
Kitsap
NCC
Natural Communities of Care
February 26th, 1:00 - 4:00 p.m.
Suquamish Clearwater Resort

Goals for Today

- An understanding of the current state of the Medicaid Transformation Project
- New and stronger community partnerships
- Awareness of key indicators influencing the community's health

Housekeeping

- Evaluation
- Note Cards
- Restrooms

Welcome and Introductions

- Name
- Organization
- Involvement with OCH (e.g., Board Member, Implementation Partner, Participant at Convenings, Three-County Coordinated Opioid Response Project, etc…)
- Favorite place you have ever traveled to

Today's Agenda

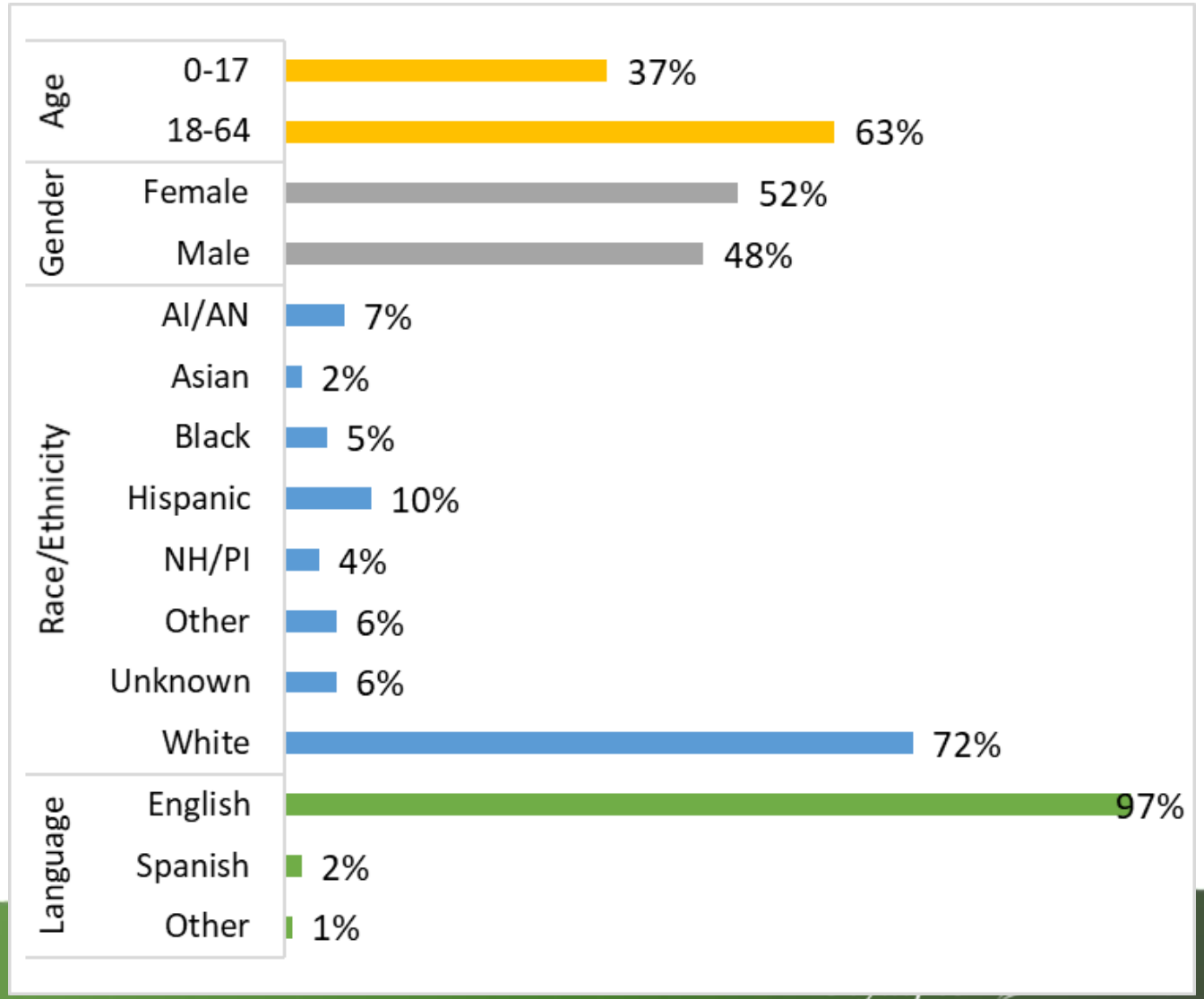
Olympic COMMUNITY of HEALTH
Clallam ● Jefferson ● Kitsap

Current State

OCH Medicaid Population

4/1/17-3/31/18

	# individuals	% of county population
Clallam	21,574	29%
Jefferson	7,653	24%
Kitsap	55,169	21%
OCH Total	84,396	



American Indian/Alaska Native (AI/AN); Native Hawaiian/Other Pacific Islander (NH/PI)

Source: HW Measures Dashboard available at: https://fortress.wa.gov/t/51/views/HealthierWashingtonDashboard/FrontPage?:isGuestRedirectFromVizportal=y&:embed=y

Healthier Washington Measures

OCH data: 4/1/17-3/31/18

green shading=better than WA

Category	Measure	Rate
Inpatient	Acute Hospital Utilization, per 1000 Members	56
	Plan All-Cause Hospital Readmissions – 18-64 years	13%
Primary Care	Adult access to preventive/ambulatory care	77%
	Chlamydia Screening- ages 16-24 years	50%
	Child and adolescent access to primary care	90%
	Well-child visits - 3-6 years	60%
	Childhood Immunizations by Age 2 <non-claims based>	31%
Emergency Department	All-Cause ED Visits, per 1000 Member Months	64
	ED Utilization, per 1000 Members	717
	Potentially Avoidable ED Visits	18%
Treatment	Mental Health Treatment Penetration	53%
	Substance Use Disorder Treatment Penetration	34%
	Substance Use Disorder Treatment Penetration (Opioid)	36%
ED/ Inpatient Follow-up	Follow-up After ED Visit for Alcohol / Other Drug Abuse or Dependence: 7 days	28%
	Follow-up After ED Visit for Alcohol / Other Drug Abuse or Dependence: 30 days	38%
	Follow-Up after ED visit for Mental Illness: 7 days	68%
	Follow-up After ED Visit for Mental Illness: 30 days	77%
	Follow-up After Hospitalization for Mental Illness: 7 days	76%
	Follow-up After Hospitalization for Mental Illness: 30 days	90%
Prescribing	Antidepressant medication management – Acute (12 weeks)	55%
	Antidepressant medication management - Continuation (6 months)	38%
	Patients Prescribed Chronic Concurrent Opioids and Sedatives	21%
	Patients Prescribed High-dose Chronic Opioid Therapy: >50 mg MED	40%
	Patients Prescribed High-dose Chronic Opioid Therapy: >90 mg MED	22%
Chronic Disease Management	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	39%
	Comprehensive Diabetes Care: HBA1c Testing	83%
	Comprehensive Diabetes Care: Medical Attention for Nephropathy	85%
	Medication Management for People with Asthma (75%)	37%
	Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	70%
Oral Health	Primary Caries Prevention Intervention by Primary Care Medical Providers	2.0%
	Utilization of Dental Services	38%
Social Determinants	Percent Arrested	7.1%
	Percent Homeless (Narrow Definition)	3.3%

Source: WA HCA: ARM_To_OCH_K2493-02_HWMR_v5_R10_Sensitive_02192019.

Child and Adolescent Access to Primary Care

OCH:

90.2%

WA State:

91.0%

2019 Targets by age (# to meet target):

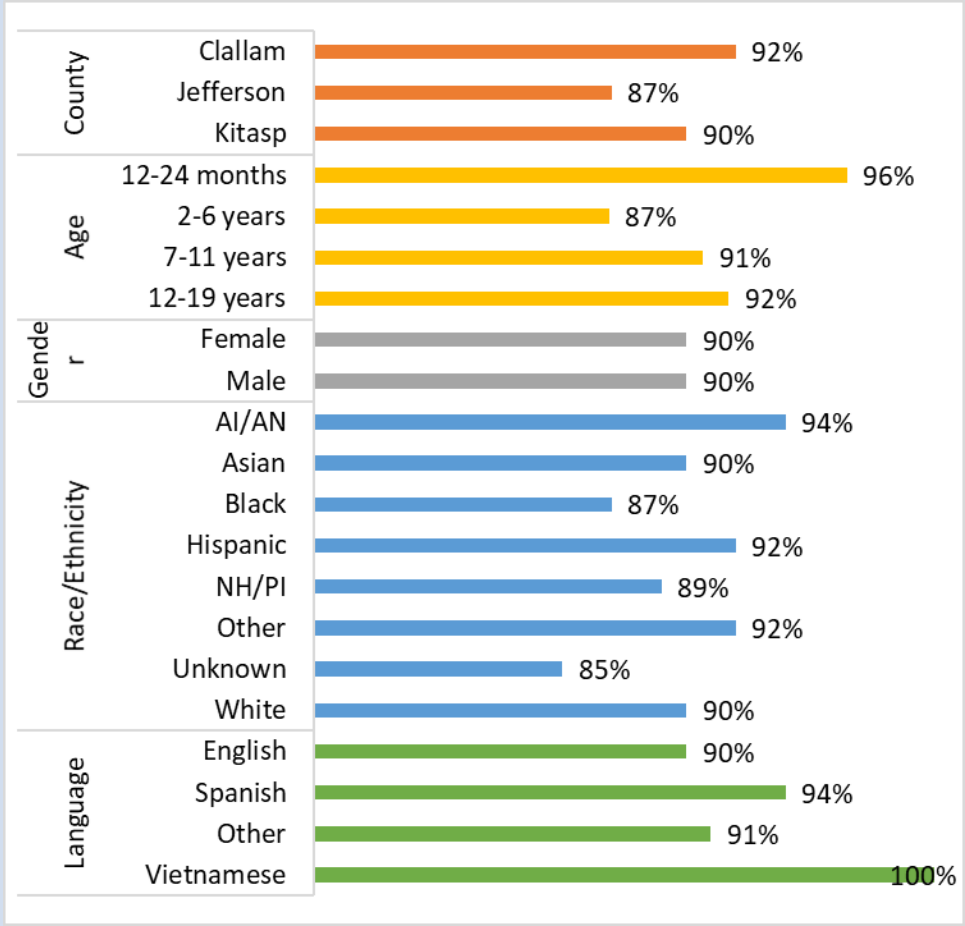
12-24 mo: 95.8% (M)

2-6 years: 87.0% (7)

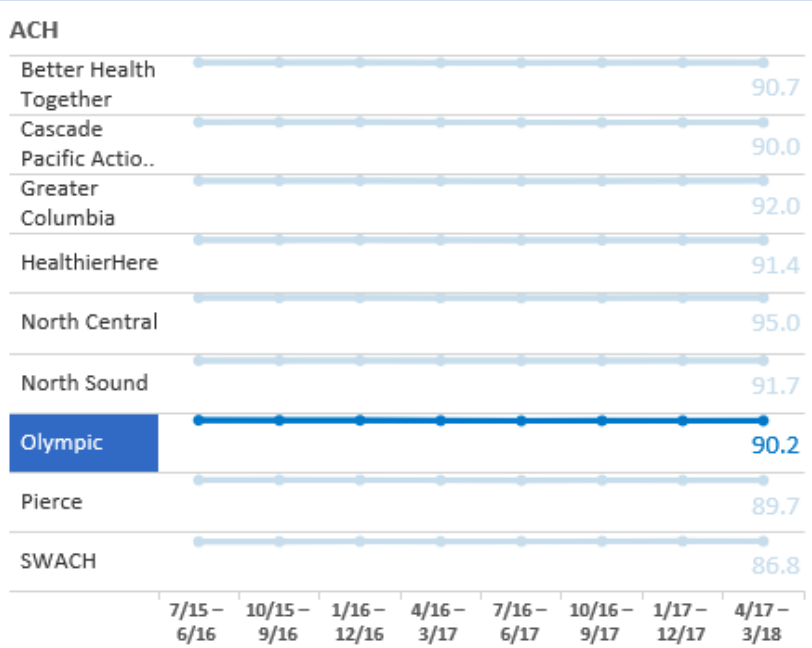
7-11 years: 91.8% (73)

12-19 years: 91.9% (15)

By sub-groups:



Comparison over time and by ACH:



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Well Child Visits, ages 3-6

OCH:

60.1%

WA State:

62.6%

Benchmark:

85%

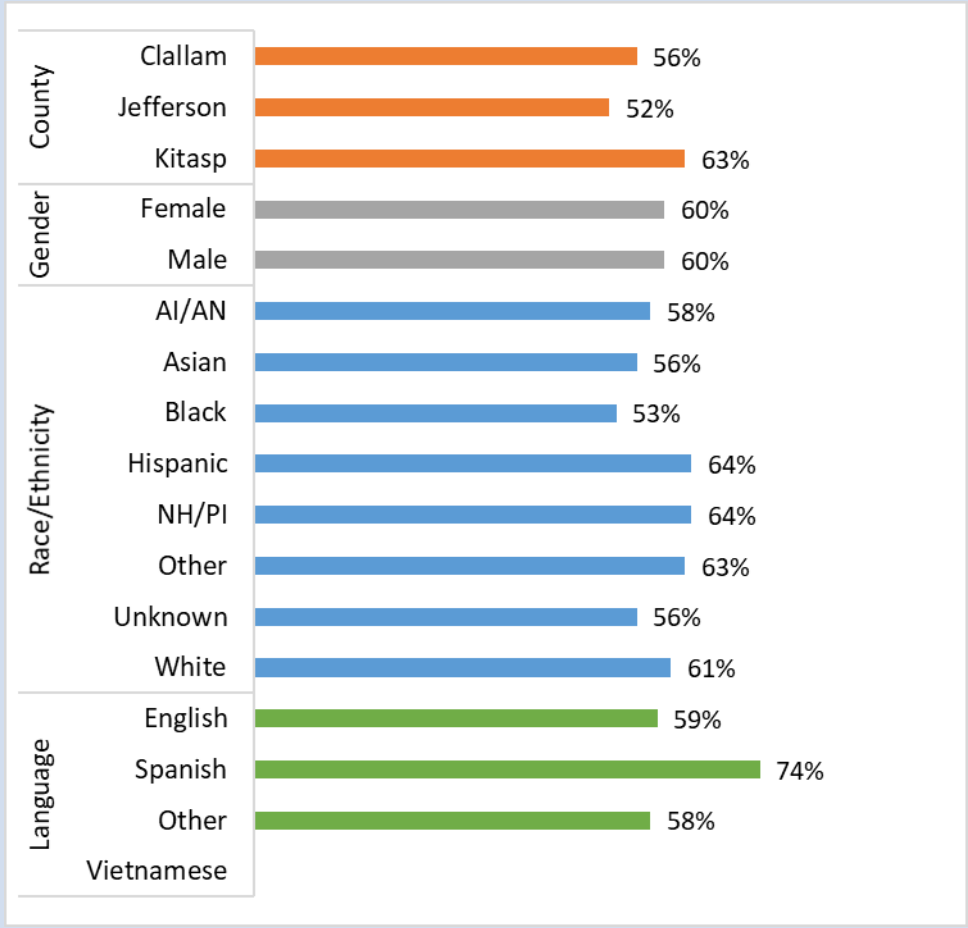
2019 Target:

63.2%

Number needed to meet target:

187

By sub-groups:



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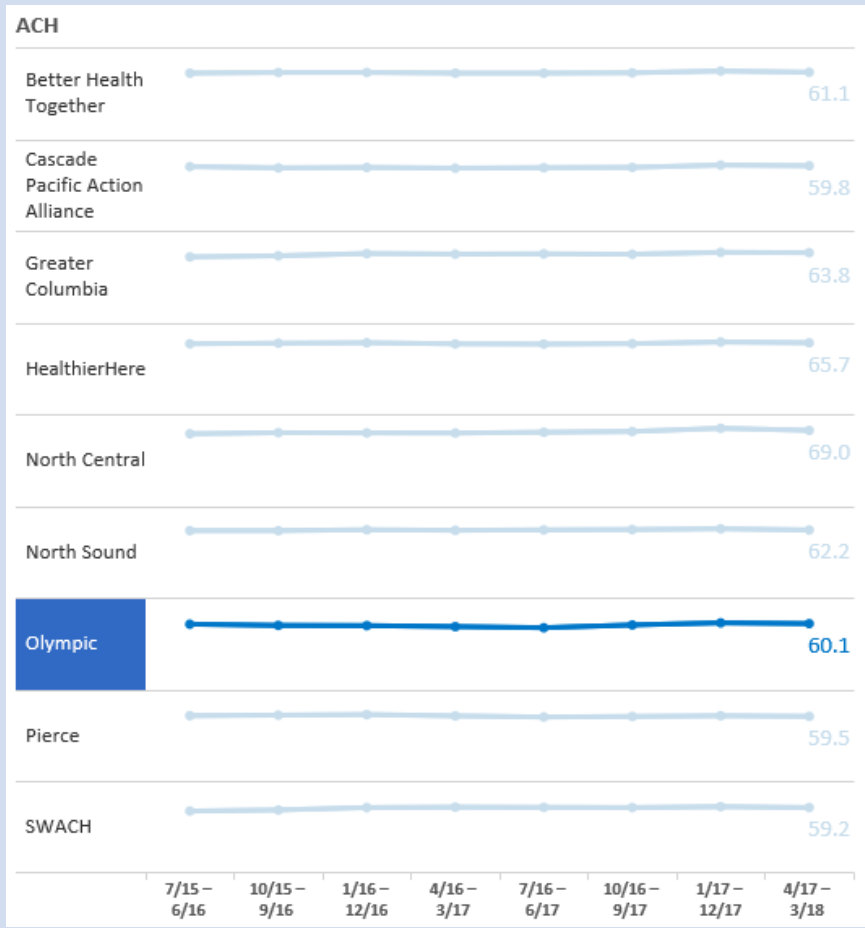

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All-Cause ED Visits, rate per 1000 member months

OCH:

64.3

WA State:

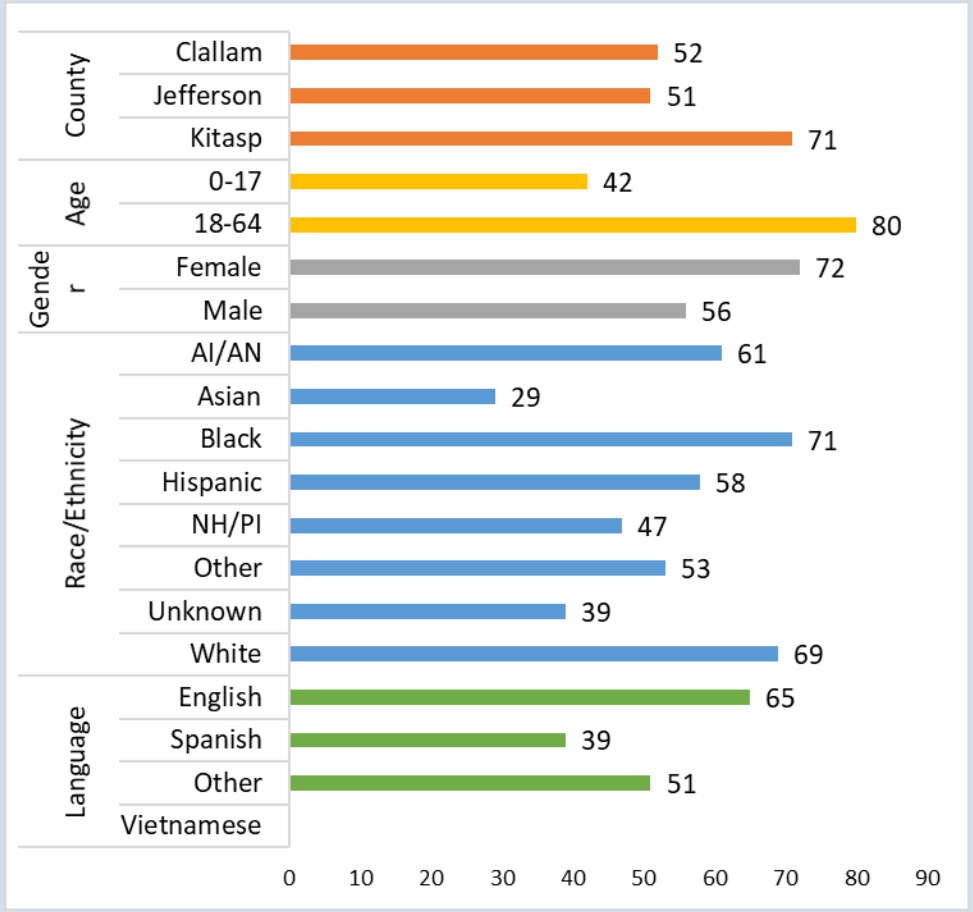
52.2

2019 Targets:

Age 0-17: 41.1

Age 18-64: 77.9

By sub-groups:



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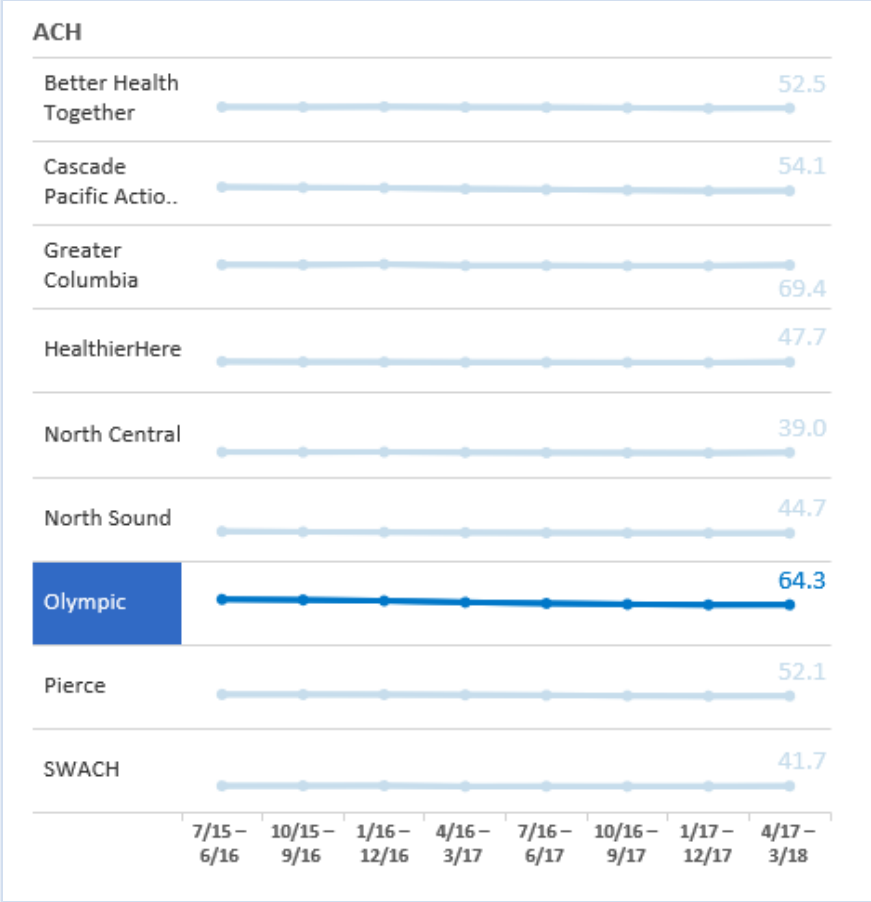

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Groups and ACHs overtime: HW Measures Dashboard available at:

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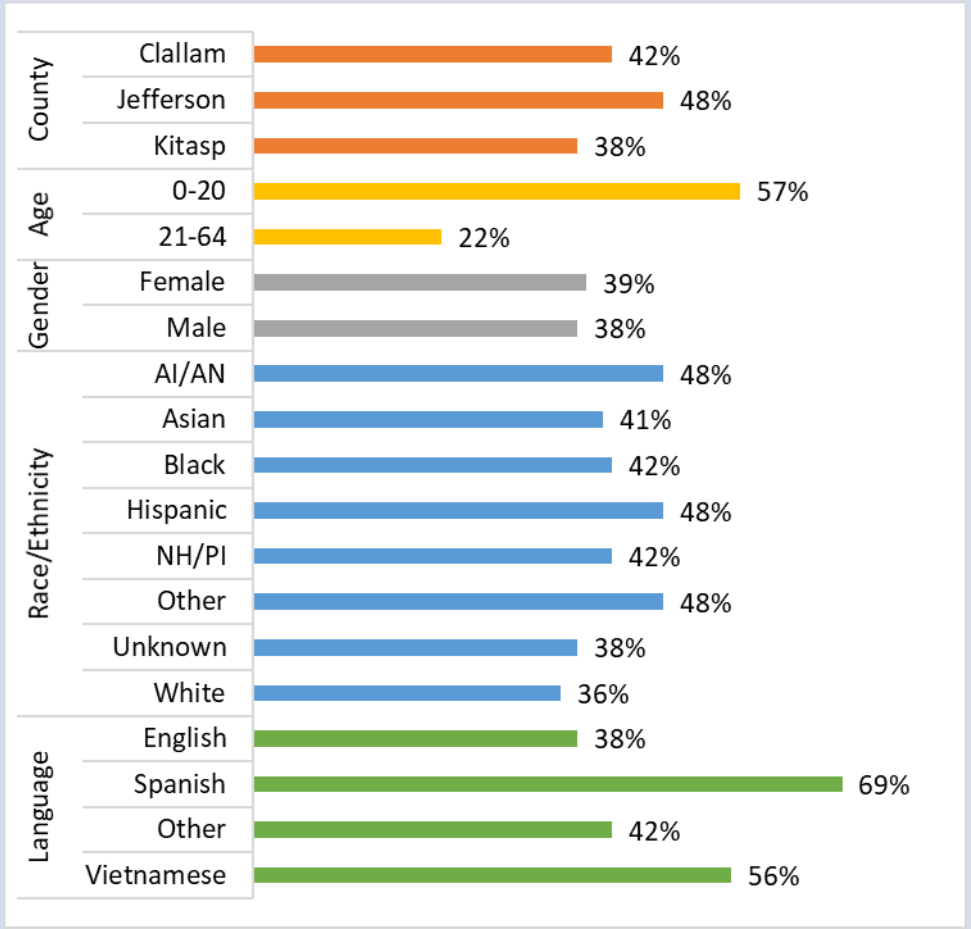
Utilization of Dental Services

	By sub-groups:	Comparison by ACH:
OCH: **38.2%** WA State: **46.6%** 2019 Targets: Age 0-20: **55.8%** Age 21-64: **21.6%** Number needed to meet target: CURRENTLY MEETING TARGETS		North Central 58% Greater Columbia 56% Better Health Together 49% North Sound 46% Healthier Here 44% SWACH 44% Pierce 43% Cascade Pacific Action Alliance 43% OCH 38%

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Substance Use Disorder Treatment Penetration

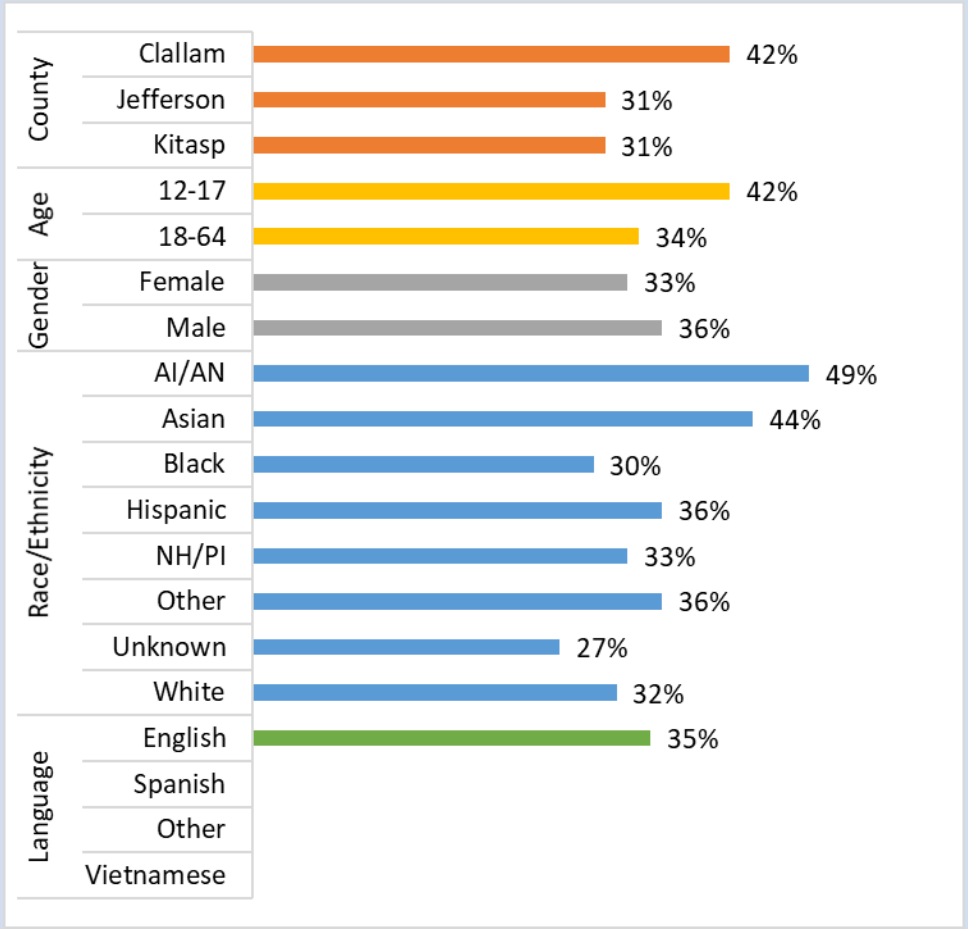
OCH:
34.4%

WA State:
31.3%

2019 Targets:
Age 12-17: 39.9%
Age 18-64: 32.4%

Number needed to meet target:
Age 12-17 and 18-64:
CURRENTLY MEETING

By sub-groups:



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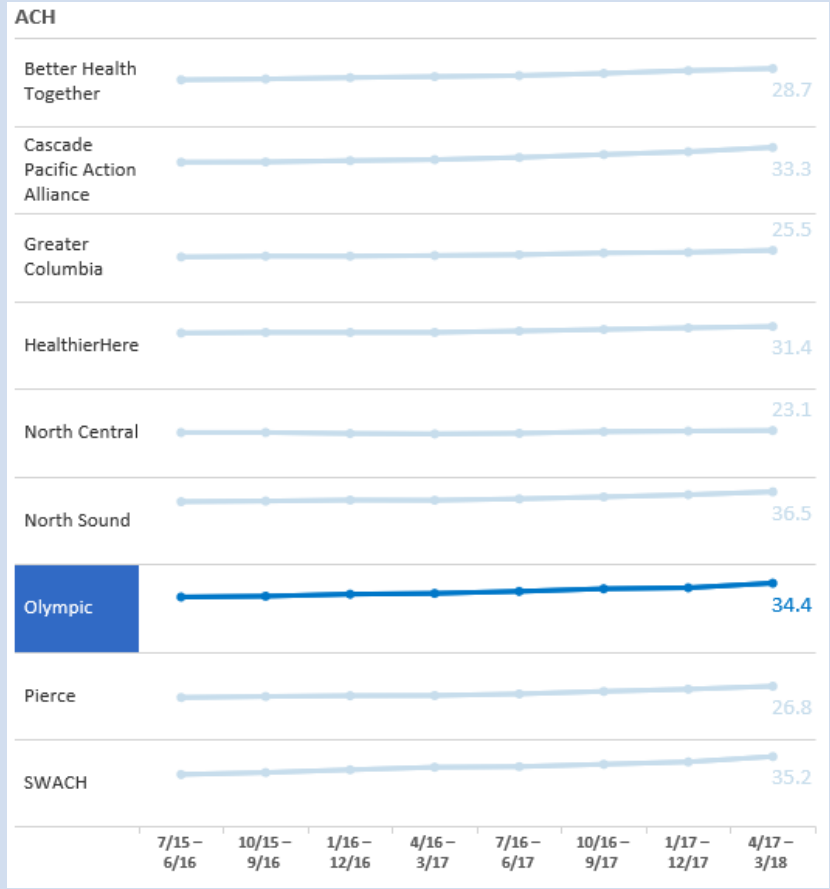

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Patients Prescribed High-dose Chronic Opioid Therapy: >50 mg MED

OCH:

40.2%

WA State:

34.4%

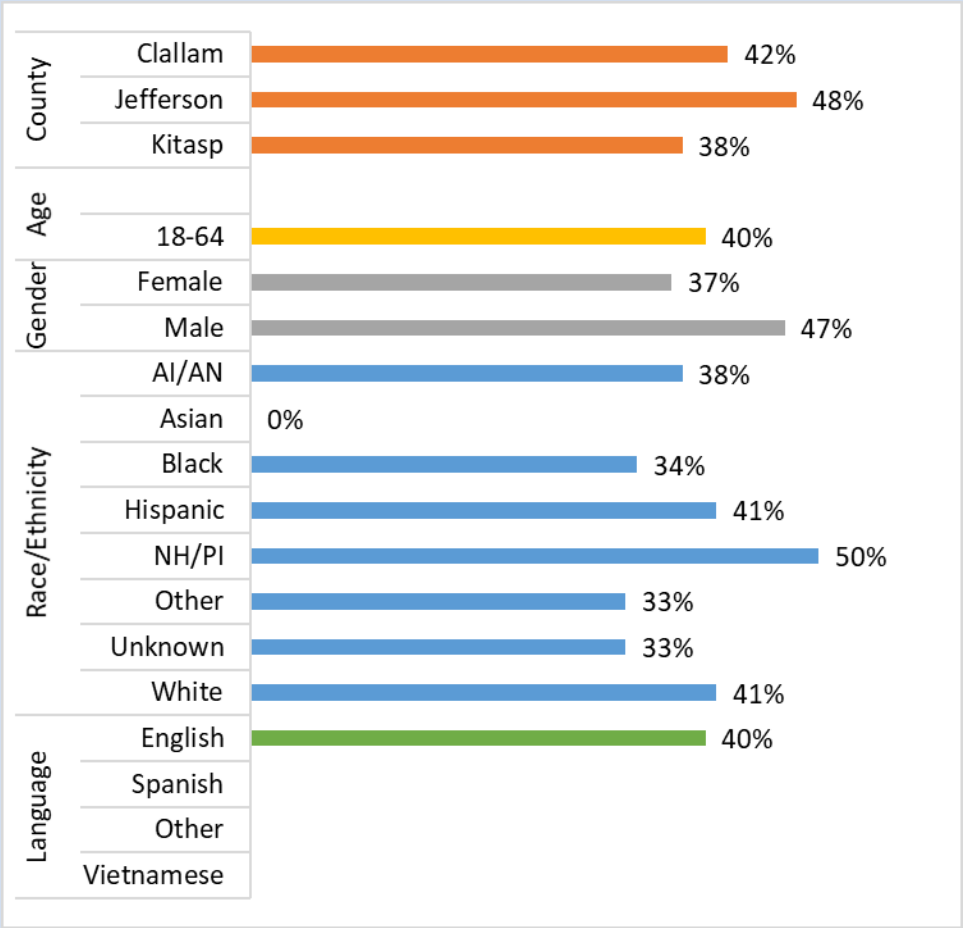
2019 Target:

39.8%

Number needed to meet target:

-21

By sub-groups:



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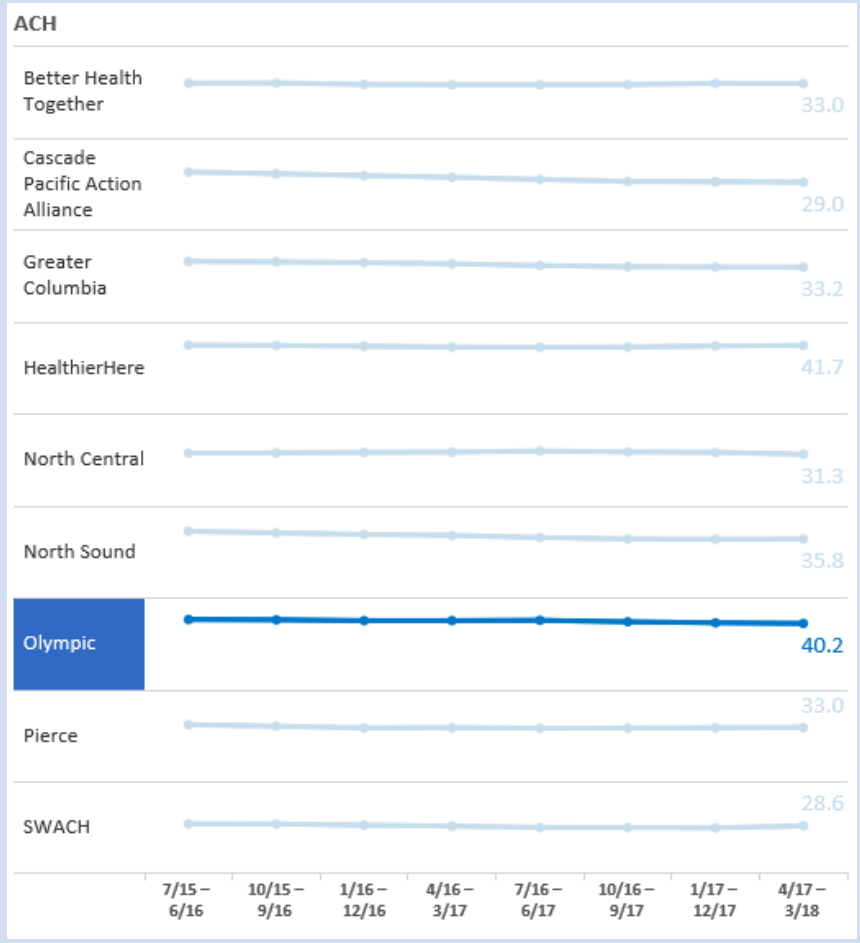

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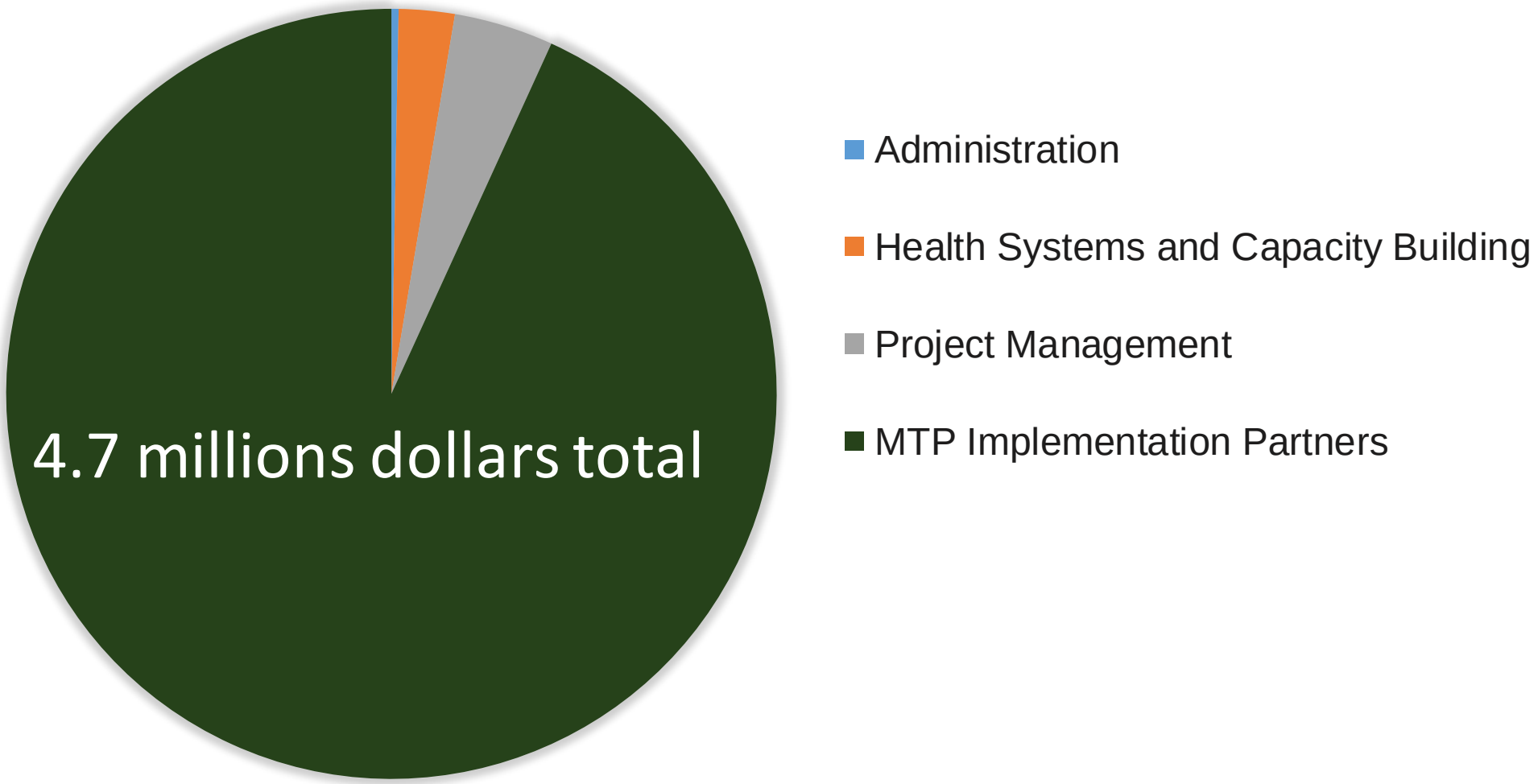
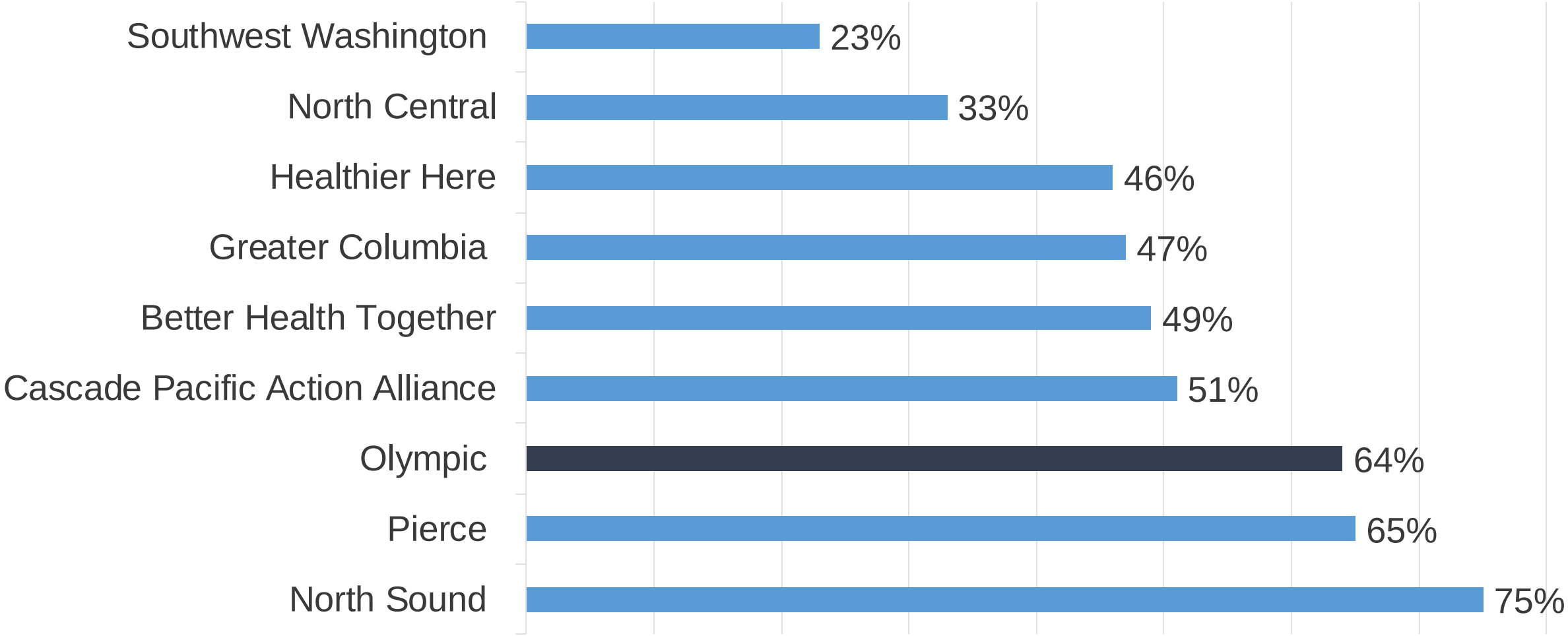
3 County Coordinated Opioid Response Project – 3CCORP

PROPORTION OF EARNED REVENUE DISTRIBUTED BY CATEGORY



Proportion of Allocated Funds from the Financial Executor Portal by ACH



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Total 33 Implementation Partners

	Partner	NCC	Primary Care	Behavioral Health	Hospital	CBOSS
1	Bogachiel and Clallam Bay Primary Care Clinics	Clallam	x			
2	Olympic Personal Growth	Clallam		x		
3	Reflections Counseling Services Group	Clallam		x		
4	Peninsula Behavioral Health	Clallam		x		
5	West End Outreach Services	Clallam		x		
6	Jamestown Family Health Clinic	Clallam	x	x		
7	North Olympic Healthcare Network	Clallam	x	x		
8	Sophie Trettevick Indian Health Center	Clallam	x	x		
9	Forks Community Hospital	Clallam			x	
10	Olympic Medical Center, Hospital	Clallam			x	
11	Olympic Medical Center (OMP)	Clallam	x			
12	First Step Family Support Center	Clallam				x
13	Olympic Peninsula Health Communities Coalition	Clallam				x
14	OlyCAP	Clallam/Jefferson				x
15	Olympic Area Agency on Aging	Clallam/Jefferson				x
16	Beacon of Hope, Safe Harbor Recovery	Jefferson		x		
17	Discovery Behavioral Health	Jefferson		x		
18	Jefferson Healthcare	Jefferson			x	
19	Jefferson Healthcare Primary Care	Jefferson	x			
20	Northwest WA Family Medical Residency	Kitsap	x			
21	Harrison Health Partners Primary Care Clinics	Kitsap	x			
22	Kitsap Children's Clinic	Kitsap	x			
23	Kitsap Medical Group	Kitsap	x			
24	Peninsula Community Health Services	Kitsap	x	x		
25	Port Gamble S'Klallam Wellness Center	Kitsap	x	x		
26	Kitsap Mental Health Services	Kitsap		x		
27	Kitsap Recovery Center	Kitsap		x		
28	West Sound Treatment Center	Kitsap		x		
29	Harrison Medical Center	Kitsap			x	
30	Answers Counseling	Kitsap				x
31	Kitsap Division of Aging and Long-Term Care	Kitsap				x
32	Kitsap Public Health District	Kitsap				x
33	YMCA (Pierce & Kitsap Counties)	Kitsap				x

Payment Disbursement by Provider Type

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Equity

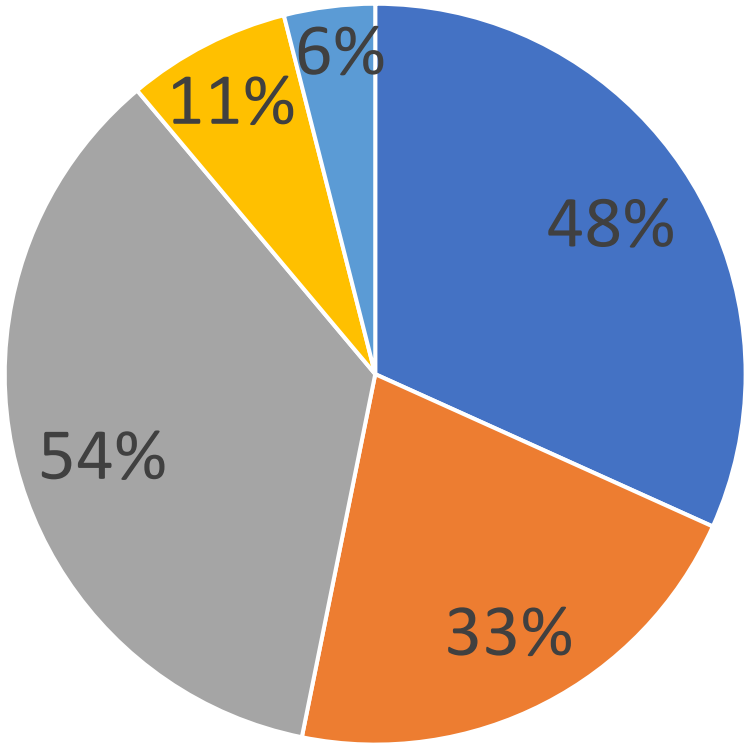
OCH Equity Survey

Survey open April 25 - June 26, 2018

Paper survey at Convening and Survey Monkey

Total responses = 83

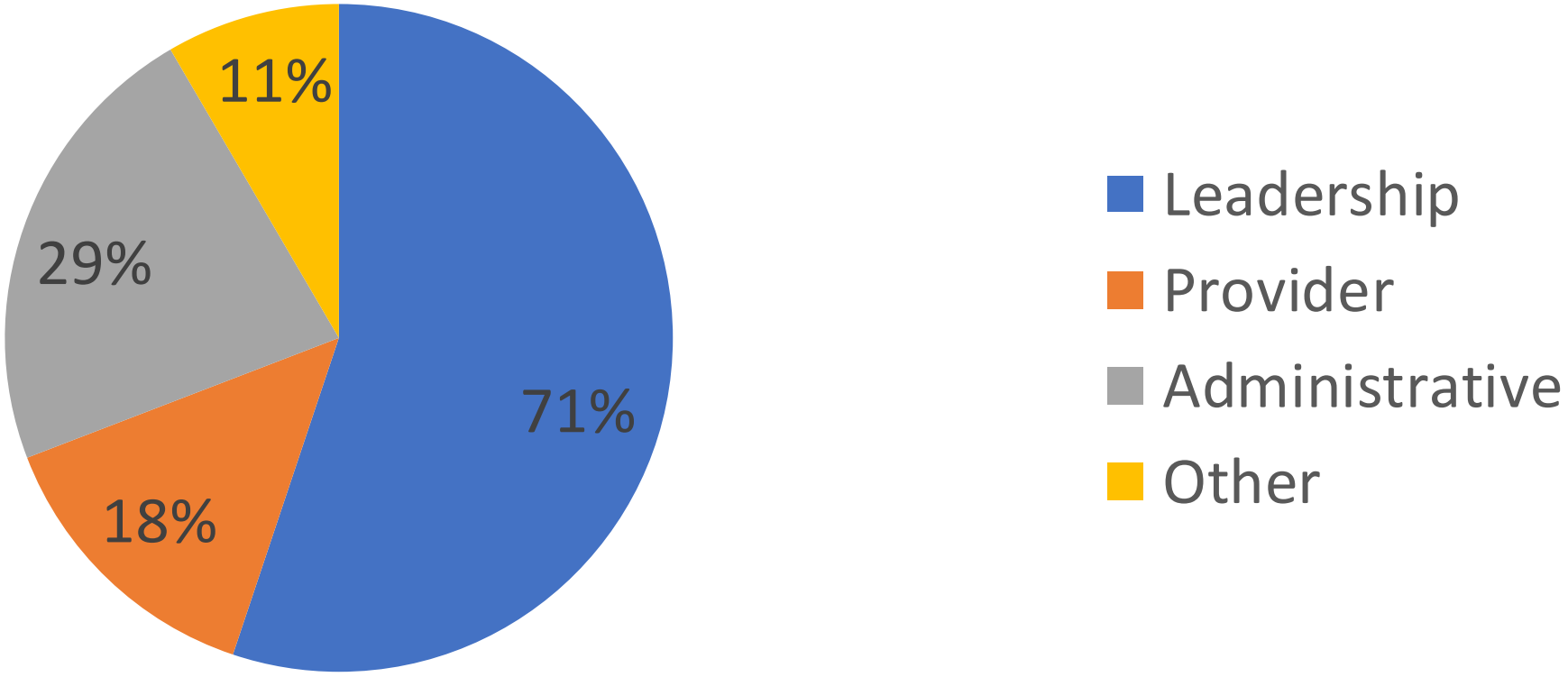
Where does your organization provide services?



- Clallam
- Jefferson
- Kitsap
- WA
- Other

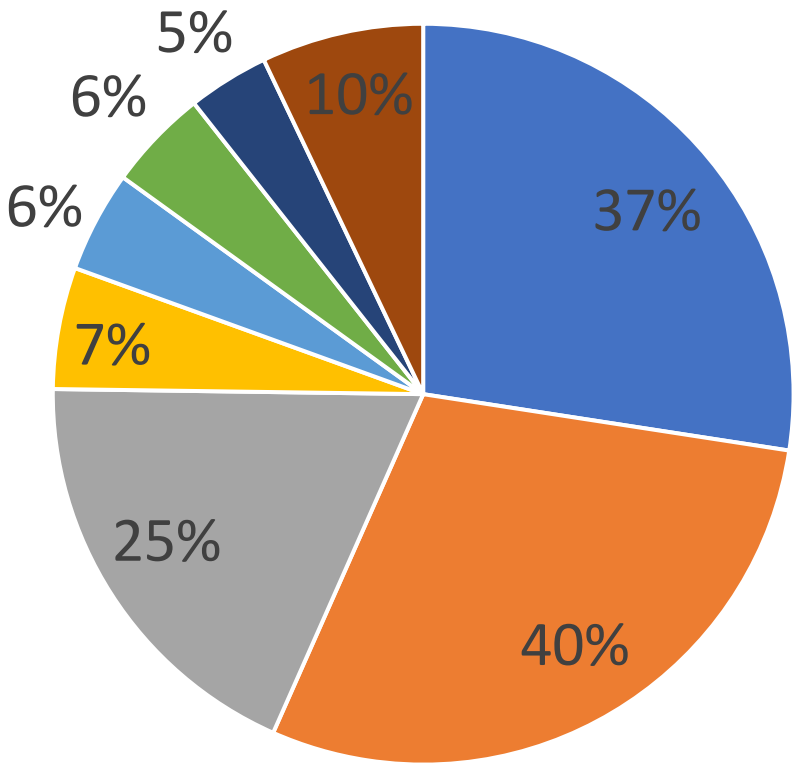
Other: Mason (2); King (1); Pierce (1); Snohomish (1); multiple other states

What is your role in your organization?



Other: Clinical (3), Social services, Community care facilitator, not listed (4)

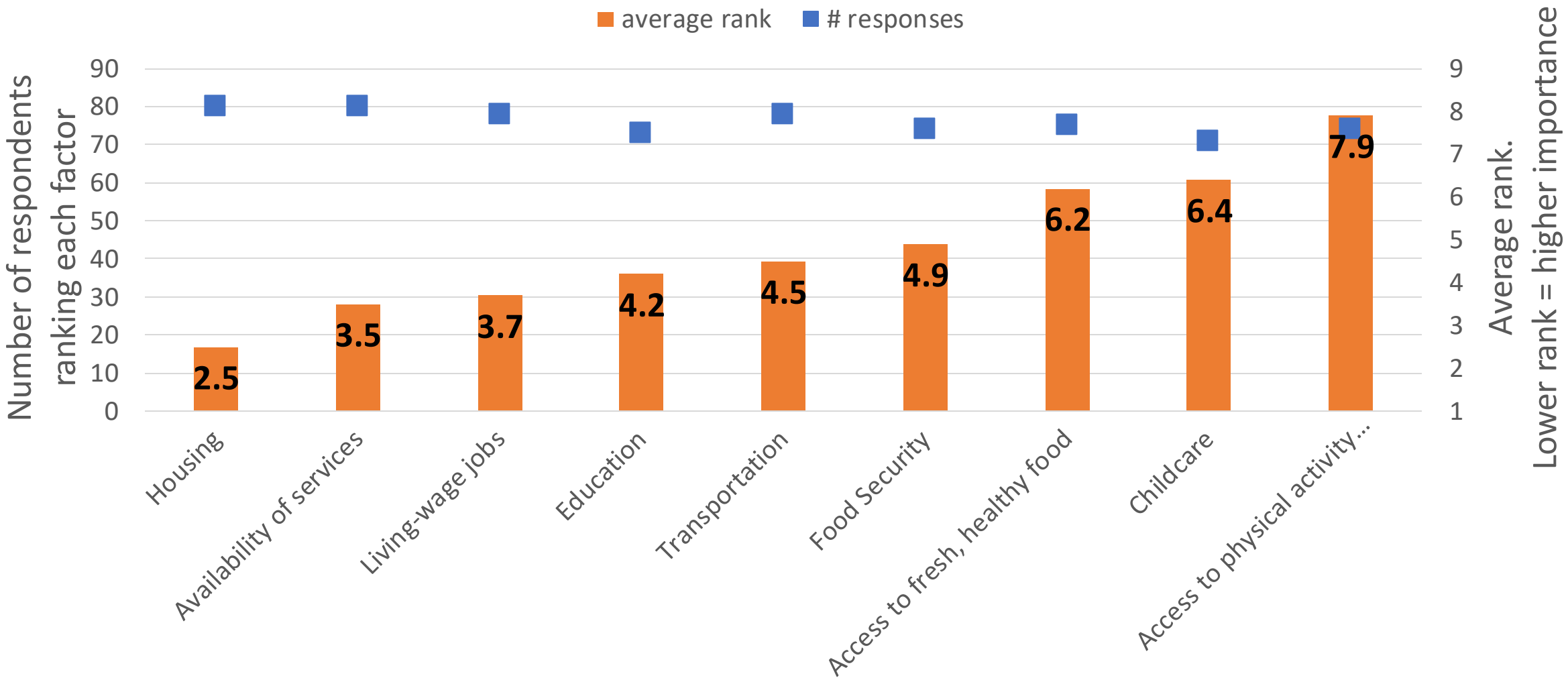
What sector(s) is your organization?



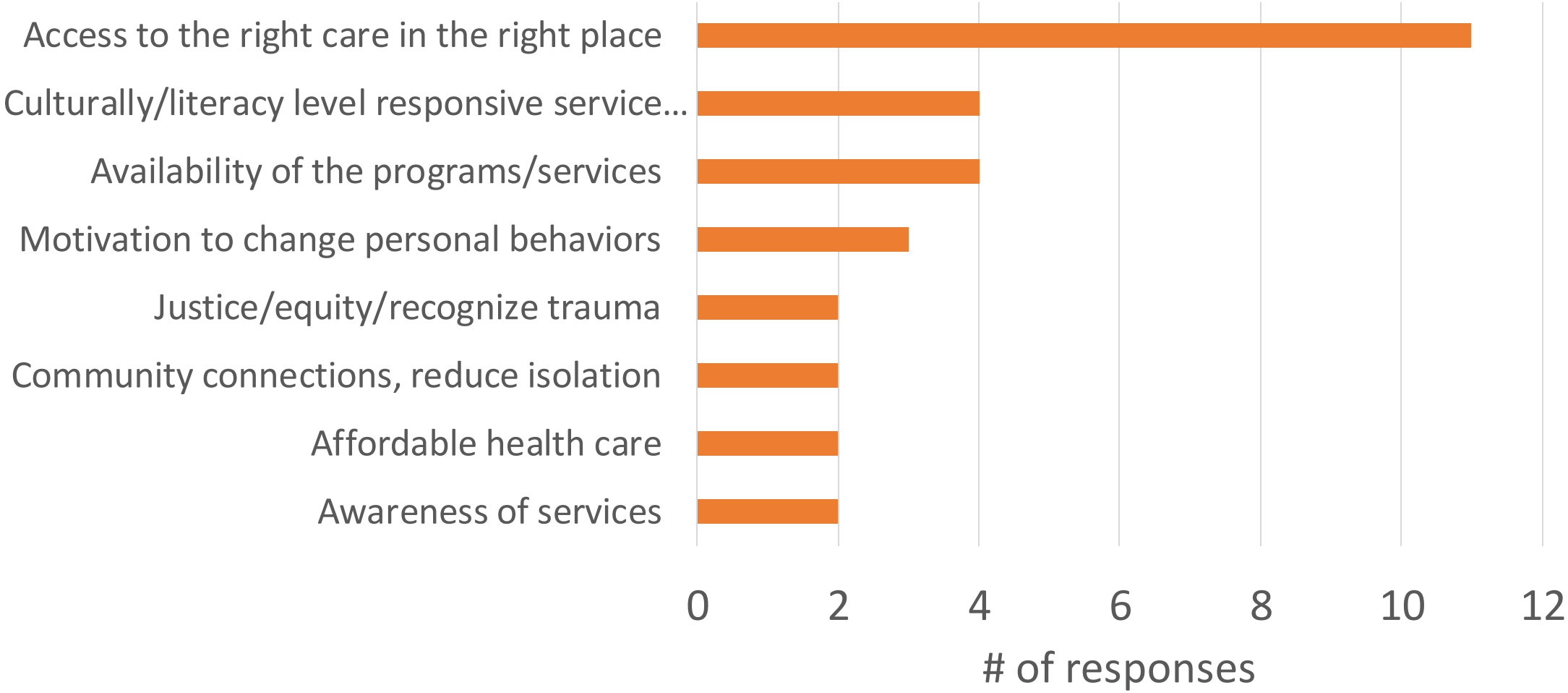
- Behavioral Health
- Physical Health
- Community Based Org
- Public Health
- Local/county government
- Fire/EMS/Law enforcement
- MCO
- Other

Other: Oral health (3); education; early childhood; public housing; tribal health; work force development

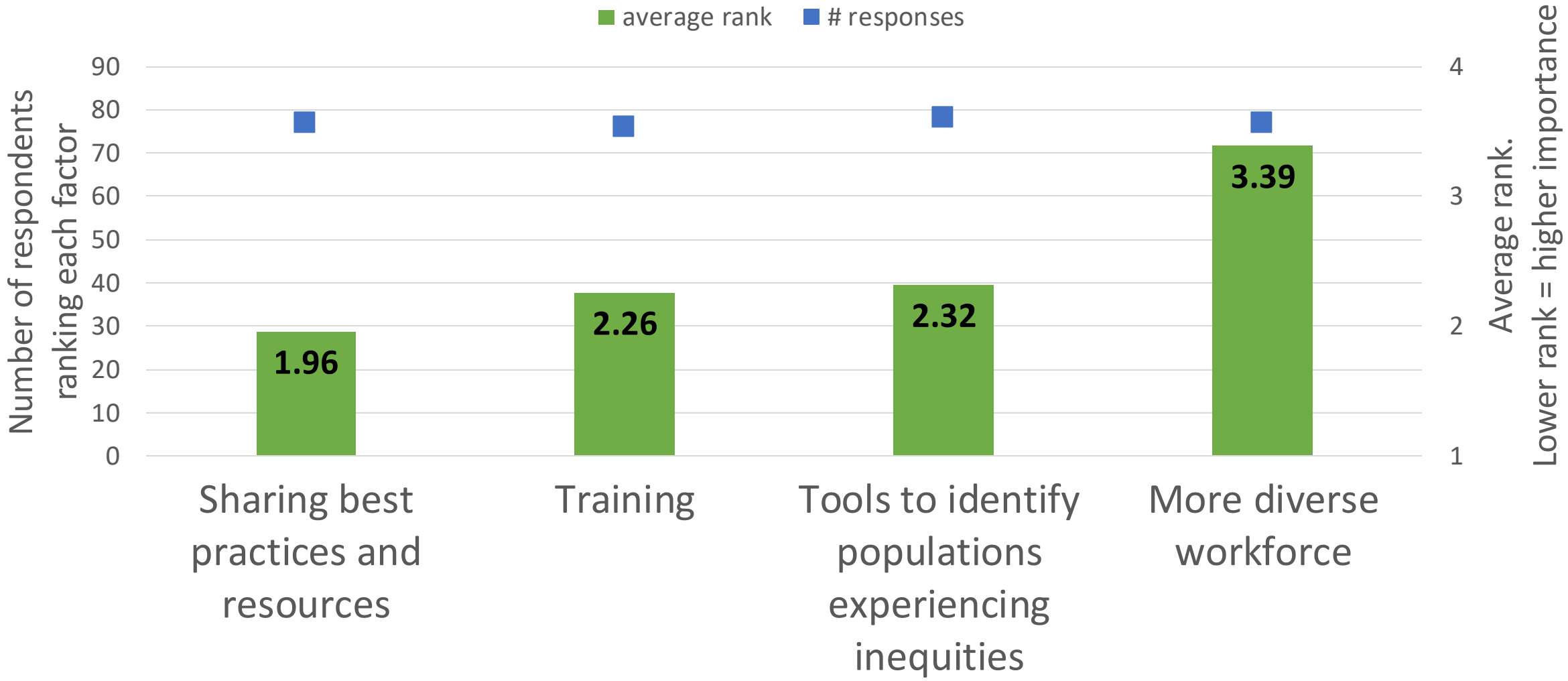
Rank of factors in order of importance to improve health equity among the clients you serve (lower rank is higher importance):



Other “write-in” factors to improve health equity among the clients you serve (grouped by theme):

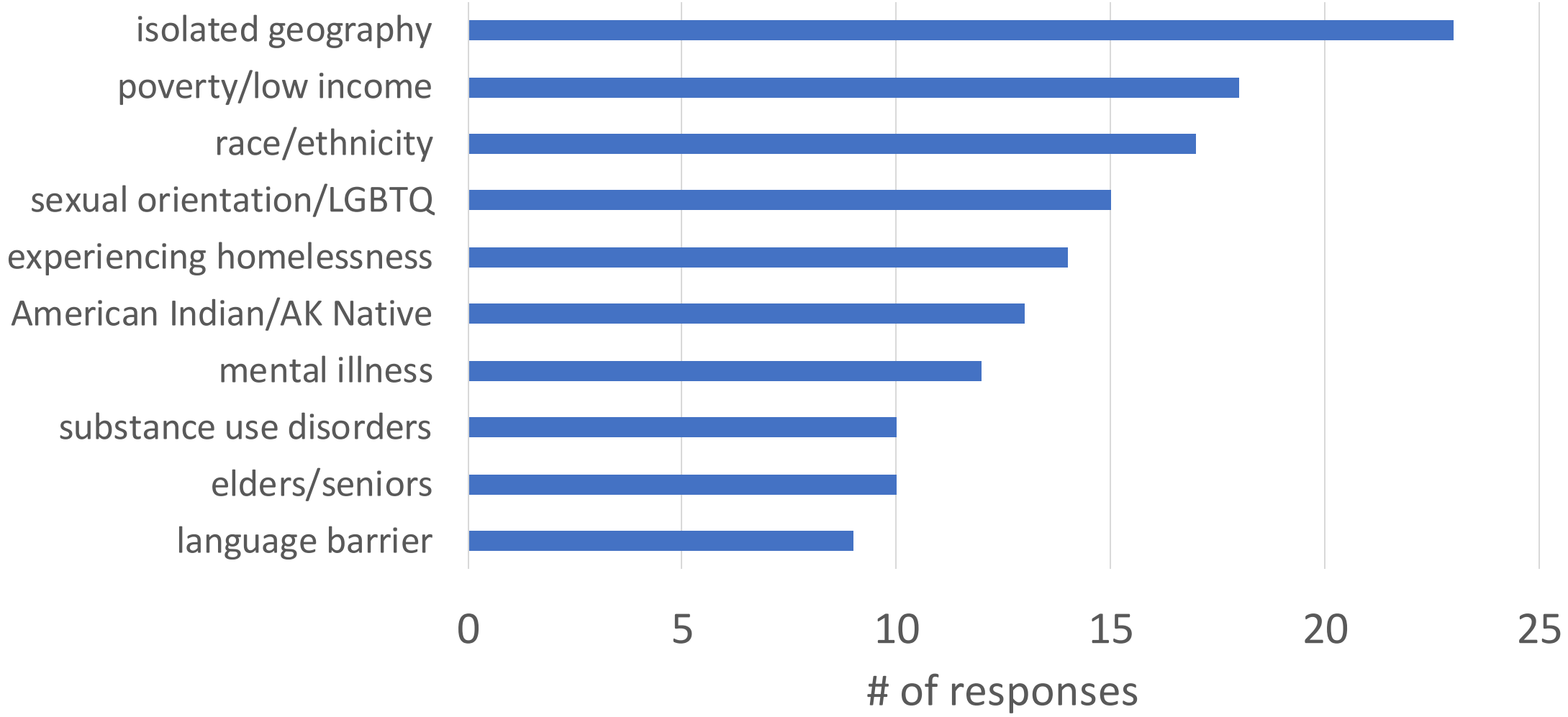


Rank of factors in order of importance to help your organization address health equity in your work (lower rank is higher importance):



Other “write-in” factors to improve health equity among the clients you serve (grouped by theme):

Among those you serve, which populations or groups does your organization consider to be excluded or marginalized populations experiencing health inequities? (top 10)



Please share some examples of what your organization is doing to address health equity.

Working to establish improved access to both permanent and temporary housing that supports improved health outcomes. Working to improve Food Access and Food Security.

Analyzing our data with health equity in mind and acting upon the information.

targeting interventions to specific populations where we see lower rates of immunizations, well child checks, preventive screenings

Advocating for clients with individual providers and agencies on underlying illnesses that contribute to behaviors.

collaborating, coordinating, and communicating with organizations for partnering in removing barriers and increasing support, referrals, advocacy and access to quality care

Sharing stories of identified gaps and working with community partners during bi-monthly meetings in an attempt to shed light and problem solve if there is a partner agency that can help.

Training; strategic priority with budgeted resources; outreach/advisory boards; attempting to staff to represent communities we serve

What would your organization want to do to improve health equity in our region and what do you need to do it?

Keep talking about it with others; connections with marginalized communities to meet their needs.

Learn more about the specifics that different minority groups need from their perspective and develop resources to meet those needs to the extent possible. Training in different cultural/minority needs.

Divert financial resources towards increasing the supply of deeply affordable housing

screening tools for SDOH; Provider training to do so

Funding for care coordination to facilitate referrals and access to community supports

we need to know which organizations can complement the services and supports we provide our members and partner to enhance not duplicate services

I would like us to use equity to guide decision-making and resource allocation; recognizing our systems are creating/maintaining the disparities/gaps we see in the community.

provide community education to improve community capacity

Please share any other comments you may have.

Many of the factors underlying inequities are in areas where we have little influence or impact

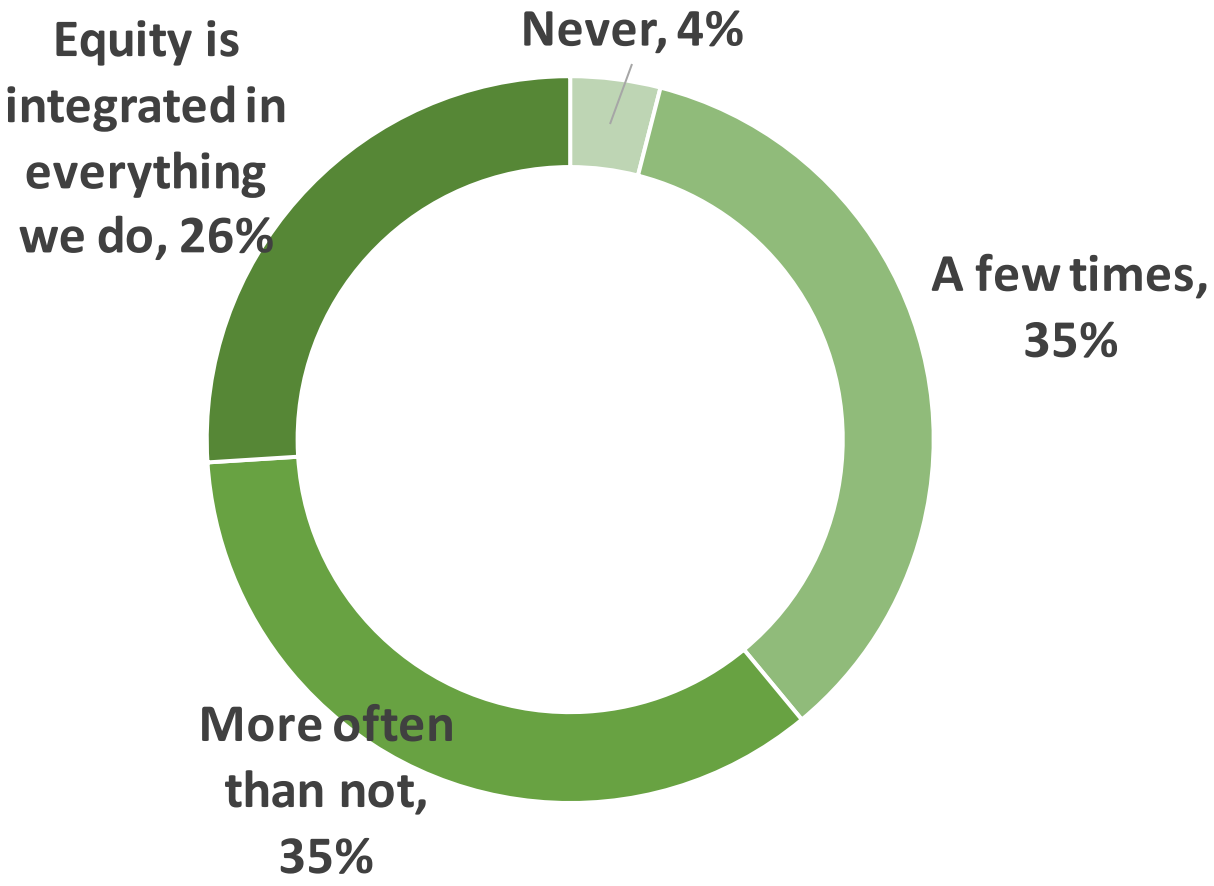
What is the process/accountability approach to ensure clients/community are driving this work and we are accountable to the community (i.e. those who are most underrepresented/served are the ones we are accountable to first/most).

Kahoot Equity Questions

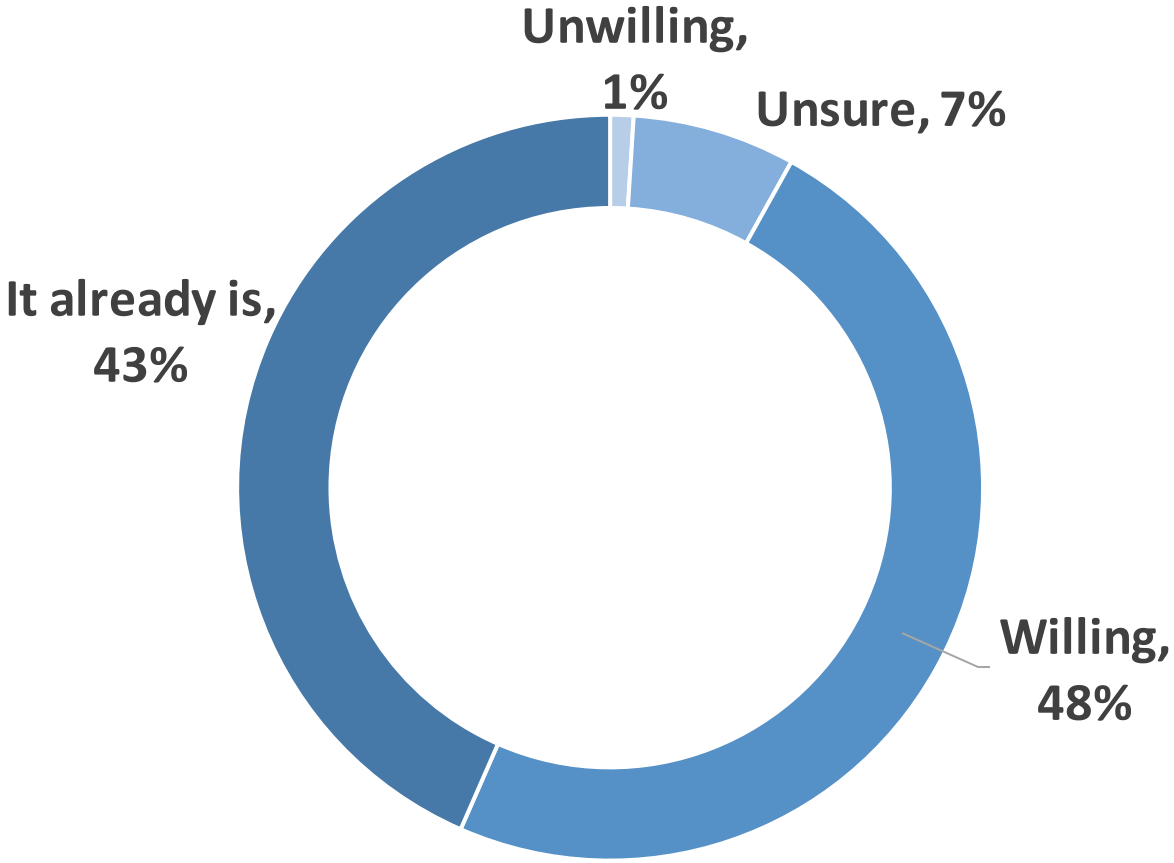
Participants used smart phones at the April convening to access website and input answers in real time

N=54

How often would you say your organization has discussed equity in the past year?



How ready do you think your organization is to make equity a strategic priority in 2019?



Networking Break

After the break, please sit with others from your organization

If you are interested in learning more about ORCA, please email Miranda@olympicCH.org

Have you logged onto ORCA lately?

ORCA is where Implementation Partners complete their reporting. All partners can access resources and stay up to date on OCH activities on ORCA!

Not registered with ORCA? Contact our Program Coordinator, Miranda Burger, at miranda@olympicch.org

Building and Strengthening Partnerships

What do we want at the end of the Medicaid Transformation Project?

1. Accessible, patient-centered primary care that is well integrated with behavioral health and dental services
2. Effective linkages between primary care, behavioral health and community-based service providers
3. Common data metrics and shared information exchange
4. Provider adoption of value-based payment contracts

Partners!

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From Partners

"It's not integrated enough in this community at this time."—BH partner

"Clinical integration is supposed to be bilateral, but it feels one-sided." –BH partner

"Clinical partners have more power. What do we do if they don't play?" –CBOSS partner

"Community-clinical linkage work is very needed. Things are currently at a very poor state." –PH partner

"The only way we are going to win the battle is if we start talking." -BH partner

"We've never seen this much collaboration between behavioral health and primary care. We're on the right track!"

Community-Clinical Linkage Assessment Tool

- Three Elements:
  - How referrals are made and received
  - How a referral loop is followed up on and closed
  - How relevant information is shared

	1	2	3	4	5	6	7	8	9	10
Assess the status of your organization making referrals to partner listed above										
Make referral to needed service provided by partner	does not occur	limited to a list or pamphlet of contact information for relevant resources		occurs informally, differs for each staff person - some staff know the right person to call and rely on personal connections		occurs through a referral process - staff discuss needs, barriers and appropriate resources before making referral (paper, email, or phone)			occurs through a shared online system for coordinated referrals	
Follow up on closed loop	does not occur	client/patient is initiates follow up steps		documentation of follow up and closed loop occurs informally and only sometimes		documentation occurs through a formal process			occurs through a shared online system for coordinated referrals	
Ongoing bi-directional **communication of relevant information**	does not occur	client/patient is responsible for transmitting information		occurs informally, some staff know the right person and rely on personal connections		ongoing bi-directional communication occurs on paper, email or phone call			occurs through a shared online system for coordinated referrals and communication	

Partnerships Activity

This is an incomplete version intended to spark meaningful discussion.
Please use this time ***to complete the matrix****.*

- A lack of a line does **not** indicate a lack of an existing partnership or a lack of a desire to work on a partnership
  - Lines represent who partner identified utilizing assessment tool may be useful to work on strengthening partnership with.
- A green line indicates a bi-directional identification
- A black line indicates one partner identified another

Partnerships Activity

- Please sit with others from your organization.
- Identify one person to represent your organization.
- Look at the matrix and ask (5 mins to caucus internally):
  - **Implementation Partner:** Is it complete? Do you have any additions?
  - **NCC Partner:** Note, were identified by an Implementation Partner? **Identify partners you may be interested in doing a Community-Clinical linkage assessment with.**

Partnerships Activity

Representative please come to the front and make your revisions/additions on the master matrix

- Both Implementation Partners and NCC Partners:
  - Draw in any additions
  - Identify your top priority connection(s) - *star sticker*
  - Identify which connection(s), if any, you would like OCH to follow-up on - *colored dot sticker*

Partnerships: Next Steps

- **OCH is looking for pilot volunteers!** Clinical-Clinical (cross-sector) *and* Clinical-Community
  - Organizations interested in receiving facilitation assistance *and*
  - Organizations interested in completing independently
- **Value:** jump start partnership work, tailored technical assistance, ability to provide in-depth feedback on future development of C&C Linkage work, improved patient care!
- **Commitment:** approximately 8 hours over April/May, present experience at June regional convening
- **Interested? On blank notecard:**
  - Your organization name with contact information
  - Top 2 organizations you want to pilot with
  - **OCH will follow up within next 2 weeks to arrange next steps**

Executive Director Updates

Welcome Celeste Schoenthaler

Committee Updates

Performance Measurement and Evaluation Committee

Contract Management and Compliance Committee

Community and Tribal Partnership Committee

Olympic COMMUNITY of HEALTH
Clallam ● Jefferson ● Kitsap

OCH Board of Directors Broad Vision of Success

CARE IS INTEGRATED

CARE IS COORDINATED

OUTCOMES ARE IMPROVED

2019 Draft Strategic Priorities

Advocacy

Financial Sustainability

Technical Assistance

Expand and Bring to Scale

Broaden Engagement

Implement Care Transformation

Assessment, Planning and Evaluation

Medicaid Transformation Project

Implementation Partners please stay for MTP specific updates. All NCC Partners are welcome to stay.

If you are not staying:

Please leave your EVALUATIONS, EQUITY SURVEY, and NOTECARDS in a blue bin or hand to staff

52

MTP Deliverables

Olympic Community of Health Change Plan Implementation Partner Deliverables Calendar 2019-2021

	January	February	March	April	May	June	July	August	September	October	November	December
Progress to Date Report (ORCA)	Action required due 1/31 (2020-)						Action required due 7/31					
Intermediary Metrics Report (ORCA)				Action required due 4/12 (2019-)				Action required Due 8/30				
Clinical-Community Linkage Assessment (Excel)	Identify partners, start work on this after Feb NCC (2019)						Continue assessments after Regional Convening (2019)					
Site Visit			x						x			
Internal Quality Improvement meetings	x	x	x	x	x	x	x	x	x	x	x	x
P4Rs (ORCA?)						Action required Due 6/30 (2019)						Action required Due 12/31
Participate in NCC Convenings	Clallam: 2/25, Kitsap 2/26, Jefferson 2/27					Regional NCC 6/25				Opioid summit (optional)		
Change Plan Updates (ORCA)											CP unlocked 11/1, action required due 11/27	
Contract Amendments	Amend contract (2019) released 1/23	Amend contract (2019) due 2/8									Amendment template distributed 11/1 (2019-)	Action required due 12/16 (2019-)
Payments						6/21/2019 schedule; 6/28/2019 payment (except						x (All partners)

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Intermediary Metrics Report

- **Your baseline intermediary metrics report covering the period July 1-December 31, 2018 is due by 12:00pm (noon) Friday April 12, 2019.**

- Moving forward, intermediary metric reporting will occur biannually (in February and July) and cover a 6-month reporting period:
  - Jan 1-June 30
  - July 1-Dec 31

Intermediary Metrics Report

Have you RSVP'd for the webinar?

- 3/5, 3/8, 3/12:
  - **Hospital:** 9:00-9:30 am
  - **Primary Care only:** 10:00-10:45 am
  - **Integrated (PC and BH):** 11:00-12:00 pm
  - **Behavioral Health (MH and SUD):** 12:30-1:15 pm
  - **CBOSS:** 1:30-2:15 pm

MTP Reporting to HCA: *P4R's*

- Bi-annual mandatory submission of *Pay for Reporting "P4R"* data to HCA
- Questions related to Bi-Directional Integration and Opioid Response

- OCH has 3 survey forms: Primary Care, Hospital, CBOSS
- Behavioral Health MEHAF data already collected

- Take a few minutes to complete your form today
- Think about future P4R data collection – we'll ask you for ideas during summer site visits

2019 MTP Payment: Scale and Scope

- ✓ Fund allocation strategy sets the Scale and Scope amounts available for each partner to earn, for 2019, based 60% on scale and 40% on scope.
- ✓ The amount of scope earned by each partner will depend on the elements in the Table.

Points assigned to each element that make up 2019 SCOPE payment		
Scope Elements	**PHBH**	**CBOSS**
Voluntary outcomes in Change Plan	20	0
Qualitative reporting completion	20	20
Quantitative reporting completion	20	20
Site visit completion	10	10
NCC convening participation	10	10
QI team formation	10	10
Community-Clinical linkage work	10	30
Total	100	100

2019 MTP Payment: Bonus Pool

Proposed MTP Bonus Pool from

1. Unearned PHBH and CBOSS funds
2. Unbudgeted DSRIP revenue

The Bonus Pool will have two parts

1. Performance (80%)
2. Technical Assistance/Reserves (20%)

Elements and points available for each that make up the Bonus Pool		
	PHBH	CBOSS
Performance (improvement over self)	80%	
Qualitative report: 'fully implemented' or 'scale and sustain'		
Quantitative, intermediary metrics		
Unduplicated Medicaid beneficiaries served		
New or improved* community-clinical linkages		
Technical Assistance and Reserves	20%	

Thank you!

Please leave your EVALUATIONS, EQUITY SURVEY, P4R DATA and NOTECARDS in a blue bin

Questions or comments lost in the hustle and bustle of today?
Email:
support@olympicCH.org

59

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Adjourn