



## Phase II Certification

August 14, 2017

### Purpose of this document

This document is intended to certify that the Olympic Community of Health (OCH) can serve as the regional lead entity and single point of performance accountability to the state for transformation projects under the Medicaid Demonstration Transformation Project (Demonstration) 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 the coordinated and collaborative actions of communities, Tribes, health care and social service providers, consumers, and payers. OCH envisions a system of care that effectively, efficiently, and compassionately addresses the health care needs of every Medicaid client, while advancing the general health and wellness of communities and Tribes.

OCH programs are animated by following guiding principles:

- The most effective, sustainable pathways to the Triple Aim begin with the client population, their needs, and the needs of their communities.
- Long-term success hinges on improving health equity and addressing social determinants of health.
- Data and evidence are the fundamental building-blocks for planning, targeting, and implementing transformation initiatives.
- No single sector, Tribe, or institution can overcome the inertia of the current system. Transformation must be a collaborative, coordinated enterprise, sustained for a much longer period than the Demonstration.
- To sustain cross-sector, region-wide collaboration and action, OCH and MCOs must establish effective partnerships to achieve Domain 1 goals.
- OCH plays an indispensable role of establishing a neutral table, around which collaborators identify needs, evaluate solutions, formulate projects, prioritize investments, and coordinate actions to achieve better care, better health, and lower costs for the Olympic region.

OCH and its stakeholders and partners have identified the following **five regional health priorities** on which to focus collective action: access, aging, behavioral health, chronic disease, and early childhood.

## OCH-adopted strategic goals and actions

### Long Term Goals 2017-2021

A more connected, healthier, equitable community: new strategies to increase availability of affordable, supportive housing in the region; local networks working to address obesity; access to oral health services.

### Mid Term Goals 2017-2019

A strong, mutually-supportive relationship with MCOs as measured by movement towards the Triple Aim and significant enhancements in value-based care.

### Short Term Goals 2017-2018

Successful implementation of Demonstration Projects; as measured by meeting contractual obligations, including pre-defined benchmarks and program toward sustainable goals.

### Actions

- 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

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

The challenges of healthcare delivery begin with the region's geography. Urban and widely dispersed remote populations are spread across nearly 4,000 square miles. Access to healthcare services is difficult due to limited roads, long distances, and intervening national forests, rivers and seas. Frequently, access to services requires costly, time-consuming travel outside of the region.

Demographics present additional challenges to health care delivery. Two Olympic region counties have a high proportion of aging adults (county median age range: 39-56), and concentrations of sub-populations (low education, income status, racial minorities) with high health behavior/outcome disparities.

The regional Medicaid health system is complex; 84,000 lives are serviced by 5 MCOs, 5 hospitals (with different parent/referral organizations), 2 FQHCs, 4 CBHCs, multiple rural health and independent clinics, 3 free clinics, and 7 tribal clinics.

The three sections below summarize OCH's review of available data to understand regional health care needs, health status, and social/economic risks and within those, geographic and sub-population disparities.

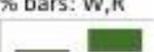
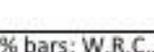
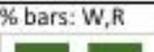
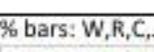
### Health Care Needs

Adults in the region remain uninsured, highest among American Indian/Alaska Natives (AIAN) and lower educated adults. There are pervasive provider capacity issues. Compared to WA, there are lower rates of adult ambulatory/preventive care visits and well-child checks and higher rates of ED utilization (disparities by county and race).

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 AIAN vs. White, non-Hispanic In Clallam, 11 times higher rate among adults with no high school compared to adults with college
Dental provider capacity:	# bars: W,C,J,K 	Dental provider capacity lower in Jefferson	No data
Primary Care provider capacity:		Primary care provider capacity lower in Kitsap	No data
Mental health provider capacity:		Mental health provider capacity lower in Clallam and Kitsap	No data
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%
Well Child Visits age 3-6	% bars: W,R,C,J,K 	55-60% across counties; all below WA average	Range across race groups 49-62%
Child Combo 10 Immunizations	% bars: W,R,C,J,K 	8% in Clallam and Jefferson, 11% in Kitsap, all below WA	No data
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%

### Health Status

Across multiple health/behavior/outcome indicators, lower income and lower educated adults and certain race groups, particularly AIAN, have worse rates. The region has higher rates of premature and opioid deaths compared to WA (disparities by county). Over 1 in 10 adults have poor mental health/depression (disparities by county, gender, age, education, income). There are persistent adult disparities in diabetes for AIAN and in asthma for lower income. Over 1 in 4 adults are obese; higher than WA (disparities by race, education, income). Smoking rates are concerning (disparities by county, gender, race, education, income). Medicaid access to dental and prenatal care are also concerning.

Indicator	Data by place	Geographic Disparity	Sub-population Disparity
Premature death (<65)	rate bars: W,R,C,J,K 	Clallam rate much higher than other counties; region higher than WA	No data
Opioid related deaths	rate bars: W,C,J,K 	Clallam rate nearly twice Jefferson & Kitsap (15 vs. 8)	No data
Adult mental health	% bars: W,R,C,J,K 	County rate range 12-15%, all above WA 11%	*female rate higher than male rate *highest among young adults 18-24 (18%) vs. older adults 65+ (8%) *higher for adults with less edu *higher for lowest-income adults (21% vs. 6-8%)
Medicaid recipients with depression	% bars: W,R 	Region rate 12% compared to WA 10%	*female rate nearly twice male rate *white rate higher than all other races, more than twice Asian and native HI/pacific islander rates
Adults ever told they have diabetes	% bars: W,R,C,J,K 	County range 7-8%	*male rate higher than female rate *AIAN twice White, Non-Hisp rate *highest among older adults 55+ *higher among adults with less education (11% vs. 5%) *2.5 times higher among lowest vs. highest income adults (13% vs. 5%)
Medicaid recipients with diabetes	% bars: W,R 		*6% of adults, 0% of children *highest among Asians and Native HI/Pacific Islanders (5%)
Obese adults	% bars: W,R,C,J,K 	Clallam rate 27% compared to 30% in Jefferson and Kitsap	*male rate higher than female rate *Black rate highest, 50% *highest among adults 45-64, 35% *higher rate for adults with high school or less vs. college, 35 vs. 25% *higher rate among lowest vs. highest income adults, 33% vs. 24%
Adults with asthma	% bars: W,R,C,J,K 	Jefferson rate 14% compared to 10% in Clallam and Kitsap	*female rate twice male rate *rate nearly 3 times higher for lowest vs. highest income, 15 vs 6%
Medicaid recipients with asthma	% bars: W,R 	Region rate 5% compared to WA 4%	*female rate 6% vs. 4% for males and WA females *highest among blacks (6%)
Adult current smoking	% bars: W,R,C,J,K 	Jefferson rate 27% compared to Clallam 20% and Kitsap 17%	*male rate higher than female rate *AIAN rate highest 40%, Black 28% *highest among adults 25-34, 26% *higher rate for adults with high school or less vs. college (25 vs. 7%) *the lower the income, the higher the smoking rate (31% vs. 8%)
Preventive Dental Use– Medicaid	% bars: W,R 	Region lower than State	*Adult rate only 6%, children 6 and under 39%
Pregnant women get early prenatal care	% bars: W,R,C,J,K 	County range 61-72%	No data

### Social and Economic Risks

Health is interconnected with social/economic factors; OCH identifies addressing these factors as foundational to making progress on strategic priorities. High school graduation rates differ by/within county (disparities by income and race). Clallam and Jefferson have lower median income and higher unemployment than Kitsap; all counties lag WA. Housing is unaffordable for many households across the region. While OCH has lower rates of prisoners and arrests than WA, county disparities exist.

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 counties: 40-97%
Median Income	\$ bars: W,C,J,K 	\$19,000 gap between Clallam and Kitsap	No data
Unaffordable housing	% bars: W,C,J,K 	35-37% of households spend at least 30% of income on housing	No data
Unemployment	% bars: W,C,J,K 	6-8% OCH unemployment rate compared to 5% in WA	No data
Prisoners in State Correctional Systems (18+)	Rate bars: W,R,C,J,K 	County rate range 1.8 to 6.4	No data
Total arrests of adolescents	Rate bars: W,R,C,J,K 	County rate range 14.6 to 42.6; region better than state	No data
Property crime arrests, age 10-17		County rate range 3.3 to 7.8; region better than state	No data
Property crime arrests, adults		County rate range 2.5 to 8.5; region better than state	No data

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

Within the five-identified regional health priority areas (see Q1), the table below describes samples of existing and planned activities/programs and strategies OCH employs to address them. A full list of OCH's [inventory of projects](#) and how they accelerate the Demonstration is available online.

Community Activity Samples Addressing Regional Health Needs/Priorities and OCH Support Strategies					
OCH Priority:	1. ACCESS	2. AGING	3. BEHAVIORAL HEALTH	4. CHRONIC DISEASE	5. EARLY CHILDHOOD
<b>Sample Activities/Programs and Description:</b>	<b>Kitsap Connect</b>	<b>Home support services</b>	<b>Hub and spoke opioid treatment</b>	<b>Healthy Eating Active Living Coalition</b>	<b>Nurse Family Partnership</b>
<b>OCH Strategies to Support Healthcare Needs and Priorities ↓</b>	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 OUD through a central coordinating provider entity and multiple treatment and referral points.	Cultivates community-driven initiatives to prevent chronic disease through healthy eating and exercise.	Provides home-based supports to new, low income, high risk moms by a public health nurse until baby turns 2.
Grant writing					
Coordinating, convening, and engaging people and organizations					
Performing ongoing regional health assessment and planning					
Promoting integration, improvement, and transformation of care delivery					
Coordinating and supporting health improvement projects					
Collecting, monitoring, and analyzing data to track performance and savings					
Identifying strategies to sustain promising projects					
Advocating for policy change					

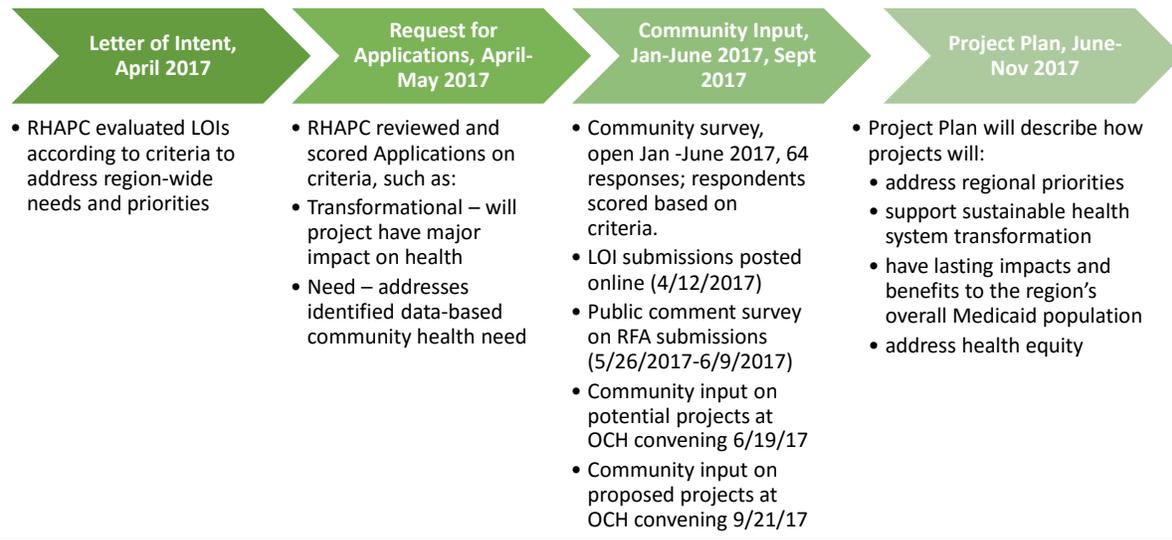
**4. Describe how your project selection approach addresses the region-wide needs and priorities.**

During the Letter of Intent and Request for Application process, project applicants learned about the region-wide needs and priorities. OCH project selection approach (image below) was guided by 10 criteria developed by the Regional Health Assessment and Planning (RHAP) Committee:

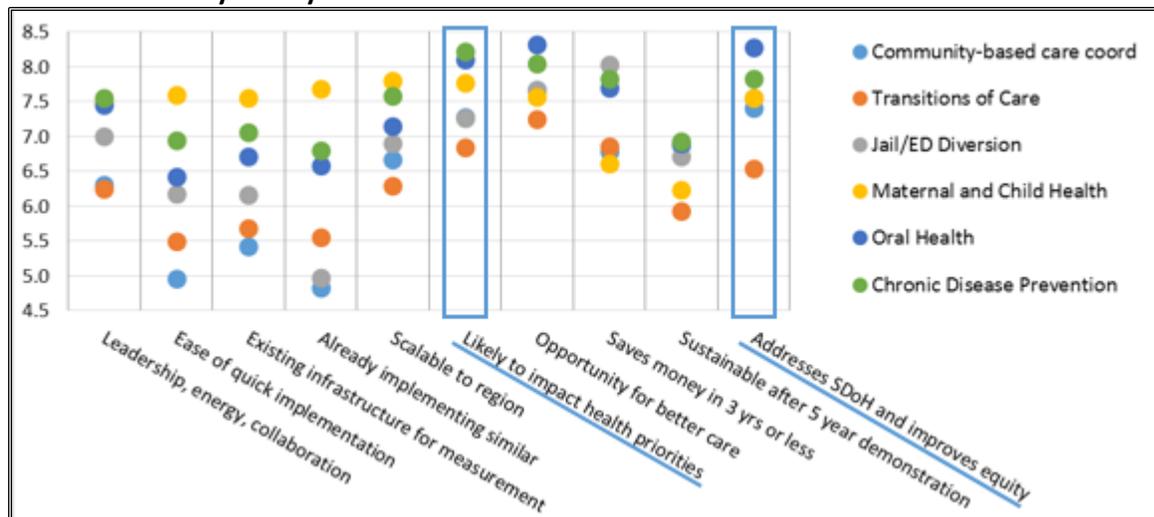
1. **Likely to improve health within one or more regional health priority area**
2. **Degree to which addresses social determinants of health and improves health equity**
3. *Existing local leadership, energy and collaboration around this project*
4. *Ease of quick implementation*
5. *Existing infrastructure 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.*

An OCH community survey (January-June 2017, 64 responses) gathered input on these 10 criteria for 6 project areas. Both “likely to impact health priorities” and “address SDOH/improve equity” received high average scores (chart below).

## Project selection approach: address region-wide needs and priorities



**Chart. Community Survey Results**



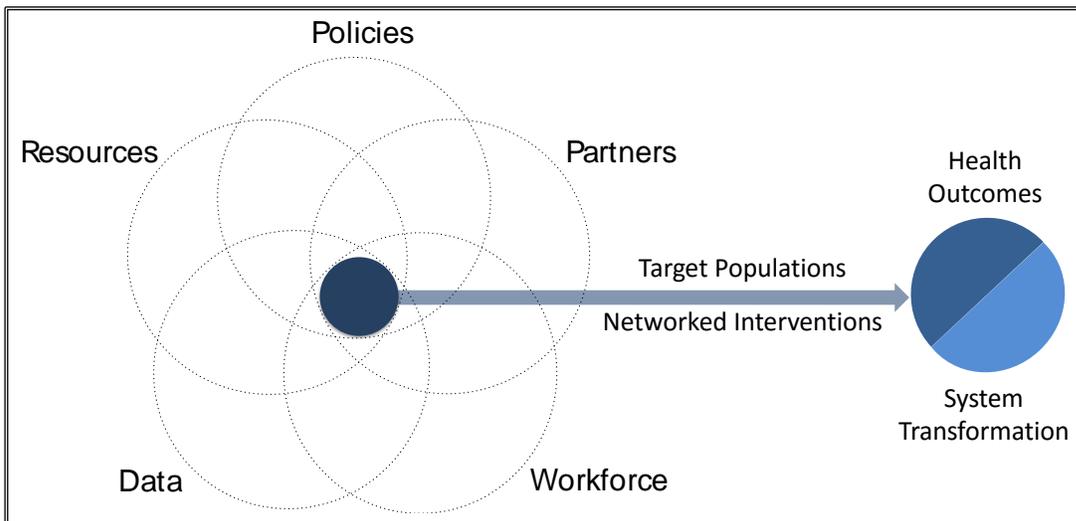
### 5. Explain how you will align existing and planned resources and activities into a region-wide strategy, including complementary projects, community resources and other investments.

Early in 2015, OCH formed a subcommittee, broadly representing all healthcare, public health, community, and tribal sectors to (1) review and synthesize assessments, plans, inventories, etc., and (2) design and implement a process for soliciting and evaluating transformation projects, consistent with HCA Demonstration protocols and guidelines. The RHAP Committee aligned Demonstration goals with community health goals to design project evaluation criteria, as well as informational webinars, and community forums. The table below highlights the RHAP committee's work to identify and align existing regional resources.

During summer 2017, the OCH team is refining required and proposed portfolio projects, including assessing for complementary strategies, especially opportunities to further workforce, IT, and VBP strategies across projects. This includes leveraging and building on existing partner, workforce, and IT

resources. With Board guidance and approval, staff will align and synthesize the emerging portfolio to reflect a region-wide strategy to transform care and improve health (image below).

Table. Alignment to identify complementary projects, community resources, and other investments			
Inventory and resources	#	Begin date	Status ongoing
Database of existing community health improvement initiatives	69	11/2015	
Database of community-based health coalitions and alignment with Demonstration project areas	28	9/2016	
Inventory of available data sources and assessments of regional health needs and disparities		10/2015	
Input from community partners on summary of assessments and agreement on top 5 priorities		4/2016	
Addition of opioid use, treatment, and outcome data into assessment		9/2016	
List of organizations/people engaged to assist in project development	60+	5/2017	
Specification of LOI and RFA proposed projects as new or enhancing existing	45	4-5/2017	
Bi-directional integration of care and practice transformation assessment	26	9/2017	



**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 (VBP) (examples below).

**Workforce**

- The 3 County Coordinated Opioid Response Project (3CCORP) team will work with Olympic College to develop and implement a continuing education unit for CDPs on best practice

treatment for opioid use disorder (OUD), including medication-assisted-treatment and care coordination with PCPs.

- The 3CCORP team will work with the NW Family Medicine Residency Program to develop an OUD treatment toolkit.
- Hiring and training of community health workers
- Training population analytic capability within care organizations to implement value-based care strategies such as condition-specific care coordination
- Training behavioral health professionals in co-occurring conditions: 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 VBP

**Assessment**

- Survey tools to support VBP, bi-directional integration, PCMH; health IT and data and analytic assessments

**Table. Infrastructure and workforce investments to be shared/reused across multiple projects**

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

**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.**

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 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 (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 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; Criminal justice; Education; and Consumer.

### Examples of sector and Tribal engagement and communication

- Each sector nominates a representative to serve on the Board.
- Each sector may designate one Alternate to serve on the Board.
- 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 expressing an interest in receiving materials.
- Board materials are posted on online
- Action items are noted in **red font** to call attention to discussions that require action.
- OCH maintains a contact list of all organizations within a 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 OCH. This is also the case for Tribes. Summaries of these meetings are shared with staff, the executive committee, or directly with the Board.
- The *Tribal Collaboration and Communication Policy* and Director of Community and Tribal Partnership advise tribal engagement.

### Expectations for engagement

Directors sign a Board Member Commitments and Operating Procedures (A) form that states:

*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 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. Staff use data, modeling, and analysis to support decision-making for the Board and committees.

The Board re-elected the current officers and delegated additional decision-making authority to the **Executive Committee**. (B)

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 the Board

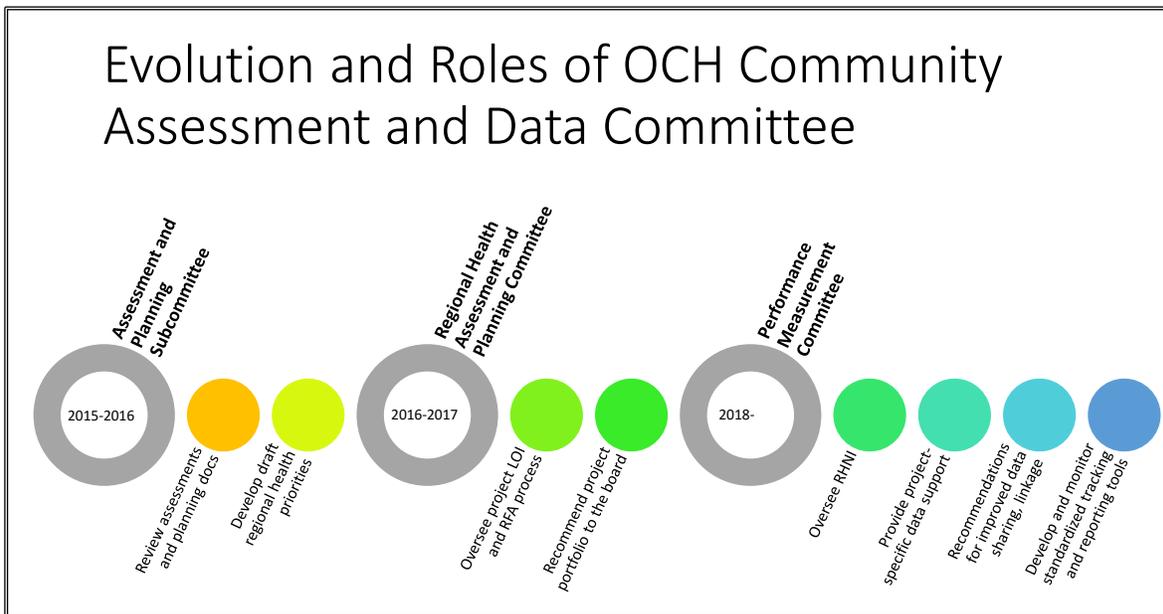
Several additional committees will phase-in during DY-2 (E):

**Performance Measurement Committee.** Oversees Regional Health Needs Inventory, provides project-specific data support, makes recommendations for improved data sharing and linkage, develops standardized tracking and reporting tools. The image below describes the evolution of the RHAP Committee (D) to the Performance Evaluation Committee.

**Community Engagement Committee.** Oversees Community Voice for Health, advises staff on community engagement strategies, synthesizes community and consumer input and feeds up recommendations to the Board.

**Care Delivery Re-Design Committee.** Advises Board on key decisions pertaining to the delivery of clinical care and social services under the Demonstration, including supporting the implementation of transformation projects and Domain I activities.

**Workforce Coalition.** A regional rural health workforce coalition is under development with Greater Columbia and Cascade Pacific Action Alliance.

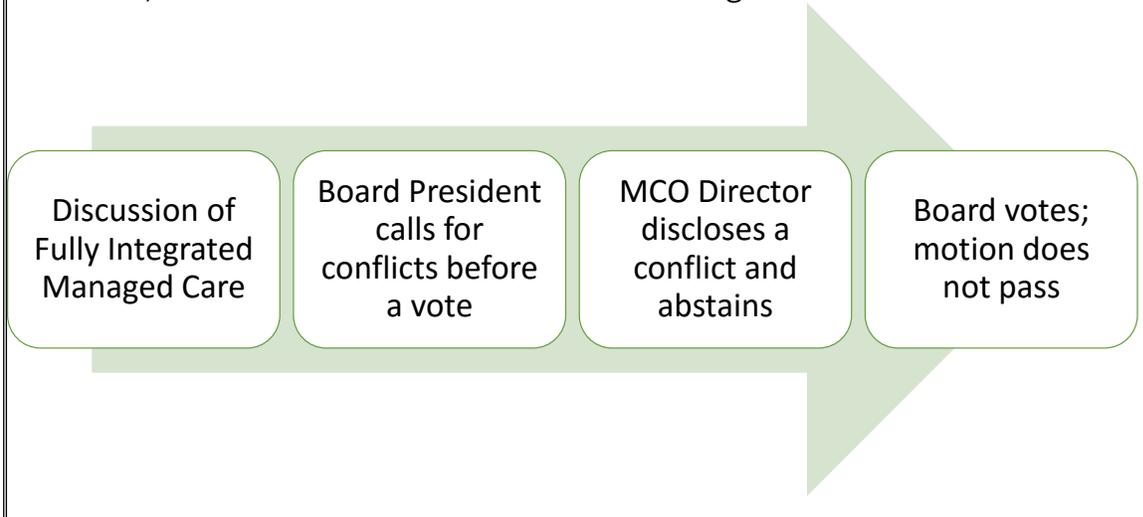


**3. Discuss how personal and organization conflict of interest concerns are addressed within the ACH, including considerations regarding the balanced and accountable nature of the ACH decision-making body to directly address identified conflicts.**

Personal, financial, and organizational conflicts of interest are governed by a conflict of interest (CoI) policy signed by Directors. The first image below illustrates the CoI policy in action and the second illustrates the process for identifying and addressing conflicts (F). The Board will review a draft Dispute Resolution Policy at the October 2017 meeting.

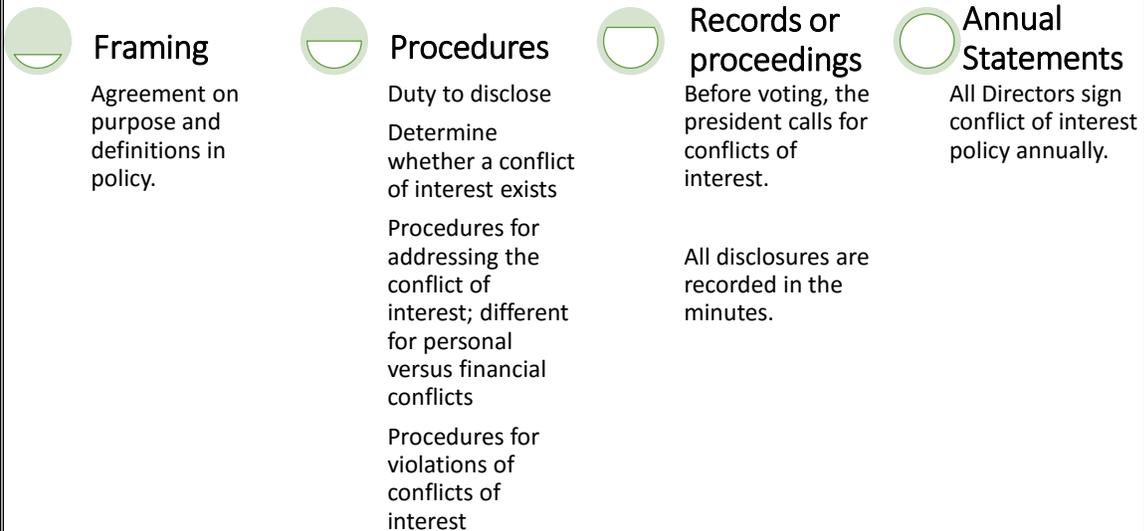
## Example of operationalization of Conflict of Interest Policy

June 10, 2017 OCH Board of Directors Meeting



## Process for identifying and addressing conflicts

*Please refer to attached conflict of interest policy*



### 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 OCH team is a hybrid staff-professional consultant model. (G) OCH invites professional consultants, most of whom live and work locally, as team members, into all aspects of Demonstration planning, including strategic planning sessions. (H)

Title	Timing and Status	Roles and responsibilities
<b>Executive Director</b>	Hired April 2016	Direct the design, implementation, and administration of the Demonstration and agency.
<b>Director of Community and Tribal Partnership</b>	Hired April 2017	Develop and implement the organization's strategic communications and engagement strategy. Lead the Three-County Coordinated Opioid Response Project.
<b>Administrative Coordinator</b>	Hired February 2017	Develop and administer human resources and administration programs and processes.
<b>Administrative Assistant</b>	Planned August 2017	Provide administrative support in planning, organizing, directing, and administering operations and projects.
<b>Analytics and Reporting Lead</b>	Contracted February 2017	Overall management of all analytic projects including timeliness, quality and value.
<b>Project Coordinator</b>	Planned 9/1/2017	Coordinate the planning, operations, assessment, analysis and performance of Demonstration projects.
<b>Director of Transformation</b>	Planned 9/1/2017	Lead the planning and implementation of programs and initiatives under the Demonstration.
<b>Transformation Coordinator</b>	Planned 1/1/2018	Coordinate the planning, operations, assessment, analysis and performance of Demonstration projects and programs.
<b>Contract and Compliance Coordinator</b>	Planned 5/1/2018	Provide contracting and compliance support for Demonstration projects.
<b>Demonstration Assistant</b>	Planned 5/1/2018	Provide administrative support for Demonstration projects.
<b>Director of Administration and Finance</b>	Planned 1/1/2019	Management of financial and HR matters.
<b>Communications Assistant</b>	Planned 1/1/2018	Provide communications support.
<b>AmeriCorps and Interns</b>	Planned 1/1/2019	To meet project needs.
<b>Attachments</b>		
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.

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 engage 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. Quileute is sending a resolution to their Council next week.
- 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 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)**

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 intent (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.

#### **Attachments**

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 Directors on the Board
- 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
- I – Port Gamble S'Klallam 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 three mechanisms, each with specific strategies, processes and actions (image below):

#### **Push Information Out**

- Disseminate information via e-newsletters, social media, public meetings, and presentations; going forward include flyers and hard copy newsletters, distributed in agencies and locations where consumers frequent.
- Manage a media list with radio, television, and print media; press releases for events or news stories (e.g., [Kitsap Sun: Three-county plan will confront opioid crisis](#))

#### **Take Information In**

- Convene one-one meetings with Medicaid consumers (G).
- Offer multiple modalities of community input; analyze, synthesize, and share with the Board:
  - o Public comment: open ≥ 3 weeks online, ≥ 5 minutes at Board meetings
  - o 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
- 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 BHO 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 so community members can participate. Add weekend and evening forums.

### **Integrate Information into Planning**

- Convene a **Community Engagement Committee** to synthesize community and consumer input and feed up recommendations to the Board.
- Dedicate resources to community engagement using Design Funds (personnel, reimbursement for consumer time, travel costs, and childcare).

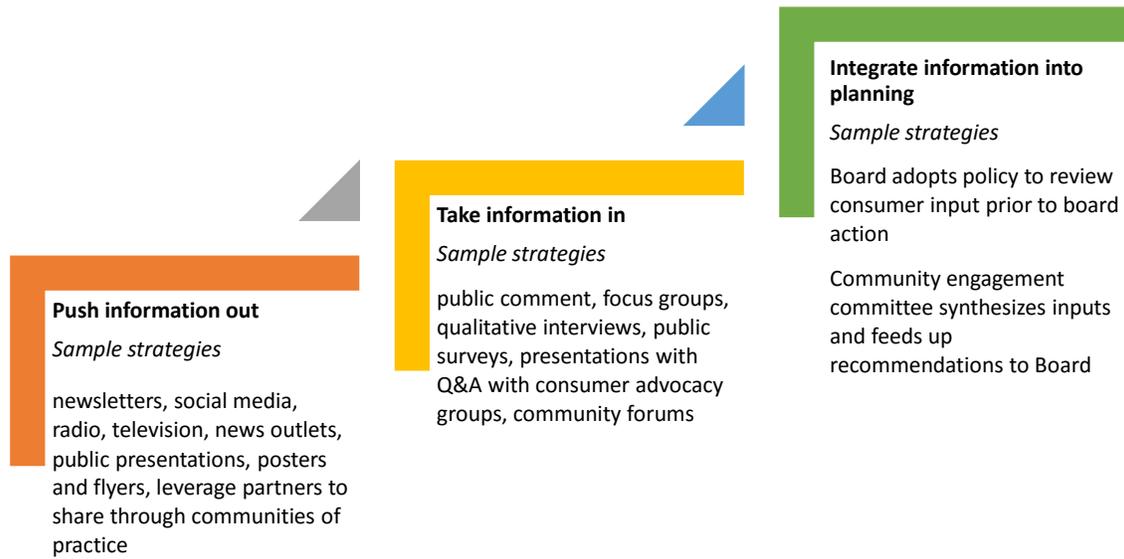
### **OCH begins with the following measures to gauge success**

- Participation in OCH activities by all sectors and Tribes
- Willingness to share honest feedback and provide clear guidance
- Willingness on the part of 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:** OCH is a young, small organization. True engagement and partnership requires face-to-face, ongoing participation across the region. Travel to and from various communities takes 1-8 hours.
- **Access to information:** The Demonstration is complicated and information changes frequently, posing a challenge to provide accessible information to constituents and partners.
- **Voice:** Partners need the opportunity to feel comfortable, welcome, and safe to provide input.

# Three steps to meaningful consumer engagement



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

OCH hosted an opioid summit (1/30/2017) to provide 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 response:

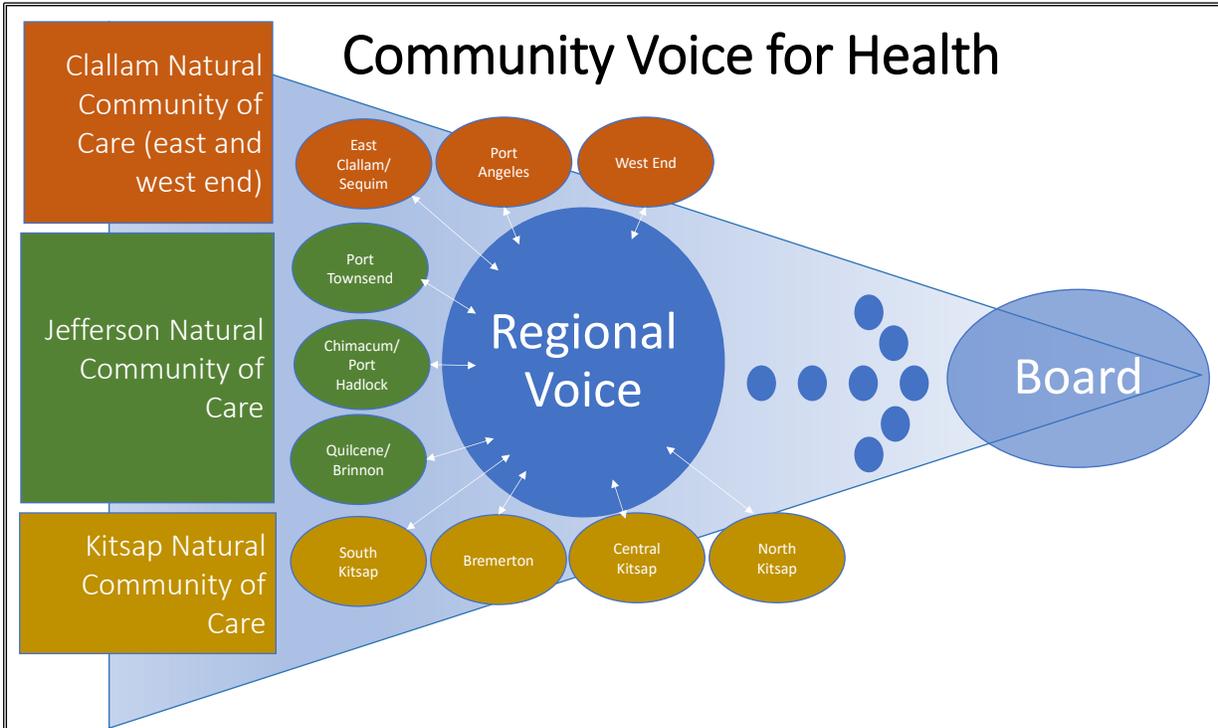
- The event was advertised in the newspaper, radio, and mainstream news television.
- Over 120 people attended from across the region and sectors/communities including Tribes, primary care, SUD providers, mental health providers, elected officials, hospitals, fire/EMS, law enforcement, schools and youth, 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 (I) 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, informing toolkit project 3A.

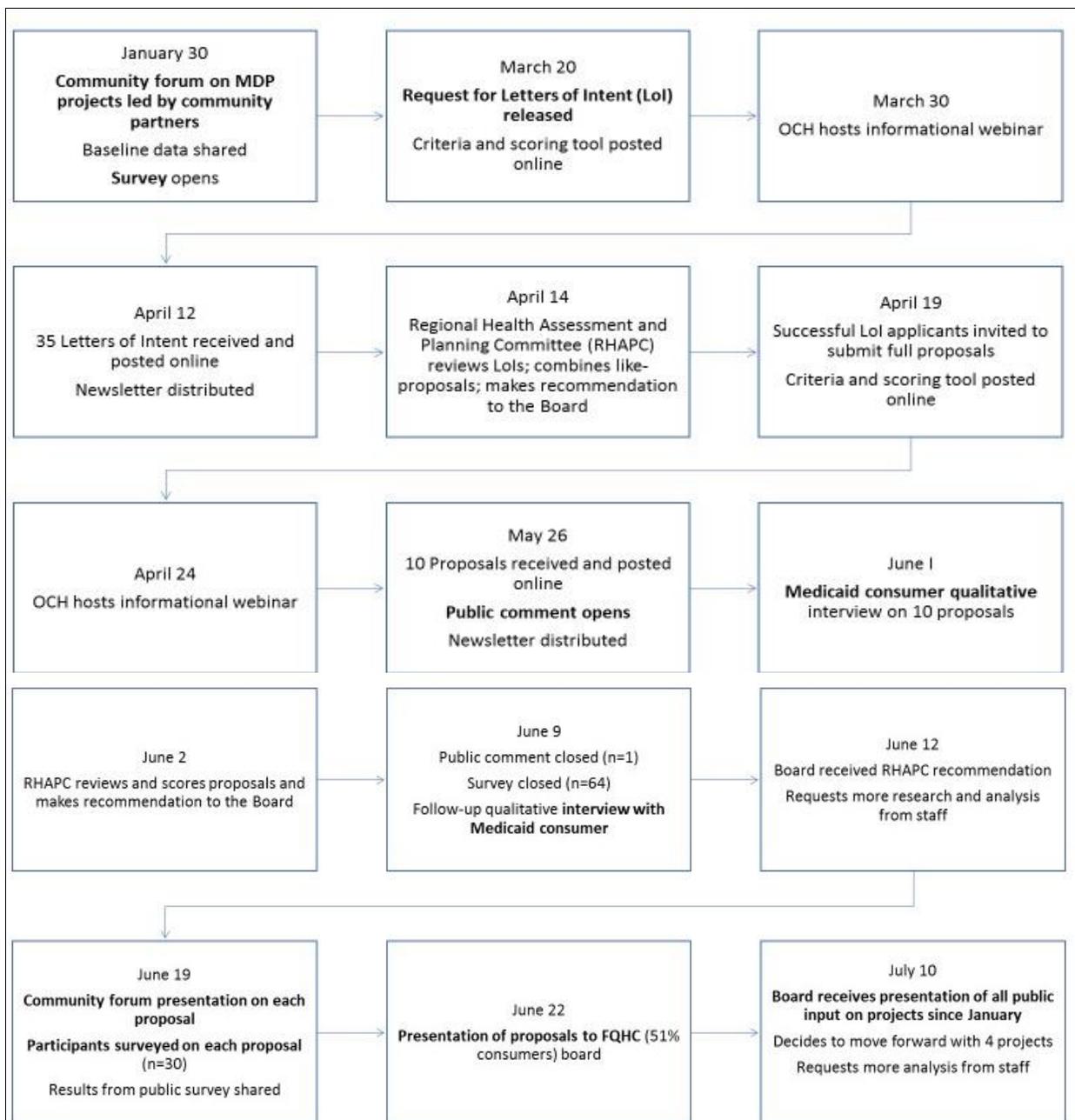
## 3. In the Project Plan, the ACH will be required to provide evidence of how it solicited robust public input into project selection and planning, including providing examples of at least three key elements of the Project Plan that were informed by community input. Demonstrate how community member/Medicaid 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** (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.

- 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 for items related to Demonstration.



2. **2017 Engagement activities** (image below), leading to preliminary project recommendations to the 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.**

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 frequently contacted to provide input.

Strategies for partner engagement (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:
  - o Salish BHO advisory meetings
  - o NW Regional EMS Council
  - o County-level sheriff's meeting
  - o Provider organization board meetings
- Convene opioid steering committee and 3 workgroups (see 5 below)
- Staff travels for face-to-face meetings with partnering providers.

A challenge with provider engagement is partner fatigue. Partners wear many hats. OCH piggy-backs on existing systems and infrastructure to “seize a moment” to gauge interest, input, and concerns from partners.

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	Receive newsletter
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
Specialty 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
<i>* Blank cells are still undergoing assessment. Will be complete in time for project plan</i>											
<i>** Dir CBP: Director of Community and Tribal Partnership</i>											
<i>*** Tribes are not sectors; therefore they may select or change their designated representative at any time</i>											

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

The 3 County Opioid Response Project partners (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
<b>Steering Committee</b>	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 Educational Service District 114, Safe Harbor Recovery, Lived Experience, County Commissioner from each county
<b>Treatment Workgroup</b>	CEO Community Behavioral Health Clinic	Frontline Psychiatric Provider	Salish BHO, Peoples Harm Reduction Alliance, Kitsap Mental Health Services, Poulsbo City Mayor, Bremerton City Mayor, Jefferson County Commissioner, Reflections Counseling Services, Qualis, Suquamish Tribe Police Department, American Indian Health Commission, 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
<b>Prevention Workgroup</b>	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
<b>Overdose Prevention Workgroup</b>	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.)**

35 LOIs and 10 RFAs were submitted by partnering providers. The organizations (tables below) that provided input into the proposals far surpasses Board representation. **Yellow cells** indicate organizations not represented on the Board. Each application required a partner commitment form.

**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		

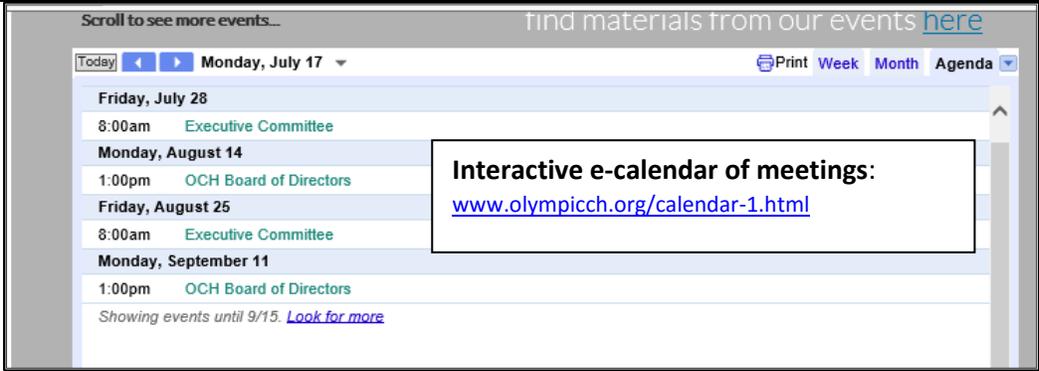
### Transparency and Communications

#### 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)?

OCH holds Board meetings (e-calendar below) the 2<sup>nd</sup> 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.

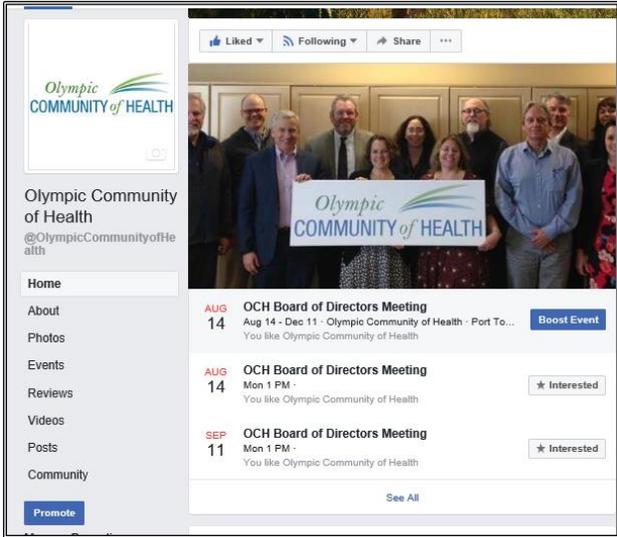
- 15 Board Directors
- 22 Tribal representatives
- 9 MCO representatives
- 6 Alternate Directors
- Partners
- Government agency representatives
- Association representatives

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. 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).



**Facebook calendar of events:**  
[www.facebook.com/OlympicCommunityofHealth](http://www.facebook.com/OlympicCommunityofHealth)

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

The bylaws allow for a special meeting of the Board if the need were to arise. Special meetings must be publicly announced with as much notice as possible and would follow the transparency principles above. In the event of an emergency, the Board authorizes the Executive Committee to act. The Executive Committee charter reflects this delegation of power.

**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 (contains Demonstration information)
- Google translator/search
- Direct contact to staff (includes email and phone number)
- Blog and e-newsletter
- Archives: 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:

- [Peninsula Daily News: January 27<sup>th</sup>: Opioid summit](#)
- [Kitsap Sun: March 11: Senator Cantwell discusses Medicaid roll back](#)



Photo: Larry Steagall / Kitsap Sun

## Attachments

### Olympic Community of Health – Community and Stakeholder Engagement – Attachment:

- A – Meeting Minutes May 8, 2017 Board of Directors Meeting
- B – Meeting Minutes June 12, 2017 Board of Directors Meeting
- C – Meeting Minutes July 10, 2017 Board of Directors Meeting
- D – Website snapshot of meeting minutes
- E – List of all public OCH-related engagements or forums for the last three months
- F – List of all public OCH-related engagements or forums scheduled for the next three months
- G-J: Evidence of meaningful participation by community members
  - o G – Attestation by a Medicaid beneficiary
  - o H – Sign-in sheets that memorialize community member attendance (January 30 and June 19 OCH Convenings)
  - o I – Note cards that memorialize community member comments
  - o J – Solicitation for public comment
- K-O: Attestation of meaningful participation from partners from multiple sectors not participating directly on the Board of Directors
  - o K – Jody Moss, Olympic Area Agency on Aging
  - o L – Terry Megiveron, Bogachiel Clinic and Forks Community Hospital
  - o M – Dunia Faulx, Jefferson Healthcare
  - o N – Kirsten Jewell, Kitsap Department of Human Services
  - o O – Stacey Smith, Kitsap Area Agency on Aging

## 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 expenses between 2017 and 2021. 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 accordingly.

Prior to July 1, 2017, OCH financed Demonstration alignment 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.

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

### **Budget Narrative (highlights) and Percent Allotments**

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

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

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

- Convene three public forums; convene monthly tribal meetings
- Use of focus groups, community surveys, consumer champions, and stipends to reduce obstacles for consumers; includes reimbursement for time, travel, childcare
- Professional tribal liaison on staff

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

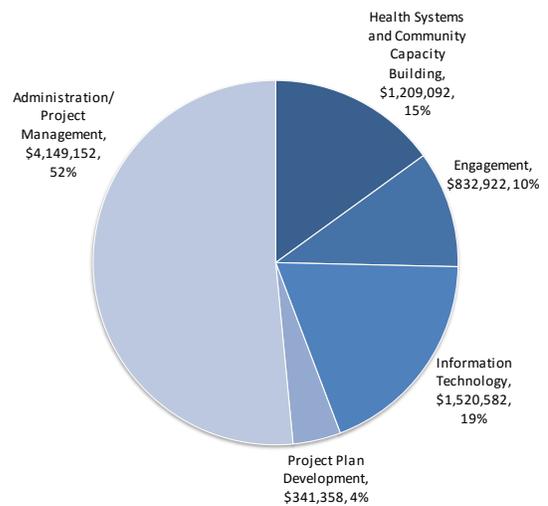
- Professional service contracts for HR, CPA, CFO services
- Administrative service contracts for bookkeeping, payroll, taxes, rent, I.T., audit
- Professional contractor to model performance and provider incentive payment and advise on data infrastructure capacity needs
- Data and evaluation contract vendor to provide ongoing assistance with the RHNI, project planning, and data technical assistance to partnering organizations
- Project management, including subcontracts with partner organizations

#### **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), a cloud-based e-referral management network
- ACH data capacity to manage analytic projects and integrate data-driven decision making into 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 (collaborative care model, six building blocks, population health management)
- 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, Director of Transformation, Transformation Coordinator
- Enhancement of community and provider engagement activity
- Feasibility testing of Apple Integrator
- Professional service contract subject matter experts:
  - o *Kitsap Public Health District (KPHD)* – provide analytics and evaluation to support selection, design, and ongoing monitoring of projects
  - o *Seattle King County Public Health* – provide data visualization to integrate data-driven decision making
  - o *Walter Sive* – provide performance and payment modeling to drive investments and engage providers
  - o *Rochelle Doan* – lead bi-directional integration of care project plan and provide strategic consultation on overall systems integration under the portfolio
  - o *Jody Carona* – portfolio assessment and planning with hospital partners
  - o *Rob Arnold* – general contractor for Apple Integrator to liaise with vendors, provide technical guidance

**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 KPHD
- Data analysis and visualization, contracted with Seattle King County Public Health
- Strategic consultation on options for data feeds, harmonization, management, performance monitoring, reporting, confidentiality, integration
- Purchase and/or licensing of statistical software, CRM, cloud-based server, reporting system

### Clinical

- Subject matter expert contracts in opioid treatment, integration, chronic disease
- Provider training, (e.g., 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, workforce training on data-mining for population management
- Clinical champions to provide input on 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 Coordinators
- Project management, including project plan design and development, through staff and subcontracts

### Strategic Development

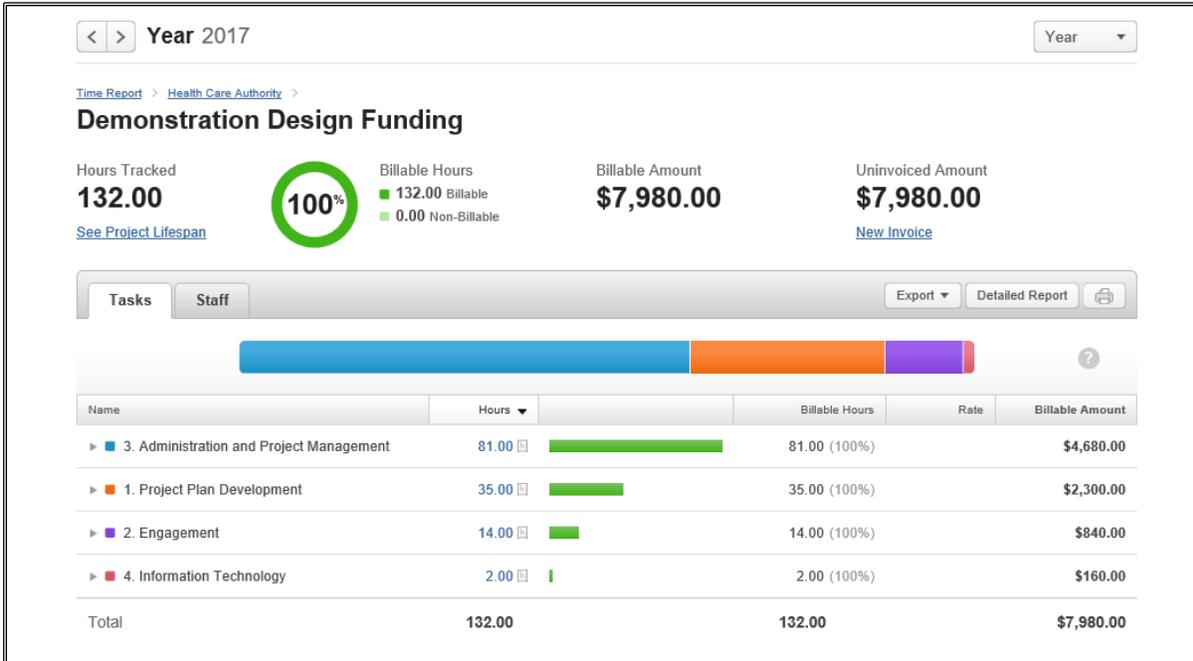
- Hiring of Director of Medicaid Transformation
- Contract with systems integration consultant
- Contract with finance and performance modeler to run simulations to guide key decisions

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

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

- 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), 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 OCH manages and oversees Design Funds. (F)
- Under the direction of the FC, OCH released an RFP for an independent audit to perform a single audit for the 2017 fiscal year (responses due August 18<sup>th</sup>).
- 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 integrate into the Profit & Loss Statement by Category. Payroll expenses are allocated based on the percentage of time reported for each budget category. Practice follows federal reporting guidelines and categories are compliant with contracts.

- To manage growth, 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 each year. The Board 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.)**

OCH is investigating mechanisms to allocate incentive payments to partner organizations (e.g., project cost-based, performance-based, relative size (#patients attributed/served), revenue loss compensation, flat participation fee, and uncovered service compensation). Multiple inputs are needed before funds flow modeling can begin and agreements can be put in place (image below):

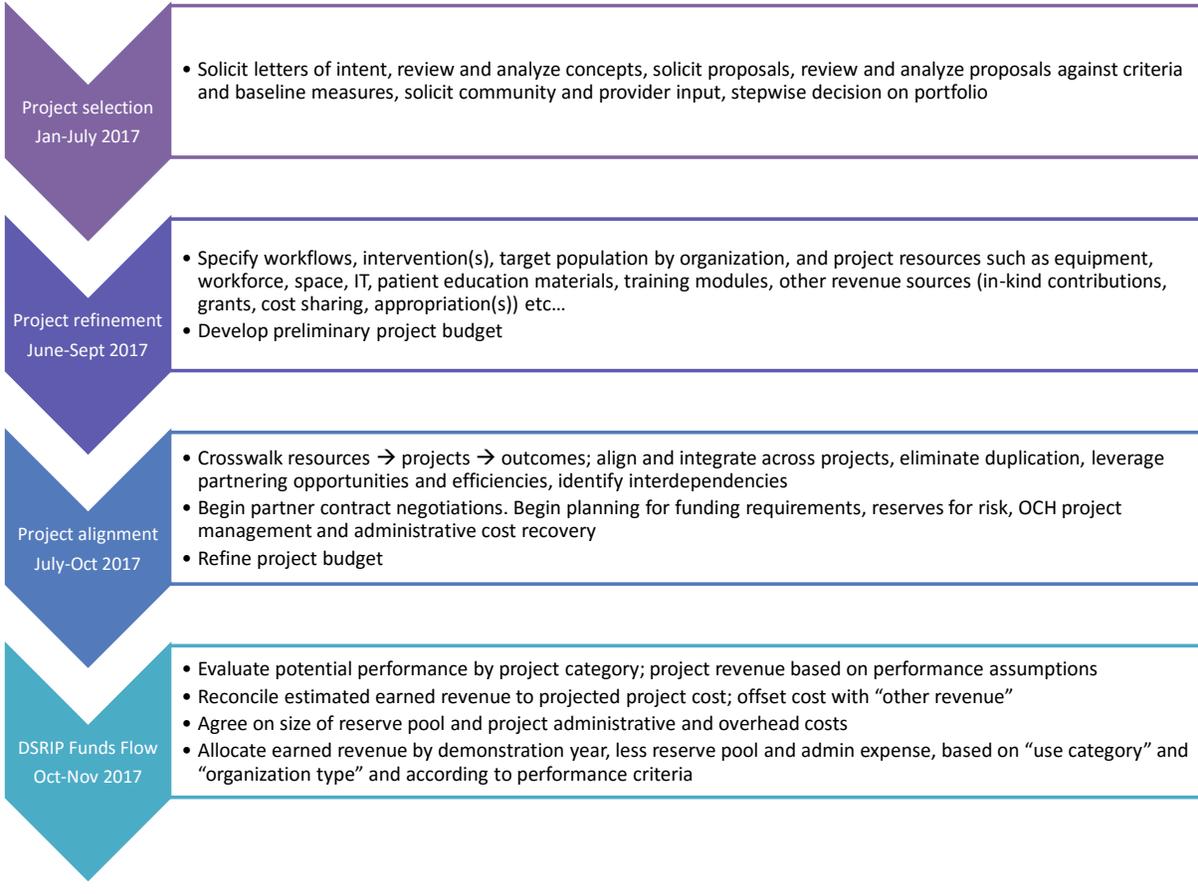
- selection of evidence based programs and target population
- assessment of project resources and in-kind contributions
- project budget projections
- alignment of resources, projects, and outcomes
- agreement on performance targets
- modeling of project parameters to predicted outcomes and earnable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

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

Other considerations for DSRIP funding allocation:

- 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)

Project incentive fund planning: project selection → incentive payment



**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).**

1. 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 to cover catering for meetings and provided bridge funding for the Opioid Response Project (February-April 2017).
3. (Planned) Local municipal funding, particularly for projects of interest to local county governments such as LEAD or community paramedic.

**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 to report measures in project proposals by most partner organizations

**Clinical**

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

**Financial and Legal**

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

**Community and program management**

- Community partners drafted 35 letters of intent and submitted 10 project proposals

**Strategic development**

- KPHD donated \$98,000 in-kind while OCH was hosted at KPHD
- Discussions with UW 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

**Attachments**

**Olympic Community of Health – Budget and Funds Flow – Attachment:**

- A – Resume: Chief Financial Officer professional service contractor
- B – Resume: Treasurer
- C – Financial statements for the previous four quarters (Audited statement not yet available)
- D – Design Funds Budget Template: Budget Detail
- E – Design Funds Budget Template: Additional Information
- F – Fiscal Policies and Procedures

## 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

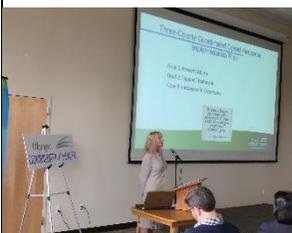
### 1. Demonstrate how clinical expertise and leadership are being used to inform project selection and planning to date.

#### 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 (A-C) and/or ARNP chair per committee); 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 (E), a three-county coordinated opioid response implementation plan was presented by Drs. Chris Frank (A) and Susan Turner (B) (image to left).



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

35 LOIs resulting in 10 proposals for project ideas were submitted by partnering providers, including multiple clinical partners (table below). Clinical providers both participated in co-authoring proposals and committed to provide data, manage data, house intervention, provide staff, provide equipment, serve on committee, or provide a clinical champion. One clinical partner, Peninsula Community Health Services (PCHS) - caring for 25% of OCH Medicaid lives - lead four of ten proposals.

Providers shared organization-level data to allow for evidence-based project selection and planning:

- 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 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			Olympic Medical Center	Olympic Workforce Development Council
	City of Poulsbo		City of Poulsbo	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 each project area. The goal is to drive systems transformation through oral health, child and reproductive health, opioid prescribing, and bi-directional integration. Many individuals listed below already have contracts, some are in development, some in negotiations. Working together, these provider champions and SMEs are developing portfolio projects with partners and synthesizing overall portfolio submittal across Domains 1 and 2. Ultimately, upon award, provider champions will work with OCH staff for project implementation.

**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 clinical 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 20-April 12, 2017) yielded clinical provider input from urban and rural geographies and Tribes. Thirty-five LOIs were received, 26 from clinical provider organizations, all 35 had committed partnerships from clinical provider organizations (table below).

The RHAP Committee recommended 10 project application teams. Project application teams included frontline providers and administrators from clinical organizations, many not participating on the Board. Teams met (April 19-May 26, 2017) to craft proposals.

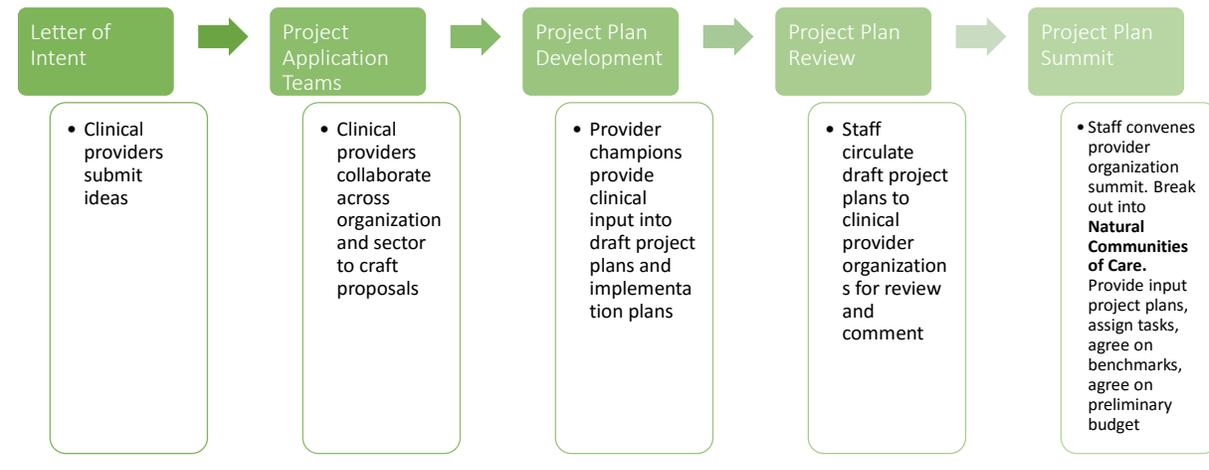
OCH is identifying and assigning provider champions to provide clinical input into further project plan development. For example:

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

Project plans will be sent out for comments to clinical provider organizations and a provider summit will be hosted this September to invite input into project plans and the *change plan*. (image below)

Letters of Intent: 35 Project Ideas Received, 26 from Clinical Provider Organizations (denoted with a "**")						
#	Lead	Project Title	Clallam	Jefferson	Kitsap	Tribe
<b>Care Coordination</b>						
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		
<b>Chronic Disease Prevention and Control</b>						
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	
<b>Diversion</b>						
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 Incarceration	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
<b>Reproductive and Maternal and Child Health</b>						
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
<b>Oral Health Access</b>						
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			
<b>Transitions of Care</b>						
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	

## Clinical Provider Input in Project Planning



### 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

Assessment of regional clinical capacity began May 26, 2017. Each project applicant provided target population, footprint, and workforce data, stratified by collaborating organization (snapshot from RFA below). 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.

January 2017, OCH released clinical provider survey results aimed to better understand current capacities 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 (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 materials 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 asking practices that assessment results be shared with OCH; OCH outreach to providers includes a strong recommendation to partner with Qualis. 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. Outreach to providers includes a 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:

- Capacity or access gaps identified by Medicaid population's healthcare and healthcare access needs
- Medicaid beneficiary population's level of access or connection to care, and greatest barriers to accessing needed health care and supportive services

Following analysis of clinical capacity assessments and gaps (October 2017) by OCH staff, SMEs and Provider Champions, workforce needs to fulfill project plan service delivery will be matched to identified gaps and used to develop workforce strategies under Domain 1.

OCH contracts professional services (H) 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

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 <i>Broad definition (e.g., pregnant women living in...)</i>	ESTIMATED # and % MEDICAID BENEFICIARIES <i>Estimated unique # of Medicaid lives; proportion of Medicaid population that will be served. Where appropriate, breakdown by county and/or Tribe.</i>	ESTIMATED # FTE and TYPE of CLINICAL MEDICAID PROVIDERS <i>Estimated # full-time equivalents and type of licensure (e.g., nurse, MD, DO, LMHP...) by each partner organization.</i>	ESTIMATED # FTE and TYPE of NON-CLINICAL MEDICAID PROVIDERS <i>Estimated # full-time equivalents and type (e.g., educator, community health worker...) by each partner org.</i>
				Organization 1:  Organization 2:  Organization 3:	Organization 1:  Organization 2:  Organization 3:

**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 is exploring opportunities to grow the healthcare workforce with the Olympic Regional Workforce Development Council.
- OCH in early discussions with WSDOT regarding transportation needs.

Attachment

Olympic Community of Health – Clinical Capacity – Attachment:

- Current bios or resumes for identified clinical and workforce subject matter experts (SME) or provider champions
  - A – Dr. Chris Frank, MD, PhD, Co-Chair, 3 County Coordinated Opioid Response Project, Steering Committee, Board Member
  - B – Dr. Susan Turner, MD, MPH, MS, Co-Chair, 3 County Coordinated Opioid Response Project, Prevention Workgroup
  - C – Dr. Jean Riquelme, MD, Co-Chair, 3 County Coordinated Opioid Response Project, Overdose Prevention Workgroup
  - D – Wendy Sisk, LMHC, DMHP, GMHS, Co-Chair, 3 County Coordinated Opioid Response Project, Treatment Workgroup
  - E – Dr. Tom Locke, MD, MPH, participating, 3 County Coordinated Opioid Response Project, Steering Committee, Board Member
  - F – Dr. Kate Weller, MD, provider champion for Chronic Disease Prevention and Control project plan
  - G – Brian Burwell, LCSW, CDPT, provider champion for Opioid Response project plan
  - H – Walter Sive, consultant, healthcare financing and modeling
  - I – Rob Arnold, consultant, healthcare and technology
  - J – Rochelle Doan, consultant, integration and workforce
  - K – Dr. Gary Kreidberg, MD, MPH, member, Regional Health Assessment and Planning Committee
  - L – Jody Carona, consultant, health facilities (SME)

## 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.**

OCH's regional health assessment and planning efforts are based on a foundation of data-driven health improvement planning in Clallam, Jefferson, and Kitsap. OCH leveraged that foundation, using new data sources, to create a regional health data repository that will inform project planning and selection, as well as inform implementation and monitoring needs.

The table below displays three columns from the **Data Resources Repository**, which contains key information on availability, timeliness, contents, format, etc. of discrete data resources. OCH starts here when assessing regional socioeconomic conditions, health needs, and disparities, and informing project selection and planning. The full table includes: sort category, title, geography, population, sub-groups, contents, date of data, source, date rec'd, format, access, and web interactive site.

In addition to sources in the table, OCH requested data from local social and healthcare providers as part of the project selection process, both during the RFA and in Project Plan development. Examples include: workforce, # Medicaid beneficiaries assigned, # of Medicaid beneficiaries (unique) seen in the previous year, patient/client population by: race/ethnicities, income, geography, immigration status, gender and sexuality, disability status, high level diagnostic categories, and others.

<b>OCH Data Resources Repository as of 7-27-17</b>		
<b>sort cat</b>	<b>title</b>	<b>source</b>
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
<b>Opioid</b>	<b>Opioid data</b>	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.xlsx	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

**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 Analytics and Reporting Lead reviewed and synthesized vast amounts of inputs from HCA and other sources to inform project selection and design. In addition, OCH compiled baseline data (snapshot below) for 25/37 Demonstration toolkit measures (data not yet available for remaining 12).

**Appendix II: Toolkit Project Metrics**

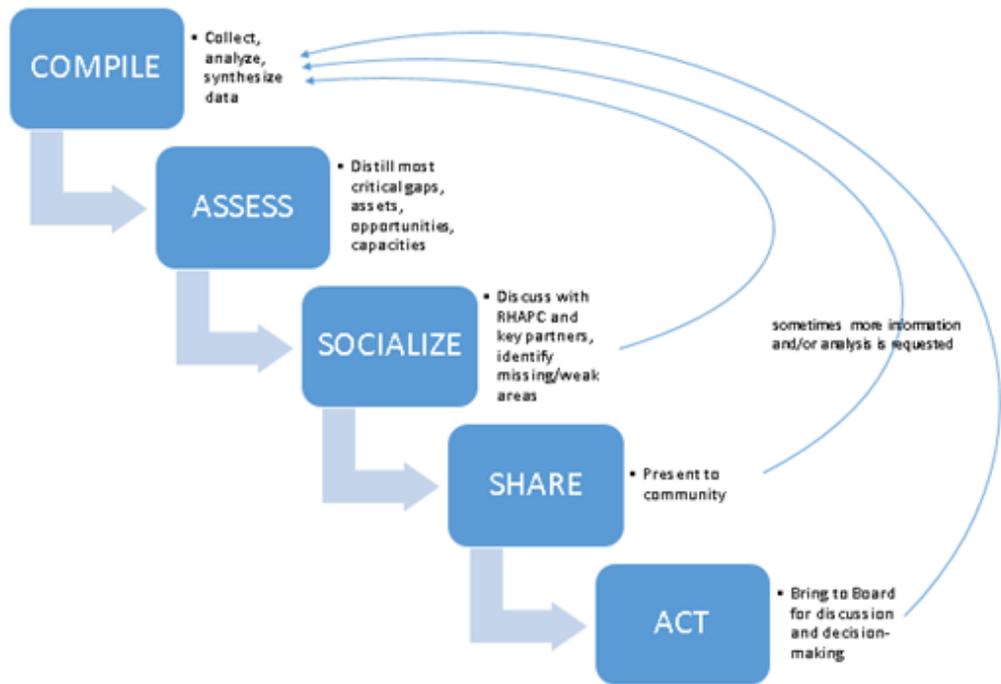
Name	OCH Status	OCH Value	Number of	Date of Data	Data Source	Measure Description	Assessment of OCH Performance & Data Availability						
							Step in Data	Reporting Frequency	Q1 18	Q2 18	Q3 18	Overall Project Status	
Improve access to services for all ages	Measure of access to services for all ages	Value of 100%	Number of 100%	Date of Data 10/1/18	Data Source: HCA, OCH, etc.	The percentage of all residents who have access to services for all ages	Step in Data	Baseline (HCA)	Y	Y	Y	Y	On Track
Improve access to services for all ages (continued)	Measure of access to services for all ages	Value of 100%	Number of 100%	Date of Data 10/1/18	Data Source: HCA, OCH, etc.	The percentage of all residents who have access to services for all ages	Step in Data	Baseline (HCA)	Y	Y	Y	Y	On Track
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Using baseline measure data and Repository data, OCH will:

1. Continue to identify the greatest regional health needs.
2. Interpret and distill data into actionable indicators.
3. Use this to inform development of projects, and their implementation and evaluation.

The **Stepwise Logic Chain** for Data-Informed Decision Making (image below) depicts detailed steps 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 RHAP Committee and partners, a critical precursor to broader sharing with the community and decision-makers. During the socialize, share, and act steps, additional information and analysis needs are identified, bringing the logic chain back to step 1.

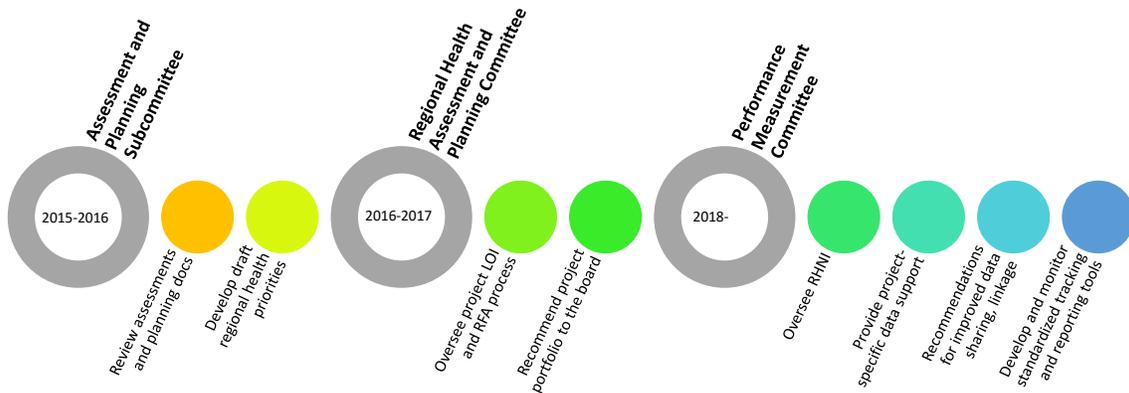
## Stepwise Logic Chain for OCH Data-Informed Decision Making



### Data socialization and sharing

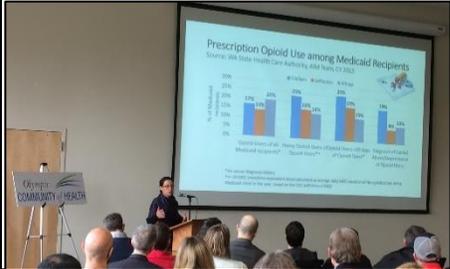
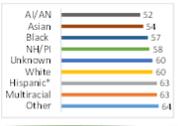
Since Fall 2015, OCH collaborated with community partners on assessment and planning activities. The timeline below shows the evolution of this work. The Regional Health Assessment and Planning (RHAP) Committee members work as data specialists, analysts, quality improvement staff, or planning leads. The RHAP Committee serves as a “GPS” – keeping OCH grounded in data.

### Evolution and Roles of OCH Community Assessment and Data Committee



### Examples of sharing data with community partners

Date	Purpose	What was shared?
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1/30/17	Opioid Summit (Kitsap)		Analytics & Reporting Lead presents results from OCH Opioid Assessment																																																					
1/30/17	Partner Convening (Kitsap)	<p><b>Dental services for Medicaid Ages 0-20</b></p> <ul style="list-style-type: none"> <li>- Clallam 41.2%</li> <li>- Jefferson 37.0%</li> <li>- Kitsap 45.8%</li> <li>- State average 55.5%</li> </ul> 	Data shared for each project category.																																																					
6/19/17	Partner Convening (Clallam)	<p><b>TARGET/REACH: 11,890 Adult Medicaid lives annually across region.</b></p> <table border="1" data-bbox="646 762 1166 909"> <thead> <tr> <th>Geography</th> <th>PCMH</th> <th>Medicaid Lives</th> <th>Hospital</th> <th>Medicaid Lives</th> <th>Other Providers</th> <th>Medicaid Lives</th> <th>Other</th> </tr> </thead> <tbody> <tr> <td>Clallam</td> <td>NOHN</td> <td>2,453 TOTAL 778 diabetes 1,289 HBP 341 asthma 320 SUD</td> <td>FCH OMC</td> <td></td> <td>Olympic AAA</td> <td></td> <td>YMCA</td> </tr> <tr> <td>Jefferson</td> <td>JHC</td> <td>6,200 TOTAL</td> <td>JHC</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Kitsap</td> <td>PCHS</td> <td>17,140 TOTAL 2,274 diabetes 5,637 HBP 1,237 asthma 900 SUD</td> <td>HMC</td> <td></td> <td>PG S'Klallam Tribe Suquamish</td> <td></td> <td></td> </tr> </tbody> </table> <p>Other Collaborators: HHP (10,000 Medicaid covered lives/3 counties), Kitsap AAA, KMHS, Clallam County HHS</p> <p><b>STAFFING –Current Budget:</b></p> <table border="1" data-bbox="646 940 1166 1087"> <thead> <tr> <th>Geography</th> <th>PCMH</th> <th>Hospital</th> <th>Other Providers</th> <th>Other</th> </tr> </thead> <tbody> <tr> <td>Clallam</td> <td>NOHN</td> <td>1 Pop Health Nurse Care Mgr 1 CHW</td> <td>FCH OMC</td> <td>Olympic AAA J5 CDSMP Proj Coord Master Trainer Lay Leaders</td> <td>YMCA .14 Assoc. Dir .3 CHD Prog Educ</td> </tr> <tr> <td>Jefferson</td> <td>JHC</td> <td>JHC</td> <td></td> <td></td> </tr> <tr> <td>Kitsap</td> <td>PCHS</td> <td>PCHS &amp; HMC</td> <td>PG S'Klallam Tribe Suquamish Tribe</td> <td>.2 Director .2 Nurse Mgr .5 CDSMP Data Analyst</td> </tr> </tbody> </table> <p><b>ROI: Chronic Care Model. ROI when viewed through lens of heart disease:</b></p> <ul style="list-style-type: none"> <li>In-Person Care Management: one study showed average cost savings associated with in-person care</li> </ul> <p><b>Facts About Medicaid Population</b></p> <ul style="list-style-type: none"> <li>What percent of children age 3-6 in the OCH region who are Medicaid recipients had a well-child visit with a PCP during the measurement year?</li> </ul> <div data-bbox="730 1239 1136 1365"> <p>A. 59%</p> <p>B. 68%</p>  </div> <p>Source: WA HCA Data Dashboard 7/1/15-6/30/16</p>	Geography	PCMH	Medicaid Lives	Hospital	Medicaid Lives	Other Providers	Medicaid Lives	Other	Clallam	NOHN	2,453 TOTAL 778 diabetes 1,289 HBP 341 asthma 320 SUD	FCH OMC		Olympic AAA		YMCA	Jefferson	JHC	6,200 TOTAL	JHC					Kitsap	PCHS	17,140 TOTAL 2,274 diabetes 5,637 HBP 1,237 asthma 900 SUD	HMC		PG S'Klallam Tribe Suquamish			Geography	PCMH	Hospital	Other Providers	Other	Clallam	NOHN	1 Pop Health Nurse Care Mgr 1 CHW	FCH OMC	Olympic AAA J5 CDSMP Proj Coord Master Trainer Lay Leaders	YMCA .14 Assoc. Dir .3 CHD Prog Educ	Jefferson	JHC	JHC			Kitsap	PCHS	PCHS & HMC	PG S'Klallam Tribe Suquamish Tribe	.2 Director .2 Nurse Mgr .5 CDSMP Data Analyst	Shared data on Medicaid population and ROI for each project
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8/14/17	Board Meeting (Jefferson)	<p><b>OCH Baseline Status on Available Toolkit Measures, updated August 7, 2017</b></p> <table border="1" data-bbox="621 1438 1218 1755"> <thead> <tr> <th>Name</th> <th>OCH Notes</th> <th>OCH value</th> <th>numerator</th> <th>denominator</th> <th>State value</th> </tr> </thead> <tbody> <tr> <td>Antidepressant Medication Management</td> <td>Acute and continuation measures available</td> <td>Acute=63% Cont=36%</td> <td>Acute=1072 Cont=704</td> <td></td> <td>Acute=52% Cont=33%</td> </tr> <tr> <td>Utilization of Dental Services by Medicaid Beneficiaries</td> <td>all ages</td> <td>overall=30% preventive=21%</td> <td>overall=29671 prev=20483</td> <td>both=99081</td> <td>overall=38% prev=29%</td> </tr> <tr> <td>Mental Health Treatment Penetration (Broad Version)</td> <td>all ages, includes duals</td> <td>44%</td> <td>7904</td> <td>17861</td> <td>43%</td> </tr> <tr> <td>Substance Use Disorder Treatment Penetration</td> <td>all ages, includes duals</td> <td>28%</td> <td>2237</td> <td>7949</td> <td>27%</td> </tr> <tr> <td>Comprehensive Diabetes Care: Blood Pressure Control</td> <td>HCA has not released</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Floor Control (≥9.0%)</td> <td>HCA has not released</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Name	OCH Notes	OCH value	numerator	denominator	State value	Antidepressant Medication Management	Acute and continuation measures available	Acute=63% Cont=36%	Acute=1072 Cont=704		Acute=52% Cont=33%	Utilization of Dental Services by Medicaid Beneficiaries	all ages	overall=30% preventive=21%	overall=29671 prev=20483	both=99081	overall=38% prev=29%	Mental Health Treatment Penetration (Broad Version)	all ages, includes duals	44%	7904	17861	43%	Substance Use Disorder Treatment Penetration	all ages, includes duals	28%	2237	7949	27%	Comprehensive Diabetes Care: Blood Pressure Control	HCA has not released					Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Floor Control (≥9.0%)	HCA has not released					Presented baseline assessment on toolkit measures.											
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Project selection and planning

The RHAP Committee designed and led the initial LOI and RFA project selection process. In the latter, applicants were asked to present a data-driven case statement for their project. They were given links to data released by HCA, which Public Health Seattle & King County visualized. (Image is a screen shot from RFA instructions).

<b>CASE STATEMENT</b> (2-3 sentences)	<p>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:</p> <p><b>Overall population</b></p> <ul style="list-style-type: none"> <li>Visualized <a href="#">Regional Health Needs Inventory (RHNI) data on the overall population</a> (produced by Public Health Seattle King County (PHSKC))</li> <li>Raw Tables: <a href="#">Regional Health Needs Inventory (RHNI) data on overall population</a> (produced by Health Care Authority, Department of Health, and Department of Social and Health Services)</li> </ul> <p><b>Medicaid population</b></p> <ul style="list-style-type: none"> <li><a href="#">Healthier Washington Data Dashboard</a> (produced by Providence CORE)</li> <li><a href="#">Cross-system performance measures (5732-1512) for Medicaid population</a> (produced by PHSKC)</li> </ul> <p><b>Joint DSHS/HCA clients</b></p> <ul style="list-style-type: none"> <li><a href="#">Demographic/health profile of joint DSHS/HCA clients</a> (produced by PHSKC)</li> </ul>
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The RHAP Committee scored proposals. A key component of scoring was whether data in proposals provided evidence of the health need, footprint, and scale (snapshot of RFA scoring tool to the right).

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

	<p>I. <b>Footprint.</b> <i>The Project will impact many people and involve wide-scale provider involvement. <b>20% of TOTAL</b></i></p> <p>a. <b>Medicaid Beneficiaries.</b> How many Medicaid Beneficiaries will this project impact by 2021. [15%] 3 points for each category met.</p> <p>i. &gt; 5,000 ; ii. 3,000-4,999; iii. 1,500-2,999; iv. 500-1,499; v. 1-499</p> <p>b. <b>Medicaid Providers</b> (clinical): <i>How many clinical Medicaid providers (# FTE, not agencies/organizations) will collaborate or participate?</i> [5%] 1 point for each category met.</p> <p>i. &gt;50; ii. 30-49; iii. 20-29; iv. 10-19; v. 1-9</p>
	<p>II. <b>Scale.</b> <i>The Project will be operational throughout three counties in the region. <b>20% of TOTAL</b></i></p> <p>a. <b>Organizations.</b> <i>How many organizations are on the commitment form?</i> [4%] 1 point for each category met.</p> <p>i. 8-10; ii. 5-7; iii. 2-4; iv. 1</p> <p>b. <b>Counties.</b> <i>How many counties are on the commitment form?</i> [10%] 5 points for each category met.</p> <p>i. 3; ii. 2</p> <p>c. <b>Tribes.</b> <i>How many Tribes are on the commitment form on this project?</i> [6%] 2 points for each category met.</p> <p>i. 5-7; ii. 3-4; iii. 1-2</p>

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

<b>Data and analytic gaps in project selection and planning:</b>	
Identified data /analytic gaps:	Steps to overcome gaps:
Provider-level performance on key measures to advise project selection	- Developing a list of data elements to request from providers informed by anticipated project measures.
Region-wide census of provider analytic capacity to support project implementation and monitoring	- Developing assessment of provider system capacity for reporting process measures to gauge project implementation.
Granular data (e.g. small enough geographies, provider level) to inform specific elements of project selection and planning	- Digging deeper into functionalities of available data resources, e.g., Washington Tracking Network, for census tract data/maps. - Reaching out to entities that do comparative reporting at regional, county, or provider level, e.g. Washington Health Alliance.
Tribal data	- Dedicating resources to tribal partnerships - Director of Community and Tribal Partnership works with the American Indian Health

	Commission and the Tribal nations within the region on data availability and access.
Lacking empirical ROI information, down to the subpopulation level, to inform selection of evidence based projects (EBPs)	- Performed literature review and compiled available ROI information for EBPs.
Lack of interactive web-based data visualization tools.	- Contracting for data visualization services from Public Health Seattle-King County

**Data-related Collaborations**

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

OCH has engaged in many collaborative data-related activities with other ACHs:

- Executive Director was one of three ACH representatives on initial AIM/ACH liaison calls.
- Shares and receives templates and methodologies.
- Analytics and Reporting Lead routinely engages in strategic thinking around current and future data and analytic needs.
- Takes lead to research and share data collection and reporting vendors used for NY DSRIP.
- Explores options for data infrastructure from vendors such as CORE, SpectraMedix, and Quality Benchmarking System (QBS).

While each region differs, all share a common need for infrastructure to collect, analyze, and report data. OCH will continue to reach out and respond to requests to collaborate with ACH partners.

ACH	Shared templates and methods	Data thought partner	Exploring options for shared data infrastructure
Better Health Together			
Cascade Pacific AA			
Greater Columbia			
King County			
North Central			
North Sound			

**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.**

In 2017, OCH’s data focus has shifted to planning for projects. Through the LOI and RFA process, OCH requested specific data elements and information about existing analytic infrastructure. In the LOI (snapshot below), OCH ascertained willingness of collaborating organizations and Tribes to provide data for project tracking.

**WILLING TO PROVIDE PROJECT-SPECIFIC DATA TO THE OCH FOR TRACKING PURPOSES (check one)**

- Yes, all the organizations and Tribes listed above are willing to provide regular data reports to the OCH
- Yes, some of the organizations and Tribes listed above are willing to provide regular data reports to the OCH
- Yes, some of the organizations and Tribes listed above are willing to provide limited data reports to the OCH
- No, the organizations and Tribes are not willing to provide data to the OCH
- Other:

Additional explanation:

Successful LOI submissions were advanced to RFA (snapshot below), wherein applicants used data to describe the community need for their project. Applicants also provided data on target population, Medicaid beneficiaries, and provider reach.

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 BENEFICIARIES <i>Estimated unique # of</i>	ESTIMATED # FTE and TYPE of CLINICAL MEDICAID PROVIDERS	ESTIMATED # FTE and TYPE of NON-CLINICAL MEDICAL PROVIDERS <i>Estimated # of</i>

Applicants described the frequency and level at which toolkit measures could be reported, and identified the data owner.

METRIC	ABLE TO REPORT THIS METRIC? IF SO, HOW OFTEN?	LEVEL	DATA OWNER
<i>Pre-populated from the toolkit</i>	<i>Weekly, Monthly, Quarterly...</i>	<i>Unit of analysis (clinic, hospital, etc.)</i>	<i>Organization(s) responsible for providing data</i>
To be determined based on			

Applicants submitted a Partner Commitment Form identifying type of participation, including “provide data” and “manage data”.

AGENCY/ ORGANIZATION NAME	TYPE OF PARTICIPATION							
	CHECK ALL THAT APPLY							
	Provide data	Manage data	House intervention	Provide staff	Provide equipment	Serve on committee	Provide clinical champion	Other Please specify

Across all project, the types of partners on the commitment forms included: hospitals, primary care clinics, FQHCs, MCOs, CBHCs, SUD providers, public health, CAPs, schools, Fire/EMS, law enforcement, Tribes, and other non-profits.

Additional examples of collaborations with community partners to collect data and leverage existing infrastructure:

- OCH was originally housed within Kitsap Public Health District, strategically positioning the two organizations for ongoing collaboration on data and analytic infrastructure
- OCH is now housed at Jefferson Healthcare, leveraging its HIPAA compliant servers
- Molina has offered to provide GIS mapping of opioid use and prescriptions
- All hospitals, FQHCs, and CBHCs submitted data for the RFAs
- Several county planners and population health analysts assisted in designing and reviewing the LOI/RFA process.

**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.**

Successful Demonstration project implementation requires detailed provider HIT system assessment and testing to ensure metrics are reportable per required specifications.

OCH’s engagement process to assess provider data systems began with the LOI and RFA process. Currently (June-November 2017), in partnership with Qualis, OCH is engaging providers (through interviews and written survey) to understand status and flexibility around:

- Type of EHR/population management system
- Use of clinical data repository and OneHealthPort
- Use of registries, data-decision support, reporting tools
- HIT, data, analytic capacity and workforce

Providers are asked to share results from HCA VBP survey and HUB assessments.

Assessment results will inform provider-specific supports necessary for successful project implementation and reporting. Gaps will be addressed with technical assistance and DSRIP investment.

Barriers are addressed in the design stage – this includes establishing a basic tracking and reporting process where inadequate/no infrastructure exists - and continuous quality improvement during implementation allows for further modifications.

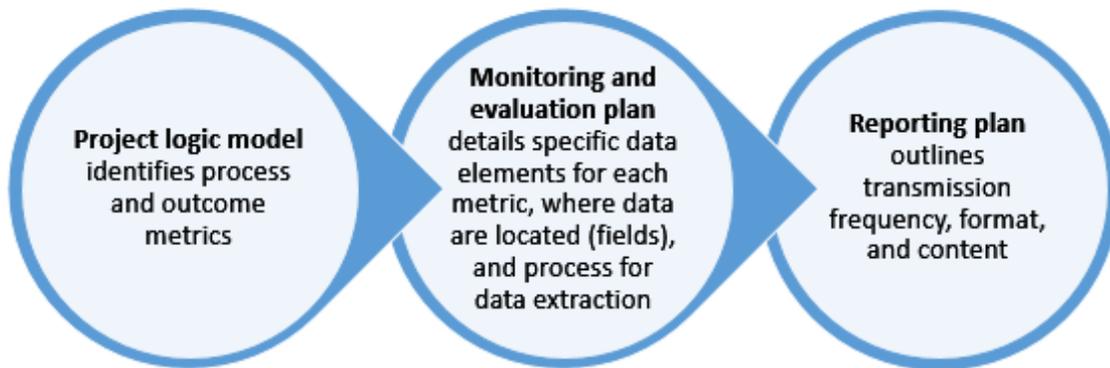
**7. Demonstrate the ACH’s process to identify data or data system requirements needed to oversee and monitor demonstration project goals.**

Using the same process described in 6 above, the diagram below outlines the steps for establishing project partner monitoring and evaluation data system requirements. These requirements will flow from key process and outcome measures identified from each project’s logic model.

OCH anticipates needing to collect data not available through existing sources. Scale is not a big concern: collecting data (through a HIPAA compliant platform) from less than 20 provider groups, with narrowly focused data elements, is doable. The OCH will not overburden the process with measurement and will be strategic about the number, type, and frequency of data elements collected from providers. During the development of the monitoring and evaluation and reporting plans, HIT barriers will be identified and addressed to ensure required reporting is possible.

OCH is exploring Customer Relationship Management (CRM) tools and other web-based data input portals to determine if efficiencies can be gained by aligning data and data systems across ACHs. OCH has hired a consultant with experience in building applications and data repositories for gathering clinical and related data from disparate provider groups engaged in collaborative health improvement initiatives.

## Project Partner Monitoring and Evaluation Data System Requirements



The process of developing the M&E and Reporting Plans requires detailed HIT system assessment and testing to ensure metrics are reportable per required specifications. Any barriers identified are addressed in the design stage – this includes establishing a basic tracking and reporting process where inadequate/no infrastructure exists - and continuous quality improvement during implementation allows for further necessary modifications.

### **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.**

Over the next 18 months, the OCH workforce development process will result in an innovative, aligned strategy for addressing gaps in capacity and training, that includes supporting practice transformation workflows ensuring providers operate efficiently, effectively and at top of license, enhancing and growing provider technology/telehealth, and population-based health analytic capacities, addressing licensure, credentialing, certification and payment barriers and opportunities, and identifying possible new innovations such as virtual interdisciplinary teams spanning boundaries across primary care, hospitals, and behavioral health.

Recognizing the need to strategically address workforce shortages and new opportunities for growth, OCH is partnering with Cascade Pacific Action Alliance and Greater Columbia to create a strategic approach to assess shared workforce capacity gaps and subsequently establish and leverage cross-ACH workforce development strategies. OCH will bring forward assessment information gathered during 2016/2017 that includes:

- Workforce capacity information gleaned during Project Portfolio development wherein participating providers identified existing workforce capacity and gaps to implement selected projects.
- Bi-directional workforce assessment included in provider interviews, with initial oral interviews and written surveys completed by September 30, 2017. Participating organizations include major Medicaid providers in the region.
- Survey results of workforce needs for opioid treatment, merged with bi-directional care and portfolio. Partnerships with the universities and colleges to develop CEU coursework for CDPs have been formed.
- OCH Directors and partners have connections with the Olympic Regional Workforce Development Council, which has prioritized healthcare workforce. OCH is exploring

partnerships can maximize mutual goals to prepare for and develop enhanced workforce capacities.

**Attachments**

*None*

## Transformation Project Planning - 15 points

### Description

Provide a summary of current transformation project selection efforts including the projects the ACH anticipates selecting.

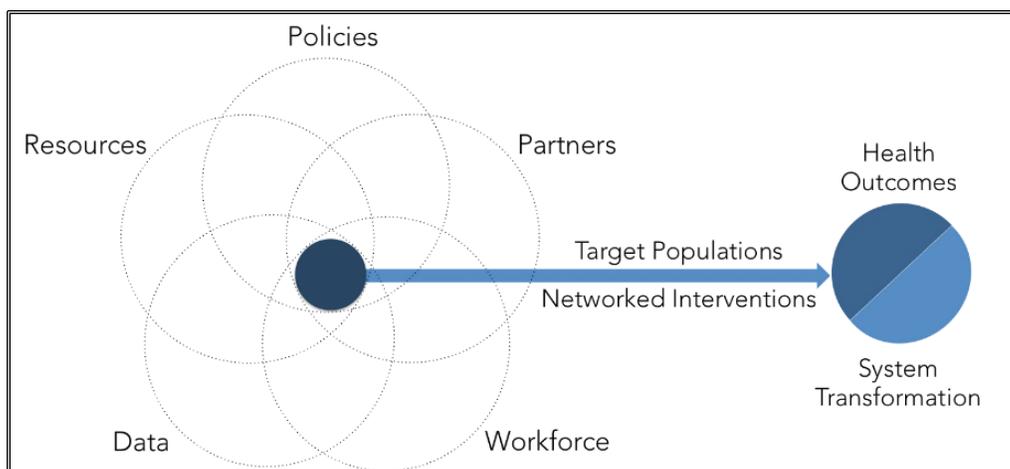
### Instructions

**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.

OCH employed a collaborative process to solicit, assess, prioritize, and select a comprehensive portfolio of projects. The process was designed to (1) integrate partners, policies, resources, data and workforce to (2) implement networked interventions that (3) serve targeted Medicaid populations to (4) achieve measurable health outcomes and system transformation goals.



For each proposed project, OCH evaluated alignment of key characteristics:

- Is the project an expansion of an existing program or a new program?
- Will the project increase VBP adoption and drive long term sustainability?
- What types of agencies will be transformed?
- How will the project impact workforce goals (new, expansion, re-trained, community health workers, population health specialists)?
- Need for coordinated referral across systems?
- Crossover with bi-directional integration? Opioid Response?

#### Alignment with Demonstration Domains and Project Categories

Project selection was influenced by evidence-based considerations of Demonstration domains and project categories:

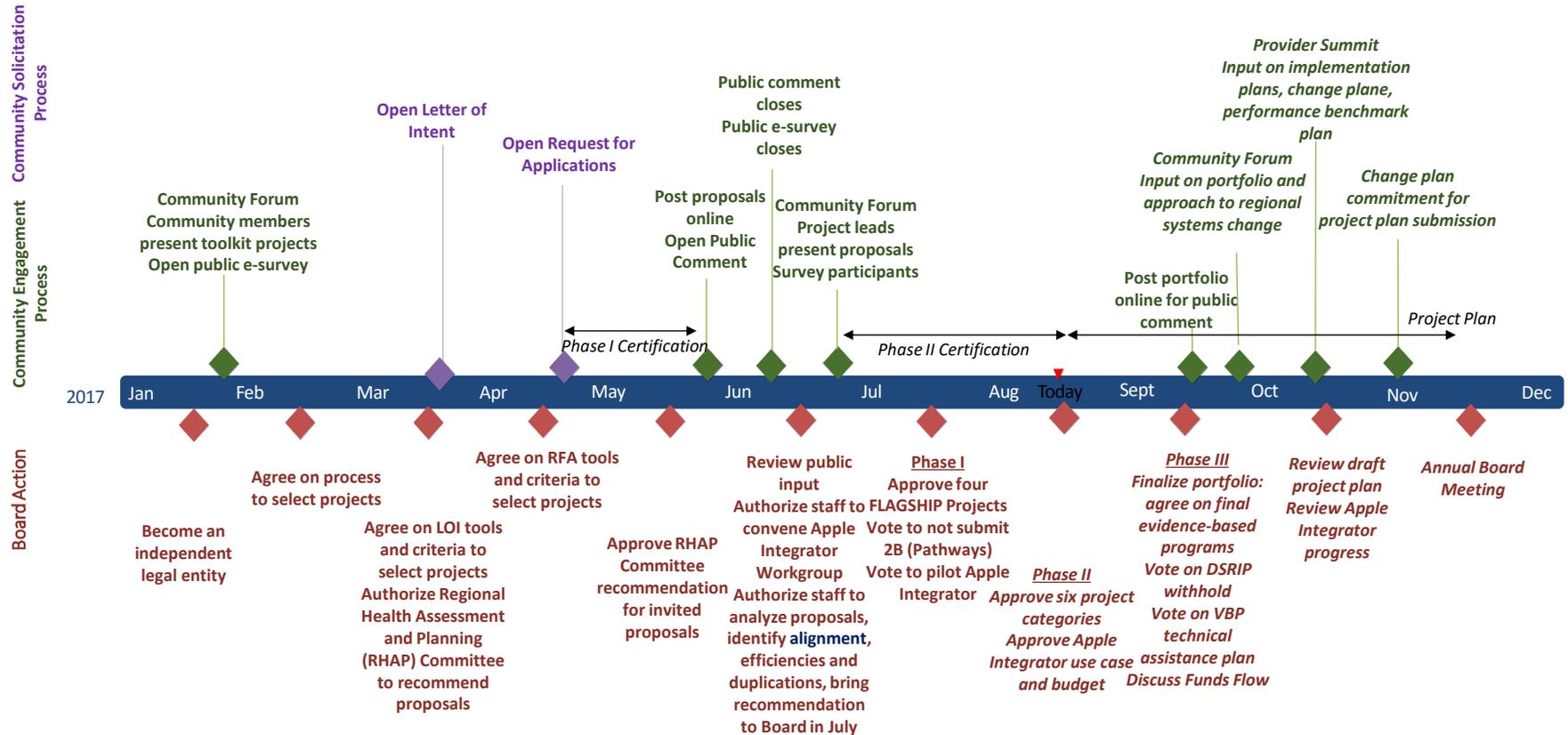
- **Performance.** OCH prioritized projects in DSRIP categories 2D, 3B and 3C because available data confirms that the region performs lower than state average in emergency department utilization, oral health access, and access to child and reproductive health services.
- **Practice Transformation.** 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. Programs include the chronic care model (3D), Bright Futures (3B), six building blocks for safe opioid prescribing (3A), and the collaborative care model (2A).
- **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 (table below).

### Measure Alignment

OCH cross-referenced projects, Demonstration metrics and measures, and Statewide Accountability Measures to identify areas of dependence, integration and alignment.

The tables below summarize the OCH project selection and development process, priority projects, Board authorization status, and metric alignment analyses.

# Summary 2017 Project Portfolio Plan, Selection, 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 <b>*Required*</b>	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 <b>*Required*</b>	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 (VOTING August 14) and Phase III Portfolio Recommendation (VOTING 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 "Diversion" 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			

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										

OCH Toolkit Metric Crosswalk and Baseline (based on data available 8.7.17)			Phase I: FLAGSHIP PROJECTS				Phase II		Statewide Accounta Measure
Name	OCH value	State value	Integrat	Diversion	Opioids	Chronic dz	MCH	Oral Health	
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/III 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.**

OCH has undertaken or participated in the following cross-ACH collaborations:

- Host a webinar with the University of Washington on *Six Building Blocks for Safe, Team-Based Opioid Prescribing* (August 16)
- Assist with a Development Council session on tribal relations and engagement (August 21)
- Arrange a demo for ACHs with *Persistent Systems* (August 18), cloud-based IT platform supporting reporting, surveying, data, and CRM for multiple PPSs in NY

OCH is 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, 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.

Other cross-ACH partnerships:

- **Pierce:** Strategize about opportunities to bring safe opioid prescribing practices to scale.
- **King:** Collaboration on data and Domain 1: Population Health and I.T. management.
- **North Central:** Bi-weekly conversations with OCH and CPAA (Cerebyte team from 2015) on data and practice transformation.
- **North Sound:** Strategize regularly 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.

#### Design and Development

MCOs participate on the Regional Health Assessment and Planning (RHAP) Committee to develop and implement the OCH project selection process. MCOs co-lead two Project Application Teams and signed partner commitment forms for four proposals.

#### Leadership

The Finance Committee, which includes an MCO representative, is tasked with recommending an approach to Demonstration incentive allocation. MCOs attend Board meetings, with a delegated voting member.

#### Moving Forward: Value-Based Care

OCH is scheduling meetings with senior 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.
- Strategies to coordinate Domain 1 work and project plan development to align/support/leverage the MCO's VBP goals.

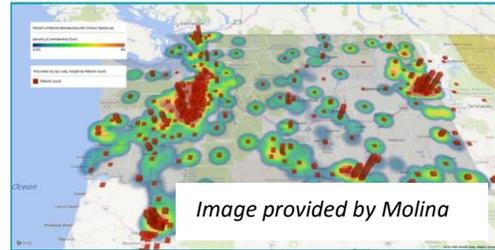
On August 14<sup>th</sup>, the Board will discuss the MCOs providing direct technical assistance to providers in value-based contracting, and the potential role of OCH in coordinating this service under the Demonstration.

**Moving Forward: Population Health Management/I.T.**

OCH is piloting and testing Apple Integrator with participation and support from MCOs.

**Moving Forward: Data**

OCH will rely on data partnerships with MCOs to help target interventions. The image depicts geolocation data to help identify Medicaid chronic opioid users and prescribers.



**Project Plan Submission**

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

OCH is developing a portfolio that (1) can be delivered in partnership with provider partners, and (b) meets regional health needs. The following table highlights factors that threaten project success:

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 <u>and</u> will improve population health <u>and</u> will be sustainable beyond the Demonstration (Aug-Sept)		
Challenge of recruiting employees to work in rural area			Staff burn out without peer network			Leverage partners for project plan development and recruitment. Explore expanded role of consultants/contractors (July-Nov)		

Incomplete baseline data to engage provider organizations	Provider skepticism to engage Challenge data-driven decision making	Share baseline dashboard with providers as soon as available. Fill-in missing data with other sources. Partner with HCA to provide feedback on data files.
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**5. Demonstrate how the ACH is identifying partnering providers who cover a significant portion of Medicaid beneficiaries.**

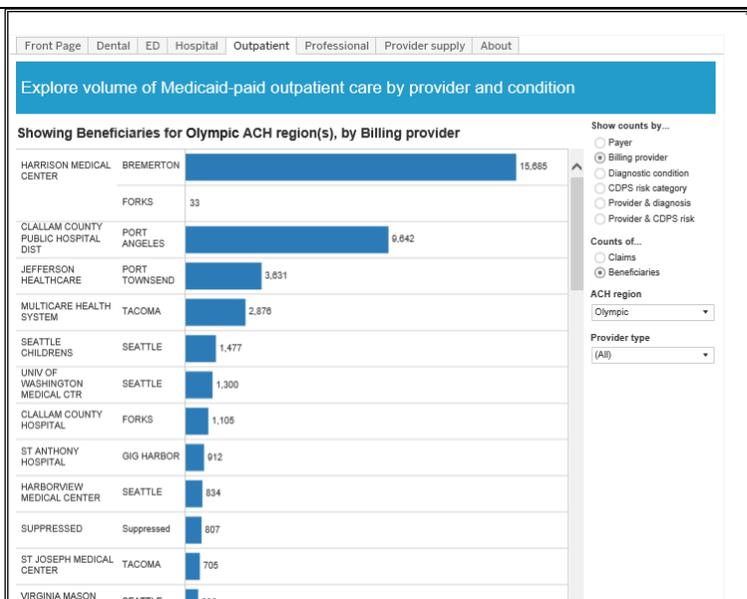
OCH maintains a database of Medicaid providers to target engagement efforts. Through its governance, committees, and outreach, OCH has engaged with all but three Medicaid provider organizations listed below, and has developed strategies to engage the remaining providers. Non-clinical Medicaid providers are engaged with OCH, serving on the Board and/or committees, and participating in project planning process. Most have committed to partner on one or more Demonstration projects. Between August and September, OCH is performing an assessment to determine the number of Medicaid clients served by each provider organization.

In July, the HCA provided Medicaid volume data by outpatient, dental, ED, hospital, and professional provider. The epidemiologist with King ACH, an OCH partner, uploaded these into Tableau (image below). Once the two sources are reconciled, the data will help determine the relative attribution of incentives to partnering providers based on the number of Medicaid beneficiaries served and claims submitted.

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			

Sample Tableau Report on Providers and Medicaid Clients



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

OCH is using the following processes to obtain commitments from partnering providers:

**Bi-Directional Integration and Primary Care Transformation**

OCH is partnering with a 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. Practices will be asked to share assessment results with the OCH. As of August 4, 2017, 26 clinic-based assessments were either underway or completed through the Hub and 9 through TCPI. OCH outreach to providers includes a strong recommendation to partner with the Hub (B) and TCPI (C) and complete the VBP Action Survey.

**Opioid Crisis Response**

Begun in 2016 with SIM grant funding, the 3 County Opioid Response Project is governed by a project charter, and supported by commitments from >40 project partners (D).

**Other Demonstration Projects**

OCH conducted an RFA process (April-May 2017) that required applicants to complete and sign a partner commitment form (snapshot below) for each project submission (A). Additional partners will likely be added.



**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.**

OCH is orienting Demonstration activity around **Natural Communities of Care (NCCs)** (image below) 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. NCCs honor longstanding, existing relationships between partners and reflect the cultural, health and social service needs of the community they serve.

The OCH will prioritize engagement based on the following:

**1. Portfolio (January – September 2017)**

Once the portfolio is finalized (September), OCH will prioritize engagement with the relevant providers to implement portfolio projects. OCH will prioritize primary care and behavioral health transformation, given their importance to the Demonstration, and their impact on the delivery and cost of care.

**2. Assessment (June – November 2017)**

Between August and November, OCH will finalize an assessment of all Medicaid service providers. Providers will be compared regionally and within each NCC. Providers that serve the largest number of Medicaid clients, and submit the most claims (clinical only), will be prioritized within each NCC and across NCCs. Stratification allows for special consideration for 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 \$30,000/year –insufficient to address the dental need.)

This assessment is tailored to each sector and includes:

- PCMH-A, MeHAF assessment
- # Medicaid beneficiaries assigned
- # 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 October, OCH will ask for provider commitment using the *change plan* concept.

Natural Communities of Care (NCC) denoted by colors; not inclusive of all partners

Convene Regional Community of Care Collaborative (RC3) 2-4 times per year or as needed. Regional NCC partnerships (denoted by patterns), supported as needed.

CHI Harrison	Peninsula Community Health Services	Kitsap Public Health District	Jefferson Healthcare	Jefferson Corrections, Courts, Fire, EMS, Law Enforcement, Schools	Jefferson Corrections, Courts, Fire, EMS, Law Enforcement, Schools	Olympic Medical Center	Forks Community Hospital
Harrison Health Partners / Doctor's Clinic	Port Gamble Clinics	Jefferson Corrections, Courts, Fire, EMS, Law Enforcement, Schools	Jefferson Clinics	Discovery Behavioral Health	Hoh Wellness Ctr	Olympic Medical Clinics	Forks Clinics
Kitsap Mental Health Services	Suquamish Wellness Clinic	Bremerton Housing Authority	Safe Harbor Recovery Center	Jumping Mouse	Clallam Public Health	Quileute Health Ctr	North Olympic Health Network
West Sound Treatment	Kitsap Community Resources	Kitsap Children Clinic	Jefferson Public Health		OPHCC	West End Outreach	Jamestown Family Health Center
United Way Kitsap	Group Health/Kaiser				First Step	Makah Health Center	Peninsula Behavioral Health
Kitsap Area Agency on Aging					Serenity House	Lower Elwha Clinic	
					Olympic Area Agency on Aging		
					Olympic Community Action Program		
					Peninsula Housing Authority		
Payers		Payers			Payers		

**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.**

Consistent with its 2017-18 Strategic Goals, OCH is evaluating each project to determine for sustainability beyond the Demonstration. Specifically, OCH included the following 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. These elements are essential to achieving sustainable, value-based care beyond the Demonstration.

OCH's commitment to sustainability is evident in current deliberations over the inclusion of two projects in the OCH portfolio. Despite strong proposals from provider partners, OCH cannot certify that either project can be sustained once the Demonstration ends.

**OCH and the MCOs**

OCH is meeting with senior leadership of each MCO to discuss mutually beneficial VBP and Domain 1 goals to sustain Demonstration transformation and a shared work plan to get there.

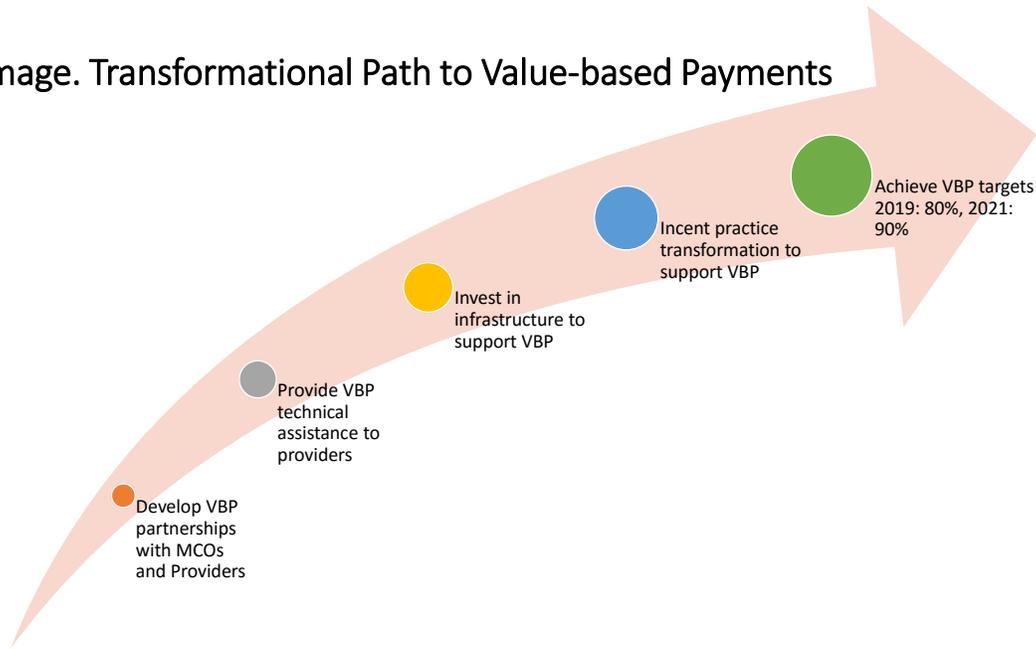
**Several additional strategies under development**

- Requiring clinical providers to accept VBP TA from MCOs 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

**Table. Sustainability Characteristics of Project Proposals (April-May 2017)**

	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 (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

**Image. Transformational Path to Value-based Payments**



**Attachments**

Olympic Community of Health – Transformation Project Planning – Attachment:

- A – List of partnering organizations committed to implementing projects
- B – List of organizations partnering on Bi-Directional Integration and Primary Care Transformation (Hub) (2A)
- C – List of organizations partnering on Bi-Directional Integration and Primary Care Transformation (TCPI) (2A)
- D – List of organizations partnering on 3 County Coordinated Opioid Response Project (3A)

## 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	
<input checked="" type="checkbox"/>	A. Copies of charters for committees and workgroups that outline purpose, members, responsibilities, and scope.
<input checked="" type="checkbox"/>	B. Conflict of interest policy.
<input checked="" type="checkbox"/>	C. Draft or final job descriptions for all identified positions or summary of job functions.
<input checked="" type="checkbox"/>	D. Short bios for all staff hired.
Tribal Engagement and Collaboration	
<input checked="" type="checkbox"/>	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.
<input checked="" type="checkbox"/>	B. Bio(s) for the representative(s) of ITUs seated on the ACH governing board. <i>If you do not have an ITU representative on the governing board, please attach a description of the efforts made to fill the seat.</i>
Community and Stakeholder Engagement	
<input checked="" type="checkbox"/>	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).
<input checked="" type="checkbox"/>	B. List of all public ACH-related engagements or forums for the last three months.
<input checked="" type="checkbox"/>	C. List of all public ACH-related engagements or forums scheduled for the next three months.
<input checked="" type="checkbox"/>	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.
<input checked="" type="checkbox"/>	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	
<input checked="" type="checkbox"/>	A. Bio or resume for the Chief Financial Officer (CFO) or equivalent person responsible for ACH financial functions.
<input checked="" type="checkbox"/>	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.
<input checked="" type="checkbox"/>	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.
<b>Clinical Capacity</b>	
<input checked="" type="checkbox"/>	A. Current bios or resumes for identified clinical and workforce subject matter experts or provider champions. <i>Re-attach bio or resume even if previously provided in Phase I Certification. ACHs should also include any additional bios or resumes, if applicable.</i>
<b>Data and Analytic Capacity</b>	
None	
<b>Transformation Project Planning</b>	
<input checked="" type="checkbox"/>	A. Initial list of partnering providers or categories of partnering organizations interested in or committed to implementing projects.

<b>Recommended Attachments</b>	
<b>Theory of Action and Alignment Strategy</b>	
<input checked="" type="checkbox"/>	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. <i>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.</i>
<b>Governance and Organizational Structure</b>	
<input checked="" type="checkbox"/>	E. Sector representation policy describing any agreements or expectations for decision-making body members to communicate with and engage partners within a defined sector.
<input checked="" type="checkbox"/>	F. Revised visual/chart of the governance structure, if there have been significant changes since Phase I Certification.
<input checked="" type="checkbox"/>	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.
<b>Tribal Engagement and Collaboration</b>	
<input type="checkbox"/>	C. Statements of support for ACH certification from every ITU in the ACH region.
<b>Community and Stakeholder Engagement</b>	
None	
<b>Budget and Funds Flow</b>	
None	
<b>Clinical Capacity</b>	
None	
<b>Data and Analytic Capacity</b>	
None	
<b>Transformation Project Planning</b>	
None	