First responder" is defined as the first personnel on the scene, including police, EMTs, paramedics, fire, street outreach, emergency shelters, family caregivers, schools, and possibly others*	Train first responders in how to safely and effectively administer Naloxone	April-June 2017	
Community education	Identify venues to deliver education about harm reduction	Aug to Dec 2017	

****** While we do not yet know the specific priorities, measures, and early tactics that will be identified during the planning phase, we offer several examples of implementation activities.*

4 – MEASURING SUCCESS: PROJECT OUTCOMES & DATA

At this time, we do not know which of the measures will be selected by the community to gauge success during the implementation phase. Some of the indicators listed below may already be available. Researching the available data sources will be part of the three-county assessment during the planning phase. For data pertaining to American Indian/Alaska Natives (AI/AN), the best practice is to obtain approval directly from Tribal leadership, such as a Tribal Council or Health Board, prior to collecting or sharing any data. We will work with Tribes to determine which data should be shared, why, how it will be used, how it will be protected, and other safe guards. Given its sensitive nature, this will be an area of early exploration and will be directed by each Tribe. Also of note, Tribes are carved out of SBHO and operate under a fee-for-service model directly with the HCA.

Outcome (Desired result)	**Outcome indicator** (How success is measured)	**Data source**	**Stakeholder(s) helping w/ data collection or analysis**	**Timeline**	**Need CCHE help?**
POSSIBLE IMPLEMENTATION PHASE OUTCOME MEASURES					
Improved health outcomes*	Decrease in opioid-related emergency department visits	EDIE	Hospitals		☒
Improved health outcomes*	Decrease in opioid-related hospitalizations	Comprehensive Hospital Abstract Reporting System (CHARS)	Kitsap Public Health District		☐
Improved health outcomes*	Decrease in births with an opiate-diagnosis	CHARS	Kitsap Public Health District		☐
Improved health outcomes	Increase in post-partum women engaged in Parent-Child Assistance Program or other related programs	Organizations offering these programs	First Step Family Resource Center and other organizations offering these programs		☐
Improved health outcomes	Decrease in opioid-related deaths (accidental or intentional)	Death Certificate	Kitsap Public Health District		☐
Improved health outcomes	Increase in opioid overdose reversals with use of Naloxone	Organizations using Naloxone	Olympic Community of Health		
Increase in access to services	Increase in number of providers with a Suboxone certification	Primary care providers, medical groups, and FQHCs	Olympic Community of Health		☐
Increase in access to services	Increase in number of outpatient substance use disorder providers trained to support Suboxone treatment	Salish Behavioral Health Organization	Behavioral Health Organization		☐
Increase in access to treatment/ Change in behavior	Increase in number of prescriptions of Suboxone filled	Health Care Authority	Olympic Community of Health		☒
Increase in access to treatment/ Change in behavior	Decrease number of opioid prescriptions filled (split out by new vs. refills)	Health Care Authority	Olympic Community of Health		☒
Increase in access to treatment/ Change in behavior	Increase in substance use disorder treatment completion for opioid addiction	Salish Behavioral Health Organization	Behavioral Health Organization		☐
Increase in access to treatment/ Change in behavior	Increase in number of first responders carrying Naloxone	EMS and law enforcement	Olympic Community of Health		☐
PLANNING PHASE PROCESS AND DELIVERABLE MEASURES					

Process	Number of people attending meetings; number of people attending Summit; list of sector and Tribe representation; meeting minutes; committee discussion papers and products; communications collateral	Olympic Community of Health	Aug to Jan 2017	
Deliverable	Opioid Summit	Olympic Community of Health	Jan 2017	
Deliverable	Opioid Response Implementation Plan, including tools and measures	Olympic Community of Health	Jan 2017	
Deliverable	Opioid Three-County Assessment	Olympic Community of Health	Jan 2017	

** These measures are categorized as "improved health outcomes"; however, they can also be categorized as "reduced cost". This would require data from the plans, the Health Care Authority, or possibly the Washington Health Alliance. For now, we focus on utilization rates, rather than associated costs.*

Connection to the statewide Common Measure Set, please explain how the project measures and overall goal will help improve one or more of the metrics from the Common Measure Set (*up to 3 sentences*):

This project connects with several measures from the Common Measure Set:

- Adult Access to Primary Care Providers *through increasing the number of Suboxone prescribers*
- Substance Use Disorder Treatment Penetration *through increasing the number of outpatient substance use disorder providers trained to support Suboxone treatment*
- Potentially Avoidable ER Use *through appropriate treatment for people with opioid addiction*

☒ Check box for additional help from CCHE on connecting the project to the Common Measure Set.

Advancing the Triple Aim, please describe how successful implementation of the project would contribute to one or more component of the Triple Aim in your community – i.e. (1) improving services (quality of care, patient experience); (2) reducing health-related costs, and (3) improving health and wellbeing in your region (*up to 4 sentences*):

Well-coordinated response to opioid addiction will result in:
Lower costs:

- fewer avoidable hospitalizations
- fewer avoidable EMS transports
- fewer avoidable emergency department visits
- fewer complicated births to mothers with an opiate-use diagnosis

Improve health:

- fewer opioid-related emergency department visits, hospitalizations and deaths
- decrease negative health impacts of chronic opioid use

Improve services:

- enhance the availability of Suboxone and Naloxone
- increase the number of opioid-addicted community members who engage in treatment for their addiction
- enhance coordination between medical and behavioral healthcare providers to maximize treatment efforts and patient success in recovery

5- WRAP-UP QUESTIONS

This section must be filled out and submitted to HCA before July 29, 2016 for project review and approval.

What top two challenges are you currently concerned about the project? (*2-3 sentences*):

This is a BIG problem; a crisis, really. Getting to our long term goals will take trust, which will take time. We are concerned about losing buy-in as we go, and getting distracted by Waiver activity.

What top two strengths in your region make you feel confident about making progress? (*2- 3 sentences*):

There was unanimous support for this project from the Regional Health Assessment and Planning Committee, the Board of Directors, and the broader OCH Partner Group. One thing is clear: the opioid problem unites us. If successful, this project will take our local communities beyond the Triple Aim, positively affecting overall community wellbeing and safety.

Do you have any questions or need clarification from HCA? (*2-3 sentences*):

It would be helpful to know as soon as possible if additional funding were available starting February 1, 2017.

APPENDIX – Health Care Authority guidance on selection and requirements for official SIM project:

Copy guidance language here when ready.

Analysis of Olympic Community of Health Regional, County, and Sub-County Opiate-Related Hospitalization and Death Rates

Data sources: Comprehensive Hospital Abstract Reporting System (CHARS) (accessed in CHAT), 2012-14 combined
Washington State Department of Health, Death Certificate Database (accessed in CHAT), 2012-14 combined
Washington State Department of Health, Death Certificate Database (KPHD analysis), 2012-14 combined

Analysis prepared by: Siri Kushner, Epidemiologist, Kitsap Public Health District. May 18, 2016 (charts divided, 5/26/16)

The data below are non-fatal inpatient hospitalizations and deaths of residents by place - Washington State total, Olympic Community of Health, Clallam, Jefferson, and Kitsap Counties and sub county areas within each county (see page 5 for a list of grouped zip codes for sub-county areas). Inpatient hospitalization rates include the discharge diagnoses (primary and contributing causes - see page 5 for list of ICD-10 codes) for accidental opiate-related poisonings, intentional poisonings are excluded; rates are age-adjusted.^ Two types of death rates are presented, both include primary and contributing opiate-related causes: age-adjusted accidental poisoning deaths and crude poisoning deaths of any intention (accidental or intentional). Age-adjusting for deaths of any intention was not available at this time. Statistical differences were assessed using non-overlapping 95% confidence intervals.

RESULTS:

Compared to Washington State:

Clallam County age-adjusted rates are statistically higher for accidental opiate-related hospitalizations and deaths; the crude death rate is statistically the same; Kitsap County age-adjusted rates are statistically lower for opiate-related hospitalizations and deaths while the crude death rate is statistically the same; Jefferson County age-adjusted rates and the crude death rate are statistically the same (Figures 1,2,3 and Tables 1,2,3).

Patient zip codes were grouped to assess rates for areas within Clallam, Jefferson, and Kitsap Counties. Rates are not calculated for all areas because the number of events was fewer than 5. Compared to Washington State: age-adjusted accidental opiate-related hospitalization rates were statistically higher in Port Angeles and the West End of Clallam County; and for all sub-county areas, age-adjusted accidental death and crude death rates were statistically the same (Figure 4,5,6 and Tables 1,2,3).

While 20% of the OCH region population is in Clallam County, Clallam's share of inpatient hospitalizations and deaths ranged from 30% to 38% of the OCH region events (Figures 7,8,9 and Tables 1,2,3).

^Age-adjusting is a statistical method to remove the effect of differences in rates that are based on different age structures in places being compared. Age-adjusting is especially useful when comparing places with very different age structures for conditions more likely to occur in specific age groups. For example, both Clallam and Jefferson counties have a higher proportion of older residents than WA State; an unadjusted rate (crude rate) for a condition such as Alzheimers disease which is known to be more prevalent among older adults would be much higher in Clallam and Jefferson compared to a WA with a lower proportion of older adults.

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Analysis prepared by: Siri Kushner, Epidemiologist, Kitsap Public Health District. May 18, 2016 (charts divided, 5/26/16)

Figure 1. Accidental Opiate-related Poisoning Hospitalizations, Age Adjusted Rates per 100,000, 2012-14 (non fatal)

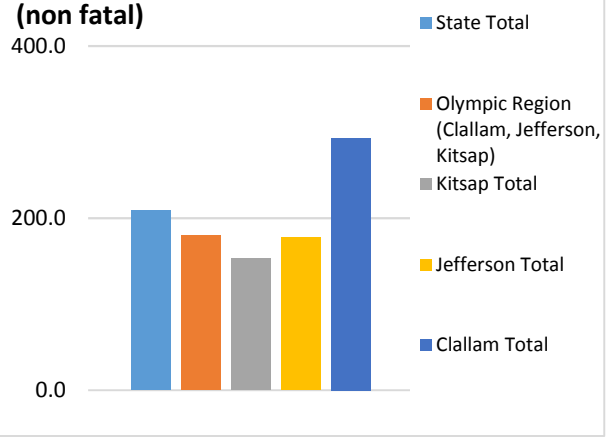


Figure 2. Accidental Opiate-related Poisoning Deaths, Age Adjusted Rates per 100,000, 2012-14

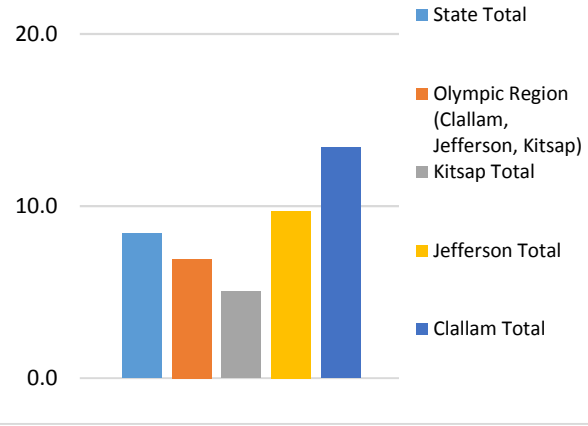


Figure 3. Crude Accidental and Intentional Opiate-related Death Rates per 100,000, 2012-14

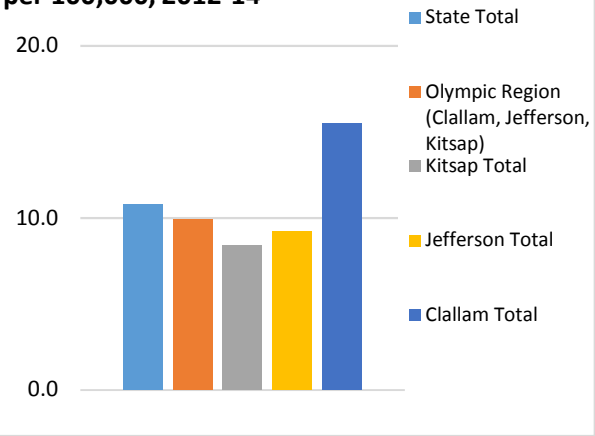


Figure 4. Accidental Opiate-related Poisoning Hospitalizations, Age Adjusted Rates per 100,000, 2012-14[1]

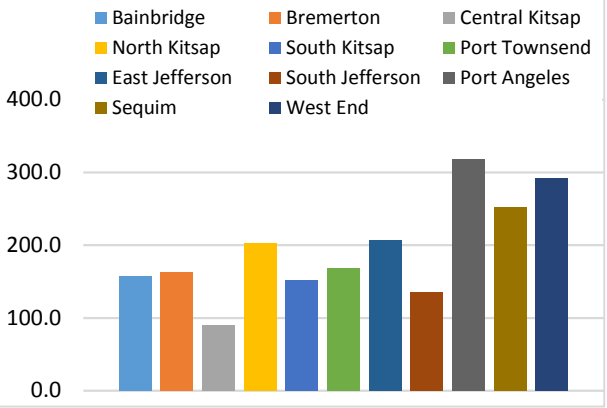


Figure 5. Accidental Opiate-related Poisoning Deaths, Age Adjusted Rates per 100,000, 2012-14[1]

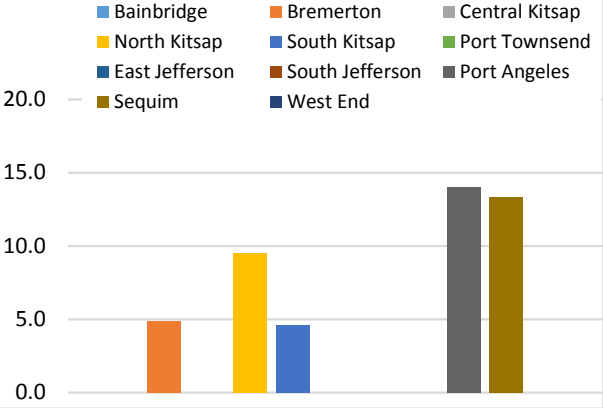
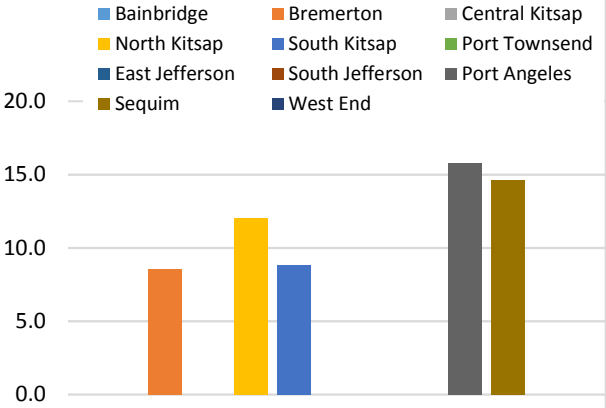


Figure 6. Crude Accidental and Intentional Opiate-related Death Rates per 100,000, 2012-14[1]



[1] Only areas with 5+ events in at least one category are in the chart; no bar indicates that the rate could not be calculated because the area had <5 events.

Analysis of Olympic Community of Health Regional, County, and Sub-County Opiate-Related Hospitalization and Death Rates

Data sources: Comprehensive Hospital Abstract Reporting System (CHARS) (accessed in CHAT), 2012-14 combined
Washington State Department of Health, Death Certificate Database (accessed in CHAT), 2012-14 combined
Washington State Department of Health, Death Certificate Database (KPHD analysis), 2012-14 combined

Analysis prepared by: Siri Kushner, Epidemiologist, Kitsap Public Health District. May 18, 2016 (charts divided, 5/26/16)

Figure 7. Accidental Opiate-related Poisoning Hospitalizations (non fatal), share by OCH county, 2012-14

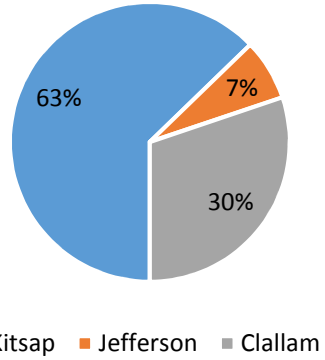


Figure 8. Accidental Opiate-related Poisoning Deaths, share by OCH county, 2012-14

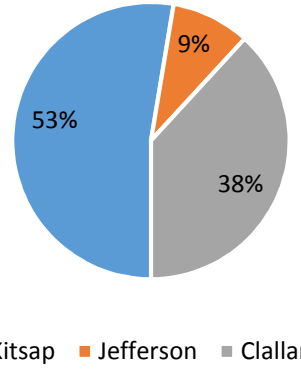
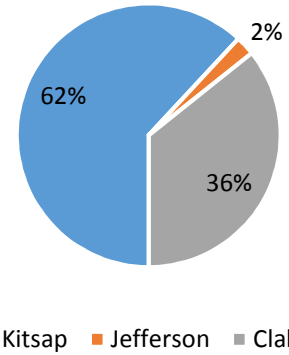


Figure 9. Accidental and Intentional Opiate-related Deaths, share by OCH county, 2012-14



Compare to acutal population share by county (2012-14 annual average)

County	*Population*	*% of total population*
Kitsap	*254800*	*71%*
Jefferson	*30383*	*8%*
Clallam	*72283*	*20%*

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Washington State Department of Health, Death Certificate Database (KPHD analysis), 2012-14 combined

Analysis prepared by: Siri Kushner, Epidemiologist, Kitsap Public Health District. May 18, 2016 (charts divided, 5/26/16)

ALL DATA FROM 2012-14:		Table 1. Accidental[3] Opiate-related Poisoning Hospitalizations (non-fatal)			Table 2. Accidental+G63[3] Opiate-related Poisoning Deaths			Table 3. Accidental and Intentional Opiate-related Deaths		
		# discharges	Age Adjusted rate per 100,000 discharges	% of total	# deaths	Age Adjusted rate per 100,000 deaths	% of total	# deaths	Crude rate per 100,000 deaths	% of total
State Total		44198	**208.3**		1785	**8.4**		2234	**10.8**	
Olympic Region (Clallam, Jefferson, Kitsap)		1853	**179.6**	**4%**	76	**6.9**	**4%**	106	**9.9**	**5%**
Kitsap Total		1163	**152.8**	**63%**	40	**5.0**	**53%**	64	**8.4**	**60%**
Kitsap Areas[2,4]	Bainbridge	78	**157.6**	**7%**	1	*	**3%**	3	*	**5%**
	Bremerton	439	**162.8**	**38%**	13	**4.9**	**33%**	22	**8.5**	**34%**
	Central Kitsap	85	**90.1**	**7%**	3	*	**8%**	4	*	**6%**
	North Kitsap	246	**201.9**	**21%**	13	**9.5**	**33%**	17	**12.0**	**27%**
	South Kitsap	300	**151.1**	**26%**	10	**4.6**	**25%**	18	**8.8**	**28%**
Jefferson Total		131	**177.2**	**7%**	7	**9.7**	**9%**	8	**9.2**	**8%**
Jefferson Areas[2,4]	Port Townsend	69	**168.1**	**53%**	3	*	**43%**	4	*	**50%**
	East	50	**206.9**	**38%**	4	*	**57%**	4	*	**50%**
	South	12	**135.1**	**9%**	0	*	**0%**	0	*	**0%**
Clallam Total		559	**292.8**	**30%**	29	**13.4**	**38%**	34	**15.5**	**32%**
Clallam Areas[2,4]	Port Angeles	316	**318.3**	**57%**	15	**14.0**	**52%**	17	**15.8**	**50%**
	Sequim	150	**251.0**	**27%**	10	**13.3**	**34%**	12	**14.6**	**35%**
	West End	93	**291.8**	**17%**	3	*	**10%**	4	*	**12%**

[2] Areas are grouped by patient zip code of residence.

[3] Includes deaths of the underlying cause X42 or X44.

[4] Post Office box zip codes do not have population associated with them however events occurring to residents with PO box address zip codes are included in the analysis.

* When the number of events is fewer than 5, a rate is not calculated.

Analysis of Olympic Community of Health Regional, County, and Sub-County Opiate-Related Hospitalization and Death Rates

Data sources: Comprehensive Hospital Abstract Reporting System (CHARS) (accessed in CHAT), 2012-14 combined
Washington State Department of Health, Death Certificate Database (accessed in CHAT), 2012-14 combined
Washington State Department of Health, Death Certificate Database (KPHD analysis), 2012-14 combined

Analysis prepared by: Siri Kushner, Epidemiologist, Kitsap Public Health District. May 18, 2016 (charts divided, 5/26/16)

ICD-10 Codes for opiate-related hospitalizations and deaths:

F11, Mental and behavioral disorders due to use of opioids
- F11.0, Acute intoxication
- F11.1, Harmful use
- F11.2, Dependence syndrome
- F11.3, Withdrawal state
- F.11.4, Withdrawal state with delirium
- F11.5, Psychotic disorder
- F11.7, Residual and late-onset psychotic disorder
- F11.8, Other mental and behavioural disorders
- F11.9, Unspecified mental and behavioural disorders

R78.1 Finding of opiate drug in blood
T40.0 Poisoning by opium
T40.1 Poisoning by heroin
T40.2 Poisoning by other opioids
T40.3 Poisoning by methadone
T40.4 Poisoning by other synthetic narcotics
T40.6 Poisoning by other and unspecified narcotics

Zip codes for sub-county areas:

Kitsap	Bainbridge:	98061, 98110
	Bremerton:	98310, 98311, 98312, 98314, 98337
	Central Kitsap:	98315, 98380, 98383, 98393
	North Kitsap:	98340, 98342, 98345, 98346, 98364, 98370, 98392
	South Kitsap:	98322, 98353, 98359, 98366, 98367, 98384, 98386
Jefferson	Port Townsend:	98368
	East:	98358, 98339, 98325, 98365
	South:	98376, 98320
Clallam	Port Angeles:	98343, 98362, 98363
	Sequim:	98324, 98382
	West End:	98305, 98326, 98331, 98350, 98357, 98381

Analysis of Selected Olympic Community of Health Regional and County and Sub-County Rates from:

Maternal and Newborn Inpatient Stays with a Substance Use or Use-Related Diagnosis
Research Brief No. 075, February 2016
Washington State Office of Financial Management
http://ofm.wa.gov/researchbriefs/2016/brief075.pdf
Data source: Comprehensive Hospital Abstract Reporting System (CHARS), 2012-14 combined

Analysis prepared by: Siri Kushner, Epidemiologist, Kitsap Public Health District. May 16, 2016

The data presented below are for maternal stays with opiate or amphetamine diagnoses and newborn discharges with withdrawl syndrome or narcotics affecting the newborn; the OFM report includes other substances not available for this analysis (see OFM report for specific diagnosis codes). Statistical differences were assessed using non-overlapping 95% confidence intervals. Data are for residents by place - Washington State (excluding Olympic Community of Health region), Olympic Community of Health, Clallam, Jefferson, and Kitsap Counties and sub county areas within each county (see page 5 for a list of grouped zip codes for sub-county areas).

Of multi-county regions in WA State, the Olympic Peninsula (Clallam, Greys Harbor, Jefferson, and Mason Counties) has among the highest rates of maternal stays with opiate-related diagnoses, newborn discharges with drug withdrawl syndrome, maternal stays with amphetamine-related diagnoses, and newborn discharges with narcotics affecting newborn.

The Olympic Community of Health (OCH) region including Clallam, Jefferson and Kitsap Counties has rates statistically higher than the rest of WA State for maternal stays with opiate-related diagnoses and amphetamine-related diagnoses but rates statistically the same as the rest of WA State for newborn discharges with drug withdrawl syndrome and narcotics affecting the newborn (Figure 1, Tables 1 and 2).

Clallam County rates are statistically higher than WA State (excluding OCH), Jefferson, and Kitsap Counties for maternal stays with opiate-related diagnoses and amphetamine-related diagnoses and newborn discharges with drug withdrawl syndrome but statistically the same for newborn discharges with drug narcotics affecting the newborn (Figure 1, Tables 1 and 2).

Patient zip codes were grouped to assess rates for areas within Clallam, Jefferson and Kitsap Counties. Rates are not calculated for all areas because the number of events was fewer than 5. Rates were higher compared to WA State (excluding OCH) for: maternal stays with opiate-related diagnoses in North Kitsap, Port Townsend, Port Angeles, Sequim and the West End; maternal stays with amphetamine-related diagnoses in Port Townsend, Port Angeles, Sequim, and the West End; and newborn discharges with drug withdrawl in Port Angeles and Sequim (Figure 2, Tables 1 and 2).

While 20% of the OCH region population is in Clallam County, Clallam's share of maternal and newborn hospitalizations with drug-related diagnoses ranges from 36% to 57% fo the OCH region events (Figures 3-6, Tables 1 and 2).

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Maternal and Newborn Inpatient Stays with a Substance Use or Use-Related Diagnosis
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http://ofm.wa.gov/researchbriefs/2016/brief075.pdf
Data source: Comprehensive Hospital Abstract Reporting System (CHARS), 2012-14 combined

Analysis prepared by: Siri Kushner, Epidemiologist, Kitsap Public Health District. May 16, 2016

Figure 1. State, Olympic Region, and County Rates per 1,000, 2012-14

(only areas with 5 or more events in at least one category are represented in the chart; no bar indicates that the rate could not be calculated because the area had <5 events)

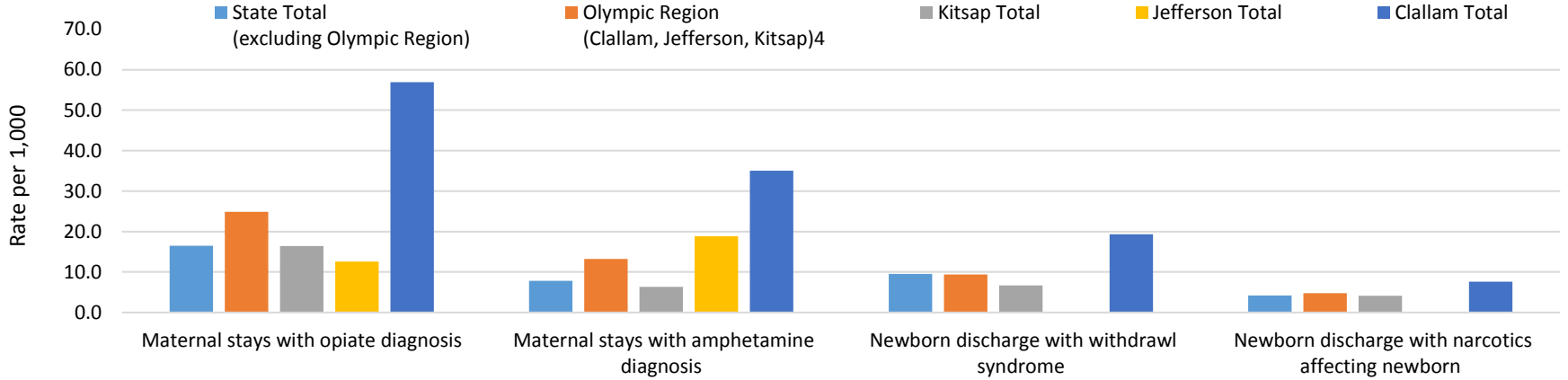
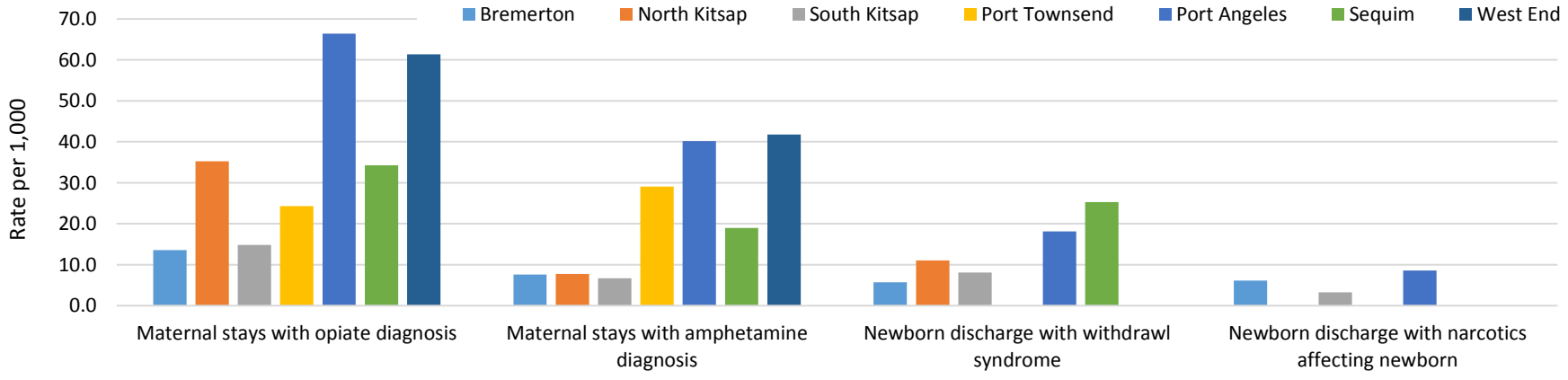


Figure 2. Sub-County Area Rates per 1,000, 2012-14

(only areas with 5 or more events in at least one category are represented in the chart; no bar indicates that the rate could not be calculated because the area had <5 events)



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Data source: Comprehensive Hospital Abstract Reporting System (CHARS), 2012-14 combined

Analysis prepared by: Siri Kushner, Epidemiologist, Kitsap Public Health District. May 16, 2016

Figure 3. Maternal stays with opiate diagnosis, share by OCH county, 2012-14

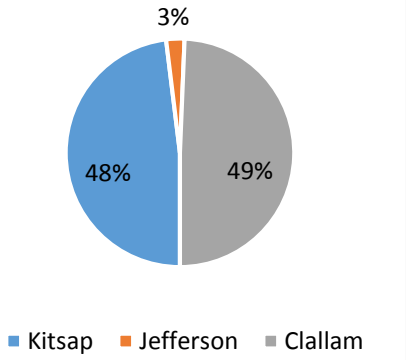


Figure 4. Maternal stays with amphetamine diagnosis, share by OCH county, 2012-14

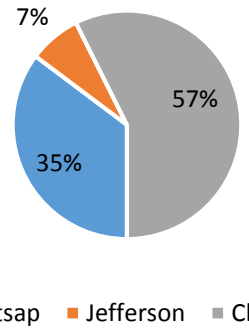


Figure 5. Newborn discharge with withdrawl syndrome, share by OCH county, 2012-14

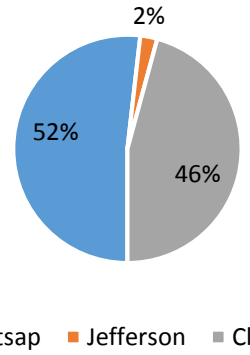
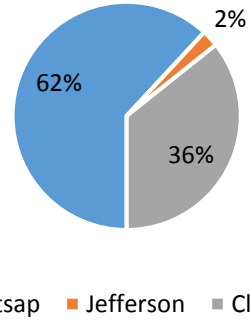


Figure 6. Newborn discharge with narcotics affecting newborn, share by OCH county, 2012-14



Compare to acutal population share by county (2012-14 annual average)

Kitsap	254800	71%
Jefferson	30383	8%
Clallam	72283	20%

Analysis of Selected Olympic Community of Health Regional and County and Sub-County Rates from:

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Data source: Comprehensive Hospital Abstract Reporting System (CHARS), 2012-14 combined

Analysis prepared by: Siri Kushner, Epidemiologist, Kitsap Public Health District. May 16, 2016

ALL DATA FROM 2012-14:		Table 1. Maternal Stays[1] by Substance Type Diagnosis						Table 2. Maternal Substance Use Affecting the Newborn					
		OPIATE			AMPHETAMINE			WITHDRAWL SYNDROME[2]			NARCOTICS[3]		
		# stays	rate per 1,000 maternal discharges	% of total	# stays	rate per 1,000 maternal discharges	% of total	# discharges	rate per 1,000 neonatal discharges	% of total	# discharges	rate per 1,000 neonatal discharges	% of total
State Total (excluding Olympic Region)		2991	**16.5**		1418	**7.8**		1626	**9.5**		725	**4.2**	
Olympic Region (Clallam, Jefferson, Kitsap)[4]		231	**24.9**	**8%**	122	**13.2**	**9%**	83	**9.4**	**5%**	42	**4.8**	**6%**
Kitsap Total		111	**16.4**	**48%**	43	**6.3**	**35%**	43	**6.7**	**52%**	26	**4.1**	**62%**
Kitsap Areas[5]	Bainbridge	2	*	**2%**	0	*	**0%**	1	*	**2%**	1	*	**4%**
	Bremerton	36	**13.6**	**32%**	20	**7.6**	**47%**	14	**5.7**	**33%**	15	**6.1**	**58%**
	Central Kitsap	3	*	**3%**	1	*	**2%**	1	*	**2%**	0	*	**0%**
	North Kitsap	41	**35.2**	**37%**	9	**7.7**	**21%**	12	**11.1**	**28%**	4	*	**15%**
	South Kitsap	29	**14.9**	**26%**	13	**6.7**	**30%**	15	**8.1**	**35%**	6	**3.2**	**23%**
Jefferson Total		6	**12.6**	**3%**	9	**18.8**	**7%**	2	*	**2%**	1	*	**2%**
Jefferson Areas[5]	Port Townsend	5	**24.3**	**83%**	6	**29.1**	**67%**	0	*	**0%**	1	*	**100%**
	East	1	*	**17%**	1	*	**11%**	2	*	**100%**	0	*	**0%**
	South	0	*	**0%**	0	*	**0%**	0	*	**0%**	0	*	**0%**
Clallam Total		114	**56.9**	**49%**	70	**35.0**	**57%**	38	**19.3**	**46%**	15	**7.6**	**36%**
Clallam Areas[5]	Port Angeles	71	**66.4**	**62%**	43	**40.2**	**61%**	19	**18.1**	**50%**	9	**8.6**	**60%**
	Sequim	18	**34.3**	**16%**	10	**19.0**	**14%**	13	**25.3**	**34%**	1	*	**7%**
	West End	25	**61.4**	**22%**	17	**41.8**	**24%**	2	*	**5%**	3	*	**20%**

[1] Some inpatient hospitalization maternal stays were not associated with child birth.

[2] Withdrawl syndrome might be due to maternal current drug use or maternal treatment with methadone or buprenorphine.

[3] Although not a narcotic, this includes methamphatemines (ICD-9 760.72).

[4] The OFM report presents rates for the "Olympic Peninsula" which includes Clallam, Greys Harbor, Jefferson, and Mason Counties.

[5] Areas are grouped by patient zip code of residence.

* When the number of events is fewer than 5, a rate is not calculated.

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	West End:	98305, 98326, 98331, 98350, 98357, 98381

Olympic Community of Health

Charter

Approved by the Governance Subcommittee May 19, 2016
Approved by the OCH Board of Directors June 1, 2016
Officers elected July 6, 2016 by the OCH Board of Directors

Executive Committee Charter

Members

	Name	Role	Agency or Affiliation
1	Roy Walker	President	Executive Director, Olympic Area on Aging
2	Jennifer Kreidler-Moss, PharmD	Vice President	CEO, Peninsula Community Health Services
3	Leonard Forsman	Secretary	Tribal Chair, Suquamish Tribe
4	Hilary Whittington	Treasurer	CFO, Jefferson Healthcare
5	Joe Roszak	At-Large	Executive Director, Kitsap Mental Health Services

Executive Committee Purpose

The purpose of the Executive Committee is to discharge the responsibilities of the OCH Board of Directors (Board) relating to the transaction of routine, administrative matters that occur between regularly scheduled meetings of the Board and to tee up policy issues for full Board discussion and decision-making. The Executive Committee will advise the Director regarding emerging issues, problems, and initiatives.

Executive Committee Operating Principles

- Committee membership will comprise of five officer positions: President, Vice-President, Secretary, Treasurer, and At-Large (to be replaced by Past-President after the first term).
- A majority of the Executive Committee shall be necessary and sufficient at all meetings to constitute a quorum for the transaction of business.
- Executive Committee members will be held to term limits outlined in the bylaws.
- The Executive Committee shall be accountable to the OCH Board and shall present all recommendations and actions for review at their next meeting.

Responsibilities

- Work with the President and Director on ongoing issues regarding the business of the organization and to hear and decide on pressing matters of business which may arise between regularly scheduled OCH Board meetings which require a decision before the next meeting.
- Support decision-making by the OCH Board by reviewing material ahead of time to ensure that options are clearly identified and sufficient background information is provided.
- The Executive Committee shall have authority to conduct business on behalf of the OCH between regular Board meetings should authority be expressly given to them by the Board.
- Specific Executive Committee duties include:
  - Preparing for OCH Board meetings
  - Recommending the annual budget to the OCH Board for approval
  - Evaluating the performance and compensation of the director
  - Facilitating development of and implementation of OCH initiatives as needed
  - Monitoring status of internal operations including financial systems, personnel issues, and information systems
  - Appointing authorized subcommittees as needed
  - Assuring that business is conducted in a manner that is consistent with OCH's mission, goals and values

Timeline

The Executive Committee shall meet as needed.

Ad Hoc Governance Subcommittee Charter

Subcommittee Members

	Name	Affiliation
1	Adam Marquis	Jefferson Mental Health Services
2	Kat Latet	Representing MCOs
3	Doug Washburn	Kitsap Human Services
4	Eric Lewis (Chair)	Olympic Medical Center
5	Joe Roszak	Kitsap Mental Health Services
6	Peter Casey	Peninsula Behavioral Health
7	Andrew Shogren	Quileute Nation
8	Leslie Wosnig	Suquamish Nation
9	*Other members TBC*	

Governance Subcommittee Purpose
To advise on a cross-sector, multi-county governance structure that identifies a clear decision making process.

OCH Governance Guiding Principles
The governance should be multi-sector, balanced, transparent, and demonstrate effective decision-making. Governance should be supported by bylaws, articles of incorporation and policies. In turn, the governance structure must support:

- Financial capacity to provide strong financial management and transparency, including budget development, the distribution of funds and financial reporting.
- Governance over data and information technology, oversight over transformations projects, and monitoring of performance.
- Binding regional partnerships.

Responsibilities
The governance subcommittee is an *ad hoc* committee of the Board of Directors (Board). On a case-by-case basis, the Board or the Executive Committee may call on the Governance Subcommittee to develop governance recommendations. Membership of the Governance Subcommittee may adapt to meet the specific charge. No single sector shall dominate the group.

Timeline
The Governance Subcommittee is an *ad hoc* committee that will meet on a case-by-case basis as delegated by the OCH Board or the Executive Committee.

Olympic Community of Health

OCH Board of Directors

Updated July 21, 2016

#	Name and Affiliation of VOTING member	Role, Committee	Service Area	Sector (primary sector(s) listed)
1	**Doug Washburn** Director Kitsap County Human Services	Member, Governance Subcommittee	Clallam Jefferson Kitsap	**Behavioral Health Organization** **Workforce Development** **Housing/Homelessness** **Long Term Care**
2	**Joe Roszak** Executive Director Kitsap Mental Health Services	At-Large, Executive Committee	Kitsap	**Mental Health** (Medicaid Provider)
3	**Gill Orr** Administrator and Provider Cedar Grove Counseling	Member	Clallam	**Chemical Dependency** (Medicaid Provider)
4	**David Schultz** Market President CHI Franciscan Harrison Medical Center	Member	Kitsap	**Private/Not for Profit Hospital**
5	**Eric Lewis** Chief Executive Officer Olympic Medical Center	Chair, Governance Subcommittee	Clallam	**Public Hospital**
6	**Hilary Whittington** Chief Financial Officer Jefferson Healthcare	Treasurer, Executive Committee	Jefferson	**Rural Health**
7	**Jennifer Kreidler-Moss, PharmD** Chief Executive Officer Peninsula Community Health Services	Vice President, Executive Committee	Kitsap	**Federally Qualified Health Clinic** **Primary Care** **Oral Health** **Mental Health**
8	**Justin Sivill** Director, Operations Harrison Health Partners	Member	Clallam Jefferson Kitsap	**Primary Care**
9	**Kat Latet** [1] New Programs Integration Manager Community Health Plan of Washington	Member, Regional Health Assessment and Planning Committee	Statewide	**Medicaid Managed Care**
10	**Thomas Locke, MD** County Health Officer, Jefferson CEO, Jamestown Family Health Clinic Board President, Washington Dental Service Foundation	Member	Statewide	**Oral Health** **Public Health** **Philanthropy**
11	**Katie Eilers** Assistant Director, Community Health Kitsap Public Health District	Chair, Regional Health Assessment and Planning Committee	Clallam Jefferson Kitsap	**Chronic Disease Prevention Across the Lifespan**
12	**Chris Frank, MD** Health Officer Clallam County Public Health	Member	Clallam	**Public Health**
13	**Roy Walker** Executive Director Olympic Area on Aging	President, Executive Committee	Clallam Jefferson	**Long Term Care/Area Agency on Aging/ Home Health**
14	**Larry Eyer** Executive Director Kitsap Community Resources	Member	Kitsap	**Community Action Program/ Social Service Agency** **Housing/Homeless**
15	**Kurt Wiest** Executive Director Bremerton Housing Authority	Member, Regional Health Assessment and Planning Committee	Kitsap	**Housing/Homelessness**
16	**Maria Lopez** [2] Tribal Chairwoman	Awaiting confirmation		**Hoh Tribe**

17	**Andrew Shogren** [2] Health Director **Naomi Jacobson** [2] Tribal Council Member	Member, Governance Subcommittee		**Quileute Tribe**
18	**Elizabeth Buckingham** [2] Health Director **Tracey Rascon** [2] Administrative Officer Sophie Trettevick Indian Health Center	Awaiting confirmation		**Makah Tribe**
19	**Dylan Dressler** [2] Health Services Director	Awaiting confirmation		**Lower Elwha Klallam Tribe**
20	**Brent Simcosky** [2] Health Clinic Director	Member		**Jamestown S'Klallam Tribe**
21	**Kelly Sullivan** [2] Executive Director, Tribal Services **Kerstin Powell** [2] Health Center Business Office Manager **Jolene George** [2] Director Behavioral Health Division	Member		**Port Gamble S'Klallam Tribe**
22	**Leonard Forsman** [2] Tribal Chair Suquamish Tribe **Leslie Wosnig** [2] Administrator of Health and Policy Suquamish Tribe	Secretary, Executive Subcommittee Member, Governance Subcommittee		**Suquamish Tribe**

1. *Kat Latet from the Community Health Plan of Washington is the selected representative from among her peers to have a voting seat on the OCH Board of Directors for a one year term starting June 1, 2016.*
2. *Tribes are governments, not sectors, therefore each Tribe is allotted one vote may appoint alternates as desired.*

Olympic Community of Health

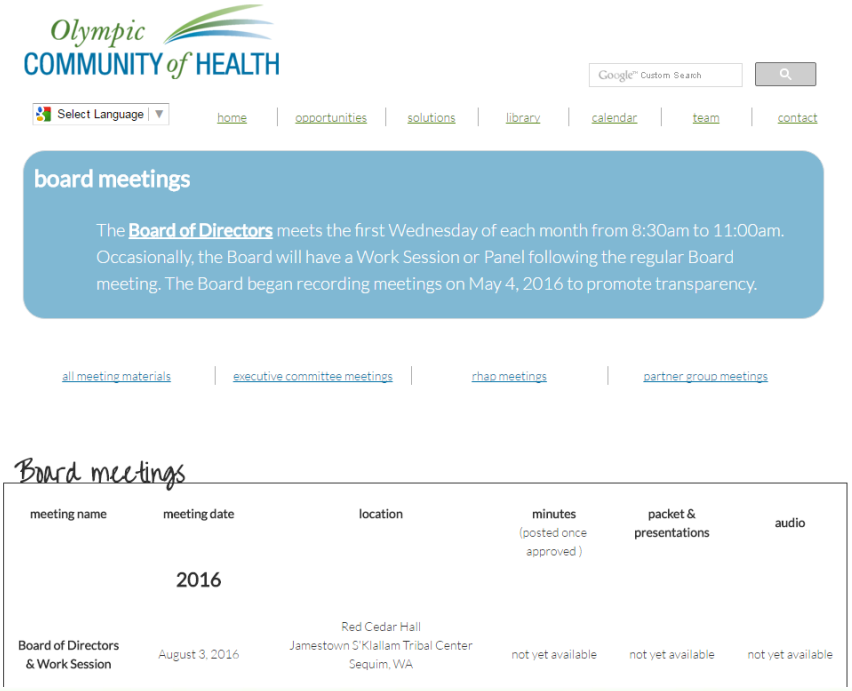
Website and Newsletter Update

July 21, 2016

Over the previous three months, the OCH has made great strides in creating a personalized website that can be managed in-house by OCH staff. The purpose of this document is to share the various functionalities and resources planned for the website.

A brand new Olympic Community of Health website will be launched by the end of 2016, most likely sooner. You can track our progress at: www.olympicch.org.

The website translates into many different languages, and offers an easy-to-use search tool within Google for search engine optimization.



The OCH subscribes to the philosophy of full transparency.

The website offers a complete list of all OCH meetings, including materials, presentations, and audio files, when available.

We will post materials on the website before meetings, and quickly post meeting summaries.

The **Board of Directors** consists of leaders from tribal nations and health sectors. Together they strive to steward a participatory process to identify the greatest areas of need and sustainably align resources and services to achieve the highest attainable level of health and wellbeing for all members of our communities.

Our Board meets once a month. Click here for Meeting Dates and Materials.

Board members

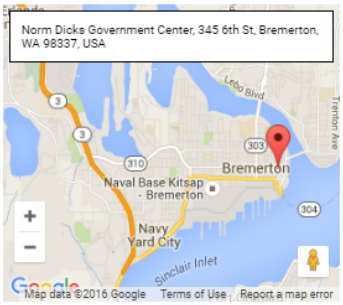
#	Name and Affiliation of VOTING member	County	Service Area	Sector (primary sector(s) listed)
1	**Doug Washburn** Director Kitsap County Human Services	Kitsap	Clallam Jefferson Kitsap	Behavioral Health Organization Workforce Development Housing/Homelessness Long Term Care
2	**Joe Roszak** Executive Director Kitsap Mental Health Services	Kitsap	Kitsap	Mental Health (Medicaid Provider)
3	**Gill Orr** Administrator and Provider Cedar Grove Counseling	Clallam	Clallam	Chemical Dependency (Medicaid Provider)
4	**David Schultz** Market President CHI Franciscan Harrison Medical Center	Kitsap	Kitsap	Private / Not for Profit Hospital
5	**Eric Lewis** Chief Medical Officer Olympic Medical Center	Clallam	Clallam	Public Hospital
6	**Hilary Whittington** Chief Financial Officer Jefferson Healthcare	Jefferson	Jefferson	Rural Health
7	**Jennifer Kreidler-Moss, PharmD** Chief Executive Officer Peninsula Community Health Services	Kitsap	Kitsap	Federally Qualified Health Clinic Primary Care Oral Health Mental Health
8	**Justin Sivill** Director, Operations Harrison Health Partners	Kitsap	Clallam Jefferson Kitsap	Primary Care
	Kat Latet			

All OCH Board of Directors will be listed on the website, with a link to their organization and direct email address.

All other committees will be similarly presented.

The purpose of this is to allow members of the community to identify who is representing their sector or community, and communicate directly with that member.

HOW TO FIND US



Olympic Community of Health

345 6th Street, Suite 300
Bremerton, WA 98377

1.360.337.5216

GET IN TOUCH

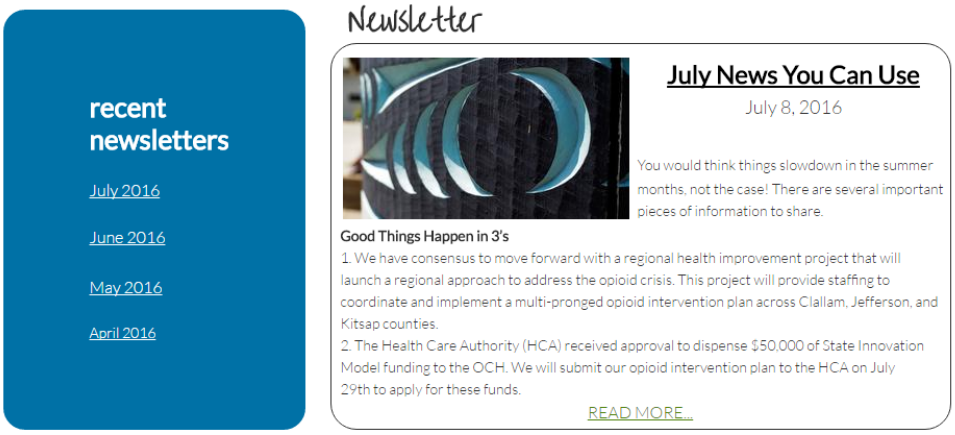
Name: *
Enter text here

Email: *
Enter email address
Check here to receive email updates

Subject: *
Enter text here

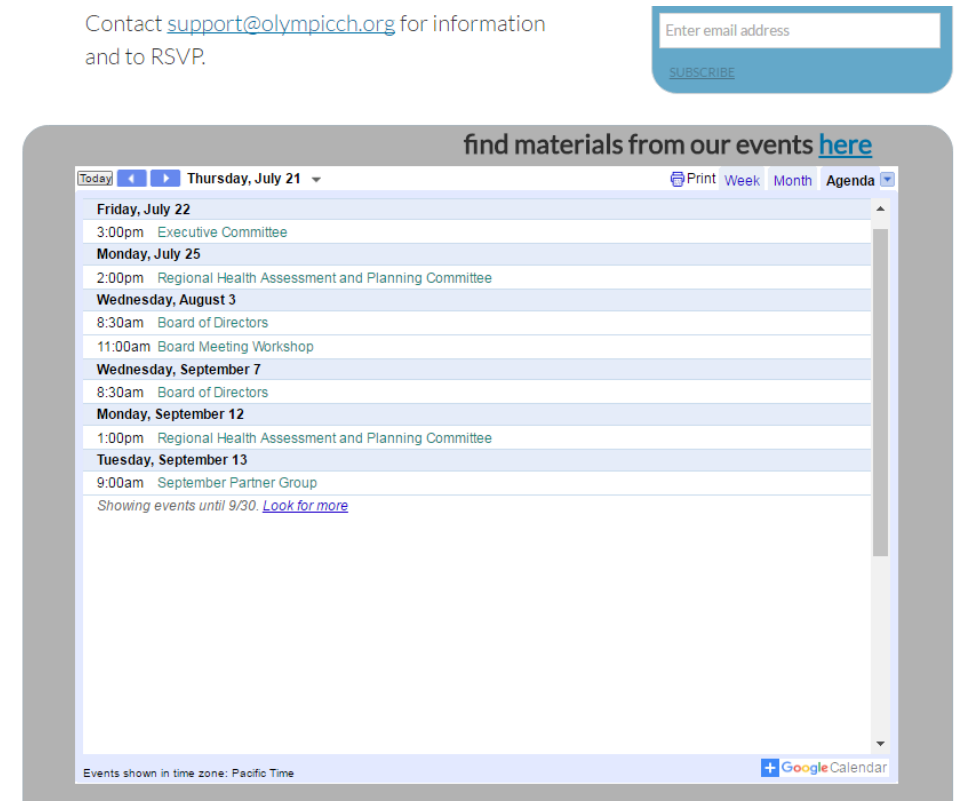
Message: *
Enter your comment here

The website will allow people to contact the OCH directly.



The website will host a blog which will serve as our electronic newsletter. All previous newsletters will be archived on the site.

Individuals can easily sign up to receive the electronic newsletter on the website. The newsletter technology will allow staff to track how many people read our messages or click on our links. This will help optimize our communications strategy.



The website will host an interactive calendar that allows individuals to view when and where various meetings are held.

It will also allow people to RSVP for meetings and upload meetings directly into their google or outlook calendars.

The calendar links with the library of meeting files, so people can easily toggle through the various resources in the website.

Olympic Community of Health

Charter

Approved by the Regional Health Assessment and Planning Committee May 19, 2016
Presented to the OCH Leadership Council June 1, 2016
Revised July 11, 2016

Regional Health Assessment and Planning Committee
Charter

Committee Members *WORK IN PROGRESS*

	Name	Representing	County representation
1	Stacey Smith	Kitsap Area Agency on Aging	Kitsap
2	Kirsten Jewell	Kitsap County Human Services/Housing	Kitsap
3	Kurt Wiest	Bremerton Housing Authority	Kitsap (also representing Clallam and Jefferson)
4	Gay Neal	Kitsap County Human Services/ 0.01% for MHCDTC	Kitsap
5	Jennifer Johnson-Joefield	Peninsula Community Health Services	Kitsap
6	TBC	Primary Care (rural provider)	Clallam and/or Jefferson TBC
7	Vicki Kirkpatrick	Jefferson County Public Health	Jefferson
8	Monica Bernhard	Kitsap Community Resources	Kitsap
9	Bobby Beaman	Olympic Medical Center	Clallam
10	John Nowak	Jefferson Healthcare	Jefferson
11	TBC	CHI Harrison Medical Center	Kitsap
12	Rochelle Doan	Kitsap Mental Health Services	Kitsap
13	TBC	Chemical Dependency	TBC
14	Katie Eilers (chair)	Kitsap Public Health District	Kitsap
15	Alyson Rotter	Olympic Educational Services District	Clallam, Jefferson, Kitsap
16	Molly Staudenraus, RN	Olympic Educational Services District	Clallam, Jefferson, Kitsap
17	TBC	Clallam County Health and Human Services	Clallam
18	Doug Baier	Bremerton EMS	Kitsap
19	TBC	EMS	Clallam and/or Jefferson, TBC
20	Bob Potter	Workforce Council	Clallam, Jefferson, Kitsap
21	TBC	Law enforcement	TBC
22	TBC	Corrections	TBC
23	Allen Fisher, Jorge Rivera, Caitlin Safford, Andrea Tull, Kat Latet	Medicaid Managed Care Organizations (MCOs)	NA
24	Siri Kushner	Kitsap Public Health District	Clallam, Jefferson, Kitsap (contract epidemiologist)
25	Dale Wilson	OlyCAP	Clallam, Jefferson
26	TBC	Salish Behavioral Health Organization	Clallam, Jefferson, Kitsap
27	Lisa Rey Thomas, PhD	University of Washington	NA
28	TBC	Suquamish Tribe	NA
29	TBC	Hoh Tribe	NA
30	TBC	Quileute Tribe	NA
31	TBC	Makah Tribe	NA
32	TBC	Lower Elwah Klallam Tribe	NA
33	TBC	Jamestown S'Klallam Tribe	NA
34	TBC	Port Gamble S'Klallam Tribe	NA

Overview
Assessment and planning are core functions of the Olympic Community of Health (OCH): they keep us grounded and focused on addressing the health needs of our communities. The Regional Health Assessment and Planning (RHAP) Committee will be accountable to the OCH Leadership Council to ensure this vital component of the OCH work is high quality and reflective of the communities we all serve.

Objective
The RHAP Committee guides the OCH to meet our contractual obligations of continually developing a Regional Health Needs Assessment (RHNA) and Regional Health Improvement Plan (RHIP).

Responsibilities
- Update the RHNA as new information comes available.
- Develop and update a RHIP.
- Submit the RHNA and RHIP to the Leadership Council for adoption at regular intervals.
- Share developments on the RHNA and RHIP with the OCH Stakeholder Group for feedback.
- Submit project ideas to the Council for discussion and approval.
- Perform RHNA and RHIP-related activities on a case-by-case basis as charged by the Council.

Timeline
The RHNA and RHIP are living documents that will be continually updated as new information comes available. The RHAP Committee will meet as needed to be accountable for the quality and accuracy of these documents. Note that the timeline may vary based on the OCH contract with the State.

OLYMPIC COMMUNITY OF HEALTH

SHARED REGIONAL HEALTH PRIORITIES

ACCESS	AGING	BEHAVIORAL HEALTH	CHRONIC DISEASE	EARLY CHILDHOOD
A continuum of physical, behavioral, and oral health care services are accessible to people of all ages and care is coordinated across providers.	**Aging adults and their caregivers are safe and supported.**	**Individuals with behavioral health conditions receive integrated care in the best setting for recovery.**	**The burden of chronic diseases is dramatically reduced through prevention and disease management.**	**Children get the best start to lifelong health and their families are supported.**

Progress on these priorities depends on improving health equity through SOCIAL DETERMINANTS – housing, education, workforce development, employment, transportation, safety, environmental conditions.

	Alignment of OCH Priority Areas with WA State Medicaid Transformation Waiver Project Categories*	ACCESS	AGING	BEHAVIORAL HEALTH	CHRONIC DISEASE	EARLY CHILDHOOD	SOCIAL DETERMINANTS
DOMAIN 1	**Health Systems Capacity Building**						
	• Primary Care Models	x	x	x	x	x	x
	• Workforce and Non-conventional Service Sites	x	x		x		
	• Data Collection and Analytic Capacity	x	x	x	x	x	X
DOMAIN 2	**Care delivery redesign**						
	• Bi-directional Integration of Care	x		x			
	• Care Coordination	x	x	x	x		x
	• Care Transitions		x	x	x		x
DOMAIN 3	**Prevention and health promotion**						
	• Chronic Disease Prevention and/or Management	x		x	x		x
	• Maternal and Child Health	x		x		x	x

*overlap based on content in HCA Medicaid Transformation Waiver Toolkit "Objectives and Outcomes" bullets available at: http://www.hca.wa.gov/hw/Pages/medicaid_transformation.aspx

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL

Instructions: The categories in this Project Proposal form request information to inform selection of the first OCH project. Ideally projects submitted are already up and running and occur in more than one of the OCH geographies; however new or county-specific projects will also be considered. Priority will be given to projects that address the WA State Common Measure Set. Using standardized evaluation criteria, projects will be scored by the Regional Health Assessment & Planning Committee and the top scoring projects will be voted on by the OCH Board of Directors (Board). The OCH must select a project by 7/31/16. At this time there is no OCH funding for the selected project(s). However, the WA State Health Care Authority submitted a request to CMMI for additional project-related funding; pending approval, OCH will have up to $50,000 for the selected project(s). Performance monitoring and evaluation of the selected project(s) will be supported by OCH staff. Please respond to all categories and limit your proposal submission to 2 double-sided legal pages (equivalent to 4 single-sided), 11 point font.

This form is due via electronic submittal to Angie Larrabee angie.larrabee@kitsappublichealth.org (fax: 360-475-9326) no later than 4pm, Tuesday, June 21, 2016. Please contact Angie if you have questions or have trouble using this form.

PROJECT TITLE:				
HOST ORGANIZATION:				
CONTACT NAME AND TITLE:				
EMAIL:		**PHONE:**		
CONTRIBUTING ORGANIZATIONS:				
COUNTIES SERVED BY THIS PROJECT: ☐ Clallam ☐ Jefferson ☐ Kitsap ☐ Other:				
TRIBES (please name each):				
THIS PROJECT IS (check one): ☐ New ☐ Enhancing an existing project or set of projects				
SECTORS ENGAGED BY THIS PROJECT (check all that apply)**:**				
☐ Aging	☐ Behavioral Health Org	☐ Chemical Dependency	☐ Chronic Disease	☐ Community Action Pgrm
☐ Early Childhood	☐ Economic Development	☐ Education	☐ Emergency Medical Services	☐ Employment
☐ FQHC	☐ Housing	☐ Justice	☐ Managed Care Organization	☐ Mental Health
☐ Oral Health	☐ Philanthropy	☐ Primary Care	☐ Private not-for-profit hospital	☐ Public Health
☐ Public Hospital	☐ Rural Health	☐ Social Services	☐ Specialty Care	☐ Workforce development
☐ Other (please list):				

BRIEF PROJECT DESCRIPTION (3-4 sentences):	
PROJECT GOAL STATEMENT (1-2 sentences):	
PROJECT SCOPE (1-2 sentences):	*Please describe what part of your regional community the project will serve (e.g. three counties, patients enrolled with two health plans, four primary care clinics, approximate number of individuals served by a social service agency in one city).*

PROJECT ACTIVITIES: (Add rows as needed)	**CONTRIBUTING PARTNERS:** (Include their roles & responsibilities)	**ACTIVITY TIMELINE:**

CATEGORY	**DESCRIPTION**	**RESPONSE**					
EVIDENCE BASE	Is project an evidence based, promising or innovative practice or model? Include source.						
ALIGNMENT TO OCH PRIORITY AREAS	Under which one or more of the OCH Priority Areas does this project align?	☐ Access	☐ Aging	☐ Behavioral Health	☐ Chronic Disease	☐ Early Childhood	☐ Social Determinants

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL

CATEGORY	DESCRIPTION	RESPONSE
VALUE ADD	What difference does OCH involvement make to the project?	
TARGET POPULATION/ SCALABILITY	Who are the project participants? How many are currently served and what is the project's potential reach in terms of individuals and communities? Describe potential for scalability.	____ Annual unduplicated number of participants served, Year: _____
IMPACT	How does the project impact/address social determinants of health, health disparities, and/or healthy equity?	
SUSTAINABILITY	How the project is currently funded? What is the sustainability plan for ongoing/future funding?	
ADVANCING THE TRIPLE AIM	Describe how project addresses the Triple Aim of better health, better care, and lower cost?	
MEDICAID WAIVER ALIGNMENT	Is this a potential Medicaid Transformation Waiver project (see table on pages 7-14)? If so, name the Waiver project.	
ALIGNMENT WITH WA COMMON MEASURE SET	List any of the *Common Measures* that this project will track; priority will be given to projects listing at least one.	

EVALUATION: How is the project evaluated? Describe measures and results if any are available. Add rows as needed.

OUTCOME (Desired result)	**OUTCOME INDICATOR** (How success is measured)	**DATA SOURCE** (Identify partner/s helping with data collection or analysis)	**TIMELINE**	**RESULTS** (Include time frame)

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL SCORING FORM

This form is for the OCH RHAP committee to score all submitted Project Proposals by category.
Reviewers will score projects in each category shaded grey using a 3-point scale (0, 1, or 2): 0= does not meet; response is unclear; 1= partially meets; response is not entirely clear or compelling, or 2= fully meets; response is clear and compelling.

Project Title	**List Counties Served**	**Tribes** (Yes or no, not scored)	**Project Description**	**Project Goal**	**Project Activities & Timeline**	**Stakeholders & Partners**	**Evidence Base**	**Alignment to OCH Priorities**	**Value Add**	**Target Population/ Scalability**	**Impact**	**Sustainability**	**Advancing the Triple Aim**	**Medicaid Waiver Alignment**	**Alignment to WA Core Measures**	**Evaluation**	**Additional Information** (not scored)	**TOTAL SCORE**
INSERT PROJECT TITLE HERE	☐ Clallam ☐ Jefferson ☐ Kitsap	☐ Yes ☐ No																
COMMENTS			The columns are not very wide but it might be helpful to have a place to make comments in each category for each project.															
INSERT PROJECT TITLE HERE	☐ Clallam ☐ Jefferson ☐ Kitsap	☐ Yes ☐ No																
COMMENTS																		
INSERT PROJECT TITLE HERE	☐ Clallam ☐ Jefferson ☐ Kitsap	☐ Yes ☐ No																
COMMENTS																		