Phase II Certification

August 14, 2017

Purpose of this document

The information included in this document is intended to certify that the Olympic Community of Health (OCH) is capable of serving as the regional lead entity and single point of performance accountability to the state for transformation projects under the Medicaid Demonstration Transformation Project (MDTP) for Clallam, Jefferson, and Kitsap counties.

Phase II Certification Submission Template

ACH Phase II Certification: Submission Contact	
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Theory of Action and Alignment Strategy – 10 points

Description

Provide a narrative describing the ACH's regional priorities and how the ACH plans to respond to regional and community priorities, both for the Medicaid and non-Medicaid population. Describe how the ACH will consider health disparities across populations (including tribal populations), including how the ACH plans to leverage the opportunity of Medicaid Transformation within the context of regional priorities and existing efforts. Identify and address any updates/improvements to the ACH's Theory of Action and Alignment Strategy since Phase I Certification. Provide optional visuals if helpful to informing the narrative; visuals will not count toward the total word count.

Instructions

Provide a response to each question. *Total narrative word-count for the category is up to 1,250 words.*

ACH Strategic Vision and Alignment with Healthier Washington Priorities and Existing Initiatives

1. Define a clear and succinct region-wide vision.

Olympic Community of Health (OCH) is dedicated to improving population health through addressing health priorities in our region, focusing on health equity and social determinants of health. The OCH **purpose** is to tackle health issues that no single sector or Tribe can tackle alone. The **vision** is for a healthier, more equitable three-county region. The **mission** is to solve health problems through collaborative action through partnerships. These are the product of a community-based planning process with health care professionals, health care payers, community and tribal leaders, local government officials, other health system stakeholders, Medicaid consumers, and residents.

OCH adopted a strategic vision for each Regional Health Priority:

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.
2. **Aging**. Aging adults and their caregivers are safe and supported.
3. **Behavioral Health**. Individuals with behavioral health conditions receive coordinated, integrated care in the best setting for recovery.
4. **Chronic Disease**. The burden of chronic diseases is dramatically reduced through prevention and disease management.
5. **Early Childhood**. Children get the best start to lifelong health and their families are supported.

OCH adopted short-, mid-, and long term strategic goals to achieve these visions:

SHORT TERM GOALS 2017-2018	MID TERM GOALS 2017-2019	LONG TERM GOALS 2017-2021
Successful implementation of Demonstration Projects*, as measured by* meeting contractual obligations, including pre-defined benchmarks and progress toward sustainable solutions	A strong, mutually-supportive relationship with MCOs as measured by movement towards the Triple Aim and significant enhancements in value-based care.	Coordinate regional plan to identify new and build on existing strategies that will increase the availability of affordable, supportive housing in the region. Support local networks working to address obesity Increase access to oral health services to kids on Medicaid, seniors, pregnant women, and adults with diabetes Increase trust and understanding between organizations, sectors, and Tribes; increased activation among consumers

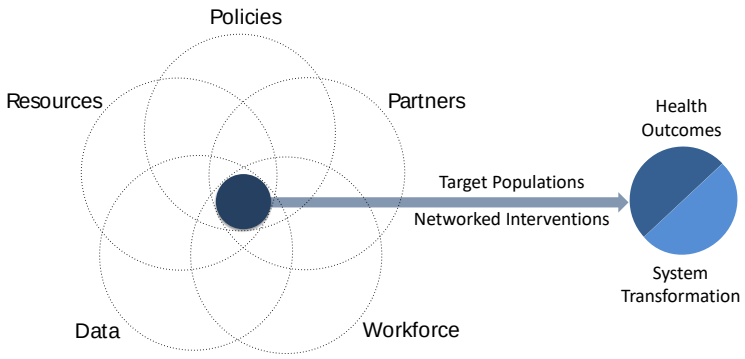
OCH acts to advance its strategic visions, goals, and aims:

- Coordinate, convene, and engage people and organizations
- Perform regional health assessments and planning
- Promote integration, improvement, and transformation of care delivery
- Coordinate and support health improvement projects
- Collect, monitor, and analyze data to track performance and savings
- Identify strategies to sustain promising projects
- Advocate for policy change

These actions are independent from and will continue beyond the Demonstration; there will continue to be a need for cross-sector, region-wide collaboration and action, inclusive of Tribes. The OCH is meeting with the leadership of each MCO to discuss:

- The ideal partnership with the OCH, beyond the Demonstration, to support shared goals.

- Mutually beneficial VBP goals to sustain Demonstration transformation and a shared work plan to get there.
- Coordination of Domain 1 work and project plan development to align/support/leverage the MCO's VBP goals.



2. Summarize the health care needs, health disparities, and social risk factors that affect the health of the ACH's local community.

The OCH geographic area includes both urban and widely dispersed remote populations with differing health and social challenges. The region is over 5,500 square miles, stretching from the Pacific Ocean to the Salish Sea. Much of the land in Clallam and Jefferson Counties is forest and mountains of the Olympic National Forest. These areas have limited road access resulting in pockets of isolated populations. While outpatient facilities are available in Port Angeles and Bremerton, most imaging and specialty services can only be obtained in the Seattle area, resulting in long drives and fragmented care.

The regional Medicaid health system is complex; 84,000 lives are serviced by five MCOs, four hospitals (with different parent/referral organizations), 2 FQHCs, 3 CBHCs, multiple rural health clinics, 3 free clinics, and 7 tribal clinics.

Some sub-populations have markedly inequitable chronic disease health outcomes related to cardiovascular disease, stroke, and diabetes. These include Tribal communities, Hispanic communities, persons with single or multiple co-morbidities including mental illnesses, substance abuse, and a chronic physical health condition. Cross-cutting issues include high prevalence of adult smoking, obesity and physical inactivity for youth and adults, and substandard housing.

County health profiles are unique:

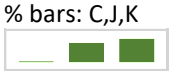
1. **Clallam** ranks among the lowest counties statewide in length and quality of life, access to clinical care, presence of physical environments supporting health, and positive social and economic factors. Small towns, large rural and remote areas make service delivery challenging. Median age is 49.5 with 26% over age 65, higher than State average. One in five west-end residents are American Indian/Alaskan Native, one in seven are Hispanic. Median household income is $41,887, lower than State average. 21% of women smoke during pregnancy, and the rate of opioid overdoses and deaths is high.
2. With a median age of 55 and highest percent of seniors in a Washington State county (30.5%), **Jefferson's** aging population presents distinct challenges. Economic disparity is evidenced by $31,000 annual salary gap between highest and lowest county census tracts. Two of every three babies are born into poverty (Medicaid), 19% of women smoke during pregnancy. One in eight deaths is related to alcohol and/or drugs.

3. **Kitsap** has high rates of no or late prenatal care access, low birth weight babies, and women with gestational diabetes, hypertension, and smoking during pregnancy. Worsening trends in unemployment rates and increasing prevalence of children living below the federal poverty level, high rates of youth suicidal ideation, attempted suicides, and social isolation are gravely concerning to service providers.

Indicators of health care needs and key disparities by geography and sub-population

Indicator	Data by place	Geographic Disparity	Sub-population Disparity
Uninsured	% bars: W,C,J,K 	Jefferson County rate 2-4% higher than Clallam and Kitsap.	*2-3 times higher rate among American Indian/AK Natives compared to White non-Hispanic *In Clallam, 11 times higher rate among adults with no high school compared to adults with college
Provider capacity: Dental	# bars: W,C,J,K 	Lack of dental provider capacity in Jefferson	
Primary Care:		Lack of primary care provider capacity in Kitsap	
Mental health:		Lack of mental health provider capacity in Clallam and Kitsap	
Adults have ambulatory/ preventive visit in past year	% bars: W,R,C,J,K 	About 3 in 4 adults across geographies; State higher than all of OCH	Range across race groups: 70-83%
Children access primary care	% bars: W,R,C,J,K 	88-89% of children across all geographies	Range across race groups: 86-91%
Emergency Department Use Rate/1,000 MM	rate bars: W,R,C,J,K 	Kitsap rate higher than other counties and WA	*Female rates higher than male *Range across race groups: 34 to 89
Plan all cause readmissions	% bars: W,R,C,J,K 	Kitsap rate twice as high as Clallam	Range across race groups: 10-18%

Indicators of social and economic conditions and key disparities by geography and sub-population

Indicator	Data by place	Geographic Disparity	Sub-population Disparity
High school graduation rate	% bars: C,J,K 	Clallam County rate well below Jefferson and Kitsap.	*Rate among low income 10% below average *Race range across all 3 counties: 40%-97%
Median Income	$ bars: W,C,J,K 	$19,000 gap between Clallam and Kitsap	
Unaffordable housing	% bars: W,C,J,K 	35-37% of households spend at least 30% of income on housing	
Unemployment	% bars: W,C,J,K 	6-8% OCH unemployment rate compared to 5% in WA	

Prisoners in State Correctional Systems (18+)	Rate bars: W,R,C,J,K 	County rate range 1.8 to 6.4	
Total arrests of adolescents	Rate bars: W,R,C,J,K 	County rate range 14.6 to 42.6; region better than state	
Property crime arrests, age 10-17		County rate range 3.3 to 7.8; region better than state	
Property crime arrests, adults		County rate range 2.5 to 8.5; region better than state	

Indicators of health status and key disparities by geography and sub-population

Indicator	Data by place	Geographic Disparity	Sub-population Disparity

3. Define your strategies to support regional healthcare needs and priorities.

Based on the health care needs, health disparities, and social risk factors, the OCH identified five Regional Health Needs and Priorities, which align with Demonstration goals.

The Table below describes samples of specific existing and planned activities and programs for each priority. A full list of the OCH's **inventory of projects** and how they accelerate the Demonstration can be found online.

Samples of Activities in the Community to Address OCH Regional Health Needs and Priorities

1. ACCESS	2. AGING	3. BEHAVIORAL HEALTH	4. CHRONIC DISEASE	5. EARLY CHILDHOOD
Kitsap Connect	**Home support services**	**Hub and spoke opioid treatment**	**Healthy Eating Active Living Coalition**	**Nurse Family Partnership**
Identifies high utilizers with complex health needs and connects them with services in the community.	Provides long term services and supports to allow people to age in their homes.	Coordinates medication assisted treatment for people with opioid use disorder through a central coordinating provider entity and multiple treatment and referral points throughout the region.	Cultivates community-driven initiatives to prevent chronic disease through health eating and exercise.	Providers home-based supports to new, low income, high risk moms by a public health nurse.

OCH applies the following strategies to address healthcare needs and priorities. The numbers in the parentheses refer to each priority:

- Grant writing (3)
- Coordinating, convening, and engaging people and organizations (3)
- Performing ongoing regional health assessment and planning (1-5)
- Promoting integration, improvement, and transformation of care delivery (1-5)
- Coordinating and supporting health improvement projects (1, 3-5)
- Collecting, monitoring, and analyzing data to track performance and savings (1&3)
- Identifying strategies to sustain promising projects (1, 3-5)
- Advocating for policy change (3)

4. Describe how your project selection approach addresses the region-wide needs and priorities.

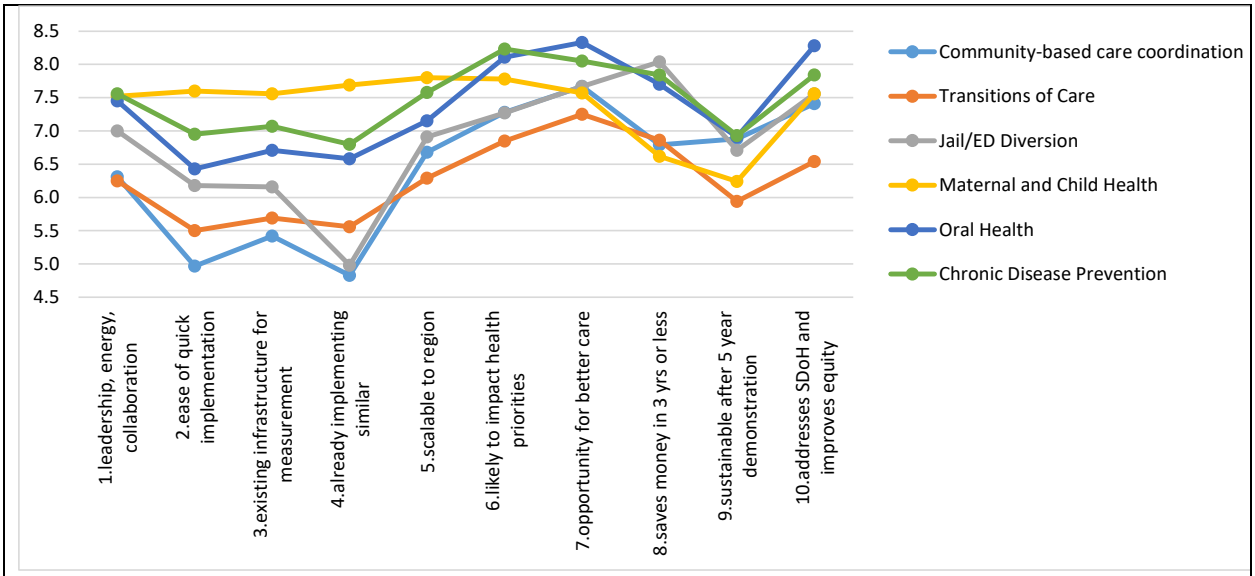
The OCH project selection approach has four elements: 1. Letter of Intent (LOI) (April 2017); 2. Request for Applications (RFA) (April-May 2017); 3. Community Input (January-June 2017 and September 2017); and 4. Project Plan (June-November 2017). The approach is guided by criteria

developed by the Regional Health Assessment and Planning (RHAP) Committee to ensure alignment with regional health needs:

1. **Likely to improve health within one or more regional health priority area**
2. **Degree to which addresses social determinants of health and improves health equity**
3. Existing local leadership, energy and collaboration around this project
4. Ease of quick implementation
5. Existing infrastructure to measure project process and outcomes
6. Already implementing 1 of the evidence-based model(s) outlined in the toolkit within the region
7. Scalable to the 3-county region
8. Offers an opportunity for Medicaid providers to provide better care
9. Saves money for Medicaid in 3 years or less
10. Sustainability is possible after 5-year Medicaid Demonstration is over Sustainability pathways can occur, e.g. through value-based payment or inclusion into Apple Health contracts.

Letter of Intent	Request for Applications	Community Input	Project Plan
During our Letter of Intent process, RHAP Committee evaluated project ideas according to the 10 criteria to identify maximum opportunity in project ideas that will address region-wide needs and priorities	RHAPC reviewed and scored Applications on: *Footprint – how many Medicaid beneficiaries and Medicaid providers *Scale – how many organizations, counties, and Tribes *Impact – ability to manage measurement and move metrics *Capacity – ability of organizations to achieve desired project goals *Transformational – will project have major impact on health *Budget – reasonable and leverages other $ *Need – addresses identified data-based community health need *Scale – how many organizations, counties, and Tribes *Impact – ability to manage measurement and move metrics *Capacity – ability of organizations to achieve desired project goals *Transformational – will project have major impact on health *Budget – reasonable and leverages other $	Community survey, open Jan - June 2017, 64 responses; respondents scored broad project areas for each of the 10 criteria, see results in the chart below. LOI submissions posted online (4/12/2017) Public comment survey on RFA submissions (5/26/2017-6/9/2017) Community input on potential projects at OCH convening 6/19/17 Community input on proposed projects at OCH convening 9/21/17	Project Plan document will include how the project will: *address regional priorities *support sustainable health system transformation *coordinate and not duplicate existing efforts *have lasting impacts and benefits to the region's overall Medicaid population The document will also describe: *anticipated scope for target population and providers *level of impact – geography and sub-pop and design elements to address health equity

We conducted a community survey (open January-June 2017, 64 responses) using the criteria:



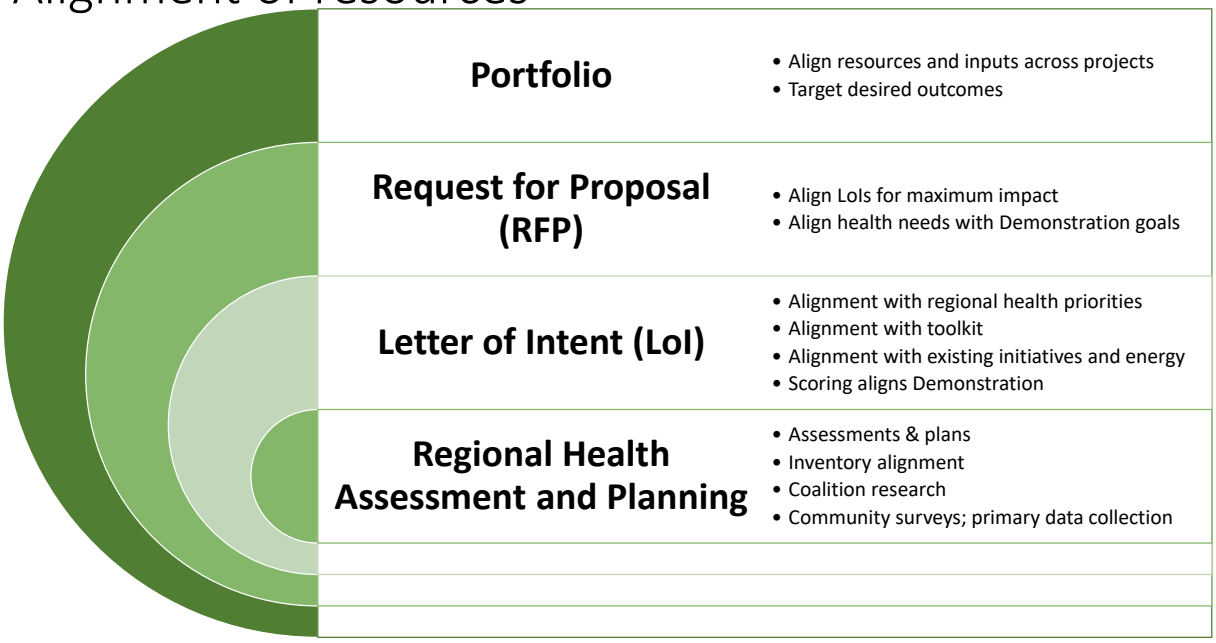
5. Explain how you will align existing and planned resources and activities into a region-wide strategy, including complementary projects, community resources and other investments.

Beginning in early 2015, the OCH formed and assessment and planning subcommittee that evolved into the RHAP Committee to review and synthesize inputs (e.g., assessments, plans, inventories, etc.), design, implement, and review a LOI process, and subsequent RFA process. The RHAP Committee aligned Demonstration goals with community health goals to design scoring schemes, informational webinars, and community forums.

Alignment/inventory of existing and planned resources, to identify complementary projects, community resources and other investments:

- A database of existing health improvement initiatives (n=69) in the community and how they align with the Demonstration project areas (data collection ongoing, began November 2015)
- A database of community-based health coalitions (n=28) and how they align with Demonstration project areas (data collection ongoing, began September 2016)
- An inventory of all data sources (n=8) and assessments (n=14, collapsed by type) available on regional health needs and disparities
- An assessment of available data sources, assessments and reports of regional health needs and disparities (ongoing)
- Input from community partners on summary of assessments and agreement on top five priorities (April 2016)
- Addition of opioid use, treatment, and outcome data into assessment (September 2016)
- List of people and organizations engaged to assist in the development of a project (May 2017, over 60 people).
- Update of new assessments and reports, including anticipated date of completion (November 2017)
- In the LOI and RFA, we ask “Is this a new or existing project?”

Alignment of resources



6. Describe the interventions and infrastructure investments that will potentially be shared or reused across multiple projects.

Interventions and infrastructure investments will be shared to enhance capability in population health data systems, health IT, workforce, and value-based payment (table and examples below).

Workforce

- The 3 County Coordinated Opioid Response Project (3CCORP) team will work with Olympic Community College to develop and implement a continuing education unit (CEU) for chemical dependency providers on the full spectrum of best practice treatment for opioid use disorder (OUD), including medication assisted treatment and how to coordinate care with primary care providers. This training may also be offered through the Peninsula Community College CDP program.
- The 3CCORP team will work with the NW Family Medicine Residency Program to develop a toolkit for residents to reduce barriers and increase facilitators for coordination of care between primary care and SUD providers for OUD treatment.
- Hiring and training of community health workers (CHWs) across organizations and sectors and supporting them in their roles
- Training population health management analytic capability within care organizations to be able to implement value-based care strategies such as registry management or disease-specific care coordination
- Training behavioral health professionals in co-occurring conditions, to record and discuss vitals, review medication management at daily huddles, tools for patient self-management
- Training primary care professionals in behavioral health screening and vice versa

Population health data systems and health IT

- E-referral systems between organizations, sectors, and Tribes
- Population health management to support value-based payment

Assessment

- Survey tools to support value-based payment readiness, bi-directional integration, patient-centered medical home status, health information technology assessment, and data and analytic assessment

Crosswalk of interventions and infrastructure investments shared across projects:

Details of the interventions/ activities and infrastructure capabilities	B-Directional Integration	Jail Transitions	Care Transitions	Jail Diversion	Community Paramedicine	ED Diversion	Opioids	Maternal and Child Health	FQHC dented	Rural County dented	Asthma home visiting	Chronic Care Model
New workforce (does not currently exist)		y				y						
Expansion of existing workforce (recruitment)	y			y			y	y	y	y	y	
Re-trained existing workforce	y		y	y	y		y					y
Community Health Workers (CHW)		y				y					y	y
Population Health Analytics Workforce	y		y									y
Population Health Data Systems	y	y	y	y	y	y	y	y	y	y	y	y

Attachments

Olympic Community of Health - Theory of Action and Alignment Strategy – Attachment:

- A – Logic Model
- B – Alignment of Resources

Governance and Organizational Structure – 10 points

Description

Provide a description on the evolution of the governance and organizational structure of the ACH. Identify and address any updates/improvements to the ACH's Governance and Organizational Structure since Phase I Certification. Visuals can be used in this section to inform the narrative and will not count toward the total word count.

Instructions

Complete the attestations and provide a response to each question. *Total narrative word-count for the category is up to 1,000 words.*

ACH Attestation(s)

ACH has secured an ACH Executive Director.

☒ **YES**

ACH has been established as a legal entity with an active contract with HCA to serve as the regional lead entity and single point of performance accountability for DSRIP transformation projects.

☒ **YES**

ACH Structure

1. Describe the ACH's sector representation approach in its governance structure. Describe how the ACH is interacting with particular sectors across the region (e.g., primary care, behavioral health, etc.), and how those sectors are engaging with the decision-making body.

The OCH Board of Directors (Board) consists of 22 directors and is the decision-making body for the organization. The Board began as an Interim Leadership Council (September 2015), transitioned into a Leadership Council (February 2016), and then became a Board of Directors (May 2016). This process, including sector representation, was informed by a governance subcommittee. Director sector representation aligns with STC 23 [representing (# of Directors)]:

- primary care (2)
- behavioral health (2)
- health plans [Medicaid Managed Care Organizations (MCOs) caucus within the sector and have a rotating director on the Board] (2)
- hospital or health system (3)
- public health (2)
- tribes (7)
- housing (1)
- aging social services and supports (1)
- social services (1)
- oral health access (1)

In June of 2016, the Board deliberated about inviting new Directors onto the Board to represent additional sectors. The Board elected to wait until after the final portfolio was selected to make this decision. Under consideration are:

- First responder: law enforcement, EMS
- Criminal justice: courts, correctional facilities
- Education
- Consumer

Examples of how sectors and Tribes engage with the OCH Board and how sector and Tribe representatives communicate with others:

- Each sector nominates a representative to serve on the Board
- Each sector may designate one alternate to serve in the absence of such sector's representative.
- Board meetings are open to the public, recorded, and streamed on Go-To-Meeting; therefore, alternates or other sector partners attend, caucusing before, during and after the meeting
- Board materials are distributed at least five business days before the Board meeting directly to all sector representatives and other persons and organizations that have expressed an interest in receiving Board materials in advance.
- Board materials are posted on the OCH website
- All action items are noted in red font to call attention to discussions that require action. Staff will always include a situational analysis and proposed motion to spur discussion. For the action item on Fully Integrated Managed Care (FIMC), staff circulated multiple messages and materials weeks in advance to potentially affected parties.
- The OCH maintains a contact list of all organizations within a given sector for information sharing.
- Several sectors (e.g., housing, public health, hospitals, FQHCs, and CBHCs) hold regular regional sector meetings, either self-organized, or convened by the OCH. This is also the case for Tribes. Summaries of these meetings are shared with staff, the executive committee, or directly with the Board.
- Tribes are not sectors; therefore, for tribal engagement, we follow the *OCH Tribal Collaboration and Communication Policy* and rely on the Director of Community and Tribal Partnership to advise an approach that honors each Tribe's preference towards engagement.

Expectations for engagement

All Directors sign a Board Member Commitments and Operating Procedures (A) form that states: *Board Members serve as the representatives of their respective sectors for the three-county Olympic Community of Health (OCH) region or of their respective Tribe.* Directors are expected to engage with others in their sector or Tribe:

Board Members are responsible to communicate with other members of their sector or Tribe to ensure effective information flow to and strong engagement on matters related to the OCH. Members bring the experience, expertise and perspective of their sector; they do not represent their personal views or their organization's interests alone:

- *All members are expected to proactively solicit the input and perspectives of other organizations within their sector and present that information to the Board*
- *All members will provide regular updates/feedback loops to interested organizations in their sector on the OCH's work*
- *All members will serve as spokespersons for the OCH*

- *Members will disclose any substantive differences of opinion or disagreements within their sector on decisions to the Board of Directors*

2. If applicable, provide a summary of any significant changes that have occurred within the governance structure (e.g., composition, committee structures, decision-making approach) since Phase I Certification, including rationale for those changes.
(Enter "not applicable" if no changes)

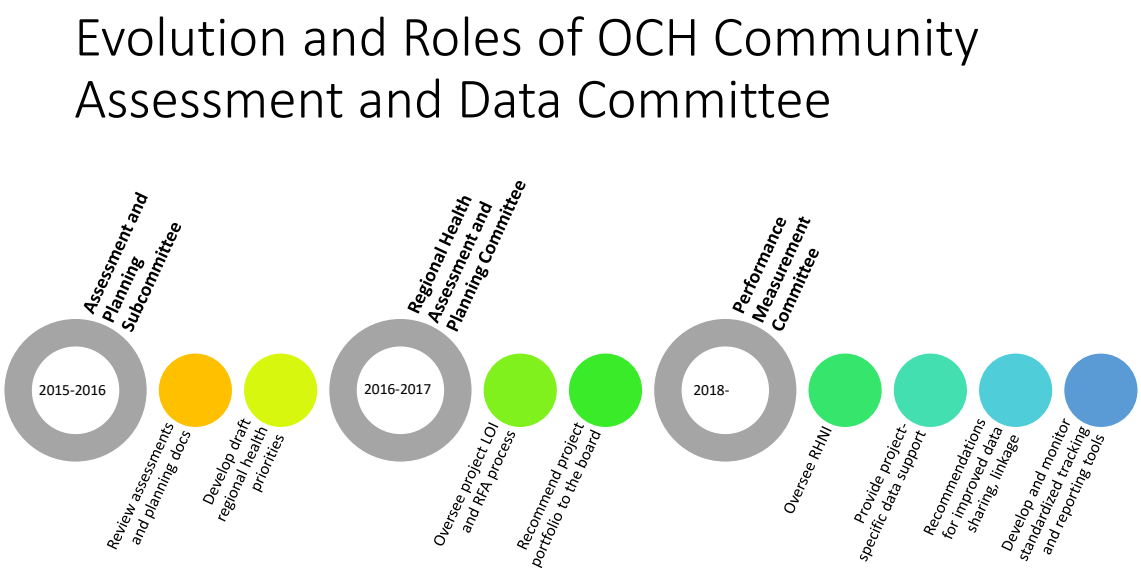
The governance structure is undergoing a few changes. Today, it consists of a Board of Directors, Finance Committee, Executive Committee, Regional Health Assessment and Planning (RHAP) Committee and workgroups and committees as charged by the Board. With two PhDs and one MPH on staff, staff have enhanced the use of data, modeling, and analysis to support decision-making for the Board and committees.

For the sake of continuity and due to the aggressive timelines under the Demonstration, the Board re-elected the same slate of officers and delegated additional decision-making authority to the **Executive Committee** (new language in executive committee charter underlined). (B)

Given the large deposit of Design Fund revenue in 2017, the **Finance Committee** (C) was delegated with the authority to:

- oversee and manage the selection of and relationship with an external auditor
- draft 2018-2021 budget
- develop an investment policy for a proposed recommendation to the Board

The graphic below describes the natural evolution of the RHAP Committee (D):



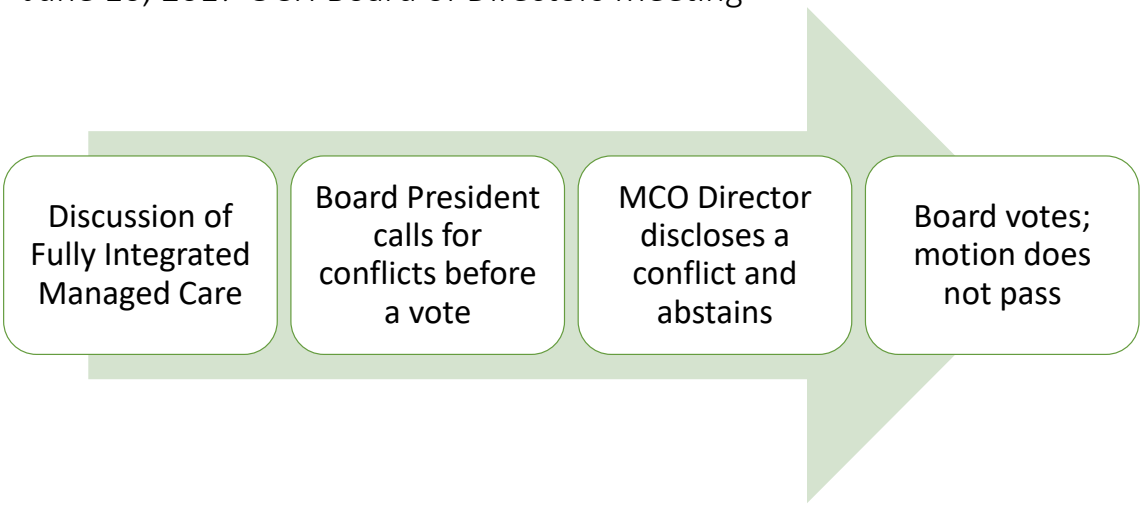
A **Performance Evaluation Committee**, **Community Engagement Committee**, **Workforce Committee** (possibly in alliance with Greater Columbia and Cascade Pacific Action Alliance) and **Care Delivery Re-Design Committee** will phase-in in DY2 (E).

3. Discuss how personal and organization conflict of interest concerns are addressed within the ACH, including considerations regarding the balanced and accountable nature of the ACH decision-making body to directly address identified conflicts.

Personal, financial, and organizational conflicts of interest are governed by a conflict of interest policy signed by Directors (approved November 7, 2016 following legal review, revised July 25, 2017).

Example of operationalization of Conflict of Interest Policy

June 10, 2017 OCH Board of Directors Meeting



Conflict of Interest Policy

The best way to mitigate a conflict of interest is to avoid it in the first place. Process for identifying and addressing conflicts (F):

Process for identifying and addressing conflicts

Please refer to attached conflict of interest policy

Framing

Agreement on purpose and definitions in policy.

Procedures

Duty to disclose

Determine whether a conflict of interest exists

Procedures for addressing the conflict of interest; different for personal versus financial conflicts

Procedures for violations of conflicts of interest

Records or proceedings

Before voting, the president calls for conflicts of interest.

All disclosures are recorded in the minutes.

Annual Statements

All Directors sign conflict of interest policy annually.

The Board of Directors will review a draft Dispute Resolution Policy at the October Board meeting.

Staffing and Capacities

4. Provide a summary of staff positions that have been hired or will be hired, including current recruitment plans and anticipated timelines.

The skills needed to design the Demonstration portfolio and implementation plan within the timeline, along with the OCH commitment to locally-driven solutions, has resulted in a hybrid staff-professional consultant team model (G). The OCH welcomes professional consultants, most of whom live and work locally, as team members, bringing them into all aspects of the Demonstration planning, including weekly strategic planning sessions. (H)

Title	Action steps and timing	Roles and responsibilities that support the Demonstration
Executive Director	Hired April 2016	Direct the design, implementation, and administration of the Demonstration and the agency.
Director of Community and Tribal Partnership	Hired April 2017	Develop and implement the organization's strategic communications and engagement strategy to ensure that all voices in the region are identified, heard, and responded to in a respectful, culturally appropriate, and consistent manner. Lead the Three-County Coordinated Opioid Response Project.
Administrative Coordinator	Hired February 2017	Develop and administer human resources and administration programs and processes; plan and carry out internal procedures relating to all phases of human resources and administration activities; computerize, classify, record, verify and maintain

		numerical data for use in maintaining financial records; assume responsibility for mail, office purchasing requests, facilities, and equipment.
Administrative Assistant	Planned August 2017	Provide administrative support in planning, organizing, directing, and administering operations and projects.
Analytics and Reporting Lead	Original contract February 2017; Planned expansion 9/1/2017	Overall management of all analytic projects including timeliness, quality and value. Integrates data-driven decision making into all elements of strategic development, operations, and communications.
Project Coordinator	Planned hire by 9/1/2017, Currently recruiting	Coordinate the planning, operations, assessment, analysis and performance of Medicaid Demonstration Transformation projects and programs.
Director of Transformation	Planned hire by 9/1/2017, Currently recruiting	Lead the planning and implementation of programs and initiatives under the Demonstration.
Transformation Coordinator	Planned hire by 1/1/2018	Coordinate the planning, operations, assessment, analysis and performance of Medicaid Demonstration Transformation projects and programs in the provider setting.
Contract and Compliance Coordinator	Planned hire by 5/1/2018	Provide contracting and compliance support for Demonstration projects.
Demonstration Assistant	Planned hire by 5/1/2018	Provide administrative support for Demonstration projects.
Director of Administration and Finance	Planned hire by 1/1/2019	Overall management of financial and HR matters.
Communications Assistant	Planned hire by 1/1/2018	Provide communications support to the Director of Partnerships to fulfill the strategic communications and engagement plan.
AmeriCorps and Interns	Planned hire by 1/1/2019	To meet project needs.

Attachments

Olympic Community of Health - Governance and Organizational Structure – Attachment:

- A – Board Member Commitments and Operating Procedures
- B – Executive Committee Charter
- C – Finance Committee Charter

- D – Regional Health and Planning Committee Charter
- E – Visual of Governance Structure
- F – Conflict of Interest Policy
- G – Organizational Chart
- H – Short Team Bios
- I – Executive Director Contract
- J – Description – Administrative Assistant
- K – Description – Administrative Coordinator
- L – Description – Director of Community and Tribal Partnership
- M – Description – Project Coordinator
- N – Description – Director of Transformation
- O – Description – Analytics and Reporting Lead

Tribal Engagement and Collaboration – 10 points

Description

Provide a narrative describing specific activities and events that further the relationship and collaboration between the ACH and Indian Health Service, tribally operated, or urban Indian health program (ITUs), including progress on implementing the requirements of the previously adopted Model ACH Tribal Collaboration and Communication Policy or other unanimously agreed-upon written policy. Identify and address any updates/improvements to the ACH's Tribal Engagement and Collaboration since Phase I Certification.

Instructions

Provide a response to each question. *Total narrative word-count for the category is up to 1,000 words.*

Collaboration

1. Provide an update on the ACH efforts described in Phase I Certification, particularly for any next steps identified.

The OCH is committed to the long-term process of engagement with the Tribes. Each of the seven tribes in the region is a unique and sovereign nation with different governmental structures and processes. No tribe can speak for another tribe unless authorized to by the elected leadership. Therefore, each tribe has a voting seat on the Board of Directors. The OCH bylaws (A) address tribal representation on the Board. Six of the seven tribes are active on the Board and one on the Executive Committee.

Specific activities and events to strengthen tribal engagement and partnership:

- At the request of the tribes, the OCH hosts monthly meetings with the seven tribes, the American Indian Health Commission of WA State (AIHC), and the Tribal Affairs and Policy Analysis Administrator and the Tribal Liaison from the HCA. These meetings are in person with call in and webinar access.
- At the request of the tribes, the ED and Tribal Liaison engaged in many conference calls and in person meetings to discuss the Demonstration. This allows tribes to make informed choices about if/how to participate and contribute.
- Tribes send representatives to OCH committee meetings (RHAP Committee, 3 County Coordinated Opioid Response Project).
- The OCH Tribal Liaison developed a listserv of the contacts in each Tribe and distributes regular updates and information.
- Three of the 7 tribes provided tribal resolutions formally designating representation on the OCH Board. Three of the 4 remaining resolutions are in process.
- The OCH contracted with an attorney who also is an expert in tribal law

- The Tribal Liaison continues to attend the AIHC meetings (June 8 and August 24 in this period) and served on the AIHC Tribal and Urban Behavioral Health Summit planning committee; the Summit, June 23, 2017.
- The Tribal Liaison participates in the monthly Tribal/HCA/BHA calls.
- The OCH team has scheduled a series of meetings in the most remote area of the region on August 29 and 30; one of these meetings is with the Makah Tribe including the health clinic, wellness center, and leadership.
- OCH staff attend events in tribal communities.

Barriers and challenges

- Engagement with the Hoh Tribe remains a challenge. The OCH team is working with the Tribal Liaison and AIHC to set up an in-person meeting with leadership to determine if the tribe is interested and able to participate

Communication: electronic communication is *efficient* but not *sufficient*; therefore, the OCH initiated monthly meetings with dual options for phone or in-person attendance.

2. If applicable, describe any opportunities for improvement that have been identified regarding the Model ACH Tribal Collaboration and Communication Policy and how the ACH intends to address these opportunities.
(Enter "not applicable" if no changes)

The OCH significantly strengthened the Model ACH Tribal Collaboration and Communication Policy (TCCP) to reflect commitment to true partnership with tribes. The OCH TCCP was vetted with the seven tribes and then approved by the Board on July 10, 2017 (B).

3. Demonstrate how ITUs have helped inform the ACH's regional priorities and project selection process to date.

- Six of the seven tribes are active members on the OCH Board
- Tribes are active with the Regional Health Assessment and Planning Committee (RHAP), which developed the process for inviting potential projects, reviewed letters of interest (LoI) and applications (RFA), and made recommendations to staff to be presented to the Board for the Demonstration portfolio.
- The Tribal Liaison met and spoke with six of the seven Tribes during the LoI and RFA process to hear concerns that resulted in some course corrections and educational opportunities for staff to improve collaboration going forward.
- Tribes were present at the January 31 and June 19 Partner Convenings where the potential projects were presented and discussed. Port Gamble S'Klallam and Makah Tribes gave direct verbal feedback about the importance of tribal engagement.
- Project selection processes are agenda items at the newly initiated monthly Tribal/OCH meetings

Board Training

4. Demonstrate the steps the ACH has taken since Phase I Certification to ensure the ACH decision-making body receives ongoing training on the Indian health care delivery system, with a focus on the local ITUs and on the needs of both tribal and urban Indian populations. Identify at least one goal in providing ongoing training in the next six months, the steps the ACH is taking to achieve this goal and the timing of these steps.

Six of the seven tribes are active on the OCH Board and one Tribe is on the executive committee; therefore, training takes place at every meeting in real time. For example, when discussing the

portfolio, a Tribal Health Director raised a concern regarding incompatible timelines with tribal government decision-making. A discussion ensued until tribal governmental decision-making processes were better understood. In one circumstance, a vote was suspended due to potential unintended consequences of a Board action on tribal sovereignty as identified by a Tribal Director. This has only occurred once and when it did, the vote was unanimously tabled until the matter was successfully resolved through the Tribe's legal counsel.

In addition, the OCH tribal liaison is Alaska Native and has worked with the tribes in the state for over 25 years and provides real-time training to staff and Directors. Formal, scheduled training:

- Schedule one Board training focused on culture, cultural humility, ITU/AIAN health and health care delivery as requested by the Board members
- Schedule one Board training on culture, cultural humility, ITU/AIAN health and health care delivery as requested by the tribes in the region

This will provide the opportunity to address training needs from multiple perspectives.

Attachment(s) Required

Olympic Community of Health – Tribal Engagement and Collaboration – Attachment:

- A – Bylaws
- B – Tribal Collaboration and Communication Policy with the Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Port Gamble S'Klallam, Quileute and Suquamish Tribes
- C – Bios for all Tribal Representatives on the OCH Board of Directors
- D – Efforts to Engage Hoh Tribe to Fill Seat on Board
- E – Lower Elwha Resolution
- F – Suquamish Resolution
- G – Port Gamble S'Klallam Resolution
- H – Suquamish Letter of Support

Community and Stakeholder Engagement – 10 points

Description

Provide a narrative that describes current and future efforts regarding community and stakeholder engagement and how these actions demonstrate inclusion of and responsiveness to the community. Identify and address any updates/improvements to the Community and Stakeholder Engagement category since Phase I Certification.

Instructions

Complete the attestations and provide a response to each question. *Total narrative word-count for the category is up to 2,000 words.*

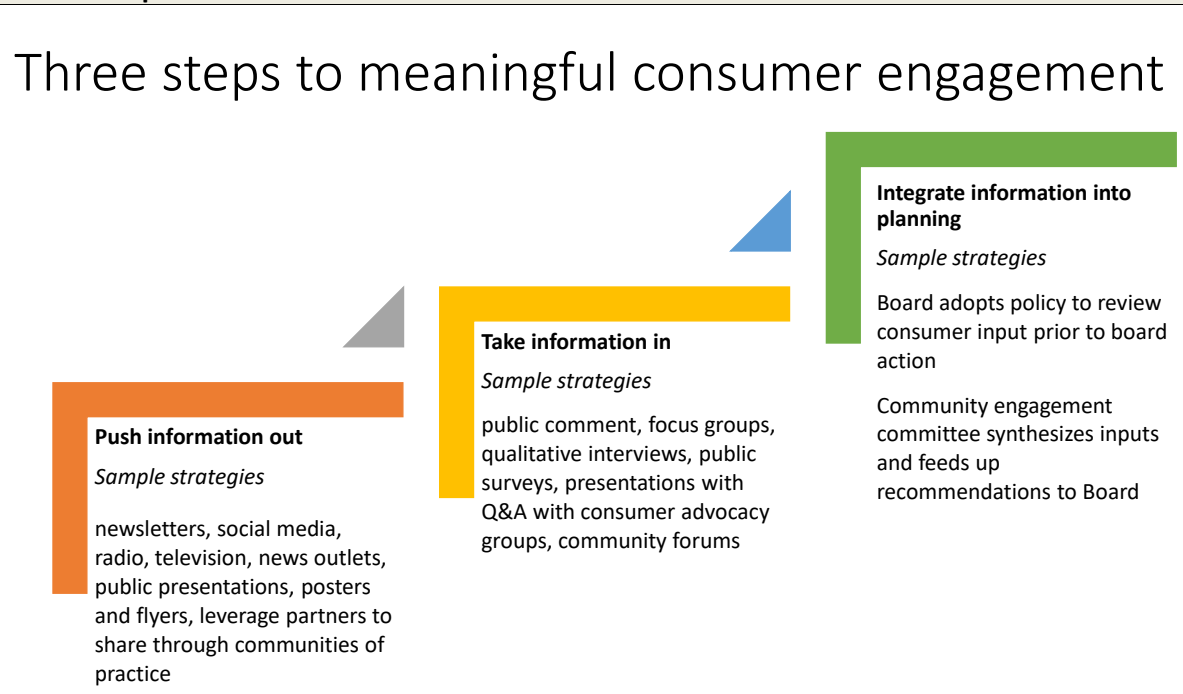
ACH Attestation(s)

ACH has convened and continue to convene open and transparent public meetings of ACH decision-making body for discussions and decisions that pertain to the Medicaid Transformation demonstration.

☒ **YES**

Meaningful Community Engagement

1. **What strategies or processes have been implemented to address the barriers and challenges for engagement with community members, including Medicaid beneficiaries, identified in Phase I Certification? What are the next steps the ACH will undertake to continue to address remaining barriers and challenges? If applicable, discuss any new barriers or challenges to engagement that have been identified since Phase I Certification and the strategies or processes that have been implemented to address them.**



OCH commits to community engagement and partnership through the following specific strategies, processes and actions:

- Convene a **Community Engagement Committee** to synthesize inputs consumer input and feed up recommendations to the Board.
- Dedicate resources to community engagement using Design Funds, the staffing the Director of Community and Tribal Partnership, and budgeting reimbursement for consumer time, travel costs, and childcare.
- Convene one-one meetings with Medicaid consumers. (see Attachment X)
- Attend, present, and discuss at existing groups with consumer representation:
    - Ongoing attendance at two FQHC Boards (most recent: 6/22 & 8/17); 51% Medicaid consumer membership
    - Ongoing attendance at CBHC Community Voice Committee: (most recent: 9/13); 15-20 Medicaid consumers with chronic and severe mental illness
    - NAMI Advisory Committee
    - Ongoing attendance at Salish Behavioral Health Organization Advisory Board
    - Regional grassroots organizations and coalitions
- Collaborate with the network of community service offices (CSO) to integrate their consumer experience into project planning.
- Hold quarterly, open, public community forums around the region and at varying times to the opportunity for community members to participate. Add weekend and evening forums.
- Offer multiple modalities of community input; all are analyzed, synthesized, and shared with the Board:
    - Public comment: open ≥ 3 weeks online, ≥ 5 minutes at each Board meeting
    - Surveys
        - Online: open ≥ 2 weeks & ≤ 6 months, 10 e-surveys circulated since 11/2016; maximum # responses = 477
        - Paper: collected, mailed, or scanned/emailed after meetings
- Disseminate information via e-newsletters, social media, public meetings, and invited presentations; going forward include flyers and hard copy newsletters to be distributed in agencies and locations.
- Manage a media list with local and Seattle-based radio, television, and print media; press releases for events or news stories (e.g., Kitsap Sun: February 4th: Three-county plan will confront opioid crisis)

The OCH begins with the following measures to gauge success:

- Participation in OCH activities by all sectors and Tribes in the region
- Willingness to share honest feedback and provide clear guidance
- Willingness on the part of the OCH leadership and staff to listen, learn, and be flexible
- Invitations from community/consumer coalitions for OCH leaders and staff to attend community events; OCH willingness to dedicate resources to this
- Documents, protocols, policies, plans, efforts that are collaboratively developed, iterative, and responsive to consumer/community input, needs, and resources
- Documented discussions and dialogue around difficult topics that are honest, respectful, and solutions-oriented
- Respectfully listen to the consumer's lived experience; allow for true problem statements and prioritization of questions

- Lines of accountability:
    - Staff analyzes and synthesizes consumer input → bring to **Community Engagement Committee** → recommendation to the Board → action plan or course correction based on input
    - OCH adopts a policy to govern the process above
    - OCH activities and documents are public; meetings are open and Board meetings are recorded

Barriers and challenges:

- **Bandwidth and resource gaps**: The OCH is a young, small organization. True engagement and partnership requires face-to-face, ongoing participation in meetings, events, coalitions, etc. across the region. Travel to and from various communities takes 1-8 hours. Reimbursement for time, travel costs, and childcare is essential.
- **Access to information**: The Demonstration is complicated and the information changes frequently, posing a significant challenge to provide accessible information to all constituents and partners.
- **Voice**: Partners need the opportunity to feel comfortable, welcome, and safe to provide input and guidance.

2. Describe any success the ACH has achieved regarding meaningful community engagement.

The OCH hosted an opioid summit on January 30, 2017 to provide the region with information about the opioid crisis, present a summary of the three-county opioid assessment, present the draft regional opioid response plan, solicit feedback, and invite community members to participate in the planning and implementation phase:

- The event was advertised in the newspaper, radio, and mainstream news television.
- Over 120 people attended from across the region and sectors/communities including tribes, primary care, substance use disorder providers, mental health providers, elected officials, hospitals, fire/EMS, law enforcement, schools and youth, criminal justice, public health and health officers, CHWs, representatives from the governor's office and state agencies, general community members, and persons in recovery.
- Extensive feedback was provided via notecards (Attachment X) that attendees could write on anonymously or with contact information; this information is helping guide the planning process

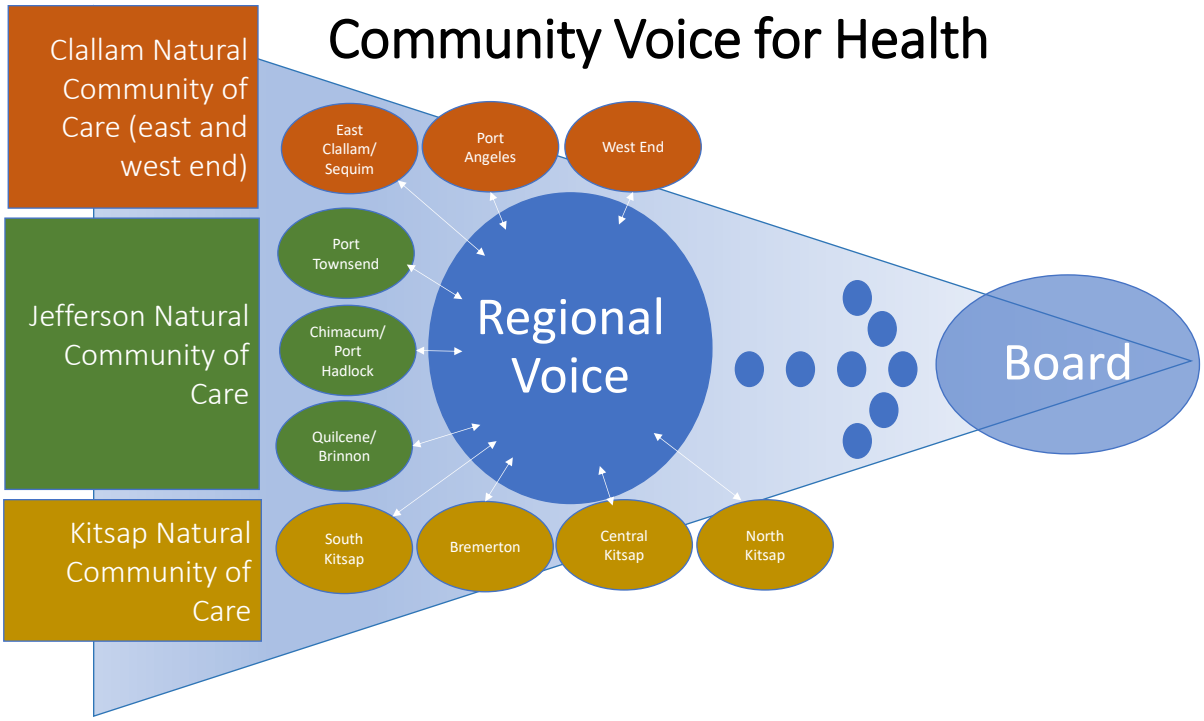
From the summit, over 50 people, including at least one consumer, volunteered to serve on workgroups to implement the regional opioid response plan. These workgroups meet monthly and have moved into action; this process is informing toolkit project 3A.

3. In the Project Plan, the ACH will be required to provide evidence of how it solicited robust public input into project selection and planning, including providing examples of at least three key elements of the Project Plan that were informed by community input. Demonstrate how community member/Medicaid beneficiary input has informed the project selection process to date. How does the ACH plan to continue to incorporate community member/Medicaid beneficiary input meaningfully on an ongoing basis and meet the Project Plan requirement?

1. The **Community Voice for Health** (see image below) ensures geographic, cultural, and economic diversity, oriented around the **natural communities of care** (NCC) for the consumer. NCCs are natural affinity groups of provider organizations, clinical and non-clinical, that serve the Medicaid population for a geographic region. This model values that 1 individual cannot represent 84,000. True engagement requires that information is mutually exchanged in the communities where our partners

live and feel most comfortable. The OCH has made it a practice and a norm to travel throughout the region to attend meetings as appropriate.

- OCH hosts sub-regional community voice gatherings. Potential project plans will be presented with opportunity for community members to voice concerns, ask questions, and provide input. This information will be synthesized and presented to the project plan teams and the Community Engagement Committee. Community members may join the project plan teams. These sub-regional gatherings will take place twice per year throughout the Demonstration.
- Each sub-region may choose to select a spokesperson(s) to represent the sub-region's voice in the NCC project planning process and to the Board.
- Board adopts policy that requires reporting of engagement efforts as part of Board decision items related to Demonstration planning.



2. Engagement activities, undertaken in 2017, leading to preliminary project recommendations to the OCH board. (**Bold** elements indicate where community input informed the Project Plan):

Partnering Provider Engagement

4. What strategies or processes have been implemented to address the barriers and challenges for engagement with providers (clinicians, social service providers, community based organizations and other people and organizations who serve Medicaid beneficiaries) identified in Phase I Certification? What are the next steps the ACH will undertake to continue to address remaining barriers and challenges? Discuss any new barriers or challenges to engagement that have identified since Phase I Certification and the strategies or processes that have been implemented to address them.

The OCH is the smallest ACH, with 84,000 Medicaid lives, 4 hospitals, 2 FQHCs, 4 CBHCs, 2 CAPs, 2 AAAs, and seven Tribal Health and/or Behavioral Health Clinics. Leadership from Medicaid providers, clinical and non-clinical, have a direct line to the OCH executive director and are tapped weekly to weigh in on ideas and decisions on-the-fly and more formally at committee or board meetings.

Strategies for partner engagement (see Table below):

- Targeted engagement approach to agencies with a central role in serving Medicaid
- Quarterly OCH convenings with broad community participation (n=50-150)
- Biannual sub-regional community voice gatherings
- Monthly Tribal/OCH meetings in Tribal facilities
- RHAP Committee with broad sector membership
- Staff regional meetings of hospital leadership
- Staff regional tribal meetings
- Build on existing substructures:
    - Salish BHO advisory meetings
    - NW Regional EMS Council
    - County-level sheriff's meeting
    - Provider organization board meetings
- Convene opioid steering committee and 3 workgroups (see 5 below)
- Staff travels for face-to-face meetings with partnering providers. (Attachment X)

Provider organizations that serve Medicaid	#*	Seat on Board	Alternate on Board	Attends Board mtg as member of public	Represented on RHAPC	Attends Partner Convening	Represented on opioid project	Individualized engagement by Exec. Dir.	Individualized engagement by Dir. CTP**	Staff presents to Orgn's Board	Receives newslette
Community behavioral health clinics	4	x	x	x	x	x	x	x	x		x
Federally qualified health clinics	2	x	x		x	x	x	x		x	x
Tribal health clinics	6	x	NA***		x	x	x		x		x
Primary care clinic groups	3	x	x		x	x	x				x
Specialy clinic groups	4	x				x	x				x
Rural health clinic groups	3	x			x	x	x	x	x		x
Substance use treatment providers	14	x			x	x	x		x		x
Hospitals	4	x	x		x	x	x	x		x	x
Emergency Departments	4	x			x	x	x				x
Pharmacies							x				x
Community action agencies	2	x	x		x	x		x			x
Schools (districts)	14						x	x	x		x
Area agencies on aging	2	x			x	x		x			x
Nonprofits and social service agencies	>50	x		x	x	x	x	x	x		x
Public health jurisdictions	3	x	x	x	x	x	x	x	x	x	x
Jails and correctional facilities	3					x	x	x	x		x
Courts	17					x	x		x		x
Law enforcement	17					x	x		x		x
EMS	24				x	x	x		x		x
Medicaid managed care organizations	5	x			x	x		x			x
Behavioral health organization	1	x			x	x	x	x	x		x
County and city elected officials	>20					x	x	x	x		x
Tribal elected officials	>20					x			x		x
Citizens and consumers	NA			x		x	x	x	x		x

** Blank cells are still undergoing assessment. Will be complete in time for project plan*

*** Dir CBP: Director of Community and Tribal Partnership*

**** Tribes are not sectors; therefore they may select or change their designated representative at any time*

A challenge with provider engagement is partner fatigue. Partners wear many hats. For this reason, the OCH piggy-backs on existing systems and takes advantage of our small size to "seize a moment" to gauge interest, input, and concerns from our partners.

5. Describe any success the ACH has achieved regarding partnering provider engagement.

The 3 County Opioid Response Project partners (see table below) exemplifies partnering provider engagement.

A recent meeting of the Treatment Workgroup experienced a breakthrough between medical and substance use treatment providers, two groups which have had historically differing philosophies on treatment of opioid use disorder. **This is an example of a hard conversation that happened because the OCH created a space for dialogue, trust, and respect.** The result of the discussion is an opening for a conversation between these two sectors to work collaboratively to support shared patients.

Opioid Project Committee	Co-Chair 1	Co-Chair 2	Provider Participation and Membership
Steering Committee	Public Health Officer (Clallam) and Frontline Primary Care Provider	Tribal Police Chief	Clallam County Public Health, Jefferson County Public Health, Kitsap County Public Health, Olympic Medical Center, Jefferson Healthcare, Discovery Behavioral Health, Peninsula Behavioral Health, Suquamish Police Department, Kitsap County Prosecutor, Clallam County Jail, Harrison Medical Center/ED, Salish BHO, Bremerton Fire, Olympic Eductional Service District 114, Safe Harbor Recovery, Lived Experience, County Commissioner from each of the counties
Treatment Workgroup	CEO Community Behavioral Health Clininc	Frontline Psychiatric Provider	Salish BHO, Peoples Harm Reduction Alliance, Kitsap Menta Health Services, Poulsbo City Mayor, Bremerton City Mayor, Jefferson County Commissioner, Reflections Counseling Services, Qualis Health, Suquamish Tribe Police Department, American Indian Health Commision, West End Outreach Services, Cedar Grove Counseling, DSHS, Kitsap County Drug Court, Kitsap County Prosecutor, Kitsap Recovery Center, Olympic Medical Center, Makah Tribe, Kitsap Public Health, Coordinated Care, Molina, Olympic College, UW ADAI/DOH, Port Gamble S'Klallam Tribe, Lower Elwha Tribe, OESD 114, Port Angeles Police Department, First Step Family Support Center, Jefferson Healthcare, North Olympic Healthcare Network, Amerigroup, Harrison Health Partners
Prevention Workgroup	Public Health Officer (Kitsap)	CMO Medical Group	Olympic Medical Center, Makah Tribe, Kitsap Public Health, Coordinated Care, CHPW, Molina, Olympic College, UW ADAI/DOH, Port Gamble S'Klallam Tribe, Lower Elwha Tribe, OESD 114, Port Angeles Police Department, Port Angeles CAN, First Step Family Support Center, Forks Community Hospital, Jefferson Healthcare, North Olympic Healthcare Network, Amerigroup, Harrison Medical Center
Overdose Prevention Workgroup	Frontline Primary Care Provider	Tribal Police Chief	Makah Tribe, OLYCAP, PCHS Pharmacy, Port Angeles Police Department, Clallam County Health and Human Services, Molina, Kitsap Public Health, Olympic College, Kitsap Mental Health Services, Coordinated Care, Port Gamble S'Klallam Tribe, Clallam County Jail, First Step Family Support Center, West End Outreach Services, Suquamish Tribe Wellness Center, Amerigroup, North Olympic Healthcare Network

6. Demonstrate how provider input has informed the project planning and selection process to date, beyond those provider organizations included directly in the ACH governance structure. ***(Note: In the Project Plan, the ACH will be required to identify partnering organizations and describe how it secured the commitment of partnering providers who: cover a significant portion of the Medicaid population, are critical to the success to the project, and represent a broad spectrum of care and related social services.)***

The 35 LOIs and 10 RFAs were submitted by partnering providers. The organizations (see tables below) that provided input into the proposals far surpasses Board representation. Yellow cells indicate organizations that are not represented on the Board as a Director or Alternate. Each

application required a partner commitment form that indicated the type of commitment: provide data, manage data, house intervention, provide staff, provide equipment, serve on committee, provide clinical champion, other.

Spotlight – **Community Paramedics**
Currently there are no first responders on the Board. Nonetheless, the Community Paramedicine application included budgets and commitments from 16 fire districts, representing all sub-districts in our region and one tribal EMS.

	2C	2C	2D	2D	2D
	Crossroads (transitions from jail to care)	Regional Care Transitions (transitions from hospital to home)	LEAD (diversions from jail booking)	Community Paramedicine	Outward Bound (community health workers in the ED)
Partner organization that took the lead in drafting the project proposal	Peninsula Community Health Services	Amerigroup	Peninsula Behavioral Health	Jefferson Healthcare	Peninsula Community Health Services
List of partnering provider organizations that formally committed to project proposal	North Olympic Health Network	Kitsap Area Agency on Aging	West End Outreach Services	East Jefferson Fire and Rescue	North Olympic Health Network
	CHI-Harrison Medical Center	Olympic Area Agency on Aging	Olympic Medical Center	Forks Community Hospital	CHI-Harrison Medical Center
	Olympic Medical Center	Forks Community Hospital	Port Angeles Police Department	Discovery Behavioral Healthcare	Olympic Medical Center
	Kitsap Community Resources	Jefferson Healthcare	Sequim Police Department	Jefferson County Public Health	Kitsap Community Resources
	Harrison Health Partners	Olympic Medical Center	Clallam County Sheriff Office	Jefferson Fire District 2, Quilcene	CHI - Harrison Health Partners
	Kitsap Mental Health Services	CHI Harrison Medical Center	North Olympic Health Network	Jefferson Fire District 4, Brinnon	Kitsap Mental Health Services
	Peninsula Behavioral Health	Peninsula Behavioral Health Services	Jamestown S'Klallam Family Health Center	Discovery Bay Fire and Rescue	Peninsula Behavioral Health
	Kitsap Dept. Human Services	West End Outreach Services	Clallam County Prosecuting Attorney	Clallam Bay	Project Access NW
	Bremerton Fire Department	Discovery Behavioral Health	Jefferson Healthcare	Clallam County Fire District 3	Kitsap County Human Services
	Kitsap Housing Authority	Kitsap Mental Health Services	Port Townsend Police Department	Neah Bay Ambulance	Bremerton Fire Department
	Bremerton Housing Authority		Discovery Behavioral Health	Olympic Ambulance	Kitsap Housing Authority
	Salish Behavioral Health Organization		CHI Harrison Medical Center	Bremerton Fire Dept	Bremerton Housing Authority
	Olympic Workforce Development Council		Kitsap Mental Health Services	North Olympic Health Network	Salish Behavioral Health Organization
	Kitsap County Sheriff's Office Jail		City of Poulsbo	Olympic Medical Center	Olympic Workforce Development Council
	City of Poulsbo		Kitsap County Human Services	Port Angeles Fire Dept	Community Health Plan of WA
	Washington State Department of Corrections		Suquamish Police Department	Peninsula Behavioral Health	Coordinated Care
	Kitsap County Treatment Court		Salish BHO	Serenity House	United Health Care
	Clallam County Sheriff			Peninsula Community Health Services	Molina
	Clallam County Superior Court			CHI Franciscan – Harrison	Amerigroup
	Kitsap County Superior Court			Central Kitsap Fire and Rescue	
	Kitsap County Prosecutor's Office			North Kitsap Fire and Rescue	
	Port Angeles Police Department			Olympic Area Agency on Aging	
	Clallam County Health and Human Services			Kitsap Mental Health Services	
	Kitsap Public Health District				
	Community Health Plan of WA				
	Coordinated Care				
	United Health Care				
	Molina				
	Amerigroup				
	OlyCAP				
	Jefferson County Sheriff				
	Jefferson County jail				
	Suquamish Tribe				
	Port Gamble S'Klallam Tribe				

	3B	3C	3C	3D	3D
	Healthy Beginnings (Nurse family partnership and parents as teachers)	FQHC Dental (expansion into North Kitsap)	Jefferson County (expansion in Jefferson County)	Breathe Easy (home visits and supports for people with asthma)	Chronic Care Model (Clinical transformation and community linkages)
Partner organization that took the lead in drafting the project proposal	Kitsap Public Health District	Peninsula Community Health Services	Jefferson Healthcare	Peninsula Community Health Services	Kitsap Public Health District
List of partnering provider organizations that formally committed to project proposal	Jefferson Public Health	North Olympic Health Network	Jefferson Public Health	North Olympic Health Network	North Olympic Health Network
	OlyCAP	CHI-Harrison Medical Center		CHI-Harrison Medical Center	Peninsula Community Health Services
	Peninsula Community Health Services	Olympic Medical Center		Olympic Medical Center	OlyCAP
	Kitsap Public Health District	Kitsap Community Resources		Kitsap Community Resources	Forks Community Hospital
	First Step Family Support Center	CHI - Harrison Health Partners		CHI - Harrison Health Partners	Kitsap Mental Health Services
		Kitsap Mental Health Services		Kitsap Mental Health Services	Olympic Area Agency on Aging
		Peninsula Behavioral Health		Peninsula Behavioral Health	CHI - Harrison Health Partners
		Project Access NW		Project Access NW	Jefferson Healthcare
		Kitsap Human Services		Kitsap Human Services	Jefferson Public Health
		Bremerton Fire Department		Bremerton Fire Department	Olympic Medical Center
		Fishline		Kitsap Area Agency on Aging	Kitsap Area Agency on Aging
		Kitsap Area Agency on Aging		Olympic Area Agency on Aging	Clallam Human Services
		Olympic Area Agency on Aging		Salish Behavioral Health Organization	Port Gamble S'Klallam Tribe
		Salish Behavioral Health Organization		Clallam County Human Services	
		Community Health Plan of WA		Kitsap Public Health District	
		Coordinated Care		Olympic Workforce Development Council	
		Amerigroup		Bremerton Housing Authority	
		Molina		Community Health Plan of Washington	
		United Health Care		Coordinated Care	
				Amerigroup	
				Molina	
				United Health Care	

Transparency and Communications

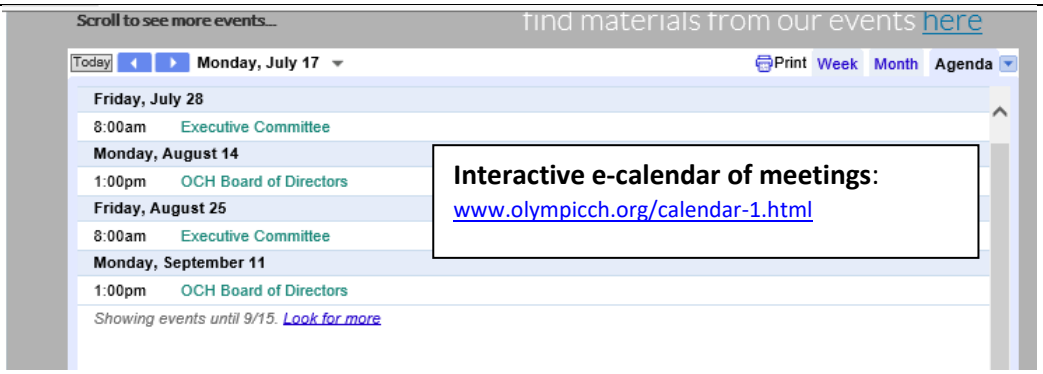
7. Demonstrate how ACH is fulfilling the requirement for open and transparent decision-making body meetings. When and where does the ACH hold its decision-making body meetings (for decisions that concern the demonstration)?

The OCH holds Board meetings (see e-calendar below) the 2nd Monday of each month, with rotating venues by county (2016: Clallam; 2017: Jefferson; 2018: Kitsap). Meetings are open with public seating, free parking, refreshments, and hard copies of materials. Meeting location, details and materials circulated and posted online at least 5 business days in advance and on Facebook, and in the monthly newsletter. Board materials are emailed to more than 60 people.

- 15 Board Directors
- 22 Tribal representatives
- 9 MCO representatives
- 6 Alternate Directors
- Partners requesting to be on the distribution list
- Government agency representatives
- Association representatives

Summary of attendance* at last 3 Board Meetings, 2017

Board Meeting Attendee	May	June	July
In-person director	13	14	17
Phone-in director	6	2	2
Non-voting members	4	3	2
Alternate director	2	1	2
Guests	13	6	6
Elected officials	2	1	0
Government agency representatives	3	1	2
Tribal members	7	2	4
** #s not mutually exclusive*			



8. What steps has the ACH taken to ensure participation at decision-making meeting? (i.e., rotating locations, evening meetings for key decisions, video conference/webinar technology, etc.) Are meeting materials (e.g. agenda and other handouts) posted online and/or e-mailed in advance?

The Board president takes questions and comments from the public during the meeting. The Board meeting location rotates by county by year. All meetings use audio and visual streaming with up to 100 dial-in lines with chats monitored by staff. Meetings are recorded and posted online. Meeting location, details and materials are disseminated and posted (website) at least 5 business days in advance (2016: 46 visitors June 2016-December 2016; 2017:46 visitors January 2017-July 2017), on Facebook and in the e-newsletter (distribution list=376).

9. Discuss how transparency has been handled if decisions are needed between public meetings.

If the need were to arise for a decision between Board meetings, which has not yet occurred, the bylaws allow for a special meeting of the Board. Special meetings must be publicly announced with as much notice as possible and would follow the transparency principles above. After deliberation at the July 2017 Board meeting, in the event of an emergency, the Board authorized the Executive Committee to act. The Executive Committee charter has been updated to reflect this new delegation of power. All Executive Committee materials are posted online ahead of meetings.

10. Describe the ACH's communications strategy and process. What communication tools does the ACH use? Provide a summary of what the ACH has developed regarding its web presence, including but not limited to: website, social media and, if applicable, any mobile application development.

OCH uses web, social media, e-newsletter, press releases, and surveys to communicate with the public, in addition to community presentations and engagement described in 4 above. The Board requires staff to collect, compile, and analyze community input to guide decision-making about projects.

Website functions:

- Resource page is updated with new materials and Demonstration information
- Google translator and search
- Direct contact to staff (includes email and phone number)
- Blog and e-newsletter
- Archives: previous newsletters, meeting materials, and other materials
- Sign-up for e-newsletter
- Interactive calendar
- Direct RSVP for meetings and upload meetings into google or outlook
- Links to social media and surveys

Social media data (as of 7/15/2017):

- Twitter: username: @olympicCH; tweets: 71; followers: 29
- Facebook: followers: 38; insights June 20-July 17: 6 posts; 2 new likes; 393 reached
- Instagram: username: olympiccommunityofhealth; posts 51; followers: 22

E-Newsletter Mailchimp insights:

- Newsletters since 1/2017: 15
- Targeted distribution lists: 6, ranging from 16 to 374 recipients
- Open rate: Upperbound=44%; Lowerbound=28%

E-survey Surveymonkey insights:

- Surveys since 1/2017: 8
- Respondents: Upperbound=477; Lowerbound=3; Average=78

Media samples:

- Kitsap Sun: February 4th: Three-county plan will confront opioid crisis
- Peninsula Daily News: January 27th: Opioid summit set Monday to review data, share potential solutions
- Peninsula Daily News: February 1st: Three-county opioid summit takes on region's opioid epidemic
- KONP radio: Regional summit planned on opioid abuse
- Kitsap Sun: March 11: Senator Cantwell discusses Medicaid roll back

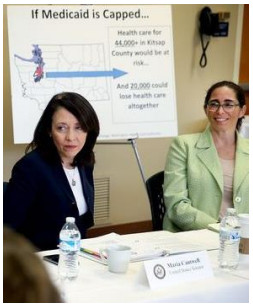


Photo: Larry Steagall / Kitsap Sun

Attachment(s) Required
A. Meeting minutes or meeting summaries for the last three decision-making body meetings and screenshot capturing distribution of meeting minutes/summaries (e.g., email distribution, website post). **B. List of all public ACH-related engagements or forums for the last three months.** **C. List of all public ACH-related engagements or forums scheduled for the next three months.** **D. Evidence of meaningful participation by community members. Examples include: attestation of meaningful participation by at least one Medicaid beneficiary, meeting minutes that memorialize community member attendance and comments, and solicitation for public comment and ACH response to public comments.** **E. Attestation of meaningful participation from at least three partners from multiple sectors (e.g., managed care organizations, Federally Qualified Health Centers, the public health community, hospitals, primary care, and behavioral health) not participating directly on the decision-making body.**

Budget and Funds Flow – 15 points
Description Design funding is designed to ensure ACHs have the resources necessary to serve as the regional lead for Medicaid Transformation. Provide a description of how design funding has been used to date to address capacity and staffing needs and ensure successful Project Plan development. Through required Attachment C, provide a projected Phase II Project Design fund budget over the course of the demonstration. ACH oversight of project incentive payments will be essential to the success of the demonstration. Summarize preliminary plans for funds flow and incentive payment distribution to partnering providers. Identify and address any updates/improvements to the ACH's Budget and Funds Flow since Phase I Certification.
Instructions ***Complete the attestations and provide a response to each question.*** *Total narrative word-count for the category is up to 1,500 words.*
ACH Attestation(s)
ACH has secured the primary decision-making body's approval of detailed budget plan for Project Design funds awarded under Phase I Certification ☒ **YES** **Date of Approval: July 10, 2017**
ACH has secured the primary decision-making body's approval of approach for projecting and budgeting for the Project Design funds anticipated to be awarded under Phase II Certification ☒ **YES** **Date of Approval: July 10, 2017**
Project Design Funds
1. Discuss how the ACH has used Phase I Project Design funds. Provide percent allotments in the following categories: ACH Project Plan Development, Engagement, ACH Administration/Project Management, Information Technology, Health Systems and Community Capacity Building, and Other.
Phase I Design Funds: The Board voted (7/10/2017) to reserve Phase I and Phase II Design Funds to cover OCH operational and project management expenses between 2017 and 2021. Any DSRIP-related expenses, not covered by Design Fund dollars, will be drawn from DSRIP payments or other funding sources. If those sources do not materialize, the OCH will scale back operations accordingly. Prior to July 1, 2017, OCH financed its Demonstration activities with Category 2 SIM resources, and $220,000 in SIM balance transferred from Kitsap Public Health District. OCH's Opioid Response

Project was financed with Category 3 SIM funding. OCH did not begin drawing down on Phase I Design Fund resources until July 1, 2017.

The budget template braids revenue from SIM, DSRIP, Phase I, and Phase II expenditures to illustrate the total estimated cost to deliver the Demonstration.

Budget Template Narrative (highlights) and Percent Allotments

Project Plan Development [4% total budget; 5% Design Funds]

- Professional service contracts to assist application teams (April-May); additional research on return on investment, budget, and workforce (June-July)
- Multiple subject matter expert professional service contractors to assist developing project plans (May-November)
- Convened 10 project action teams to provide project plan technical assistance
- Data and evaluation contractor to assist application teams, synthesize data, collect baselines, and analyze community surveys

Engagement [10% total budget; 11% Design Funds]

- Convene three public meetings (January, June, and September) for bi-directional communication of projects; convene monthly tribal meetings
- Use of focus groups, community surveys, consumer champions, stipends and other assistance to reduce obstacles to consumer engagement; includes reimbursement for time, travel, and childcare
- Professional tribal liaison on staff

ACH Administration/Project Management [52% total budget; 64% Design Funds]

- Professional service contracts for HR, CPA, CFO services
- Administrative service contracts for bookkeeping, payroll, taxes, rent, I.T., audit [Note: In 2018 OCH will internalize many of these services with the Director of Finance and Administration]
- Professional services contract with a predictive modeler to model performance and provider incentive payment and advise on data infrastructure capacity needs
- Data and evaluation contract vendor to provide ongoing assistance with the regional health needs inventory, project planning, and data technical assistance to partnering organizations
- Project management subcontracted to partner organizations to allow for organization-based coordination of projects.

Information Technology [19% total budget; 6% Design Funds]

- Administrative systems such as statistical software, customer relationship management software and contract compliance software
- Health IT/HIE development of Apple Integrator (A.I) to connect health and social service providers into a cloud-based e-referral management network. A.I. can transition into Pathways later and is defined as Domain 1 activity in the toolkit:

  "… information exchange for community-based, integrated care… tailored based on regional providers' current state of readiness and the implementation strategies selected within Domain 2 and Domain 3".

- ACH data capacity to manage all analytic projects and integrate data-driven decision making into all elements of OCH strategic development, operations, and communications
- Provider data capacity development to assist in population health information technology build-out and workforce training

Health Systems and Community Capacity Building [15% total budget; 14% Design Funds]

- Provider training: e.g., collaborative care model (integration), six building blocks (opioid treatment), population health management (VBP)
- VBP preparedness through investments in governance/workflow, care coordination/care management, population health management, and clinical-community linkages
- Clinical input into design and review of protocols

2. Describe how the ACH plans to use Phase II Project Design funds to support successful Project Plan development.

Phase II Project Design funds directly support project plan development through:

- Hiring of key personnel:
  - Project Coordinator: Coordinate the planning, operations, assessment, analysis and performance of Medicaid Demonstration Transformation projects and programs.
  - Director of Transformation: Lead the planning and implementation of programs and initiatives under the Demonstration.
  - Provider Outreach Coordinator: Coordinate the planning, operations, assessment, analysis and performance of Medicaid Demonstration Transformation projects and programs in the provider setting.
- Enhancement of community and provider engagement activity
- Feasibility testing of Apple Integrator
- Professional service contracts based on subject matter expertise:
  - *Kitsap Public Health District* – provide analytics and evaluation to support selection, design, and ongoing monitoring of projects
  - *Seattle King County Public Health* – provide data visualization to integrate data-driven decision making
  - *Walter Sive* – provide performance and payment modeling to drive investments and engage providers
  - *Rochelle Doan* – lead bi-directional integration of care project plan and provide strategic consultation on overall systems integration under the portfolio
  - *Jody Carona* – portfolio assessment and planning with hospital partners
  - *Rob Arnold* – general contractor for Apple Integrator, liaise with vendors and provide technical guidance
  - *National Support Bureau* – law enforcement assisted diversion
  - *Brian Burwell* – opioid use disorder treatment expert

3. Describe what investments have been made or will be made through Project Design funds in the following capacities: data, clinical, financial, community and program management, and strategic development.

Data

- 0.6 FTE Reporting and Analytics Lead; 0.3 FTE Analyst, both subcontracted with Kitsap Public Health District
- Data analysis and visualization, contracted with Seattle King County Public Health
- Strategic consultation on options for data feeds, harmonization, management, performance monitoring, reporting, confidentiality, and integration
- Purchase and/or licensing of statistical software package, CRM, cloud-based server, reporting system

Clinical

- Subject matter expert contracts in opioid treatment, integration, and chronic disease management
- Provider training, such as the 6 building blocks for safe, team-based opioid prescribing
- VBP preparedness investments in core infrastructure components such as care coordination/management, referral management, performance management and patient engagement
- Support of population health management, such as data aggregation and risk stratification, and workforce training on how to use data to manage population-level health
- Clinical champions to provide input into design and review of protocols

Financial

- Contract with accounting firm to provide accounting, bookkeeping, payroll, and CFO services
- Investment in funds flow modeling
- Hiring Director of Administration and Finance; Contract Compliance Coordinator

Community and Program Management

- Hiring of key personnel
- Project management, including project plan design and development, both within the OCH and subcontracted within key implementing organizations

Strategic Development

- Hiring of Director of Medicaid Transformation
- Contract with systems integration consultant
- Contract with finance and performance modeler to run simulations to guide key decisions:
    - Target population, subpopulation
    - Evidence-based intervention(s)
    - Footprint
    - Number, type, and location of participating providers
    - Timing to bring to scale to hit P4P benchmarks

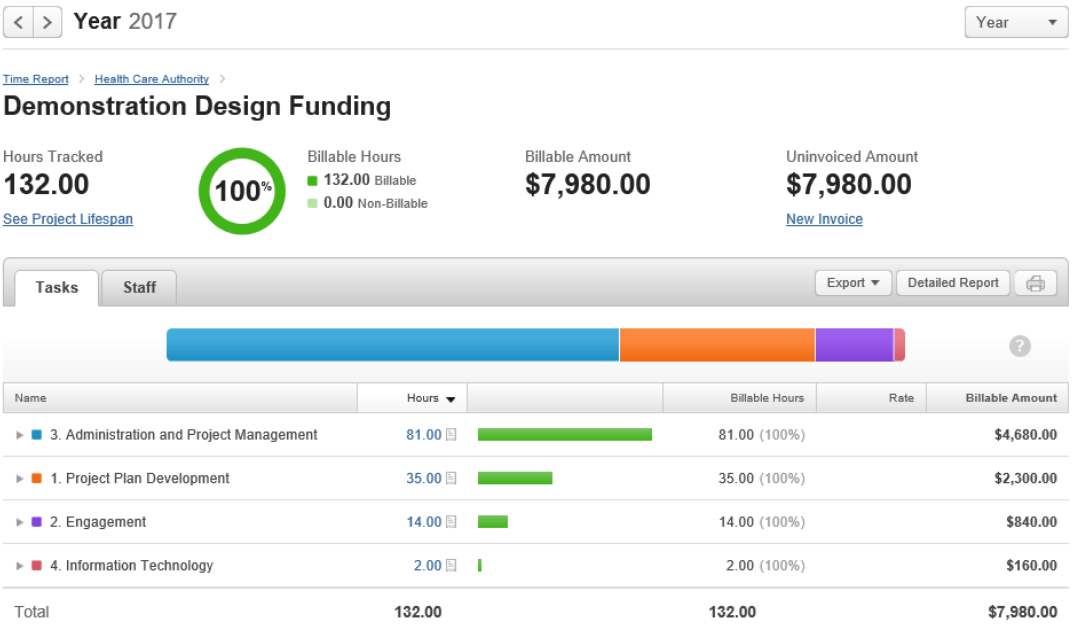
4. Describe the process for managing and overseeing Project Design fund expenditures.

The OCH has fiscal policies and procedures (Attachment X) in place to manage and oversee Project Design Funds.

- The OCH receives accounting, bookkeeping, payroll, tax, and CFO services from Gooding, O'Hara, & Mackey. The CFO meets every other week with the executive director (ED), quarterly with the ED and Treasurer, and attends Finance Committee meetings. Currently the CFO sends monthly financials to the ED for review. Quarterly financials are prepared and reviewed in 4 stages: 1) the ED, 2) the Treasurer, 3) the Finance Committee (FC) to

recommend to the Board, and 4) to the Board for acceptance. Quarterly financials include a Balance Sheet, Profit and Loss Budget vs. Actual with Variance, and a Profit and Loss by Class.

- A *Fiscal Policies and Procedures Manual,* approved by the Board, articulates internal controls by which the OCH manages and oversees Design Funds. (Attachment X)
- Under the direction of the FC, the OCH released an RFP for an independent audit to perform a single audit for the 2017 fiscal year (responses due August 18th).
- The OCH uses Harvest Google (see below), an online timekeeping service that tracks employee hours by budget category. Data from Harvest Google is exported each month and sent to the bookkeeper to be integrated into the Profit & Loss Statement by Category. All payroll expenses are allocated based on the percentage of time reported for each budget category. Our practice follows federal reporting guidelines and our categories are compliant with our contracts.
- With the onboarding of 10+ staff, the OCH will hire a Director of Administration and Finance in 2018, reducing the role of Gooding, O'Hara and Mackey.
- Board reviews and approves the operating budget at the annual meeting in November and in accordance with the bylaws. The Board is the ultimate decision-making authority and has fiduciary responsibility over the organization, including the Demonstration.



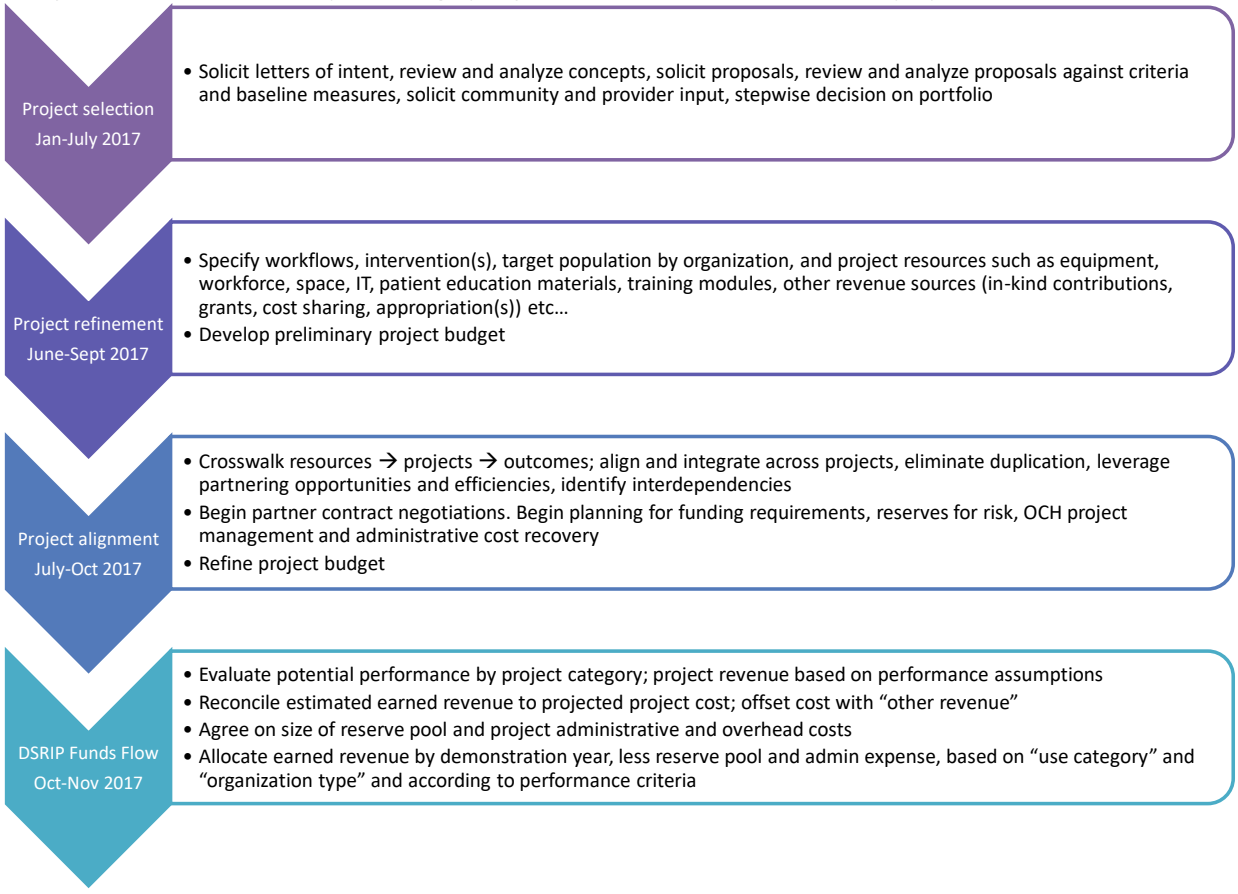
Incentive Fund Distribution Planning

5. Describe the ACH's Project Incentive fund planning process to date, including any preliminary decisions, and how it will meet the Project Plan requirement. *(Note: In the Project Plan, the ACH will be required to describe how Project Incentive funds will be distributed to providers.)*

The OCH is investigating models to allocate incentive payments to partner organizations. Models include project cost-based, performance-based, relative size (#patients attributed/served), revenue loss compensation, flat participation fee, and uncovered service compensation. As indicated in the graphic below, there are multiple specifications that are needed before funds flow modeling can begin and agreements between OCH and its project partners can be put in place, such as:

- selection of evidence based programs and target population
- assessment of project resources and in-kind contributions
- project budget projections
- alignment of resources, projects, and outcomes
- agreement on performance targets
- modeling of project parameters to predicted outcomes and earnable incentives per participating partner organization

Project incentive fund planning: project selection → incentive payment



The OCH scheduled five meetings between the Executive Committee, Executive Director, and senior leadership of each MCO to discuss mutually beneficial strategies and value-based purchasing (VBP) goals to sustain transformation post Demonstration.

Other considerations under discussion for DSRIP funding allocation include:

- Create an Olympic Community of Health Contracting Authority, comprised of representatives of OCH and project partners, to receive full allocation from financial executor and allocate to project partners
- Withhold for OCH operational reserves and regional transformation activity (e.g., Domain 1 activity)
- Withhold for a risk/reward pool

- Withhold for a Wellness Fund to support projects not able to be supported under the Demonstration, that address upstream, social influences of health (e.g., early childhood and family supports), and that align with the OCH five-year strategic plan (e.g., obesity, housing, oral health)

Relationship to Other Funds and Support

6. Describe any state or federal funding provided to the ACH and how this does or does not align with the demonstration activities and funding (e.g., state and federal funds from SIM, DOH, CDC, HRSA).

The OCH has two funding sources outside of the Demonstration:

1. SIM – The OCH expended SIM funds through June 2017 to *align regional priorities and projects with activities across Healthier Washington (e.g., MTP Demonstration)* in accordance with Category 2 in the SIM Y3 contract.
2. Partner contributions – The OCH sought partner contributions to cover food/refreshment expense for meetings and to provide bridge funding for the Opioid Response Project (funding gap: February to April 2017).

Depending on final portfolio, the OCH may also seek local municipal funding, particularly for projects of interest to local county governments such as LEAD or community paramedics.

7. Describe what investments (e.g., convening space, volunteer positions, etc.) have been made or will be made for the demonstration through in-kind support from decision-making body/community members in the following capacities: data, clinical, financial, community and program management, and strategic development.

Data

- Pledged commitment in project application by most partner organizations to report measures

Clinical

- Frontline provider participation on Committees and Board
- Frontline provider chairs Opioid Steering Committee
- Frontline provider and administrators draft and review materials and proposals

Financial and Legal

- Treasurer meets monthly with the ED and is always on call to answer questions
- Financial review of documents and contracts by hospital and FQHC CFOs
- Legal review of bylaws and policies by legal counsel on retainer by hospital and tribal representatives on the Board

Community and program management

- Treasurer coaches ED in financial management under the Demonstration
- Financial review of documents and contracts by hospital and FQHC CFOs
- Community partners drafted 35 letters of intent and submitted 10 project proposals

Strategic development

- Kitsap Public Health District donated $98,000 in-kind while OCH was hosted at KPHD
- Discussions with University of Washington and Olympic Community College to host student intern or practicum opportunities; Plan to apply for AmeriCorps workforce

Other

- Jamestown S'Klallam donates venue, coffee, and audio/visual for community forums
- Jamestown S'Klallam and Suquamish Tribe covered catering for the annual Board meeting

Attachment(s) Required
A. Bio or resume for the Chief Financial Officer (CFO) or equivalent person responsible for ACH financial functions. **B. Financial Statements for the previous four quarters. Audited statements preferred. If an ACH does not have four quarters of financial statements available, provide as many as possible.** **C. Completed Phase II Project Design Funds Budget Template, which includes Projected Project Design fund budget over the course of the demonstration, additional funding sources, and in-kind resources that the ACH expects to leverage to prepare their Project Plans and build the capacity and tools required to implement the Medicaid Transformation Project demonstration.**

Clinical Capacity – 15 points

Description

Provide a summary of current work the ACH is undertaking to secure expertise and input from clinical providers. The ACH should describe strategies that identify and address gaps and make progress toward a redesigned system using statewide and regional education, workforce, and clinical systems partners. Identify and address any updates/improvements to the ACH's Clinical Capacity and Engagement since Phase I Certification.

Instructions

Provide a response to each question. *Total narrative word-count for the category is up to 1,250 words.*

Clinical Expertise

1. Demonstrate how clinical expertise and leadership are being used to inform project selection and planning to date.

Clinical and workforce expertise is incorporated through:

Board and Committee membership

- Board of Directors: 3 MDs, 1 RN, 1 MSW, 1 PharmD, 1 CDP
- Regional Health Assessment Planning Committee: 2 RNs, 1 Paramedic, Director of Regional Workforce Council
- Opioid Steering Committee/Workgroups: > 5 MDs (at least one MD and/or ARNP chair per committee - Attachment X); CDPs, MSWs, Paramedics

Leadership in community forums

Process for project selection and planning included two community forums; local clinical providers attended and presented project ideas e.g. an oral health project was presented by Dr. Tom Locke (Attachment X), a three-county coordinated opioid response implementation plan was presented by Drs. Chris Frank (Attachment X) and Susan Turner (Attachment X, image to left).

Participation and Leadership: Letter-of-intent (LoI) and Proposal Teams

35 LOIs and 10 proposals for project ideas were submitted by partnering providers, including multiple clinical partners (see table below). Clinical providers participated in co-authoring proposals and dozens formally committed to these proposals (i.e. provide data, manage data, house intervention, provide staff, equipment, serve on committee, provide clinical champion, other). One clinical partner, Peninsula Community Health Services (PCHS) - caring for 25% of OCH Medicaid lives - played a significant leadership and convening role in four of ten proposals.

Providers shared key, organization-level data elements to allow for evidence-based project selection and planning with data points for:

- Existing workforce (e.g., FTE for MDs, RNs, MSWs)
- Data measurement, reporting capacity
- Emergency department visits (by age, year, primary reason)
- Hospitalizations (by age, year, primary reason)
- Prevalence of disease burden (by major chronic condition such as diabetes, hypertension, asthma)

Green cells indicate clinical provider organizations that formally committed to project proposals.

	2C	2C	2D	2D	2D
	Crossroads (transitions from jail to care)	Regional Care Transitions (transitions from hospital to home)	LEAD (diversions from jail booking)	Community Paramedicine	Outward Bound (community health workers in the ED)
Partner organization that took the lead in drafting the project proposal	Peninsula Community Health Services	Amerigroup	Peninsula Behavioral Health	Jefferson Healthcare	Peninsula Community Health Service
List of partnering provider organizations that formally committed to project proposal	North Olympic Health Network	Kitsap Area Agency on Aging	West End Outreach Services	East Jefferson Fire and Rescue	North Olympic Health Network
	CHI-Harrison Medical Center	Olympic Area Agency on Aging	Olympic Medical Center	Forks Community Hospital	CHI-Harrison Medical Center
	Olympic Medical Center	Forks Community Hospital	Port Angeles Police Department	Discovery Behavioral Healthcare	Olympic Medical Center
	Kitsap Community Resources	Jefferson Healthcare	Sequim Police Department	Jefferson County Public Health	Kitsap Community Resources
	Harrison Health Partners	Olympic Medical Center	Clallam County Sheriff Office	Jefferson Fire District 2, Quilcene	CHI - Harrison Health Partners
	Kitsap Mental Health Services	CHI Harrison Medical Center	North Olympic Health Network	Jefferson Fire District 4, Brinnon	Kitsap Mental Health Services
	Peninsula Behavioral Health	Peninsula Behavioral Health Services	Jamestown S'Klallam Family Health Center	Discovery Bay Fire and Rescue	Peninsula Behavioral Health
	Kitsap Dept. Human Services	West End Outreach Services	Clallam County Prosecuting Attorney	Clallam Bay	Project Access NW
	Bremerton Fire Department	Discovery Behavioral Health	Jefferson Healthcare	Clallam County Fire District 3	Kitsap County Human Services
	Kitsap Housing Authority	Kitsap Mental Health Services	Port Townsend Police Department	Neah Bay Ambulance	Bremerton Fire Department
	Bremerton Housing Authority		Discovery Behavioral Health	Olympic Ambulance	Kitsap Housing Authority
	Salish Behavioral Health Organization		CHI Harrison Medical Center	Bremerton Fire Dept	Bremerton Housing Authority
	Olympic Workforce Development Council		Kitsap Mental Health Services	North Olympic Health Network	Salish Behavioral Health Organization
	Kitsap County Sheriff's Office Jail		City of Poulsbo	Olympic Medical Center	Olympic Workforce Development Council
	City of Poulsbo		Kitsap County Human Services	Port Angeles Fire Dept	Community Health Plan of WA
	Washington State Department of Corrections		Suquamish Police Department	Peninsula Behavioral Health	Coordinated Care
	Kitsap County Treatment Court		Salish BHO	Serenity House	United Health Care
	Clallam County Sheriff			Peninsula Community Health Services	Molina
	Clallam County Superior Court			CHI Harrison Medical Center	Amerigroup
	Kitsap County Superior Court			Central Kitsap Fire and Rescue	
	Kitsap County Prosecutor's Office			North Kitsap Fire and Rescue	
	Port Angeles Police Department			Olympic Area Agency on Aging	
	Clallam County Health and Human Services			Kitsap Mental Health Services	
	Kitsap Public Health District				
	Community Health Plan of WA				
	Coordinated Care				
	United Health Care				
	Molina				
	Amerigroup				
	OlyCAP				
	Jefferson County Sheriff				
	Jefferson County jail				
	Suquamish Tribe				
	Port Gamble S'Klallam Tribe				

	3B	3C	3C	3D	3D
	Healthy Beginnings (Nurse family partnership and parents as teachers)	FQHC Dental (expansion into North Kitsap)	Jefferson County (expansion in Jefferson County)	Breathe Easy (home visits and supports for people with asthma)	Chronic Care Model (Clinical transformation and community linkages)
Partner organization that took the lead in drafting the project proposal	Kitsap Public Health District	Peninsula Community Health Services	Jefferson Healthcare	Peninsula Community Health Services	Kitsap Public Health District
List of partnering provider organizations that formally committed to project proposal	Jefferson Public Health	North Olympic Health Network	Jefferson Public Health	North Olympic Health Network	North Olympic Health Network
	OlyCAP	CHI-Harrison Medical Center		CHI-Harrison Medical Center	Peninsula Community Health Services
	Peninsula Community Health Services	Olympic Medical Center		Olympic Medical Center	OlyCAP
	Kitsap Public Health District	Kitsap Community Resources		Kitsap Community Resources	Forks Community Hospital
	First Step Family Support Center	CHI - Harrison Health Partners		CHI - Harrison Health Partners	Kitsap Mental Health Services
		Kitsap Mental Health Services		Kitsap Mental Health Services	Olympic Area Agency on Aging
		Peninsula Behavioral Health		Peninsula Behavioral Health	CHI - Harrison Health Partners
		Project Access NW		Project Access NW	Jefferson Healthcare
		Kitsap Human Services		Kitsap Human Services	Jefferson Public Health
		Bremerton Fire Department		Bremerton Fire Department	Olympic Medical Center
		Fishline		Kitsap Area Agency on Aging	Kitsap Area Agency on Aging
		Kitsap Area Agency on Aging		Olympic Area Agency on Aging	Clallam Human Services
		Olympic Area Agency on Aging		Salish Behavioral Health Organization	Port Gamble S'Klallam Tribe
		Salish Behavioral Health Organization		Clallam County Human Services	
		Community Health Plan of WA		Kitsap Public Health District	
		Coordinated Care		Olympic Workforce Development Council	
		Amerigroup		Bremerton Housing Authority	
		Molina		Community Health Plan of Washington	
		United Health Care		Coordinated Care	
				Amerigroup	
				Molina	
				United Health Care	

** Note: for purposes of this example, payers, first responders, and long-term care services are not categorized as "clinical providers".*

2. Discuss the role of provider champions for each project under consideration.

OCH is aligning provider champions and subject matter experts (SMEs) in population health management/I.T., workforce development, and project activity. The goal is to evolve from *project-specific* → *transformation* activity. To do this, we will align multiple champions and SMEs to drive systems transformation through oral health, child and reproductive health, opioid prescribing, and bi-directional integration. Many individuals listed below already have contracts with the OCH, some are in development, some in negotiations. OCH's preference is to identify champions with subject matter expertise and local experience, through life or work, or previous working relationships. **Local** is a core value of our community.

Alignment of clinical, SME, and workforce champions for each project under consideration								
Domain 1			Integration and Transformation	Diversion*	Opioid Response	Maternal and Child Health and Reproductive Health	Oral Health Access	Chronic Disease Prevention and Control
Workforce	Value-Based Payment	Population Health Management/ I.T.	Bree Collaborative Collaborative Care Model Millbank Report 6 Building Blocks Bright Futures	Community Health Workers in E.D. and corrections/jail	Three-County Coordinated Opioid Response (related to integration)	Bright Futures (related to integration)	Expansion of dental; oral health in long term care; oral-primary care integration	Chronic Care Model; Stanford Chronic Disease Self-Management; Diabetes Prevention Program; Asthma home assessment (related to integration)
Rochelle Doan`	Walter Sive`	Rob Arnold`	Rochelle Doan`	Jennifer Kreidler Moss, PharmD**	Chris Frank, MD, PhD**	TBD	Tom Locke, MD**	Kate Weller, MD^
Elizabeth Court	MCOs	Walter Sive`	Maria Klemesrud	Mike Maxwell, MD^	Susan Turner, MD^		Arcora Foundation^	Katie Eilers, RN**
	SBHO	Simcosky	Jody Carona`	Gary Kreidberg, MD^	CDPT^			
		Joe Roszak	Maccoll Institute		Jean Riquelme, MD^			
			Karen Pastori		Wendy Sisk, LMHC, DMHP, GMHS^			
** OCH is still deliberating on two additional diversion strategies: 1) law enforcement-assisted diversion and 2) community paramedicine*								
*** Board Director clinincal champion*								
^ Non-Board Director clinical champion								
` Paid (or planned paid) contractor								
NOTE: The table above depicts our assumptions as to the final OCH Portfolio. This will likely not be finalized until September 2017								

Clinical Input

3. Demonstrate that input was received from clinical providers, including rural and urban providers. Demonstrate that prospective clinical partnering providers are participating in project planning, including providers not serving on the decision-making body.

The LOI and proposal process (March 20th to April 12th) yielded clinical provider input from urban, rural geographies and Tribes. The Board asked the RHAP Committee to review LOIs and invite promising ideas to submit full applications. Thirty-five LOIs were received, 26 from clinical provider organizations, all 35 listed committed partnerships from clinical provider organizations. The RHAP Committee recommended 12 project application teams, achieved by combining multiple LOIs into single applications and expansion of partner organizations and regions.

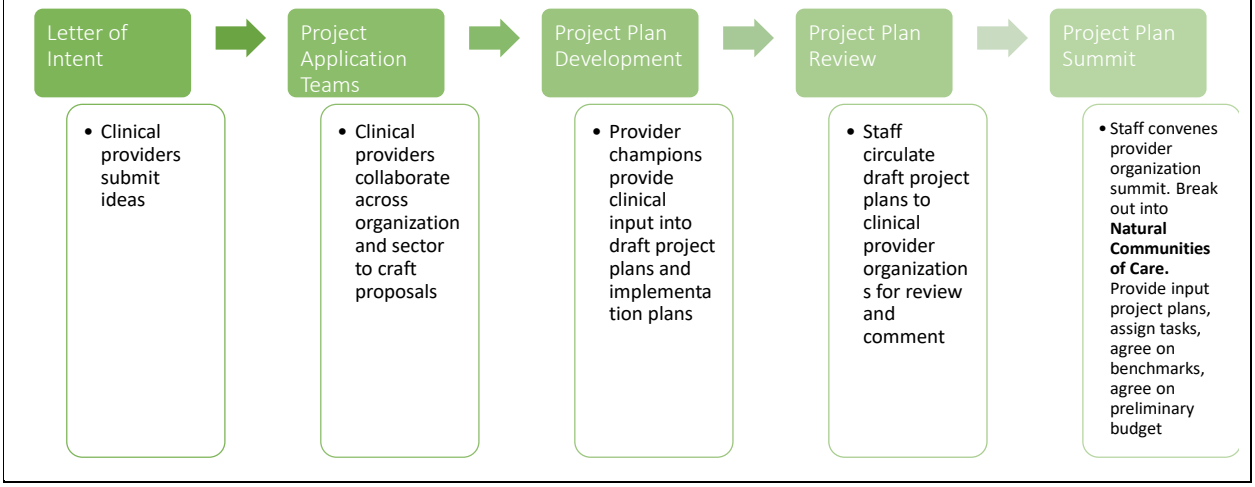
Project application teams included frontline providers and administrators from local clinical organizations, many not participating on the Board. Teams met multiple times April through May to craft proposals.

OCH is identifying and assigning provider champions to provide clinical input into further project plan development. For example:

- **Kate Weller, MD**, (Attachment X) CMO for North Olympic Health Network - Chronic Care Model implementation plan for primary care
- **Brian Burwell, LCSW, CDP**, (Attachment X) co-occurring disorders specialist at Suquamish Tribe Wellness Center - opioid treatment/prevention implementation plan.

All project plans will be sent for comments to partner clinical provider organizations, a summit hosted, and clinical provider organizations asked to break-out into **Natural Communities of Care** to provide key project plan elements inputs.

Clinical Provider Input in Project Planning



Letters of Intent: 35 Project Ideas Received, 26 from Clinical Provider Organizations (denoted with a "*")						
#	Lead	Project Title	Clallam	Jefferson	Kitsap	Tribe
Care Coordination						
1	Project Access NW	Care Coordination		1	1	
2	Olympic Medical Center*	Case Management in Primary Care	1			
3	MCOs	Community-Based Care Coordination: Olympic Community of Health	1	1	1	
4	Suquamish*	Suquamish Tribe Horizontal Integration of Services			1	Suquamish
5	Peninsula Behavioral Health*	Expanding Community Based Care Coordination Services	1	1		
Chronic Disease Prevention and Control						
6	Peninsula Community Health Services*	Breath Easy - Kitsap and Clallam	1	1	1	
7	Suquamish*	Chronic Disease Prevention and Self-Management Program: Diabetes within a Tribal Community			1	Suquamish Port Gamble
8	Public Health	Coordinated chronic disease prevention and control in the Olympic Community of Health region	1	1	1	all
9	North Olympic Health Network*	Chronic Care Model	1			
10	Peninsula Community Health Services*	Club Good Life - Kitsap	1		1	
11	Olympic Area Agency on Aging	Region Wide Chronic Disease Self-Management Program	1	1	1	all
12	Olympic Medical Center*	Improving population health through community-based chronic disease management and disease prevention through wellness	1			Jamestown
13	North Olympic Health Network*	Population Health Management using iTi and Centerprise	1			Jamestown
14	Peninsula Community Health Services*	Million and One Hearts – Kitsap			1	
Diversion						
15	North Olympic Health Network*	Community Paramedic	1			Jamestown
16	Jefferson EMS	Decreasing Use of Emergency Services and Improving Health through Community Paramedicine	1	1	1	Makah
17	North Olympic Health Network*	Emergency Department (ED) Diversion and Transitions of Care Out of ED	1		1	Jamestown
18	Peninsula Community Health Services*	Outward Bound – Kitsap			1	
19	North Olympic Health Network*	Law Enforcement Diversion and Transitional Care Management for People Leaving Incarceratio	1		1	Jamestown
20	Peninsula Behavioral Health*	Criminal Justice Diversion Intervention	1			Lower Elwha Jamestown
21	North Olympic Health Network*	Mobile Care Team	1		1	Jamestown
Reproductive and Maternal and Child Health						
22	Public Health	Nurse-Family Partnership-Bridge Partnership Expansion to Clallam County	1	1	1	Port Gamble
23	Peninsula Community Health Services*	Bright Parents (Parents as Teachers and Bright Futures)			1	
24	Family Institute	Parents as Teachers			1	
25	Planned Parenthood*	Improving Reproductive Health: A Partnership between Planned Parenthood and Tribal Nations	1	1	1	all
Oral Health Access						
26	Service with a Smile*	Dental Health Rewards			1	
27	Jefferson Healthcare*	Improving Access to Dental Care in Jefferson County: A Multipronged Approach		1		
28	Peninsula Community Health Services*	FQHCs – Achieving Oral Health Delivery Integration in Primary Care	1		1	
29	North Olympic Health Network*	School Based Health Clinic	1			
Transitions of Care						
30	Forks Community Hospital*	West-End Chronic Disease Prevention and Control, Diversion Intervention and Care Transitions				
31	Kitsap Area Agency on Aging	Regional Care Transitions Project	1	1	1	
32	Serenity House	Outreach, Stabilization & Economic Growth Program	1	1	1	
33	Peninsula Behavioral Health*	Expanding Transitional Care in Clallam County	1			Lower Elwha Jamestown
34	Suquamish and Port Gamble S'Klallam*	Transitional Care for Persons with Health and Behavioral Health Needs After Incarceration			1	Suquamish Port Gamble
35	Peninsula Community Health Services*	Crossroads Kitsap and Crossroads Clallam	1	1	1	

4. Demonstrate process for assessing regional clinical capacity to implement selected projects and meet project requirements. Describe any clinical capacity gaps and how they will be addressed.

Phase I

Snapshot below depicts first phase regional clinical capacity assessment for project implementation, completed May 26, 2017 (proposal template image). Each applicant provided target population, footprint, and workforce data, stratified by each collaborating organization. Applicants were asked to list specific metrics (pre-populated from toolkit) the project would impact, report how they would use each metric to drive performance improvement, whether they could collect and share a metric on behalf of their organizations, how frequently and at what level (e.g., provider-level, disease-level, demographic-level.)

SECTION D. POPULATION, APPROACH, AND RESULTS - Use the prepopulated Section D table for the specific project area of your application. The prepopulated information comes directly from the first pages for each project area as written in the Toolkit.

ELEMENT	DESCRIPTION	RESPONSE			
TARGET POPULATION	Who is the target population for your project? How many unique individual do you expect to serve? How many Medicaid providers?	**TARGET POPULATION** *Broad definition (e.g., pregnant women living in…)*	**ESTIMATED # and % MEDICAID BENEFICARIES** *Estimated unique # of Medicaid lives; proportion of Medicaid population that will be served. Where appropriate, breakdown by county and/or Tribe.*	**ESTIMATED # FTE and TYPE of CLINICAL MEDICAID PROVIDERS** *Estimated # full-time equivalents and type of licensure (e.g., nurse, MD, DO, LMHP…) by each partner organization.*	**ESTIMATED # FTE and TYPE of NON-CLINICAL MEDICAID PROVIDERS** *Estimated # full-time equivalents and type (e.g., educator, community health worker…) by each partner org.*
				Organization 1: **Organization 2:** **Organization 3:**	**Organization 1:** **Organization 2:** **Organization 3:**

January 2017 OCH released clinical provider survey results aimed to better understand current practices and opportunities for responding to the opioid crisis (N_{Total}=75; Clallam N=28; Jefferson N=12; Kitsap N=35). A survey of SUD providers is under development by the Opioid Treatment Workgroup (planned release, September 2017).

Phase II

Next phase, completed and distributed June 2017, was a literature search on each proposed evidence-based program to gauge impact and return on investment. The Reporting and Analytics Lead compiled and shared baseline data for each project.

Phase III

OCH receives data from HCA AIM Team, these are synthesized and integrated into Board reports for data-driven decision-making.

OCH partners with Practice Transformation HUB Coach and Transforming Clinical Practice Coaches to integrate practice-based assessments (workforce, HIT, PCMH-A, MeHAF) into our assessment. Qualis and OCH co-developed a letter to practices asking that a copy of assessment results be shared with OCH; OCH outreach to providers includes a strong recommendation to partner with the Hub. As of August 4, 2017, 26 clinic-based assessments were underway or completed!

OCH engaged NW Center for Public Health Practice to ask that results from the Washington Practice Transformation Assessment be shared. This survey contains information on:

- number, type of providers
- patient demographics (of interest are measures of SDOH)
- payer mix
- clinical-community linkages
- physical and behavioral health integration
- value-based payment contracts

OCH has two delegates on VBP Action Team: Joe Roszak and Karol Dixon. OCH outreach to providers makes strong recommendation to cc all VBP survey results directly to OCH.

Phase IV

OCH staff carefully reviewed the project plan template, matching data sources with each requirement. Two identified clinical capacity gaps will require primary data collection between now and November 2017:

1. capacity or access gaps identified by Medicaid population's health care and health care access needs
2. Medicaid beneficiary population's level of access or connection to care, and greatest barriers to accessing needed health care and supportive services

OCH contracting professional services (Attachment X) to integrate data inputs described here and the Data/ Analytic Capacity Section into a simulator to predict performance and associated payment. Minimum viable set of inputs include:

- Target population (including subpopulation)
- Evidence-based intervention(s)
- Footprint (number people touched)
- Number, type, location of participating providers
- Timing to bring to scale to hit P4P benchmarks

5. Demonstrate how the ACH is partnering with local and state clinical provider organization in project selection and planning (e.g., local medical societies, statewide associations, and prospective partnering providers).

OCH partners with local and state clinical provider organizations in the Demonstration process, including project selection and planning. OCH clinical providers have working relationships with their respective associations and societies, leveraging these relationships to build connection such that:

- WSHA-WSMA Opioid Task Force draws on Dr. Scott Kennedy's leadership, CMO at Olympic Medical Center, participant 3CCORP Steering Committee.
- Bree Collaborative Opioid Workgroup draws on Dr. Dave Beck, Port Gamble S'Klallam Tribe physician, 3CCORP participant.
- Each county public health department health officer is WSALPHO member, active in 3CCORP.

- Eric Lewis, CEO Olympic Medical Center, is Secretary-Treasurer of WSHA Board of Trustees; Elya Moore invited to present about Demonstration at WSHA conference.
- WSHA convened two meetings of WSHA members, UW experts, and ACH teams, to collaborate on project planning for toolkit opioid project, OCH Team attended.
- OCH staff attend county MH/SUD provider meetings to provide updates.
- OCH works with PNW Family Medicine Residency Program to collaborate on curricula for residents to improve clinical care and coordination of treatment; Olympic Community College CDP Training Program to develop CEU eligible training.
- OCH asked to present at NW EMS Council.
- OCH in early discussions with WSDOT regarding transportation needs.

Attachment(s) Required

A. Current bios or resumes for identified clinical and workforce development subject matter experts or provider champions.

Re-attach bio or resume even if previously provided in Phase I Certification. ACHs should also include any additional bios or resumes, if applicable.

Data and Analytic Capacity – 15 points

Description

The ability to utilize regional data will be foundational to ACHs' success as part of the Washington Medicaid Transformation demonstration. From understanding regional health needs to project selection to project planning, ACHs will be expected to access, interpret, and apply data to inform their decisions and actions.

The HCA has supplemented previously existing public data (e.g. Healthier Washington Dashboard, the Washington Tracking Network, and RDA data resources) with releases of regional population health and provider utilization data for ACH use. ACHs must identify additional, supplementary, data needs and determine, in consultation with HCA, which of those needs can be met by HCA within the timeline. ACHs will then need to detail plans to leverage data and analytics capabilities from their partner organizations (providers, CBOs, MCOs, other regional stakeholders) to further inform their decision-making.

Provide a summary of how the ACH is using this data in its assessment of regional health needs, project selection, and project planning efforts.

Instructions

Provide a response to each question. *Total narrative word-count for the category is up to 1,750 words.*

ACH Data and Analytic Capacity

1. List the datasets and data sources that the ACH is using to identify its regional health needs and to inform its project selection and planning process.

Data-driven planning is key to identifying the right work with the right people to ensure equitable improvement in health outcomes, quality of care, and decreases in health-related costs over time. OCH is building its regional health planning upon a historical foundation of data-driven county health improvement planning; adding new data provided from HCA and other partners and sources to the build a regional health data repository.

The table below displays three columns from the OCH Data Resources Repository, a worksheet that contains key information to understand availability, timeliness, contents, format, etc. of the data resources OCH is using to assess regional socioeconomic conditions, health needs, and disparities and inform project selection and planning. The full table includes the following columns: sort category, title, geography, population, sub-groups, contents, date of data, source, date rec'd, format, access, and web interactive site.

OCH Data Resources Repository as of 7-27-17		
sort cat	**title**	**source**
Access	Health Professional Shortage Areas (HPSA)	WA DOH/ HRSA
CHA	Community Health Assessment and Health Improvement Plan	Kitsap Community Health Priorities
CHA	Community Health Assessment	Clallam County
CHA	Community Health Assessment and Health Improvement Plan	Jefferson County
CHA	Comprehensive Community Assessment	Kitsap Interagency Coordinating Council; Head Start/ECEAP Partnership
CHA	Community Needs Assessment	Olympic Community Action Programs
CHA	Kitsap County Core Public Health Indicators	Kitsap Public Health District
Client	Current Client Counts and Characteristics of Persons Served Jointly by HCA-DSHS in ACHs	by email from HCA
Client	RDA Cross-Agency Measures	RDA
Client	RDA Measure Decomposition	RDA
Client	local provider patient counts and subpopulations	local providers
Common meas	WA Health Alliance, Community Checkup	WA Health Alliance web
Common meas	Healthier WA dashboard	HCA from P1 claims; BRFSS; PRAMS; WIIS (immunizations)
Demo	American Community Survey (ACS), Census	
Dental	Dental Services Reports	HCA from WDSF on box.com
Dental	Medicaid Dental Access	HCA
ED	ED utilization by facility	HCA on box.com
Inpt	Hospital Census and Charges by Payer	DOH CHARS on box.com
MCO	MCO coverage by county	HCA
Opioid	Opioid data	HCA
PH	WA Tracking Network	WA DOH
PH	Risk and Protection Profile for sub use prevention	DSHS RDA
PH	Community Health Assessment Tool (CHAT)	WA DOH Center for Health Statistics
PH	Healthy Youth Survey (HYS)	askhys.net; KPHD database from DOH
PH	Behavioral Health Risk Factor Surveillance System (BRFSS)	KPHD database from DOH
PH	Birth Certificate Database/Vital Statistics	KPHD database from DOH
PH	Death Certificate Database/Vital Statistics	KPHD database from DOH
PH	Opioid Related Death Certificate Database/Vital Statistics	KPHD database from DOH
Provider	Provider Reports	by email & box.com from HCA
Provider	Provider contact info	by email
RHNI	RHNI Phase 3 4.25.17.xslx	HCA
Rx	All Prescriptions Report	HCA on box.com with opioid data
Wkforce	WA State Health Workforce Sentinel Network	UW, Center for Health Workforce Studies

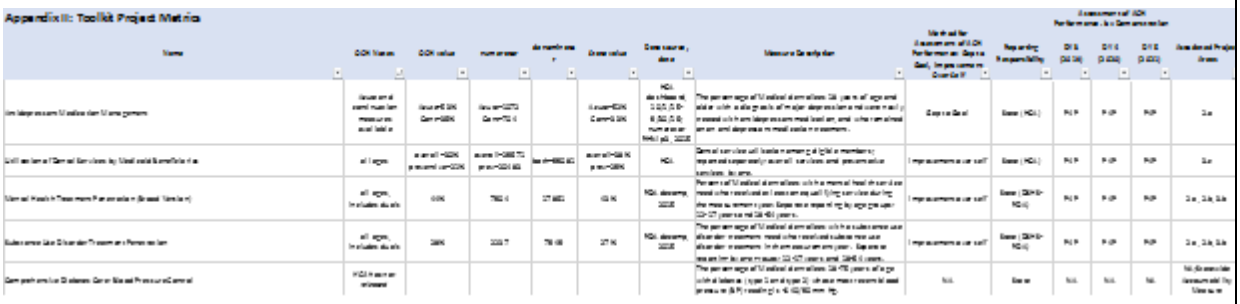
In addition to the sources in the table, OCH has requested data from local social and health care providers as part of the project selection process, both during the Request for Applications and in the Project Plan process.

DO WE NEED TO DETAIL THESE?

WHERE DO WE HAVE THE LIST OF DATA ROCHELLE WAS GOING TO WORK WITH PROVIDERS TO GET?

2. Describe how the ACH is using these data to inform its decision-making, from identifying the region's greatest health needs, to project selection and planning.

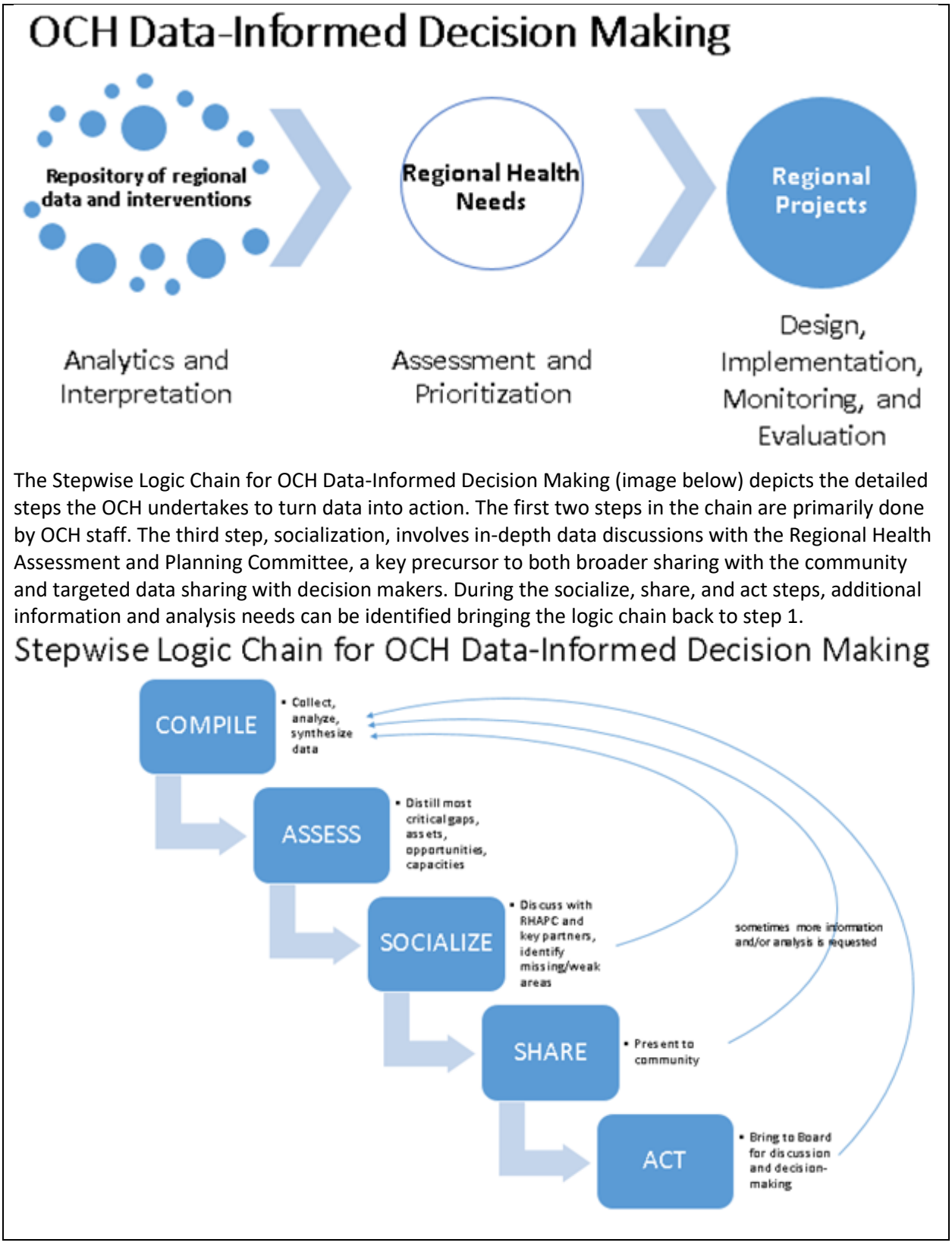
The OCH Data and Analytics Lead has done ongoing review and synthesis of vast amounts of data inputs from HCA and other sources as they have become available to inform ongoing work on project design. In addition, OCH has compiled baseline data for the Demonstration toolkit measures for which data are available (25 out of 37). The image below is an extract of the Excel file with OCH and State baseline results.



Appendix II: Toolkit Project Metrics

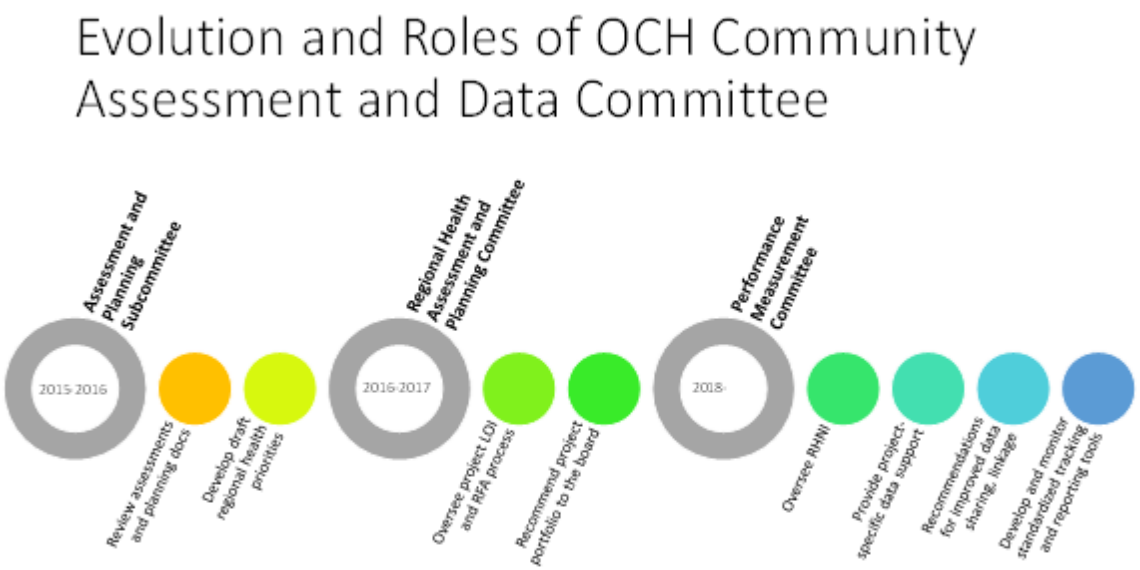
Name	OCH Name	OCH value	numerator	denominator	Data value	Data source; date	Measure Description	Method for Assessment of OCH Performance - Gap to Goal; Improvement over Prior Period	Reporting Frequency/Entity	Assessment of OCH Performance - Gap to Demonstration			

The high-level diagram below depicts the OCH data-informed decision-making process for identifying regional health needs and regional projects. Analytics and interpretation turn the repository of regional data and interventions into actionable information which is distilled through assessment and prioritization to identify the greatest regional health needs which then inform design and implementation of regional projects which are monitored and evaluated to ensure they are making progress toward project goals.



The Stepwise Logic Chain for OCH Data-Informed Decision Making (image below) depicts the detailed steps the OCH undertakes to turn data into action. The first two steps in the chain are primarily done by OCH staff. The third step, socialization, involves in-depth data discussions with the Regional Health Assessment and Planning Committee, a key precursor to both broader sharing with the community and targeted data sharing with decision makers. During the socialize, share, and act steps, additional information and analysis needs can be identified bringing the logic chain back to step 1.

Since Fall 2015, the OCH has convened community partners to collaborate on assessment and planning activities. The timeline below shows the evolution of this work over time. From 2015-2016, OCH regional health priorities were established by community partners following on a comprehensive review of health and community needs assessments and planning documents. In 2016, the group expanded, was renamed Regional Health Assessment and Planning Committee (RHAP), and approved a charter, formalizing its role as an advisory committee to the Board of Directors. RHAP Committee members live and breathe data; most members are data, analytics, quality improvement, evaluation, or planning leads for their agencies.



Project selection and planning

In 2017, the RHAP Committee designed and led the early project selection process, Letters of Intent and Request for Applications. In the latter, applicants were asked to describe with data, the community need for their project. They were given links to data released by HCA and visualized by Public Health Seattle & King County to support them in building a data-driven case statement for their submission (image is a screen shot from application instructions).

CASE STATEMENT *(2-3 sentences)*	*Briefly describe the community need for this project including baseline data that are available. Bullets of data points are acceptable, include the source and year of the data. Here are some useful links to regional-level data:* ***Overall population*** • Visualized Regional Health Needs Inventory (RHNI) data on the overall population *(produced by Public Health Seattle King County (PHSKC))* • Raw Tables: Regional Health Needs Inventory (RHNI) data on overall population *(produced by Health Care Authority, Department of Health, and Department of Social and Health Services* ***Medicaid population*** • Healthier Washington Data Dashboard *(produced by Providence CORE)* • Cross-system performance measures (5732-1519) for Medicaid population *(produced by PHSKC)* ***Joint DSHS/HCA clients*** • Demographic/health profile of joint DSHS/HCA clients *(produced by PHSKC)*

RHAP Committee members scored submitted applications in several categories, the need category was based on an evaluation of the case statement, project "addresses identified data-based community health need."

In addition, applicants were asked to provide data on their target population and Medicaid beneficiaries and providers reach (image is a screen shot from the application):

ELEMENT	DESCRIPTION	RESPONSE			
TARGET POPULATION	Who is the target population for your project? How	TARGET POPULATION *Broad definition (e.g., pregnant women living in…)*	ESTIMATED # and % MEDICAID BENEFICARIES *Estimated unique # of*	ESTIMATED # FTE and TYPE of CLINICAL MEDICAID PROVIDERS	ESTIMATED # FTE and TYPE of NON-CLINICAL MEDICAID PROVIDERS *Estimated # full-*

RHAP Committee members also scored submitted applications in a footprint category that was based on an evaluation of the target population response, "how many Medicaid beneficiaries and Medicaid providers."

In June 2017, the RHAP Committee portfolio of projects was presented at the OCH Partner Convening and to the Board. Staff have taken feedback from both groups and continue to refine the OCH project portfolio.

PENDING from here down. Define process for sharing/socializing data with regional stakeholders involved in project selection and planning

- Right data in front of the right person at the right time
- Presentation Jan 31 – data for each project category and opioid data assessment
- "Interactive analysis"
- Jan 31- June 19: "At-a-glance" shared with Board and RHAP Committee containing data on return on investment…
- June 19 – presentation of updated data for each project category
- Post data online
- Next debut: Baseline toolkit measures will go out in e-newsletter and on website and to Board
    - For each item above: Add graphic that were presented previously and cite where/who

3. Identify any data and analytic gaps in project selection and planning efforts, and what steps the ACH has taken to overcome those barriers.

Identifies any data and analytic gaps in project planning and selection to-date
Defines any steps taken to overcome barriers

Gaps:

- Missing provider-level performance on key performance measures to advise project selection, as well as to help implement and monitor selected projects.
- Tribal data
- Missing return on investment information, down to the subpopulation level, to help determine which EBPs yield the best return and which are most suitable to the populations within OCH.
- Geographic-level, actionable data such as…

Solutions:

- We will continue to reach out to various entities that do comparative reporting at the regional and provider level (e.g. Washington Health Alliance, others?), to expand our baseline knowledge of provider performance. There may be an opportunity to develop greater depth (provider-level view) on measures currently reported at the regional level.
- Develop list of data elements to request from providers – These data elements will be informed by the measures we expect to use for our current slate of proposed projects. It's also important that we develop systems to capture real-time process measures to gauge implementation of and performance under our selected projects. We anticipate this could require some-type of customized portal for user input and a related data repository, both HIPAA. We have begun investigating these systems.
- Ask for assistance from Seattle King County, such as…
- Literature search on ROI for EBPs
- Dedicated resources to tribal partnerships

Data-related Collaborations

4. Describe if the ACH is collaborating, or plans to collaborate, with other ACHs around data-related activities.

Describes collaborative efforts to date and/or future plans and rationale.

North Sound

King County

Plan to collaborate on data infrastructure, discussion with Providence Core, contractor for multiple other ACHs

Greater Columbia ACH and Cascade Pacific Action Alliance

Shared project survey with BHT, NCACH, GCACH and Cascade

5. Describe to what extent to date the ACH is collaborating with community partners (e.g. providers, CBOs, MCOs) to collect data or leverage existing analytic infrastructure for project planning purposes.

Defines process for collaborating with community partners to collect data to support project selection and planning

Defines process for leveraging existing analytic infrastructure through community partners for project selection and planning

Provider Data and Analytic Capacity

6. Demonstrate the ACH's engagement process to identify provider data or data system requirements needed to implement demonstration project goals.

Defines process for identifying provider data/data systems requirements to implementing Demonstration project goals

Provides clear logic/rationale for how this process allows for identification of provider data or data system requirements

Provides specific examples, if any, of how ACH has identified provider data or data system requirements to date

We have hired consulting staff (Attachment X) who have long-standing experience and have built applications and data repositories for gathering clinical and related data from disparate provider groups engaged in collaborative population health improvement initiatives.

This consulting staff, along with our in-house epidemiological staff, will coordinate with provider groups to develop a dependable system for collecting data that is not otherwise available through current data repositories (e.g. HCA, WA Health Alliance, APCD). We will survey for information on EHR data-marts, current reporting by providers to State agencies (HCA, DSHS), trade associations (WSHA, MGMA) and national associations (NCQA).

CommentWS – Not sure what we have already done in this vein, responding to third bullet above.

7. Demonstrate the ACH's process to identify data or data system requirements needed to oversee and monitor demonstration project goals.

Defines process for identifying HIT requirements to oversee and monitor projects
Provides clear logic/rationale for how this process allows for identification of HIT barriers
Provides specific examples, if any, of how ACH has identified HIT barriers to date
Data and data system requirements will flow from the key process and outcome measures we identify for each project. We do not anticipate that scale is a big concern, as we anticipate collecting data—in HIPAA compliant ways—from less than 20 provider groups and the data requests will be narrowly focused. This is desirable, both not to burden the process, but also to take advantage of the knowledge that selecting just a few metrics (as opposed so many that it complicates processes) is key to successful change initiatives.

8. Identify the ACH's process to complete a workforce capacity assessment to identify local, regional, or statewide barriers or gaps in capacity and training.

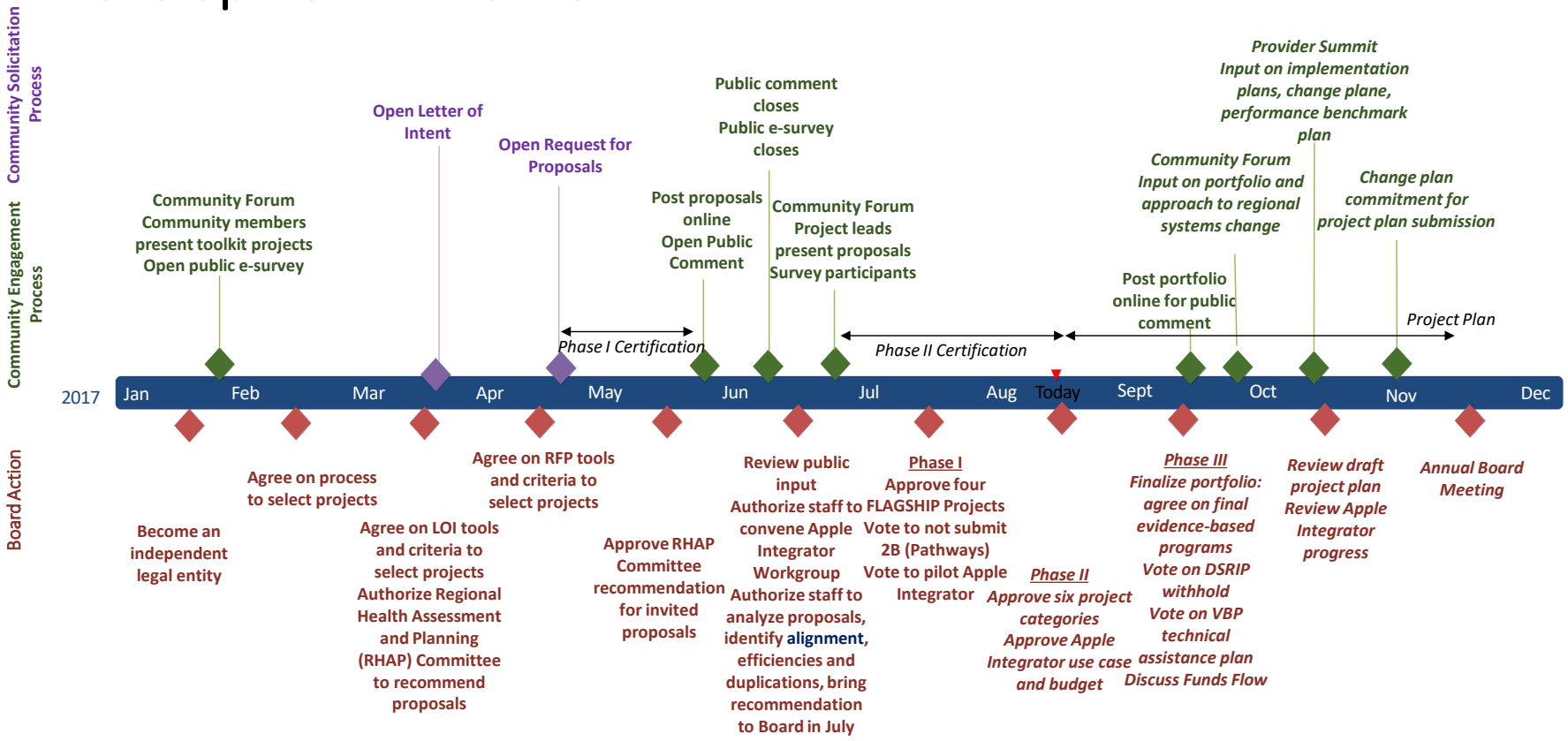
Defines process for completing workforce capacity assessment
Provides clear logic/rationale for how this process will result in an aligned strategy for addressing gaps in capacity and training.
Specifies action steps, timing, points of accountability for process

Attachment(s) Required

None

Transformation Project Planning - 15 points
Description Provide a summary of current transformation project selection efforts including the projects the ACH anticipates selecting.
Instructions ***Provide a response to each question.*** *Total narrative word-count for the category is up to 2,000 words.*
Anticipated Projects
1. Provide a summary of the anticipated projects and how the ACH is approaching alignment or intersections across anticipated projects in support of a portfolio approach.

2017 Project Selection and Project Plan Development Timeline



Phase I Project Selection 5 FLAGSHIP PROJECTS (projects that address OCH health needs, based on baseline assessment), **APPROVED** July 10, 2017

Project	Status	Transformation	Evidence-Base	Recommendation	Rationale	Baseline Assessment
2A. Bi-Directional Integration	Board voted FLAGSHIP 7.10.17 ***Required***	Practice	Bree Collaborative; Collaborative Care Model; Millbank Report	Move forward with assessment. Tailor approach to each community of care. Build off existing momentum and innovation.	Required. High need. Strong willingness.	Mental health treatment penetration: OCH 44% vs. State 43% SUD treatment penetration: OCH 28% vs. State 27% Anti-depression Rx Management (acute): OCH 53% vs. State 52% Anti-depression Rx Management (cont.): OCH 36% vs. State 33%
3.A. Opioid Response	Board voted FLAGSHIP 7.10.17 ***Required***	Practice Systems	State's Interagency Plan; Six Building Blocks; CDC guidelines; AMDG guidelines	Continue with momentum from Three-County Coordinated Opioid Response Project	Required. High need. Strong willingness.	Medication assisted therapy OCH 17% vs. State 27% Patients on high dose chronic opioid Rx OCH 20% vs. State 20%
2.D. Diversion	Board voted FLAGSHIP 7.10.17	Workforce Systems	ER is for emergencies; Community health workers in ED	Move forward as flagship project	Low performers in ED utilization. Opportunity for workforce development.	Outpatient ED visits/1000 MM (18yo+) OCH 89 vs. State 68 Outpatient ED visits/1000 MM (< 18 yo) OCH 46 vs. State 37 Percent arrested OCH 6% vs. State 7%
3.D. Chronic Disease	Board voted FLAGSHIP 7.10.17	Practice Systems	Chronic Care Model; Stanford Chronic Disease Self-Management; Diabetes Prevention Program; Asthma home visiting/healthy homes	Move forward as flagship project	Emphasis on practice transformation. Strong willingness from clinical and non-clinical providers. Good preparation for value-based contracting.	Diabetes care: nephropathy OCH 83% vs. State 86% Diabetes care: HbA1c OCH 83% vs. State 84% Med Management for asthma OCH 29% vs. State 28%
Domain 1. Population Health Management/I.T.	Board voted to pilot Apple Integrator 7.10.17	Systems	Cloud-based e-referral and eventually care coordination system	Pilot first use case	Can do Pathways later. Create a community health shared information network. Supports entire portfolio. Right-sized and can be scaled. Can learn quickly what works.	Not applicable Depends on use case

Phase II Portfolio Recommendation, VOTING August 14, 2017

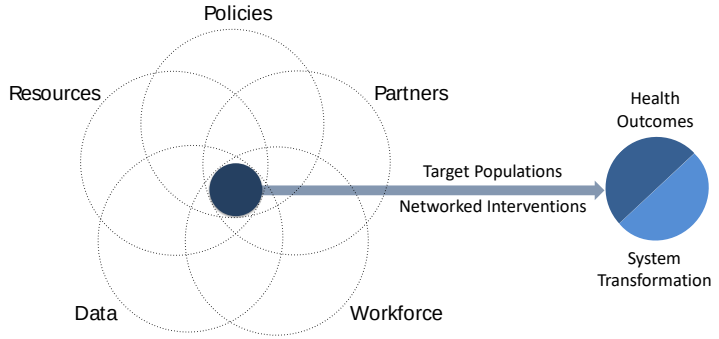
Project	Status	Transformation	Evidence-Base	Recommendation	Rationale	Baseline Assessment
2C. Transitional Care from Hospitals and Jails	Board voting 8.14.2017	Systems Workforce	Care Transitions Intervention	Do not move forward	Region performs well on measures. Will be challenging to earn incentives. Low volume of Medicaid hospitalization.	Plan all cause readmission rate OCH 14% vs. State 15% Follow-up after hospitalization for mental illness (7 days) OCH 72% vs. State 72.4% Follow-up after hospitalization for mental illness (30 days) OCH 84.5% vs. State 87.8%
	Board voting 8.14.2017	Systems Workforce	Jail Transitions	Do not move forward as "Transitional Care". Move into Diversion.	Strong community support but will not impact all measures in "Transitional Care" category. Rebase Transitional care DSRIP funds into other project categories	
3B. Maternal, Child, and Reproductive Health	Board voting 8.14.2017	Practice Systems Workforce	Bright Futures	Original proposal was to expand Nurse Family Partnership and Parents as Teachers. Recommend Bright Futures to refer to/from programs.	Original proposal will not move measures; therefore, project will not be sustained throughout the demonstration.	Childhood immunization status OCH 10% vs. State 12% Chlamydia screening OCH 49% vs. State 51% Contraceptive care – access to LARC OCH 7% vs. State 8% Contraceptive care – access to effective methods OCH 33% vs. State 31% Prenatal care in first trimester OCH 63% vs. State 65%
3C. Access to Oral Health Services	Board voting 8.14.2017	Practice Systems Workforce	Expansion of FQHC dental; dental hygiene services in long term care settings; expansion of school based clinics; oral-primary care integration	Combine and move forward	Strong community interest. Strong community need. Project partners can deliver.	Utilization of dental services by Med. Benes (overall) OCH 30% vs. State 38% Utilization of dental services by Med. Benes (preventative) OCH 21% vs. State 29% Dental sealants for high-risk kids (6-9yo) OCH 43.2% vs. State 37.9% Dental sealants for high-risk kids (10-14 yo) OCH 17.8% vs. State 14.7% Primary caries prevention as part of well child visit OCH 0.1% vs. State 0.4%

Continuation Phase II and Phase III Portfolio Recommendation (Jail Diversion, August 14; LEAD and Community Paramedicine, September 11

Project	Status	Transformation	Evidence-Base	Recommendation	Rationale	Baseline Assessment
2.D. Diversion	Board voting 8.14.2017	System Workforce	Jail Diversion Community health workers in jails	Move forward	Strong community support. Originally recommended in "Transitions" category. Better fit in "Diversions" as an extension of Outward Bound (CHWs in ED).	Outpatient ED visits/1000 MM (18yo+) OCH 89 vs. State 68 Outpatient ED visits/1000 MM (< 18 yo) OCH 46 vs. State 37 Percent arrested OCH 6% vs. State 7% Percent homeless OCH 5% vs. State 5%
	Board voting 9.11.2017	System Workforce	Community Paramedicine	Hold for vote in September: Phase III	Staff evaluating potential pilots and exploring sustainability mechanisms following the Demonstration	
	Board voting 9.11.2017	System Workforce	Law Enforcement Assisted Diversion			

Performance

To the extent baseline data were available, measures were presented and integrated into materials to support the decision-making process. Relative to the State, the OCH performs poorly in emergency department utilization, oral health access, and access to child and reproductive health services. Hence, these project areas (2D, 3B, and 3C) were recommended. The opportunity for "gap-to-goal" improvement on these measures is greater than on those measures where the OCH is performing well. Most importantly, investment in these areas will improve the health of the region's Medicaid population.



Practice Transformation

OCH prioritized evidence-based programs that support practice transformation, workforce development, and system redesign, because these are essential steps in achieving sustainable, value-based care. Examples of include the chronic care model, bright futures, six building blocks for safe opioid prescribing, and the collaborative care model.

Workforce, Target Population, Systems, and Funds Flow Alignment

Staff analyzed inputs from project proposals (e.g., target population, budget) and the two required projects to crosswalk potential alignments in workforce, VBP, transformation, and population health IT management (see table below). This exercise highlighted the importance of funds flow analysis: the earnable incentives in a category will not cover the related costs.

In this crosswalk, we assume that OCH will earn 75% of its maximum valuation on average across the Demonstration period and that 65% would be passed through to providers. In this scenario, the OCH would withhold approximately $650,000 per year to cover operations, Domain 1 activity, a risk/reward pool, and a wellness fund (note: concepts currently under development)

Toolkit Category (Domain.Project)	Bi-Directional Integration and Primary Care Transformation (2.A.)	Diversion (2.D.)				Opioid Response (3.A.)	MCH (3.B.)	Access to Oral Health Services (3.C.)		Chronic Disease Prevention and Control (3.D.)	
Total Max Ave Earnable Incentives for 1 Year w/o Pathways	**$3,162,600**	**$1,284,820**				**$395,200**	**$494,200**	**$296,600**		**$790,600**	
Total Estimated Earnable Incentive Funds for 1 Year (75% of max)	**$2,371,950**	**$963,615**				**$296,400**	**$370,650**	**$222,450**		**$592,950**	
Total Estimated Allocated Incentive Funds for 1 Year (65% of max)	**$2,055,690**	**$835,133**				**$256,880**	**$321,230**	**$192,790**		**$513,890**	
Title	Bi-Directional Integration and Primary Care Transformation	Crossroads (community health workers in jail)	LEAD (diversions from jail booking)	Community Paramedicine	Outward Bound (community health workers in the ED)	Three-County Coordinated Opioid Response	Bright Futures	FQHC Dental (expansion into North Kitsap)	Jefferson County (expansion in Jefferson County)	Breathe Easy (home visits and supports for people with asthma)	Chronic Care Model (Clinical transformation and community linkages)
Medicaid #/year	26,667	4,551	3000-6000	8,000	28,320	20,000	21000	2,800	1162.5	1,799	11,880
Medicaid #/4 yrs	80,000	18204	12,000-24,000	32000	113280	25000	52500	11200	4650	7196	47520
Requested Budget	NA	$390,354	$859,100	$2,969,590	$506,360	NA	$545,104	$463,552	$39,677	$372,167	$1,161,261
Staff Recommended Allocation for planning purposes only	$2,055,690	$208,783	$0	$0	$626,350	$256,880	$321,230	$192,790		$513,890	
Cost per person per year (based on recommended allocation)	$25.70	$45.88	$0.00	$0.00	$22.12	$12.84	$15.30	$48.65		$37.57	
Expansion (E) or new (N) program	E	N	N	N	N	E	E	E	N	N	N/E
VBP adoption will drive long term sustainability *	Very Likely	Very likely	Likely	Not likely	Very likely	Likely	Very Likely	Likely	Likely	Likely	Very likely
Type of agency *transformed* *											
Law Enforcement and Criminal Justice		y	y			y					
EMS			y	y		y					
Social Services Organizations			y	y		y	y			y	y
Hospitals and E.D.s	y			y	y	y			y		y
Behavioral Health Care Organizations	y		y			y					y
Primary Care Organizations	y	y			y	y	y	y		y	y
Workforce *											
New workforce (does not currently exist)		y			y						
Expansion of existing workforce (recruitment)	y		y			y	y	y	y	y	
Re-trained existing workforce	y		y	y		y	y				y
Community Health Workers (CHW)		CHW			CHW					CHW	CHW
Population Health Analytics Workforce	y										y
Need for coordinated referral across systems *	**y**	y	y	y	y	y	y	y	y	y	y
** staff assessment*											

Summary	
Total Max Earnable Incentives for 1 Year	**$4,818,015**
Total Proposed Allocation of Incentive Funds for 1 Year	**$4,175,613**

Measure Alignment

The OCH understands the importance of the State Accountability Measures (SAM); therefore, the projects and programs were cross-walked (see table below) to ensure alignment between project, project-specific metrics, and SAM metrics.

OCH Toolkit Metric Crosswalk and Baseline (based on data available 8.7.17)			Phase I: FLAGSHIP PROJECTS				Phase II		Statewid
Name	**OCH value**	**State value**	**Integration**	**Diversion**	**Opioids**	**Chronic dz**	**MCH**	**Oral Health**	**Accounta Measure**
Antidepressant Medication Management	Acute=53% Cont=36%	Acute=52% Cont=33%	x						x
Utilization of Dental Services by Medicaid Beneficiaries	overall=30% preventive=21%	overall=38% prev=29%						x	
Mental Health Treatment Penetration (Broad Version)	44%	43%	x				x		x
Substance Use Disorder Treatment Penetration	28%	27%	x				x		x
Comprehensive Diabetes Care: Blood Pressure Control			x			x			x
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)			x			x			x
Controlling High Blood Pressure			x			x			x
Depression Screening and Follow-up for Adolescents and Adults			x						
Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence			x						
Inpatient Hospital Utilization			x		x	x			
Ongoing Care in Adults with Chronic Periodontitis								x	
Patients with concurrent sedatives prescriptions					x				
Periodontal Evaluation in Adults with Chronic Periodontitis								x	
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)						x			
Substance Use Disorder Treatment Penetration (Opioid)			x						
Well-Child Visits in the First 15 Months of Life									
Medication Assisted Therapy (MAT): With Buprenorphine or Methadone	17%	27%			x				
Childhood Immunization Status	10%	12%					x		
Contraceptive Care – Postpartum	Most/mod=36.9% LARC=9.4%	Most/mod=41.2% LARC=15.8%					x		
Chlamydia Screening in Women Ages 16 to 24	49%	51%					x		
Outpatient Emergency Department Visits per 1000 Member Months	0-17=46 per 1000MM 18+=89 per 1000MM	0-17=37 per 1000MM 18+=68 per 1000MM	x	x	x	x	x	x	x
Follow-up After Hospitalization for Mental Illness	7d=72% 30d=84.5%	7d=72.4% 30d=87.8%	x						
Patients on high-dose chronic opioid therapy by varying thresholds	20%	20%			x				
Child and Adolescents' Access to Primary Care Practitioners	12-24mo: 93% 2-6 yr: 84% 7-11 yr: 90% 12-19 yr: 91%	12-24mo: 94% 2-6 yr: 86% 7-11 yr: 91% 12-19 yr: 90%	x			x			
Comprehensive Diabetes Care: Eye Exam (retinal) performed	29%	31%	x			x			
Comprehensive Diabetes Care: Hemoglobin A1c Testing	83%	84%	x			x			
Comprehensive Diabetes Care: Medical Attention for Nephropathy	83%	86%	x			x			
Contraceptive Care – Access to LARC	7%	8%					x		
Contraceptive Care – Most & Moderately Effective Methods	33%	31%					x		
Dental Sealants for Children at Elevated Caries Risk	age6-9=43.2% age10-14=17.8%	age6-9=37.9% age10-14=14.7%						x	
Medication Management for People with Asthma (5 – 64 Years)	29%	28%	x			x			x
Percent Arrested	6%	7%		x					
Percent Homeless (Narrow Definition)	5%	5%		x					
Plan All-Cause Readmission Rate (30 Days)	14%	15%	x						x
Prenatal care in the first trimester of pregnancy	63%	65%					x		
Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers	0.1%	0.4%						x	
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	59%	61%					x		x

2. Describe any efforts to support cross-ACH project development and alignment. Include reasoning for why the ACH has, or has not, decided to undertake projects in partnership with other ACHs.

The OCH has supported cross-ACH collaboration:

- Host a webinar with the University of Washington on the *Six Building Blocks for Safe, Team-Based Opioid Prescribing* (August 16)
- Arrange a demo for ACHs with *Persistent Systems* (August 18), the cloud-based IT platform supporting reporting, surveying, data, and CRM for multiple PPSs in New York State

The OCH is a multi-county, largely rural ACH with a proud tribal culture. Therefore, we are aligning with **Greater Columbia** (GC) and **Cascade Pacific Action Alliance** (CPAA) around multiple strategies:

- Community Health Worker Workforce Coalition
- Demonstration incentive allocation strategy and design
- Engagement and alignment with MCOs around sustainability beyond the Demonstration
- Identification of common platforms for customer relationship management, data warehouse, reporting, analysis, cybersecurity, survey management, and contract and compliance management
- Exploration of a shared audit firm for economies of scale
- Tribal training and engagement (OCH, GC, and CPAA regions cover 15 of 29 WA Tribes)
- Project Alignment: CPAA and OCH are contiguous ACHs and Medicaid beneficiaries seek care from both regions, particularly people with complex health needs and/or opioid use disorder. Therefore, we have begun sharing information and aligning our approaches towards integration, addressing opioids, and community paramedicine

Partnerships with other ACHs

- **Pierce ACH**: Strategize about opportunities to bring the Six Building Blocks for Safe, Team Based Opioid Prescribing to scale across both ACHs.
- **King ACH**: Collaboration on data and Domain 1: Population Health and I.T. management.
- **North Central ACH**: Bi-weekly conversations with OCH and CPPA (Cerebyte team from 2015) on data and practice transformation.
- **North Sound ACH**: Strategize regularly with about funds flow, budgets, provider engagement, data, and tribal engagement.

3. Demonstrate how the ACH is working with managed care organizations to inform the development of project selection and implementation.

MCOs are an essential partner for health systems transformation.

Design and Development

MCOs participate on the Regional Health Assessment and Planning (RHAP) Committee, which informed, developed, and ultimately executed the OCH's project selection materials, criteria, and process. The Board asked the RHAP Committee to review LOIs and invite promising ideas to submit a full application. Thirty-five LOIs were received and reviewed by the RHAP Committee on April 14th. The RHAP Committee recommended 12 Project Application Teams, combining multiple LOIs into single application and expanding the list of partner organizations, Tribes, and regions. MCOs participated on, and on two occasions co-lead, Project Application Teams. MCOs signed commitment forms for four of the 10 proposals.

Leadership

The Treasurer requested an MCO on the Finance Committee. This committee is tasked with recommending an approach to Demonstration incentive allocation. MCOs attend Board meetings, with delegated voting member that rotates annually.

Moving Forward: Value-Based Care

Acknowledging the MCO's role in Medicaid health systems transformation beyond the Demonstration, the OCH scheduled five meetings between the Executive Committee, Executive Director, and senior leadership of each MCO to discuss:

- **In the future:** Describe the ideal partnership with the OCH, beyond the Demonstration, to support shared goals.
- **In the long term**: Identify mutually beneficial VBP goals to sustain Demonstration transformation and a shared work plan to get there.
- **In the short term**: Coordinate Domain 1 work and project plan development to align/support/leverage the MCO's VBP goals.

Additionally, on August 14th the Board will discuss the value of MCOs providing direct technical assistance to providers in value-based contracting, and the potential role of the OCH in coordinating this service under the Demonstration.

Moving Forward: Population Health Management/I.T.

The Apple Integrator is headed into a pilot testing phase. This population health management tool will be co-developed with the MCOs.

Moving Forward: Data

The image depicts geolocation data to help identify Medicaid chronic opioid users and prescribers.

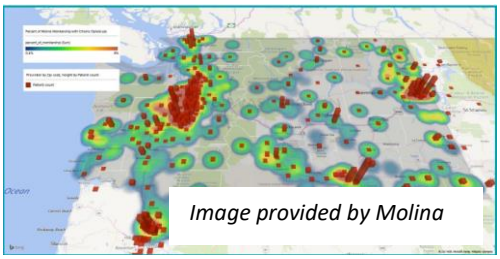


Image provided by Molina

Project Plan Submission

4. What risks and mitigation strategies have been identified regarding successful Project Plan submission?

Since January 2017(see timeline above), the OCH has planned for a project plan submission that a) would meet the health needs of the community and b) the providers could deliver. There are several threats to a successful project plan submission.

Threat	Result	Mitigating Strategies July-November 2017
Relatively small DSRIP pool allocation to the OCH region	Insufficient funding for regional transformation, especially in low-weighted project categories (e.g., MCH)	Focus projects on only those the OCH can deliver and will improve population health and will be sustainable beyond the Demonstration (Aug-Sept)
Challenge of recruiting employees to work in rural area	Staff burn out	Leverage partners to assist in project plan development and recruitment. Explore expanded role of consultants/contractors (July-Nov)
Incomplete baseline data to engage provider organizations	Provider skepticism to engageChallenge to data-driven decision making	Share baseline dashboard with providers as soon as available. Fill in missing pieces with other data source. Partner with HCA to provide feedback on data files soon after receipt.

5. Demonstrate how the ACH is identifying partnering providers who cover a significant portion of Medicaid beneficiaries.

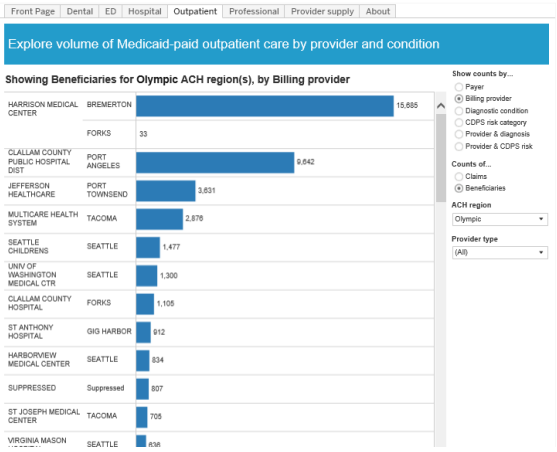
Since April 2017, staff has been developing a database of Medicaid providers. The OCH, through its governance, committees, and outreach, is already engaged with all but three Medicaid provider organizations listed below (a plan is in place to reach these). Most have committed to partner on one or more Demonstration projects.

Not included below are the non-clinical Medicaid providers, such as housing, public health, community action agencies and area agencies on aging. These providers are also engaged with the OCH, both on the Board and on committees, and through the project planning process.

Medicaid Providers in the Region

Hospitals and Rural Health Clinics	Federally Qualified Healthcare Clinics	Clinics	Tribal Clinics	Behavioral Health Clinics	Payers
CHI Harrison	North Olympic Health Network	Bogachiel Medical Clinic	Jamestown Family Health Center	Discovery Behavioral Health	Amerigroup
Forks Community Hospital	Peninsula Community Health Services	Harrison Health Partners/Doctor's Clinic/Family Medicine Residency	Lower Elwha Health Clinic	Kitsap Mental Health Services	Coordinated Care
Jefferson Healthcare		Jamestown Family Health Center	Makah Health Center	Kitsap Recovery Services	Community Health Plan of Washington
Olympic Medical Center		Jefferson Healthcare Adult and Pediatric Clinics	Port Gamble S'Klallam Health Clinic and Wellness Center	Peninsula Behavioral Health	Molina
		North Kitsap Family Practice and Urgent Care	Quileute Health Center	Safe Harbor Recovery	Salish Behavioral Health Organization
		Olympic Medical Physicians	Suquamish Wellness Center	West Sound Treatment Center	United Health Care
		Group Health/Kaiser	Hoh Wellness Center	West End Outreach Services	
		Kitsap Children's Clinic			

In July, the HCA provided Medicaid volume data by outpatient, dental, ED, hospital, and professional provider. Eli Kern, epidemiologist in Seattle King County Public Health, uploaded these into Tableau. The snapshot to the right shows the number of beneficiaries seeking outpatient care. These data are largely consistent with the table above. Some issues have been uncovered in these data that are being addressed. Once resolved, this will be a vital input to determining the relative attribution of incentives to partnering providers based on the number of Medicaid beneficiaries served and claims submitted.



6. What strategies are being considered to obtain commitments from interested partnering providers? What is the timeline for obtaining these commitments?

During the RFA process (April-May 2017) the OCH asked applicants to complete a partner commitment form (see snapshot below) for each project submission. Implementation partners and/or clinical provider partners filled out and signed this form.

Olympic Community of Health
ATTACHMENT B. PARTNER COMMITMENT FORM
REQUEST FOR APPLICATIONS – APRIL 19, 2017
PROJECT TITLE: _____

Please have all anticipated implementation partners and/or clinical provider partners fill out and sign this form. If unable to engage with potential partners due to time constraints, please still note each one and their anticipated types of participation in the table below, and check the box in the last column. Please fill out the questions on the back of this form to describe how the partnership will work together, how partners planned/worked together to prepare the application, and previous experience in project management.

PARTNER NAME	AGENCY/ ORGANIZATION NAME	TYPE OF PARTICIPATION CHECK ALL THAT APPLY								GEOGRAPHIC SERVICE AREA (County/City/Tribal Reservation)	COMMITMENT LEVEL	
		Provide data	Manage data	House interve-ntion	Provide staff	Provide equipt-ment	Serve on commit-ee	Provide clinical champi-on	Other Please specify		ENGAGED PROVIDE SIGNATURE ELECTRONIC OK	INTEND TO ENGAGE
												☐
												☐
												☐
												☐
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The partnering providers that signed commitments form is attached (Attachment X).

For the two required projects the partnership process is different.

1. Bi-Directional Integration and Primary Care Transformation

The OCH partners with the Practice Transformation HUB Coach and Transforming Clinical Practice Coach to integrate practice-based assessments (including workforce, HIT, PCMH-A, and MeHAF) into the regional clinical assessment. Qualis and the OCH co-developed a letter to practices asking that a copy of assessment results be shared with the OCH. As of August 4, 2017, 26 clinic-based assessments were either underway or completed in our region through the Hub and 9 through TCPI. OCH outreach to providers includes a strong recommendation to partner with the Hub and TCPI and share assessment results directly to the OCH. (Attachment X)

2. Opioid Response

The 3 County Opioid Response Project is already underway and has multiple committed partners (Attachment X). In addition to the providers listed in the attached table, the OCH manages an opioid distribution list that initiated from the Opioid Summit (January 30).

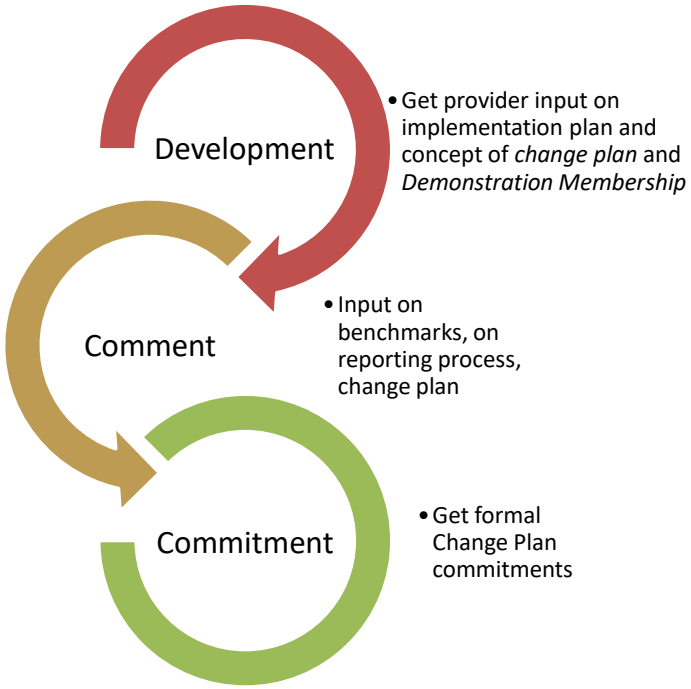
Plan moving forward: Committing to Change Plans **concept still under development**

Standardize what you can. Customize what you should

A concept currently under development for the OCH is the *change plan.* This concept, borrowed from North Central ACH, is an agreement between the OCH and provider organizations for a scope of work during the Demonstration. The OCH funds flow strategy will support the *change plan,* which will be co-designed by partnering providers between now and November.

To become Demonstration members, organizations will submit a *change plans* to the OCH. Membership entitles provider organization to earn incentive revenue and receive technical assistance. While some elements of the *change plan* will be standardized, most will be customizable to meet the local community of care's needs.

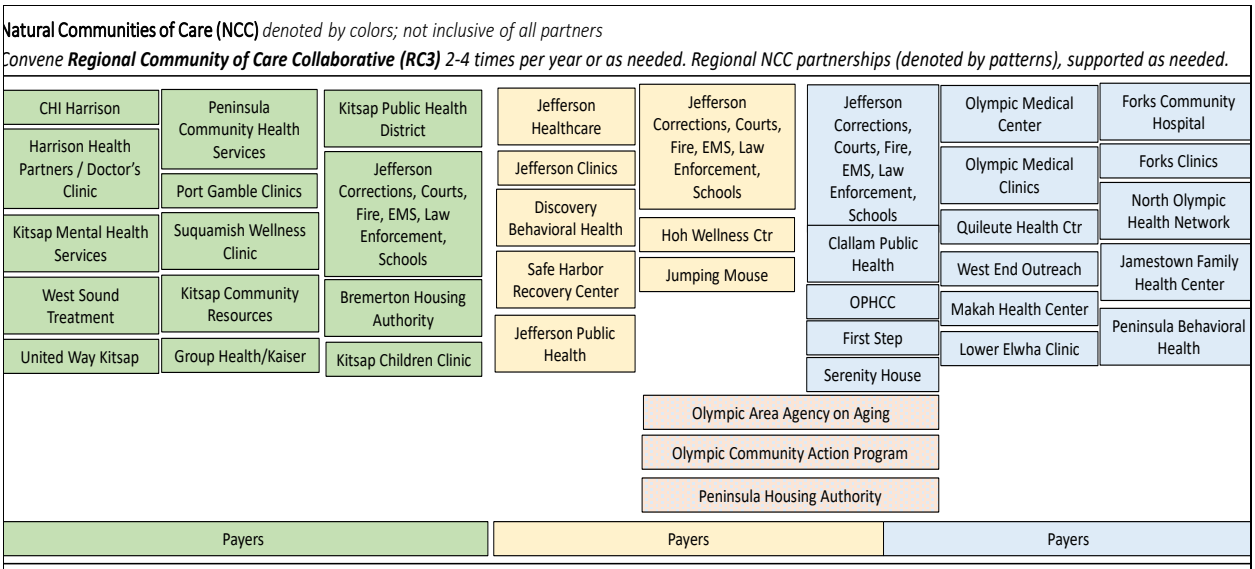
Change plans will accelarate practice transformation and integration, incentivizing strategies such as team-based care and care coordination, and tactics such as chlamydia screening, depression screening, and HbA1C control. The *change plan* will also incentivize workforce development, VBP contracting, and population health management.



The *change plan* will include a minimum set of requirements for each member organization. At a minimum, all provider organizations, clinical and non-clinincal, must agree to submit timely and complete reports to the OCH, respond to surveys, participate in shared learning and educational training opportunities, and agree to contribute towards these Demonstration areas: 1) addressing the opioid crisis and 2) population health management. Some technical assistance will be required, such as VBP technical assistance for clinincal provider organizations. Clinical provider organizations will also be required to undergo a baseline assessment from Hub and TCPI.

7. Demonstrate how the ACH is ensuring partnering providers represent a broad spectrum of care and related social services that are critical to improving how care is delivered and paid for.

The OCH is orienting Demonstration activity around **Natural Communities of Care (NCCs)**. NCCs are natural affinity groups of provider organizations, clinical and non-clinical, tribal and non-tribal, that together serve a Medicaid population for a geographic region. The NCCs honor longstanding, existing relationships between partners, many of which bore innovative solutions over the years.



Each NCC configuration reflects the cultural, health and social service needs of the community it serves. The payer mix tends to vary by NCC.

The OCH will prioritize engagement based on two pending inputs:

1. The Portfolio (January – September 2017)

Once the portfolio is finalized (September), the OCH will prioritize engagement with the broad spectrum of providers that will be called to implement portfolio projects. For example, EMS and Fire will be prioritized for engagement if Community Paramedicine is selected. Given the Demonstration's focus on primary care and behavioral health transformation, and their impact on how care is delivered and paid for, these sectors have been and will continue to be the major focus for OCH engagement.

2. The Assessment (June – November 2017)

Between August and November, the OCH will finalize an assessment of all Medicaid service providers. Providers will be compared regionally and within NCC. Providers that serve the largest number of Medicaid consumers, and submit the most claims (clinical only), will be prioritized within NCC and across NCCs. Stratification allows for special consideration for DSRIP investment for those NCCs with a smaller Medicaid attribution but in dire need of transformation incentives to close gaps. For example, Jefferson County represents only 10% of the Medicaid population in the region; however, they experience the lowest rates of access to dental services in the State. 10% of the total earnable incentives under the oral health project category is only $30,000 per year – far insufficient to address the major dental needs facing Jefferson county.

This assessment is tailored to each sector and includes:

- PCMH-A, MeHAF assessment
- Number of Medicaid beneficiaries assigned
- Number of Medicaid beneficiaries (unique) seen in the previous year
- Patient/Client population by: Race/ethnicities, Income, Geography, Immigration status, Gender and sexuality, Disability status
- VBP Action Survey

- Workforce shortages and gaps
- Population Health Management Systems: EHR, sending data to CDR, OneHealthPort; Registries, analytics, decision support and reporting tools that support decision-making and care management
- High level diagnostic categories

In September, the OCH will ask for commitment from providers using the *change plan* (see 6 above).

8. Demonstrate how the ACH is considering project sustainability when designing project plans. Projects are intended to support system-wide transformation of the state's delivery system and ensure the sustainability of the reforms beyond the demonstration period.

OCH has focused on sustainability and will not move forward with projects that cannot be sustained beyond the Demonstration.

2017-2018 OCH Strategic Goal:

Successful implementation of Demonstration Projects, as measured by meeting contractual obligations, including pre-defined benchmarks and progress toward sustainable solutions

Criteria for project selection:

Sustainability is possible after 5-year Medicaid Demonstration is over (e.g. through value-based payment or inclusion into Apple Health contracts)

Throughout the project selection process, OCH prioritized evidence-based programs that support practice transformation, workforce development, and system redesign, because these are essential steps in achieving sustainable, value-based care and therefore, sustainability. The primary reason the OCH has not solidified its portfolio is because it is unclear how or whether two projects, Community Paramedicine and LEAD, can be sustained.

	2A	2C	2C	2D	2D	2D	3A	3B	3C	3C	3D	3D
Details of the interventions/activities and infrastructure capabilities (e.g., population health data systems, health IT, workforce) and logically describes why specific ones will be shared or reused.	Bi-Directional Integration and Primary Care Transformation	Crossroads (transitions from jail to care)	Regional Care Transitions (transitions from hospital to home)	LEAD (diversions from jail booking)	Community Paramedicine	Outward Bound (community health workers in the ED)	Three-County Coordinated Opioid Response	Healthy Beginnings (Nurse family partnership and parents as teachers)	FQHC Dental (expansion into North Kitsap)	Jefferson County (expansion in Jefferson County)	Breathe Easy (home visits and supports for people with asthma)	Chronic Care Model (Clinical transformation and community linkages)
Expansion (E) or new (N) program	E	N	E	N	N	N	E	E	E	N	N	N/E
VBP adoption will drive long term sustainability	Very Likely	Likely	Very likely	Likely	Not likely	Very likely	Likely	Not likely	Likely	Likely	Likely	Very likely
New workforce (does not currently exist)		y				y						
Expansion of existing workforce (recruitment)	y			y			y	y	y	y	y	
Re-trained existing workforce	y		y	y	y		y					y
Community Health Workers (CHW)		CHW				CHW					CHW	CHW
Population Health Analytics Workforce	y		y									y
Population Health Data Systems	y	y	y	y	y	y	y	y	y	y	y	y

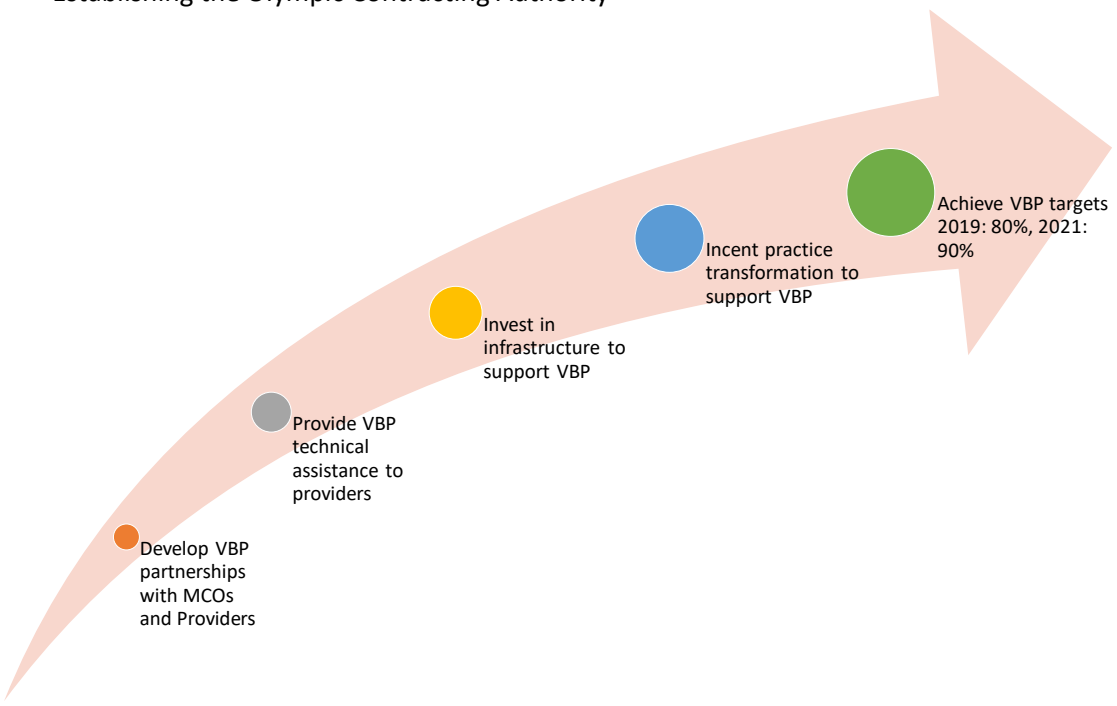
OCH ismeetings with senior leadership of each MCO to discuss:

- **In the future:** Describe the ideal partnership with the OCH, beyond the Demonstration, to support shared goals.
- **In the long term**: Identify mutually beneficial VBP goals to sustain Demonstration transformation and a shared work plan to get there.

- **In the short term**: Coordinate Domain 1 work and project plan development to align/support/leverage the MCO's VBP goals.

Several tactics are under strategic development:

- Requiring clinincal providers to accept VBP technical assistance from MCOs in order to earn Demonstration incentives
- Committing providers to *change plans* that incent practice transformation and systems integration
- Establishing a Wellness Fund to support investment in social determinants of health
- Developing a public utility for cloud-based population health management (Apple Integrator)
- Establishing the Olympic Contracting Authority



Attachment(s) Required

A. Initial list of partnering providers or categories of partnering organizations interested in or committed to implementing projects.

Attachments Checklist

Instructions: Check off each required attachment in the list below, ensuring the required attachment is labeled correctly and placed in the zip file. To pass Phase II Certification, all required attachments must be submitted. Check off any recommended attachments in the list below that are being submitted, ensuring the recommended attachment is labeled correctly and placed in the zip file.

Required Attachments	
Theory of Action and Alignment Strategy	
None	
Governance and Organizational Structure	
☐	A. Copies of charters for committees and workgroups that outline purpose, members, responsibilities, and scope.
☐	B. Conflict of interest policy.
☐	C. Draft or final job descriptions for all identified positions or summary of job functions.
☐	D. Short bios for all staff hired.
Tribal Engagement and Collaboration	
☐	A. Demonstration of adoption of the Model ACH Tribal Collaboration and Communication Policy, either through bylaws, meeting minutes, or other evidence. Highlight any modifications that were agreed to by all required parties.
☐	B. Bio(s) for the representative(s) of ITUs seated on the ACH governing board. *If you do not have an ITU representative on the governing board, please attach a description of the efforts made to fill the seat.*
Community and Stakeholder Engagement	
☐	A. Meeting minutes or meeting summaries for the last three decision-making body meetings and screenshot capturing distribution of meeting minutes/summaries (e.g., email distribution, website post).
☐	B. List of all public ACH-related engagements or forums for the last three months.
☐	C. List of all public ACH-related engagements or forums scheduled for the next three months.
☐	D. Evidence of meaningful participation by community members. Examples include: attestation of meaningful participation by at least one Medicaid beneficiary, meeting minutes that memorialize community member attendance and comments, and solicitation for public comment and ACH response to public comments.
☐	E. Attestation of meaningful participation from at least three partners from multiple sectors (e.g., managed care organizations, Federally Qualified Health centers, the public health community, hospitals, primary care, and behavioral health) not participating directly on the decision-making body.
Budget and Funds Flow	
☐	A. Bio or resume for the Chief Financial Officer (CFO) or equivalent person responsible for ACH financial functions.
☐	B. Financial Statements for the previous four quarters. Audited statements are preferred. If an ACH does not have four quarters of financial statements available, provide as many as possible.
☐	C. Completed Phase II Project Design Funds Budget Template, which includes Projected Project Design fund budget over the course of the demonstration, additional funding sources, and

	in-kind resources that the ACH expects to leverage to prepare their Project Plans and build the capacity and tools required to implement the Medicaid Transformation Project demonstration.
Clinical Capacity	
☐	A. Current bios or resumes for identified clinical and workforce subject matter experts or provider champions. *Re-attach bio or resume even if previously provided in Phase I Certification. ACHs should also include any additional bios or resumes, if applicable.*
Data and Analytic Capacity	
None	
Transformation Project Planning	
☐	A. Initial list of partnering providers or categories of partnering organizations interested in or committed to implementing projects.

Recommended Attachments	
Theory of Action and Alignment Strategy	
☐	A. Logic model(s), driver diagrams, tables, and/or theory of action illustrations that visually communicate the region-wide strategy and the relationships, linkages and interdependencies between priorities, key partners, populations, regional activities (including workforce and population health management systems), projects, and outcomes. *Note: These documents are intended to reflect the thought process that the ACH went through to define a vision for transformation that is grounded in community needs and tied to the broader Healthier Washington objectives, and to define how it will align its activities and resources to advance the vision in an efficient manner.*
Governance and Organizational Structure	
☐	E. Sector representation policy describing any agreements or expectations for decision-making body members to communicate with and engage partners within a defined sector.
☐	F. Revised visual/chart of the governance structure, if there have been significant changes since Phase I Certification.
☐	G. Revised organizational chart that outlines current and anticipated staff roles to support the ACH, if there have been significant changes since Phase I Certification.
Tribal Engagement and Collaboration	
☐	C. Statements of support for ACH certification from every ITU in the ACH region.
Community and Stakeholder Engagement	
None	
Budget and Funds Flow	
None	
Clinical Capacity	
None	
Data and Analytic Capacity	
None	
Transformation Project Planning	
None	