



Section 1 Project Plan

November 16, 2017

Purpose of this document

This document presents the approach the Olympic Community of Health (OCH) is pursuing to transform the Medicaid delivery system in Clallam, Jefferson, and Kitsap counties. The region shares a vision of a health care delivery system that facilitates:

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

The following project proposal reflects our best thinking of the required upfront investments and subsequent scope of work to drive towards these objectives. Our work is guided by a recognition that true system reform is not advanced by a series of projects, but by motivated providers willing to transform their practice, integrate new workflows, improve health equity, and forge new partnerships all in service to our community.

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REGIONAL HEALTH NEEDS INVENTORY

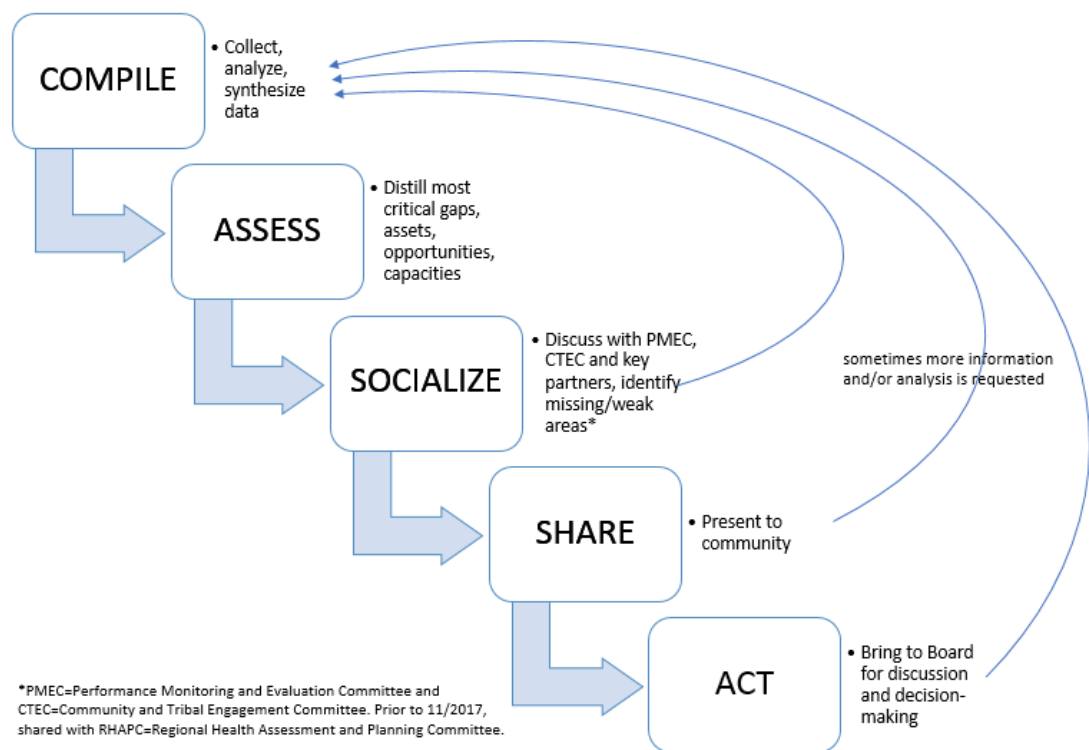
Use of Data to Inform Project Selection and Planning

Olympic Community of Health's (OCH) regional health assessment and planning efforts are based on a foundation of historical data-driven health improvement planning in Clallam, Jefferson and Kitsap Counties. OCH leveraged that foundation using previous and new data sources to create a regional health data repository to understand the context of and complexities within our region and identify the greatest regional health needs and inform project selection and planning. OCH will use the data repository to continue to inform the planning, implementation and monitoring needs of projects. OCH compiled baseline data for all available Toolkit measures to identify the greatest areas of opportunity.

The Stepwise Logic Chain for Data-Informed Decision Making (Figure 1) depicts the detailed steps OCH undertakes to turn data into action. The first two steps in the chain are primarily done by OCH staff. The third step, socialization, involves in-depth data discussions with the members of OCH performance monitoring and evaluation and community/tribal engagement committees and partners, a critical precursor to broader sharing with the community and decision-makers. During the socialize, share, and act steps, OCH identifies additional needs for information and analyses, bringing the logic chain back to step 1.

Figure 1.

Stepwise Logic Chain for OCH Data-Informed Decision Making



Data Sources to Inform Decision-making

The diverse range of data sources OCH has relied upon are outlined in table 1 below in a snapshot that includes 3 columns of the *OCH Data Resources Repository*. The *Repository* is an Excel worksheet containing key information about each data source to track availability, timeliness, contents, format, etc. OCH uses these data resources to assess regional socioeconomic conditions, health needs, and disparities and inform project selection and planning. The full table includes additional columns: sort category, title,

geography, population, sub-groups, contents, date of data, source, date received, format, access, and web interactive site. The “sort cat” column broadly categorizes data sources, including those provided by partners such as public health and early learning, letter of intent/request for proposals (LOI/RFP) participating providers and community based organizations.

Additional partner organization sources and contributions include:

- FQHC partners have shared their regular MCO performance dashboards with OCH;
- OCH surveys of partnering clinical and community-based organizations;
- Practice Transformation Hub assessments conducted with 24 primary care and behavioral health providers via a collaborative agreement with Qualis/regional Department of Health Practice Transformation Hub; and
- hospital-based needs assessments conducted by a facilities consultant.

Table 1.

OCH Data Resources Repository Update: 11-15-17			
sort cat	title	geography	source
Access	Health Professional Shortage Areas/HPSA	census tract, tribe, county	WA DOH/ HRSA
CHA	Community Health Assessment and Health Improvement Plan	Kitsap, WA	Kitsap Community Health Priorities
CHA	Community Health Assessment	Clallam, WA	Clallam County
CHA	Community Health Assessment and Health Improvement Plan	Jefferson, WA	Jefferson County
CHA	Comprehensive Community Assessment	Kitsap County, state	Kitsap Interagency Coordinating Council; Head Start/ECEAP Partnership
CHA	Community Needs Assessment	Clallam and Jefferson counties, state	Olympic Community Action Programs
CHA	Community Needs Index	zip code, county, state	http://cnl.doh.wa.gov/Truven_Health_2014_Source_Notes_Community_Needs_Index.pdf
CHA	Kitsap County Core Public Health Indicators	Kitsap, state	kitsappublichealth.org
Client	Current Client Counts and Characteristics of Persons Served Jointly by HCA-DSHS	regional	DSHS via HCA AIM, box.com
Client	RDA Cross-Agency Measures	region, state	DSHS via HCA AIM, box.com
Client	RDA Measure Decomposition	region	DSHS via HCA AIM, box.com
Client	local provider patient counts and subpopulations	provider level	personal communication from local providers, healthcare and community based organizations
Client	PRISM scores	county, region, state	HCA AIM via email
Common meas	WA Health Alliance, Community Checkup	regional, county	WA Health Alliance web
Common meas	Healthier WA dashboard	state, region, county	HCA from P1 claims; BRFSS; PRAMS; WIIS (immunizations)
Demo	American Community Survey (ACS), Census	county, city, school district, census tract	american fact finder online
Dental	Dental Services Reports	region, state	HCA from WDSF on box.com
Dental	Medicaid Dental Access	county, state	HCA and ARCORA foundation
Dental	Oral health ED visits	county, region, state	HCA AIM on box.com
ED	ED utilization by facility	hospital by region	HCA on box.com
Inpt	Hospital Census and Charges by Payer	hospital	DOH CHARS on box.com; DOH CHAT
LOI/RFA	Local clinical and non-clinical provider patient counts, disease prevalence	provider level	OCH regional clinical and non-clinical providers
MCO	MCO coverage by county	region x county	HCA
PH	WA Tracking Network	varies by measure	WA DOH online
PH	Risk and Protection Profile for sub use prevention	county, school district	DSHS RDA online
PH	Community Health Assessment Tool (CHAT)	varies by measure: regional, county, zip, census tract	WA DOH Center for Health Statistics, online
PH	Healthy Youth Survey (HYS)	county, state	askhys.net; KPHD database via DOH
PH	Behavioral Health Risk Factor Surveillance System (BRFSS)	zip code, county, state	KPHD database from DOH
PH	Birth Certificate Database/Vital Statistics	zip code, county, state	KPHD database from DOH
PH	Death Certificate Database/Vital Statistics	zip code, county, state	KPHD database from DOH
PH	Opioid Related Death Certificate Database/Vital Statistics	zip code, county, state	KPHD database from DOH
Provider	Long Term Care providers	city, county, state	DSHS, Aging and Long Term Support Administration
Provider	Provider Reports	county	box.com from HCA
Provider	Provider contact info		box.com from HCA
RHNI	RHNI Phase 3 4.25.17.xlsx	region	HCA
Rx	All Prescriptions Report	County	box.com from HCA
Wkforce	WA State Health Workforce Sentinel Network	region, state	UW, Center for Health Workforce Studies
Wkforce	WA State Health Workforce reports	region, state	UW, Center for Health Workforce Studies

Medicaid Beneficiary Population Profile

The OCH region is home to approximately 84,000 Medicaid beneficiaries (excluding those dually-eligible for Medicare and Medicaid), about 23% of the region's population. The regional Medicaid beneficiary rate is lower than the state average and varies by county – highest at 30% in Clallam County, 25% in Jefferson and 21% in Kitsap County. (Figure 2) (HW Dashboard 10/1/15-9/30/16) The distribution of Medicaid beneficiaries in the OCH region is as follows: nearly two-thirds reside in Kitsap County, another quarter in Clallam and the remaining 9% in Jefferson County. (Figure 3)

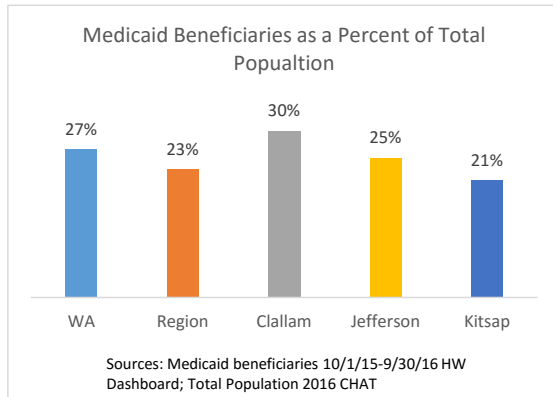
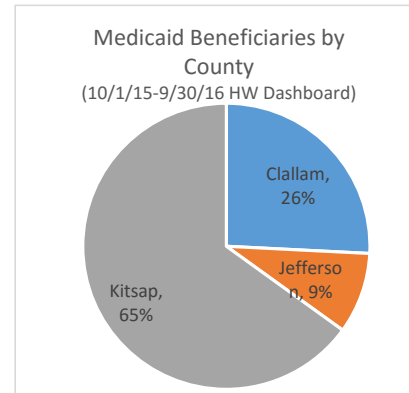
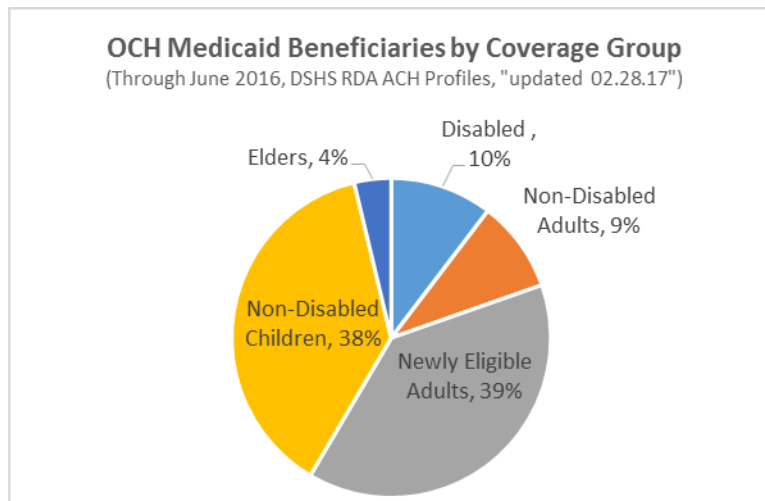
Figure 2.**Figure 3.****Figure 4.**

Figure 4 shows the distribution of OCH Medicaid beneficiaries (including duals and third party) by coverage group as of June 2016. Following implementation of the Affordable Care Act, 39% of OCH Medicaid beneficiaries, nearly 31,000 individuals classified as “new adults,” became eligible for coverage. The second largest coverage group is Non-disabled children, nearly 30,000 individuals. There are over 8,000 individuals in the Disabled group (10%) and over 7,000 are Non-Disabled adults (9%), individuals who continue to qualify under pre-Expansion eligibility rules: Categorically Needy (CN) Family Medical adults and CN Pregnant Women. The smallest group of Medicaid beneficiaries are about 3,000 Elders age 65 and older.

Just over half of OCH Medicaid beneficiaries are female. Thirty-six percent of OCH Medicaid beneficiaries are children age 0-17 compared to 20% in the total population. There are more adult beneficiaries in OCH compared to WA, 61% compared to 55%. (Figure 5)

Figure 5.

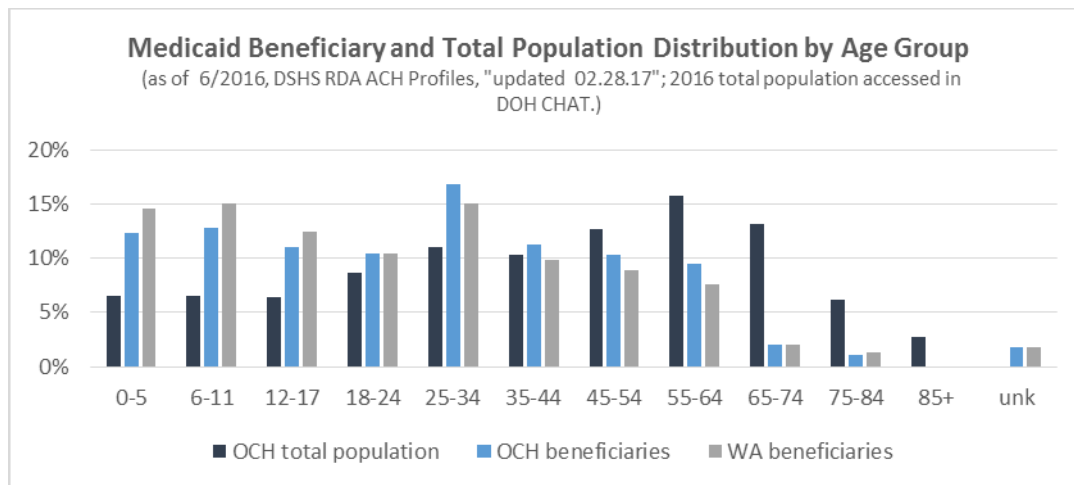
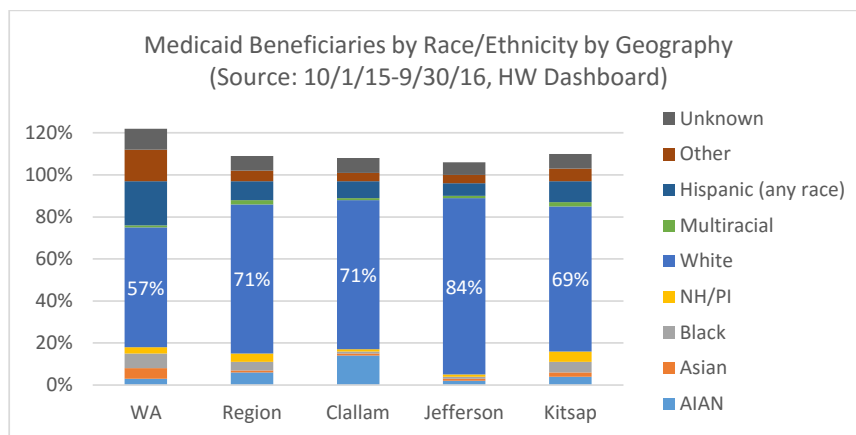


Figure 6 presents the distribution of Medicaid beneficiaries by race/ethnicity by place. Seventy-one percent of OCH region Medicaid recipients are White compared to 57% in WA. American Indian/Alaska Natives (AI/AN) make up 12% of Medicaid recipients in Clallam and 6% in the region, which is double the state average. Nine percent of OCH region Medicaid recipients are Hispanic, less than half the state average (21%).

Figure 6.



Geographic, Demographic and Socioeconomic Characteristics, and Prevalence of Adverse Social Determinants of Health

Health is highly influenced by social and economic factors; OCH has identified addressing these factors as foundational to making progress on its strategic priorities. (Theory of Action, Table 1)

The Community Need Index (CNI) is a tool to determine geographic areas with the greatest healthcare needs based on socioeconomic factors, indicators of barriers in the following categories: income, culture, education, insurance, and housing. CNI scores range from 1, lowest need, to 5, highest need. CNI scores based on 2015 data by OCH county are as follows: Clallam 3; Jefferson 2.7; Kitsap 2.8 - a score of 2.6-3.3 is considered mid-need. Figure 7 is a map of CNI scores by OCH zip code. The Port Angeles and areas to the west are the darkest areas or areas of highest need while the other area of higher need (dark orange) is Bremerton in Kitsap County. (accessed [here](#))

Figure 7.

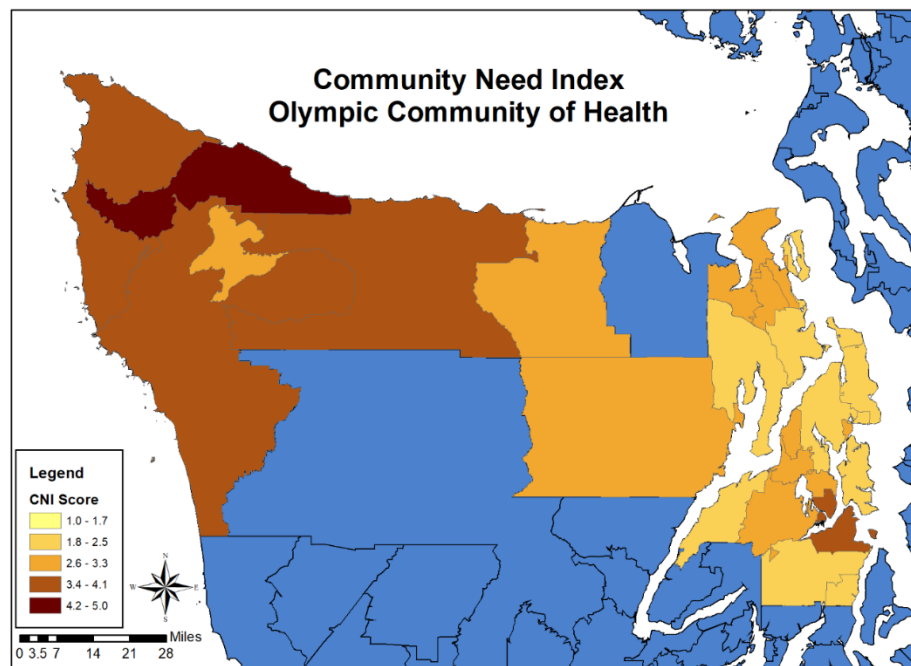






Table 2 highlights several key socioeconomic characteristics of the region and disparities by geography and within sub-populations. In summary, high school graduation rates differ by county and within county, disparities exist by income and race. Clallam and Jefferson have lower median income and higher unemployment compared to Kitsap; all three counties lag behind the WA average. Across the region, more than 1 in 3 households struggles to pay for housing. While OCH has lower rates of prisoners and arrests compared to WA, disparities exist by county.

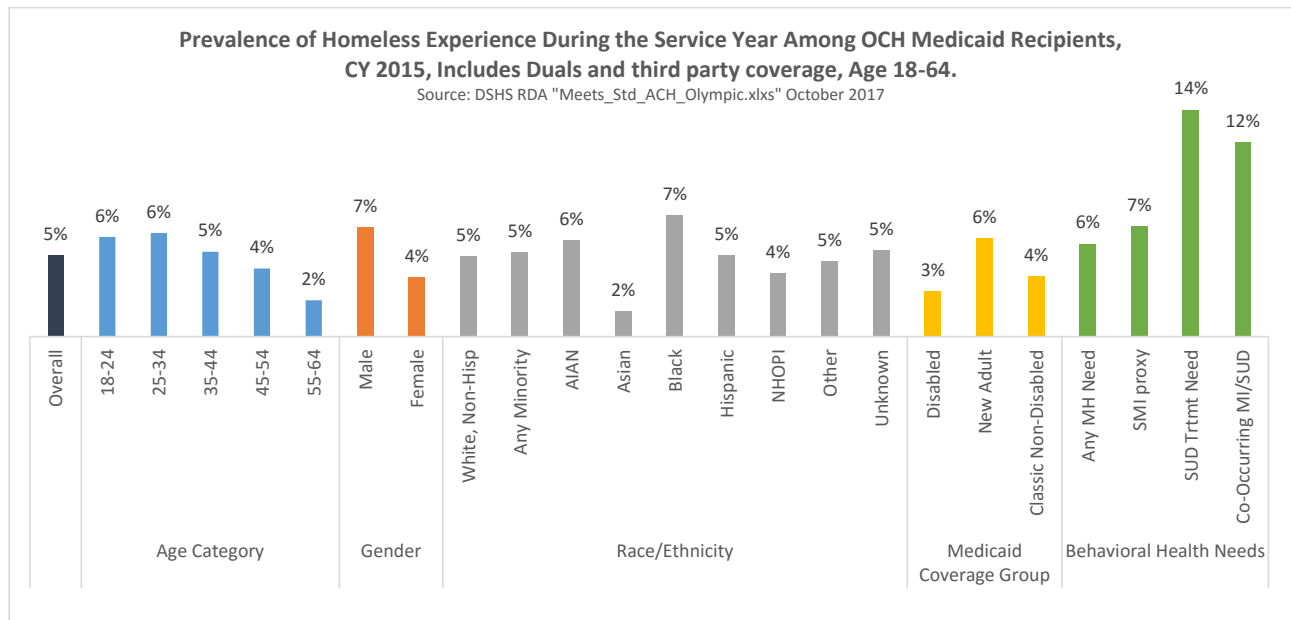
Table 2. Indicators of social and economic conditions and key disparities by geography and sub-population

Indicator	Data by place	Geographic Disparity	Sub-population Disparity
High school graduation rate (2015-16)*	% 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 (2015)*	\$ bars: W,C,J,K 	\$19,000 gap between Clallam and Kitsap	\$11,000-\$22,000 gap between AIAN and White across counties \$24,000 gap between Black/AA and White in Kitsap County Male householders \$2,500-\$15,500 above female householders across counties
Unaffordable housing (2008-12)*	% bars: W,R,C,J,K 	35-37% of households spend at least 30% of income on housing	Data not available
Unemployment (2016)**	% bars: W,C,J,K 	6-8% OCH unemployment rate compared to 5% in WA	Across 3 counties, AIAN rate (17%-21%), Black/AA (12%-33%) both approximately 2+ times the rate among Whites Approx. 2% higher among males over females across counties

Indicator	Data by place	Geographic Disparity	Sub-population Disparity
Prisoners in State Correctional Systems (18+) (2015)^	Rate bars: W,R,C,J,K 	County rate range 1.8 to 6.4	Data not available
Total arrests of adolescents (2015)^	Rate bars: W,R,C,J,K 	County rate range 14.6 to 42.6; region better than state	Data not available
Property crime arrests, age 10-17 (2015)^		County rate range 3.3 to 7.8; region better than state	Data not available
Property crime arrests, adults (2015)^		County rate range 2.5 to 8.5; region better than state	Data not available
Note: W=WA; R=OCH region; C=Clallam; J=Jefferson; K=Kitsap Sources: *HCA AIM RHNI phase 3, 04.25.17; **Bureau of Labor, Accessed here , August 2017; ^DSHS Risk Profiles, Accessed at: here , August 2017			

Lack of adequate, stable housing is a major adverse social influence of health, and for many individuals with complex chronic physical and behavioral health conditions, homelessness or housing instability can be the most significant barriers to health care access, often resulting in excessive use of expensive emergency department, inpatient treatment, and crisis services. Figure 8 below shows prevalence of homeless experience among OCH Medicaid beneficiaries, 5% were homeless for at least one month during CY 2015. Prevalence of homeless experience was higher among younger adults, males, AI/AN and Blacks, adults in the new coverage group and dramatically higher among those with substance use disorder (SUD) treatment need or co-occurring mental health and SUD.

Figure 8.



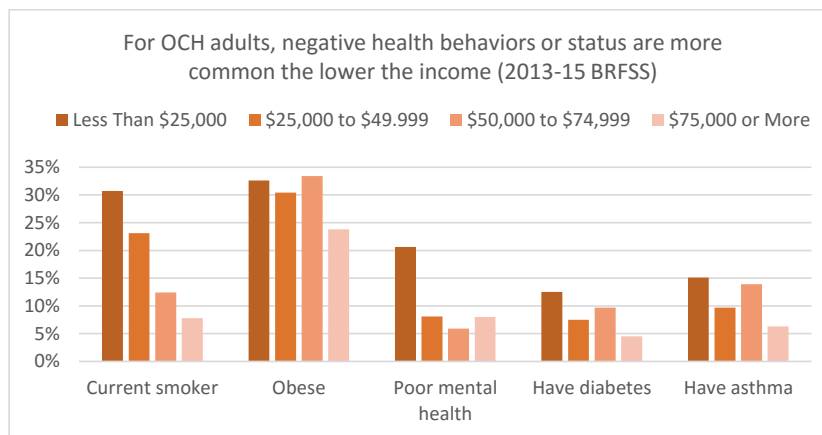
Medicaid Beneficiary Population Health Status

What follows are analyses of selected data related to measures of health among OCH Medicaid beneficiaries. OCH will continue quests for quality data from reliable and credible sources to assist in answering key questions about as well as monitor changes in health status.

Similar to the population as a whole, the leading causes of death among OCH Medicaid recipients in 2015 were cancers and cardiovascular diseases, together comprising nearly half of all deaths. Other chronic diseases (liver-related and diabetes) made up an additional 13% of deaths. Notably, accidents were the 3rd leading cause and suicide was the 5th leading cause of death, 1 in 5 deaths annually. (HCA AIM RHNI phase 3, 4.25.17)

The critical importance of the work outlined in this proposal is underscored by the data presented in Figure 9. Among OCH adults, negative health behaviors or health status are more common among those of lower incomes. Rates of unhealthy behaviors and poor health status increase as income decreases – the poorest adults have the poorest health. This information is foundationally important to the OCH approach and guides our vision for selecting specific target populations for projects. While those at lower incomes are at higher risk, there are sub-groups within lower income at even higher risk, indicating disparities within disparities. Understanding these drivers is critical to targeting intervention strategies to those who stand to benefit the most.

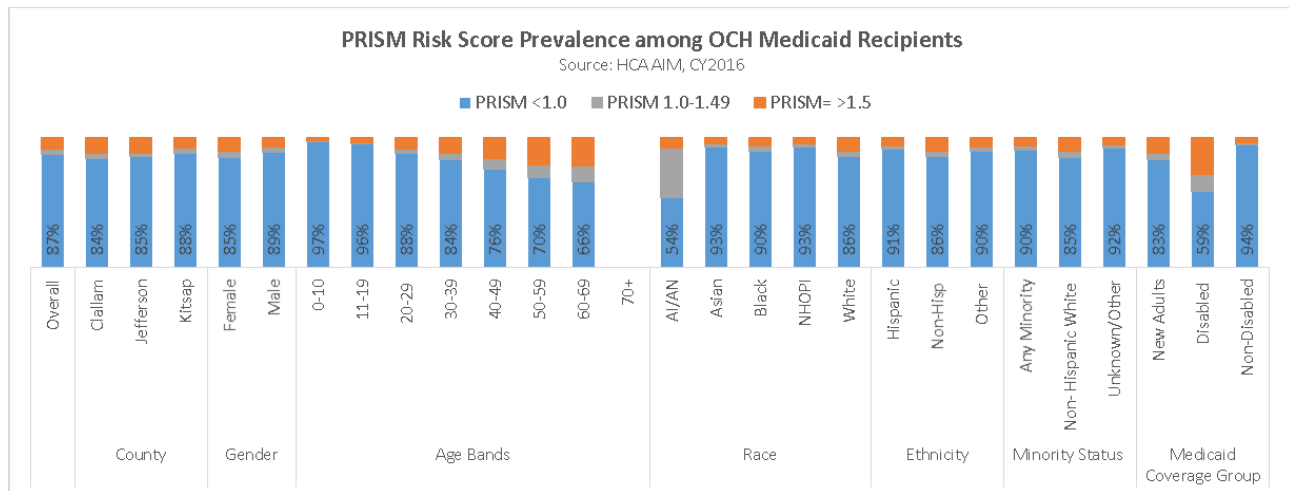
Figure 9.



The PRISM risk score, also known as the Future Medical Expenditure Risk Score, provides an estimate of future medical cost and the risk of an individual experiencing an event in the future based on their characteristics in the past. The PRISM risk score can be used to triage a population of interest so that resources can be focused on those with the highest expected medical costs in the next 12 months. Among OCH Medicaid beneficiaries, 87% have a risk score of 1.0 indicating average risk, 4% have a score of 1.0-1.49 and 9% have a score of 1.5 or greater, a risk of future medical costs of 50% above average. (Figure 10)

The distribution of risk scores within OCH counties indicates a higher proportion (12%) of individuals with risk scores of ≥ 1.5 in both Clallam and Jefferson compared to 8% in Kitsap. By gender and age, females have higher risk compared to males and risk increases with age. Among race groups, American Indian/Alaska Natives have substantially higher risk, 38% with a risk score of 1.0-1.49 and an additional 7% at ≥ 1.5 . Non-Hispanic Whites are the next highest risk group by race, 4% at 1.0-1.49 and 10% at ≥ 1.5 . Within Medicaid coverage type, disabled have substantially higher risk, 13% with a score of 1.0-1.49 and 28% at ≥ 1.5 .

Figure 10.

**Chronic Disease Including Behavioral Health**

Chronic disease prevalence based on data provided by the HCA from claims and encounters indicates nearly 1 in 4 OCH Medicaid recipients has at least 1 chronic condition. Prevalence by disease type ranges, notably over 17,000 or 1 in 5 recipients has both a mental health (MH) and at least one chronic condition. (Figure 11)

Figure 11.

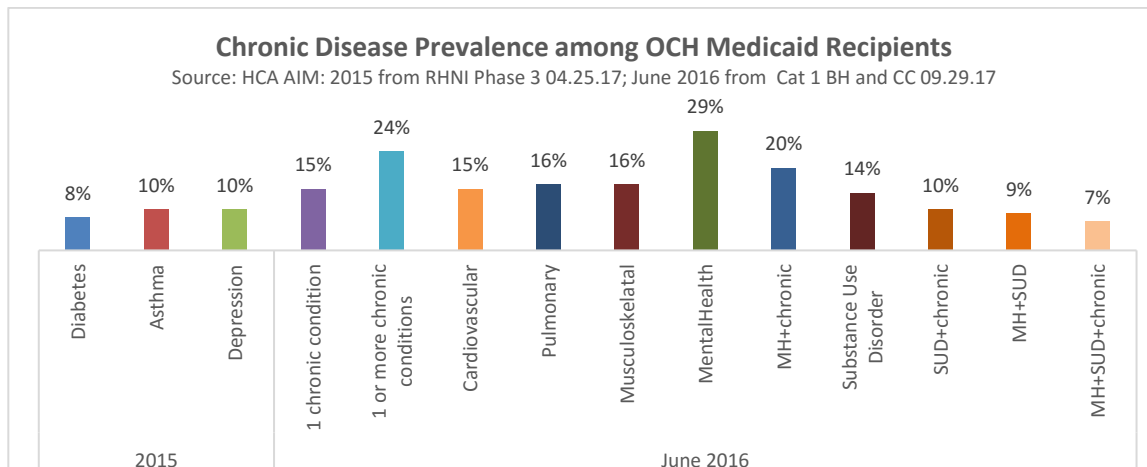
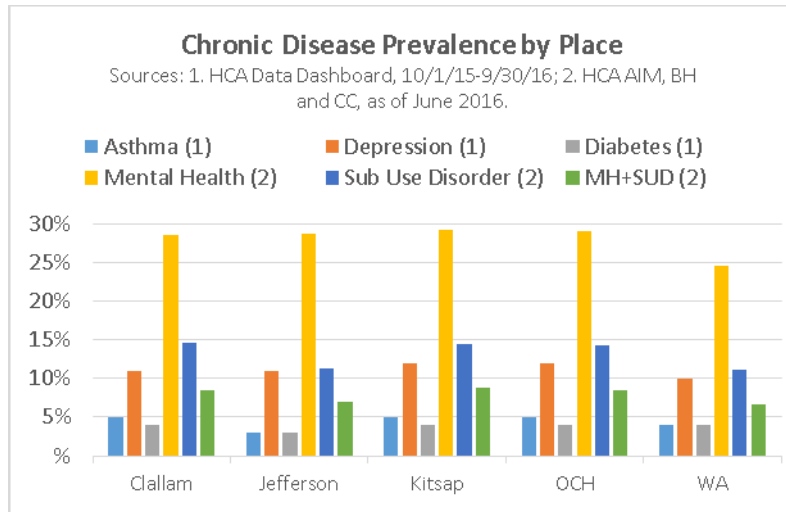


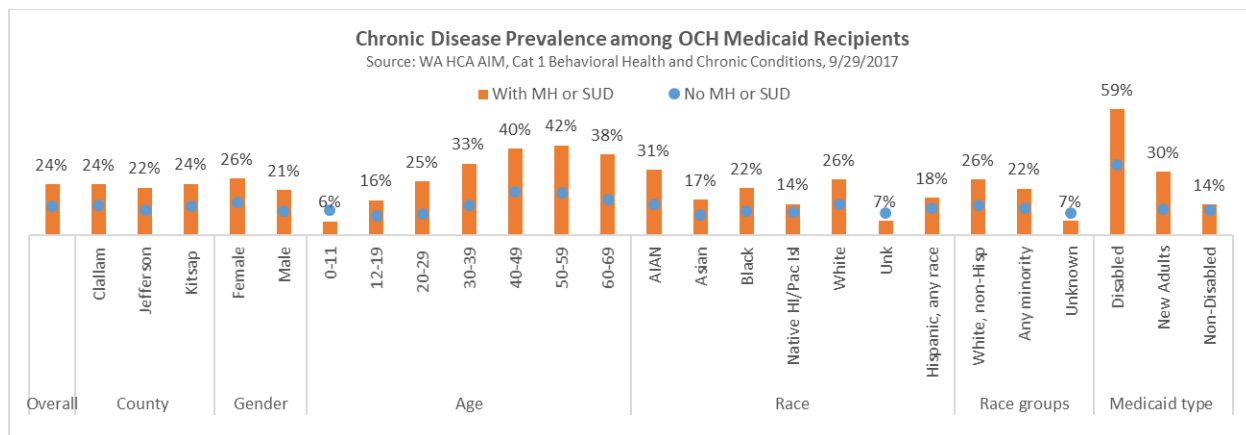
Figure 12 shows variation in chronic disease prevalence across OCH counties and OCH region and state averages. Chronic disease rates are relatively comparable by county, varying by two percentage points at most with the exception of substance use disorder (SUD) which is 4% lower in Jefferson compared to Clallam and Kitsap. The regional average is the same as the state for diabetes and above the state as follows; 1% for asthma, 2% for depression and MH+SUD, 3% for SUD, and 4% for MH. The most striking differences by demographic group are among American Indian/Alaska Natives who have the highest rates of mental health, substance use disorder and comorbid mental health and substance use disorder. Chronic disease rates are 2.5 to 13 times higher among those with Medicaid coverage group of 'disabled' compared to non-disabled. (HCA AIM Cat 1 BH and CC 09.29.17, as of June 2016)

Figure 12.



Among all OCH Medicaid beneficiaries, the prevalence of chronic disease is nearly double for those with MH and/or SUD (13% vs 24%). (Figure 13) Increased rates of chronic disease among individuals with MH or SUD are pervasive across demographic groups with only two exceptions, children age 0-11 and unknown race (presented in both race and race groups). Highest rate differences (at least twice as high) are among adults age 20-69 (of note, highest difference is among those age 20-29), AI/AN, and new adult coverage type.

Figure 13.



Opioid Use

The use and abuse of opioids is a critical and complex health issue in the OCH region affecting beneficiaries, families and the greater community. In 2016, 14% of OCH Medicaid beneficiaries with no cancer diagnosis history had at least one opioid prescription claim compared to 12% in Washington State. (HCA AIM RHNI Phase 3, 4.25.17, FY 2016) Of those, about 1 in 5 were heavy users or chronic users, slightly more had a diagnosis of opioid dependence or abuse; all rates are similar to the state average. (Figure 14) Of those Medicaid opioid users with a diagnosis of opioid abuse/dependence, about 1 in 8 participated in Medication Assisted Treatment with Buprenorphine, above the state average, while only 1 in 25 were treated with Methadone, four times below the state average (Figure 15).

Figure 14.

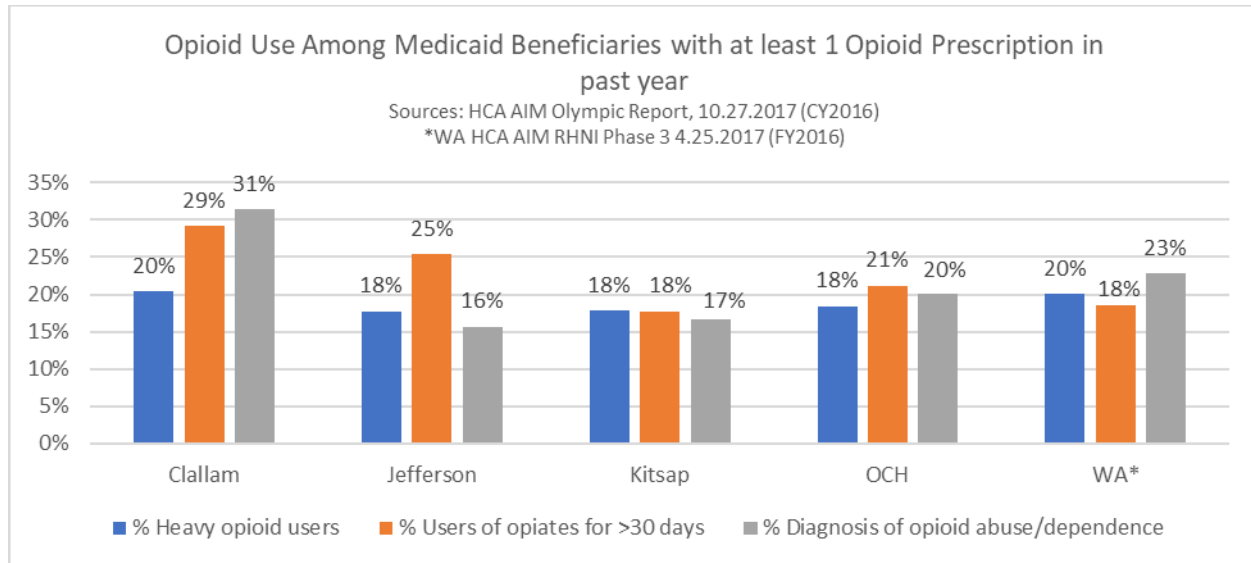
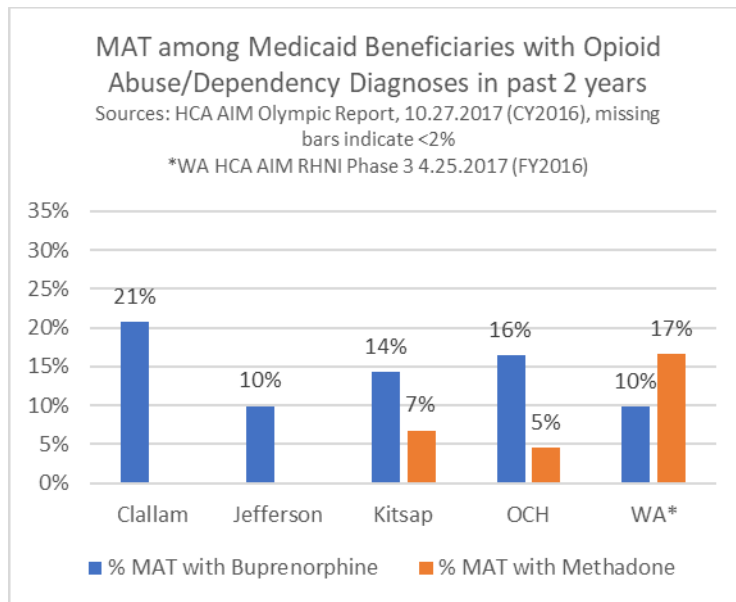


Figure 15.



The proportion of OCH Medicaid beneficiaries with an opioid prescription in the past year and no cancer history are classified as:

- heavy users (Figure 16, blue bars), is higher among older adults and relatively the same across gender and race groups
- chronic users (Figure 17, orange bars), increases with age such that the rate is 6 times higher among those age 60-69 compared to those 20-29; highest rates among AI/AN-non-Hispanic (25%) and White-NH (22%); rates are similar across gender
- with a diagnosis of dependence/abuse (Figure 18, grey bars), rate is 1.5 times higher among males; decreases with age (not counting those 10-19 who have the lowest rate of any sub-group) such that the rate is 2 times higher among adults age 20-29 compared to those 60-69; highest rates among

AI/AN-NH (46%) and White-NH (23%), AI/AN-NH is 3-4 times higher and White-NH is 1.5-2 times higher than Black-NH, Hispanic and other/unknown race.

Figure 16.

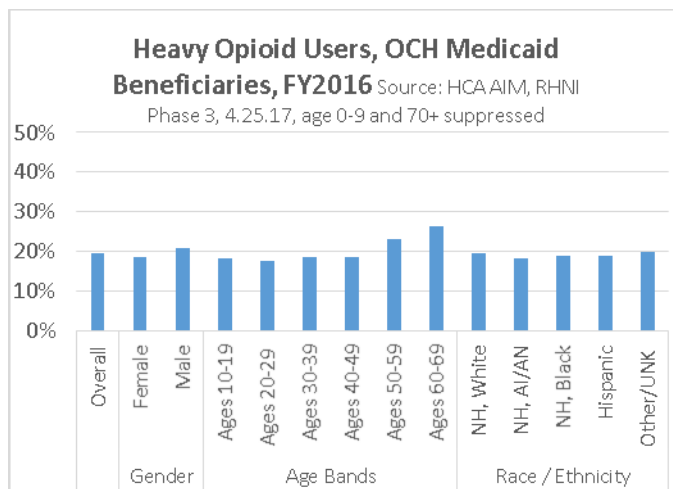


Figure 17.

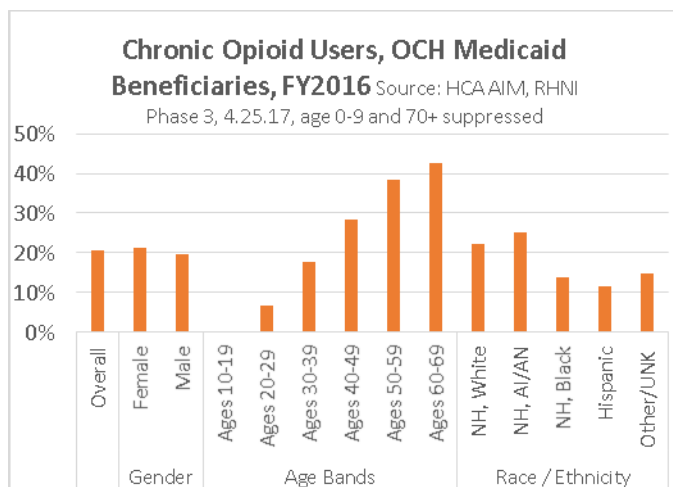
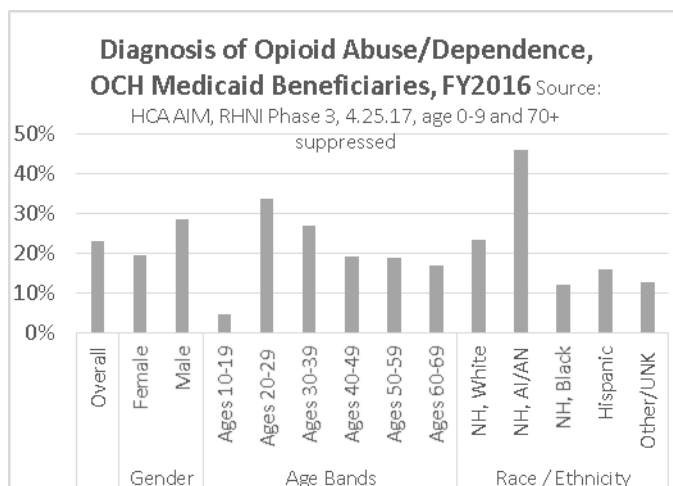


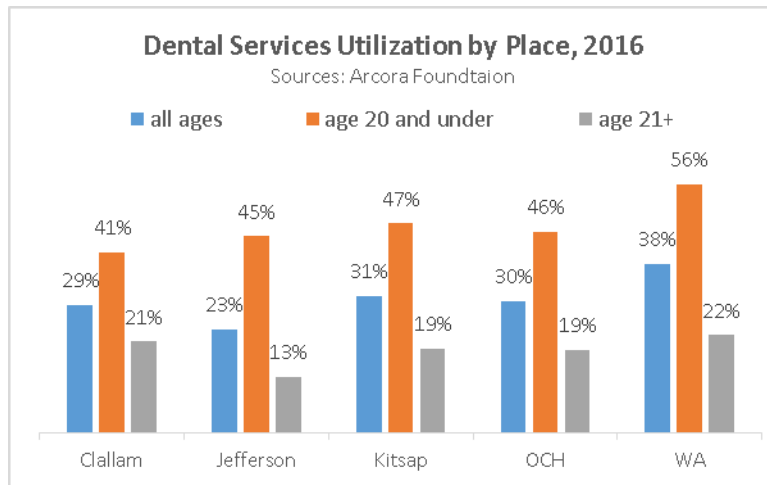
Figure 18.



Oral Health

We have limited information to characterize the scope of oral health status among Medicaid beneficiaries; however, the information we do have indicates a regional crisis in access across the lifespan. Dental services utilization in the OCH region is quite low, for all ages, 30% compared to 38% statewide; age 20 and under, 46% compared to 56%, and adults age 21+ 19% compared to 22%. (Figure 19) Review of rates by county identifies important differences in utilization – overall for all ages (blue bars), Jefferson has the lowest rate, less than 1 in 4 eligible individuals; Clallam has lowest rate for children (orange bars); and Jefferson has lowest rate for adults (grey bars).

Figure 19.



Oral health status among Kitsap County and WA State adults is marked by income disparities – those with lower incomes have lower reported access and insurance coverage and higher rates of disease and pain. (Table 3) (BRFSS, 2011-14)

Table 3. Kitsap County and WA State Oral Health Indicators, 2011-2014

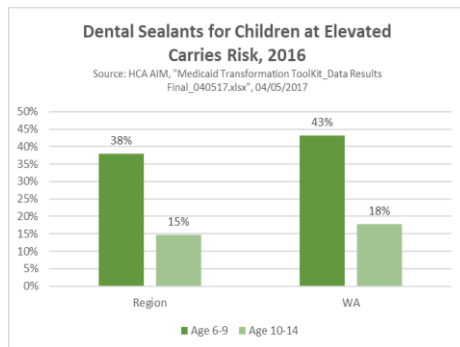
	Annual Income <\$50,000		Annual Income >\$50,000	
	Kitsap	WA	Kitsap	WA
Less than one year since last dental visit	56%	54%	78%	81%
No teeth lost to disease/decay	49%	52%	72%	69%
Never had painful aching in mouth in past year	55%	50%	58%	61%
Have any insurance that pays for some or all routine dental care	55%	48%	82%	82%

Many individuals seek oral health care in the emergency department setting. Table 4 shows data for 2016 OCH Medicaid beneficiaries – there were nearly 2,200 ED visits related to oral health, 4% of all ED visits. The distribution by oral health issue (dental caries, disease of the pulp/periapical tissues, and other disorders of teeth/supporting structures) for OCH was similar to the state average but differed by county.

Table 4. Oral Health related Emergency Department visits, 2016. HCA AIM Custom Report, 10262017

	Clallam	Jefferson	Kitsap	OCH	WA State
Count of Oral Health related ED visits	644	103	1,415	2,162	
Oral Health Related as % of all ED	5%	3%	3%	4%	3%
Dental caries	16%	22%	11%	13%	13%
Diseases of pulp and periapical tissues	30%	26%	46%	40%	36%
Other disorders of teeth and supporting structures	54%	51%	43%	47%	51%

Other oral health data indicate opportunities for prevention and early intervention among children to establish a lifelong trajectory of good oral health. Little or no primary caries prevention interventions are happening (or being billed) as part of primary care visits and fewer than 1 in 2 children ages 6-9 and 1 in 5 children ages 10-14 at elevated risk for caries are getting dental sealants. (Figure 20)

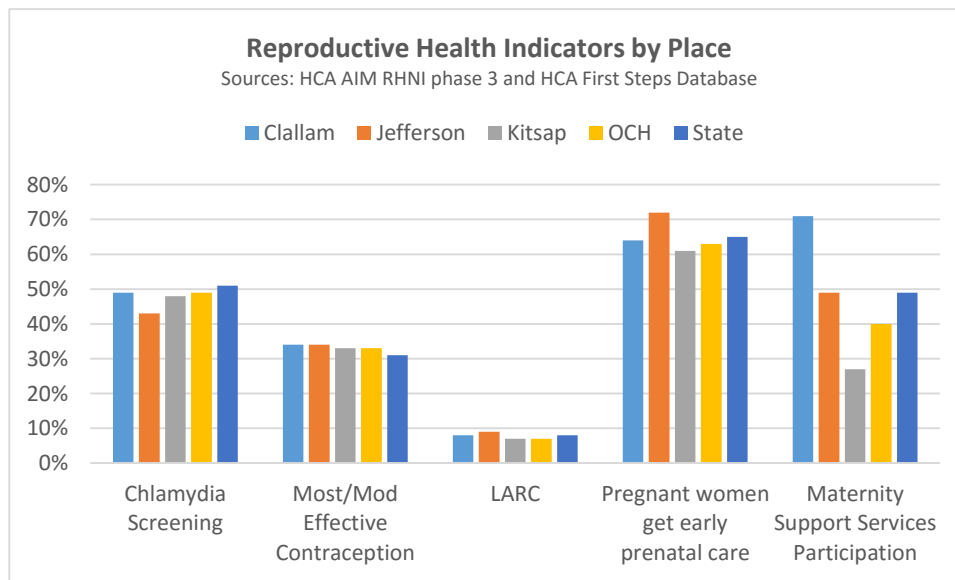
Figure 20.

Reproductive and Maternal and Child Health

The OCH region has over 33,000 children receiving Medicaid (HW data dashboard 10/1/15-9/30/16), nearly 15,000 women of reproductive age (2015, HCA AIM, RHNI phase 3 4.25.17), and over 1,600 babies born to women receiving Medicaid (2015, HCA First Steps Database accessed [here](#)).

On several key reproductive health indicators, (Figure 21) OCH performs below the state average - Chlamydia screening, access to long-acting reversible contraception (LARC), and early prenatal care rates. Within OCH counties, Jefferson has lower rates of Chlamydia screening and higher rates of early prenatal care. One indicator with particular geographic disparities is participation in Maternity Support Services, fewer than 30% of Kitsap eligible women, nearly half in Jefferson and over 70% of women in Clallam County. Across the region and state, access to LARC is low.

Figure 21.



Child health indicator regional data (Table 5) indicate that while nearly 9 in 10 children access primary care, only 6 in 10 children 3 to 6 years of age receive regular well-child checks. Access to primary care is consistent across geographies with a range of 5% across age and race groups. Well child visit rates for children ages 3-6 are lower in Clallam and Jefferson counties and range from 49% to 62% across race groups. OCH has lower rates of child immunizations compared to the state.

Table 5. Child Health Indicators and key disparities by geography and sub-population

Indicator	Rates	Rates by place	Geographic Disparity	Sub-population Disparity
Children access primary care (all ages)*	W: 89% R: 89% C: 88% J: 88% K: 89%		None	Range across race groups: 86-91%;
				Range by age group: 12-24 months= 94%
				25 mths-6 years: 86%
				age 7-11= 91%
				age 12-19= 90%
Well Child Visits age 3-6*	W: 61% R: 59% C: 55% J: 56% K: 60%		Clallam and Jefferson rates below Kitsap and WA average	Range across race groups 49-62%
				Rates vary greatly: One Kitsap FQHC reports 75% within one MCO; 981 well child visits in August 2017 alone
Child Combo 10 Immunizations^	W: 12% R: 10% C: 8% J: 8% K: 11%		All counties below WA; Clallam and Jefferson lowest	No data

Note: W- Washington State, R- OCH Region, C- Clallam County, J- Jefferson County, L- Kitsap County

*HW Dashboard, 10/1/15-9/30/16; ^HCA AIM RHNI phase 3, 4.25.17, 2016

Continuum of Healthcare Providers

The OCH region is served by a continuum of healthcare providers (Table 6): hospitals ranging from large to small, rural to urban, public to private; two federally qualified health centers; numerous primary care provider groups; tribal clinics. The services offered by these providers vary widely – medical, behavioral, oral health; and behavioral health clinics offering mental health or substance use disorder treatment services or both.

Table 6.

OCH Region Healthcare Providers		
Primary Service Area	Type	Organization Name
Clallam	behavioral health	Cedar Grove Counseling
Clallam	behavioral health	Olympic Personal Growth
Clallam	behavioral health	Peninsula Behavioral Health Services
Clallam	behavioral health	Reflections Counseling Services Group/SUD
Clallam	behavioral health	West End Outreach Services
Clallam	clinic	Bogachiel Clinic
Clallam	clinic	Clallam Bay Clinic
Clallam	clinic	Peninsula Children's Clinic
Clallam	clinic	Planned Parenthood Port Angeles Health Center
Clallam	fqhc	North Olympic Healthcare Network
Clallam	hospital	Forks Community Hospital
Clallam	hospital and clinic	Olympic Medical Center
Clallam	public health	Clallam County Health and Human Services
Clallam	public health	First Step Family Support Center
Clallam	tribal clinic	Lower Elwha Tribal Health Center
Clallam	tribal clinic	Makah Tribe
Clallam	tribal clinic	Quileute Tribe
Clallam and Jefferson	clinic	Jameson S'Klallam Family Health Center
Jefferson	behavioral health	Discovery Behavioral Health
Jefferson	hospital and clinic	Jefferson Healthcare
Jefferson	public health	Jefferson County Public Health
Kitsap	behavioral health	Agape
Kitsap	behavioral health	Kitsap Mental Health Services
Kitsap	behavioral health	Kitsap Recovery Center
Kitsap	behavioral health	WestSound Treatment and Recovery Services
Kitsap	clinic	Harrison Health Partners
Kitsap	clinic	Kaiser Permanente
Kitsap	clinic	Kitsap Children's Clinic
Kitsap	clinic	Kitsap Medical Group
Kitsap	clinic	North Kitsap Family Medicine
Kitsap	clinic	Northwest WA Family Residency
Kitsap	clinic	Planned Parenthood Bremerton Health Center
Kitsap	clinic	Silverdale Pediatrics Clinic
Kitsap	fqhc	Peninsula Community Health Services
Kitsap	hospital	CHI Harrison Medical Center
Kitsap	public health	Kitsap Public Health District
Kitsap	tribal clinic	Port Gamble S'Klallam Tribe
Kitsap	tribal clinic	Suquamish Tribe

Table 7 includes the number of Medicaid beneficiaries and claims by age group (0-17 and 18+) for major OCH Medicaid healthcare provider entities and service category for outpatient and professional services. *(Note: the counts of beneficiaries provided by HCA in table 7 do not match counts generated by our providers. We are only including the HCA generated counts in this table so that all data come from a single source.)*

Table 7. Outpatient Institutional and Professional Claims and Number of Beneficiaries Served by OCH Region Major Medicaid Providers, 2016

		OUTPATIENT INSTITUTIONAL						OUTPATIENT PROFESSIONAL					
		# Beneficiares			# Claims			# Beneficiares			# Claims		
		0-17	18+	Total	0-17	18+	Total	0-17	18+	Total	0-17	18+	Total
Hospitals and Rural Health Clinics	CHI Harrison	3,796	11,420	15,216	7,508	35,082	42,590	2,173	5,379	7,552	3,435	12,229	15,664
	Forks Community Hospital	209	887	1,096	354	2,784	3,138	124	581	705	198	1,301	1,499
	Jefferson Healthcare	694	2,821	3,515	1,504	10,104	11,608	109	1,007	1,116	172	2,593	2,765
	Olympic Medical Center	2,162	7,083	9,245	4,821	34,905	39,726	0	39	39	0	39	39
FQHCs	North Olympic Healthcare Network	0	204	204	0	1,296	1,296	865	1,367	2,232	3,281	7,878	11,159
	Peninsula Community Health Services	0	1,345	1,345	0	4,909	4,909	4,380	8,045	12,425	10,703	27,115	37,818
Clinics	Bogachiel Medical Clinic	0	147	147	0	753	753	709	975	1,684	2,164	4,821	6,985
	Harrison Health Partners/Drs Clinic		SUPPRESSED	0		SUPPRESSED	0	2,027	8,798	10,825	4,469	35,536	40,005
	Jefferson Healthcare Adult and Pediatric Clinics	0	506	506	0	2,113	2,113	1,477	2,615	4,092	3,682	8,880	12,562
	North Kitsap Family Practice and Urgent Care			0			0	730	1,305	2,035	1,679	3,744	5,423
	Olympic Medical Physicians			0			0	880	5,448	6,328	2,243	25,712	27,955
	Group Health/Kaiser Permanente			0			0	1,008	1,101	2,109	3,223	5,327	8,550
	Kitsap Children's Clinic			0			0	2,436	186	2,622	8,318	432	8,750
	Peninsula Children's Clinic			0			0	3,403	314	3,717	13,604	923	14,527
	Jamestown Family Health Center			0			0	185	2,067	2,252	695	12,796	13,491
Tribal Clinics	Lower Elwha Health Clinic			0			0	96	700	796	261	3,398	3,659
	Makah Health Center			0			0	SUPPRESSED	55	55	14	702	716
	Port Gamble S'Klallam Health Clinic and Wellness Center			0			0	338	427	765	2,030	3,292	5,322
	Quileute Health Center			0			0	96	141	237	276	844	1,120
	Suquamish Wellness Center			0			0	56	174	230	338	2,094	2,432
	Hoh Wellness Center			0			0			0			0
	Discovery Behavioral Health							66	456	522	326	5,587	5,913
Behavioral Health	Kitsap Mental Health Services							1,490	5,125	6,615	18,609	78,685	97,294
	Peninsula Behavioral Health							195	722	917	526	5,615	6,141
	SUD Providers (n=4, data unavailable for many)							62	948	1,010	412	14,317	14,729

OCH surveyed its largest Medicaid serving healthcare provider organizations to better understand reach, capacity, and barriers to serving the Medicaid population. Not all organizations were able to

submit information in time to submit this proposal, data are included for 13. Among those 13 are large clinics, hospitals, BH, SUD and a first responder; all three counties are represented.

Not quite half of responding provider organizations (n=6) reported they are able to meet the current level of demand for services among their Medicaid population, with one organization recognizing a need to adopt a more proactive strategy in the face of increasing numbers. Seven reported the following challenges:

- need more providers (5)
- workforce shortage, some positions difficult to fill (1)
- challenge with patients assigned via Managed Care Organizations (MCO) we cannot find (1)
- challenge with patients staying engaged in care (1)

How These Healthcare Providers Currently Serve the Medicaid Population

The OCH region has 4 hospital systems:

- *CHI Harrison Medical Center (HMC)* is a private nonprofit hospital level 3 trauma center. HMC currently has two locations in Kitsap County, Bremerton (253 beds) and Silverdale (154 beds), and serves residents of Kitsap as well as Jefferson and Clallam Counties. Notably, the Bremerton hospital will be closing as HMC centralizes into the Silverdale location following a recent decision from the WA State District Attorney's office. HMC is part of the larger *Catholic Health Initiatives Franciscan Health* system in the Puget Sound region. Under Franciscan Medical Group, are urgent care facilities, specialty care and primary care clinics throughout Kitsap County managed by Harrison Health Partners and The Doctor's Clinic. (<https://www.chifranciscan.org/>)
- *Jefferson Healthcare (JHC)* is located in Port Townsend, Jefferson County. JHC is a 25-bed critical access care hospital level four trauma center operating as a public hospital district. The hospital has 24 hour coverage by a physician staff of hospitalists, has top rated surgical services and includes an emergency department, laboratory services, swing bed unit, the latest in digital imaging and a comprehensive array of respiratory, physical, speech and occupational rehabilitation therapies. JHC has seven primary care clinics, some located in rural parts of Jefferson County, a surgery/endoscopy center, and home health and hospice office. (<http://www.jeffersonhealthcare.org/welcome.aspx>)
- *Olympic Medical Center (OMC)* is located in Port Angeles, Clallam County. OMC is a 67-bed acute-care hospital level 3 trauma center operating as a public hospital district. OMC has a level-three trauma designated emergency department, surgical services, and labor and delivery. OMC's outpatient services include cardiac, imaging, physical therapy and rehabilitation, laboratory, nutrition and diabetes, surgical services, home health, primary care, a walk-in clinic, a sleep center, specialty physician services, and comprehensive regional cancer care at locations in Port Angeles and Sequim. OMC is a rural referral center, one of only two in the state, as designated by Medicare. (<http://www.olympicmedical.org/>)
- *Forks Community Hospital (FCH)* is located in Forks, in the rural west end of Clallam County. FCH is a 15-bed critical access hospital level 4 trauma center also operates two primary care clinics, in Forks and Clallam Bay, a behavioral health clinic, and an Ambulance. In response declining census at the hospital and a dire community need, the hospital converted one wing into long term care beds. (<http://www.forkshospital.org/>)

All four hospitals and their affiliated clinics serve Medicaid beneficiaries. The region has 2 Federally Qualified Health Centers, *Peninsula Community Health Services* and *North Olympic Healthcare Network* both with multiple sites, offering primary care, behavioral health and 1 offers oral health services. The region has 4 Community Behavioral Health Centers, the largest, Kitsap Mental Health Services, provides crisis line services and inpatient evaluation and treatment as well as IT infrastructure for the region; and for Kitsap, provides behavioral health crisis services, outpatient and residential treatment and some housing. The region has multiple rural health and independent clinics, 3 free clinics, 7 tribal clinics, and numerous substance use disorder treatment providers. (data gathered through regional environmental scan and communication with providers) The numbers of providers by type serving the region are presented in Table 11. Across the region there are 15 licensed nursing home facilities all accepting Medicaid, 58 licensed adult family homes 90% accepting Medicaid, and 33 licensed assisted living facilities 64% accepting Medicaid. (DSHS Aging and Long Term Support, Accessed [here](#), November 2017)

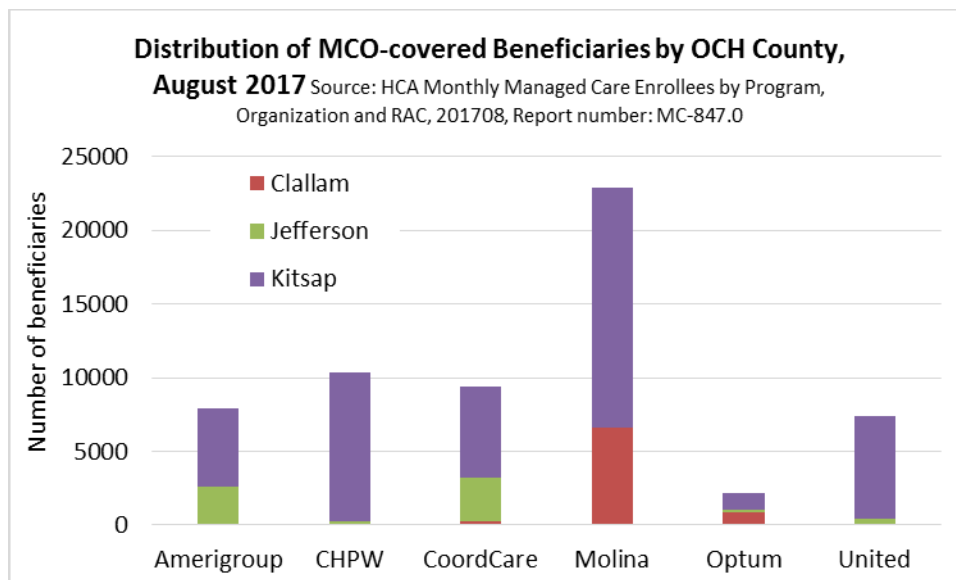
Continuum of Medicaid Payers

Another important set of partners in the OCH region are payers - MCOs and the Salish Behavioral Health Organization (SBHO). (Table 8) Different MCOs serve different parts and different volumes (Figure 22) across the region.

Table 8. OCH Region Payers

Primary Service Area	Type	Organization Name
Clallam and Kitsap	MCO	Molina
Jefferson and Kitsap	MCO	Amerigroup
Jefferson and Kitsap	MCO	Community Health Plan of Washington
Jefferson and Kitsap	MCO	United Health Care
Region	BHO	Salish Behavioral Health Organization
Region	MCO	Coordinated Care

Figure 22.



Continuum of Community Based Organizations

The OCH region is served by a network of community-based organizations including governmental, non-governmental, coalitions, and some for-profits. (Table 9) Most organizations have a primary service area

of one county but several have two or three county service areas. Examples of the types of organizations include advocacy, social services, law enforcement, justice, housing, workforce, aging, community action, education, physical activity, ACEs/resiliency, and access to care.

Table 9. OCH Region Community Based Organizations

Primary Service Area	Type	Organization Name
Clallam	coalition	Olympic Peninsula Healthier Communities Coalition
Clallam	first responder	Port Angeles Fire Department
Clallam	government	Clallam County Commissioner
Clallam	housing	Serenity House
Clallam	justice	Clallam County Prosecuting Attorney
Clallam	justice	Clallam County Superior Court
Clallam	law enforcement	Clallam County Sheriff Office
Clallam	law enforcement	Port Angeles Police Department
Clallam and Jefferson	aging	Olympic Area Agency on Aging
Clallam and Jefferson	community action	Olympic Community Action Programs
Jefferson	government	Jefferson County Commissioner
Jefferson	justice	Jefferson County Jail
Jefferson	law enforcement	Jefferson County Sheriff
Kitsap	access to care	Project Access NW
Kitsap	aging	Kitsap Area Agency on Aging
Kitsap	coalition	Kitsap Strong
Kitsap	education	Olympic College
Kitsap	first responder	Bremerton Fire Department
Kitsap	government	City of Poulsbo
Kitsap	government	Kitsap County Commissioner
Kitsap	government	Kitsap County Coroner
Kitsap	housing	Bremerton Housing Authority
Kitsap	housing	Housing Kitsap
Kitsap	justice	Kitsap County Prosecutor's Office
Kitsap	justice	Kitsap County Sheriff's Office Jail
Kitsap	justice	Kitsap County Superior Court
Kitsap	justice	Kitsap County Treatment Court
Kitsap	law enforcement	Suquamish Police Department
Kitsap	physical activity	YMCA of Kitsap and Pierce Counties
Kitsap	social services	Fishline
Kitsap	social services	Kitsap Community Resources
Kitsap	social services	Kitsap County Human Services
Region	education	Olympic Educational School District 114
Region	education	Washington Department of Early Learning
Region	tribal health policy	American Indian Health Commission WA
Region	workforce	Olympic Workforce Development Council

OCH surveyed five Community Based Organizations broadly engaged across the OCH portfolio to better understand their reach, services, capacity, and barriers to serving the Medicaid population. Those five represent Community Action Programs, Area Agencies on Aging and Workforce. (Table 10)

Table 10. Select Community Based Organizations: Service Area and Number of Medicaid Served

Community Based Organization	Service Area	Estimated # Medicaid served in 2016
Kitsap Area Agency on Aging	Kitsap	1,300
Kitsap Community Resources	Kitsap	12,000
Olympic Area Agency on Aging	Clallam and Jefferson	1,300
Olympic Community Action Program (OlyCAP)	Clallam and Jefferson	8,000
Olympic Workforce Development Council	Region	Did not submit

How Community Based Organizations Serve the Medicaid Population

The Area Agencies on Aging organizations (AAA) offer a specific service, Long Term Case Management, for a specific Medicaid sub-population, frail elders and adults with disabilities. These services “connect clients to many other services they may need and be eligible in order to stay in their homes. This may include contracting with the following: home care agencies, environmental modification, a personal emergency response unit (like Life Line), counseling, training, coaching / respite for a family care giver, skilled nursing services, Health Homes, Home Delivered Meals, helping clients to transition from a Nursing home back into the community, and other services.”

Community Action Programs (CAP) serve the Medicaid population with the following:

- housing, shelter, early childhood education, and energy/weatherization
- one CAP in the OCH region offers:
 - nutrition services
 - Women Infant and Nutrition programs
 - WorkSource affiliate and offer WIOA employment services and Community Jobs and business entrepreneurial start-up programs
 - Veterans Assistance programs and Kinship Care.

One AAA reports it is able to meet the current level of demand for services among its Medicaid population, the other AAA identified meeting the need but noted “there is always greater need for supportive services than we can necessarily provide.” Both CAPs reported that they are not meeting current need for the following reasons:

- Demand for housing exceeds community capacity, large shortage of affordable housing for income eligible households – “It is not uncommon to have people approved for assistance that are unable to secure housing due to low vacancy rates and rising rents.”
- Lack of permanent supportive housing for people who are chronically homeless with mental health and/or substance use disorders.
- Lack of living wage jobs – unemployment rate has come down but many people work for minimum wage at less than full time
- Energy assistance generally sufficient to meet demand but can fluctuate year-to-year depending on grant award and current energy costs.

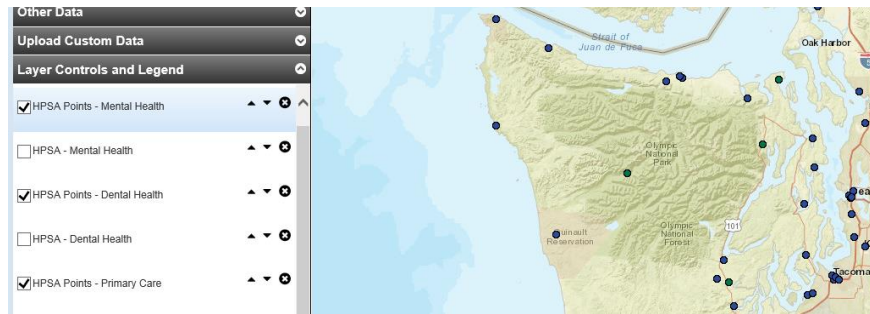
Refer to the Community Engagement section for a summary of how OCH has and will continue to meaningfully solicit input from partners and use this input to inform its project plan development and processes.

Medicaid Beneficiary Population’s Level of Access or Connection to Care and Barriers to Accessing Needed Health Care and Supportive Services

Access to Care

Although the OCH region has a broad network of health care and community based organization providers, there are critical access-to-care challenges. Review of current HRSA designations for health professional shortage areas (HPSA) demonstrates access gaps across the OCH region. Primary care shortages exist for specific low-income population groups in Clallam and Kitsap, as well as for specific service areas in Clallam and Jefferson and in facilities in all three counties. Dental shortages exist for low-income population groups in the east side of Clallam County, the west side of the Olympic Peninsula, and in facilities in all Clallam and Kitsap counties. Mental health shortages exist for the entirety of all three counties and in facilities in Clallam and Kitsap counties. (Figure 23) (HRSA Data Warehouse, accessed [here](#), November 2017)

Figure 23.



Review of provider workforce rates per 100,000 population identifies significant disparities compared to the state average and within OCH. The 2016 physical health provider workforce rates compiled by the University of Washington Center for Health Workforce Studies indicate that the OCH region has fewer physicians, primary care physicians and ARNPs compared to the state and a higher rate of RNs. Notably for physicians, county level rates identify differing levels of capacity by place – Jefferson has the lowest rate of physicians overall but has the highest rate of primary care. Kitsap has the lowest rate of primary care. Clallam has the highest rates of all physicians and primary care; however, these rates do not show the deep complexities related to accessing care in rural/isolated and low-resource communities. Additional provider data made available by HCA for mental health care providers (2015) and dental providers (2014), although not as recent, show Jefferson with high rates of mental health care providers and very low rates of dental providers. Clallam and Kitsap have mental health care provider rates below the state average. Clallam has a substantially higher dental provider rate compared to the region and state averages. (Table 11)

Table 11. Rate of Providers per 100,000 Residents

	Year	WA	Region	Clallam	Jefferson	Kitsap
All Physicians providing direct care*	2016	229	170	189	145	168
Primary Care providing direct care*	2016	81	67	83	87	60
Licensed ARNPs**	2016	73	65			
Licensed RNs^	2016	972	1007			
Mental Health Care Providers^^	2015	263	241	235	288	237
Dental Providers ^^	2014	77	74	91	50	73

*accessed [here](#), November 2017; ** accessed [here](#), November 2017; ^accessed [here](#), November 2017; ^^ HCA AIM RHNI Phase 3 4.25.2017

Table 12 summarizes several indicators of health care access and highlights disparities by geography and sub-population. More than 1 in 20 adults in the region remain uninsured, highest among American

Indian/Alaska Natives (AI/AN) and lower educated adults. Dental access is dire, fewer than 1 in 3 eligible individuals was served. Compared to WA, the region has:

- **lower rates** of dental services, adult ambulatory/preventive care visits, well-child checks, child immunizations, and early prenatal care;
- **about the same rates** of child access to primary care and plan all cause readmissions; and
- **higher rates** of potentially avoidable ED and ED utilization which also has marked disparities by county and race.

Table 12. Indicators of access to care and key disparities by geography and sub-population

Indicator	Data by place	Geographic Disparity	Sub-population Disparity
Uninsured (2015)*	% bars: W,C,J,K W: 8%, C: 7%, J: 9%, K: 5%	Jefferson County rate 2 and 4% higher than Clallam and Kitsap.	2-3 times higher rate among American Indian/AK Natives compared to White non-Hispanic. In Clallam, 11 times higher rate among adults with no high school compared to adults with college
Receive dental services (2016)*	% bars: W,R,C,J,K W: 38%; R: 30%; C: 29%; J: 23%; K: 31%	Jefferson rate 15% below WA, 6-8% below Clallam and Kitsap.	OCH county rates are 41-47% for age 20 and under; only 13-21% for adults age 21 and over.
Adults have past year ambulatory/preventive visit (10/1/15-9/30/16)^	% bars: W,R,C,J,K W: 77%; R: 75%; C: 76%; J: 74%; K: 75%	About 3 in 4 adults across geographies; State higher than all of OCH	Lower among males and adults age 20-44 compared to age 45-65. Range across race groups: 70-83%
Children access primary care (10/1/15-9/30/16)^	% bars: W,R,C,J,K W, R, K: 89%; C, J: 88%	similar across all geographies	OCH average by age group: 93% age 12-24 months; 84% age 25 months-6 yrs; 90% age 7-11; 91% age 12-19. Range across race groups: 86-91%
Well Child Visits age 3-6 (10/1/15-9/30/16)^	% bars: W,R,C,J,K W: 61%; R: 59%; C: 55%; J: 56%; K: 60%	Jefferson and Clallam 4-5% below Kitsap; all below WA average	Range across race groups 49-62%
Child Combo 10 Immunizations (2016)*	% bars: W,R,C,J,K W: 12%; R: 10%; C, J: 8%; K: 11%	Clallam and Jefferson 3% below Kitsap, all below WA	No data
Pregnant women get early prenatal care (2015)*	% bars: W,R,C,J,K W: 65%; R: 63%; C: 64%; J: 72%; K: 61%	Region average below WA; Kitsap lowest	No data
Emergency Department Use Rate/1,000 MM (10/1/15-9/30/16)^	rate bars: W,R,C,J,K W: 54; R: 72; C: 62; J: 47; K: 79	Kitsap rate higher than other counties and WA	Female rates higher than male Under age 18 rates about half adult rates Range across race groups: 34 to 89
Potentially avoidable ED (10/1/15-9/30/16)^	% bars: W,R,C,J,K W: 17%; R: 19%; C: 15%; J: 16%; K: 21%	Kitsap higher than state and Clallam and Jefferson	Female rate higher than male Under age 18 rates about 10% higher than adult rates Range across race groups: 16-23%

Plan all cause readmissions (age 18-64) (7/1/15-6/30/16)^	% bars: W,R,C,J,K W: 14%; R: 14%; C: 7%; J: 13%; K: 15%	Kitsap rate twice as high as Clallam	Range across race groups: 10-18%
Mental Health Treatment Penetration (2015)^	W: 42.9% R: 44.3%	Region slightly above state average	No data
Substance Use Disorder Treatment Penetration (2015)^	W: 26.7% R: 28.1%	Region slightly above state average	No data
Key: W=Washington; R=OCH Region; C=Clallam County; J=Jefferson County; K=Kitsap County			
*HCA AIM RHNI Phase 3 4252017; ^HW Dashboard; ^^DSHS RDA "mcaid_wa_ach.xlsx"			

Eight provider organizations (2 FQHC, 1 clinic, 1 hospital, 4 BH) submitted data to OCH on current wait time to next appointment:

- for **new** Medicaid patients, the range was **1 day to 6 months**

1 day	7-21 days	9 days	10 days	10-14 days	2 weeks	55 days	6 months
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- for **current** Medicaid patients, the range was **same day to 22 days**

same day	1 day	1-5 days	7-10 days	~ 1 week	10 days	22 days
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Barriers to Accessing Needed Health Care and Supportive Services

Healthcare provider organizations answered an open-ended question about their perceptions of Medicaid patient barriers to accessing needed care (n=11). (Table 13) The most common barriers mentioned were **transportation** and **housing**, an additional group of barriers was related to lack of access to specific types of care.

Table 13.

Perceptions of Medicaid patient barriers to accessing needed care:	
Themes	Selected responses
Transportation	transportation to all services that is easy to use and doesn't take an entire day to navigate transportation challenges make getting to appointments challenging for some as a rural community with very rural geographic areas, transportation to the clinics is an issue
Housing	limited affordable housing housing taking more of income; about 9% of adult clients are without sufficient housing, making it more difficult to find, serve them when appointments are missed. the housing crisis has decreased the availability of affordable housing, which often means that people have to make choices between healthcare and other necessary expenses, especially individuals who are low income (and who are often on Medicaid). unstable living arrangements
Lack of access to needed care	access to certain specialists such as oral surgery and dermatology limited options for mental health lack of providers taking medicaid continuity of services for incarcerated population workforce shortage for primary care providers, medical assistants, and other support staff lack of preventive services need access to prescribers
Other barriers	lack of culturally sensitive translation office staff attitudes towards patients patients lack health literacy to understand benefits

Community based organizations provided their perceptions of barriers to accessing needed services among individuals on Medicaid in several categories outlined in Table 14. The summary column is shaded to indicate most extreme barrier across respondents as red and less severe as yellow. The most extreme barrier mentioned was **housing**.

Table 14.

Perceptions of barriers to accessing needed services among individuals on Medicaid						
Category	Summary	CBO 1	CBO 2	CBO 3	CBO 4	CBO 5
a. housing/homeless services		transportation, lack of affordable housing, lack of income to support permanent housing, insufficient shelter space	Lack of housing stock (safe and affordable housing)	Extreme	To some extent, mostly we serve individuals in housing. It can be inadequate housing, or not set up for frail elders to easily manage.	affordable housing is a barrier to a percentage of our customers.
b. financial assistance		Having documentation to prove eligibility requirements	Source documentation	Significant	This is a big problem – by nature Medicaid clients are very low income and all expenses they encounter continue to increase, also at risk of financial fraud from family and others taking advantage of decreasing acuity, fear, etc; Many reporting "poor/bad" quality of life in 2015 survey also report experiencing financial insecurity	
c. health care		transportation, disengagement from providers, not perceiving the importance, lack of income	We ensure our disabled population have access to PCP and record functional ability	Significant	Often these clients are dual eligible so accessing services has been addressed, however we do find that not all providers will accept new clients and specialty care may be difficult to access in rural areas.	
d. nutritional assistance		lack of access to nutritional foods (often fresh healthier foods are the most expensive and not carried by most food banks. Food banks limit access to a few times per month.		Significant	a problem either because clients have obesity problems or lack knowledge about good nutritional practices, or have lost interest in food and do not eat enough to sustain themselves. In a 2016 survey, 14% report that dental issues affect their ability to eat healthy food, 13% have trouble preparing a healthy meal, 11% can't afford a healthy meal, 6% can't get to the store; 10% report skipping buying food because of family finances	
e. transportation		Lack of evening and Sunday schedule.	Lack of public transportation options	Average	Transportation can be a significant problem although resources do exist for the population we serve. Many reporting "poor/bad" quality of life also report lack of access to transportation, 6% can't get to the store for groceries. Most reporting good life quality also report they are able to drive themselves wherever they need to go. Only ½ of those reporting poor life quality reported that they drive themselves. In this group there is a much heavier use of public and/or volunteer transportation and 1/3 reported experiencing isolation and/or other transportation issues.	transportation is a barrier to a percentage of our customers.
f. education/workforce training		Funding for training. Funding for basic needs (housing, utilities, food) while pursuing education.		Average	Not really an issue at the point in time we serve these individuals - with more education, our clients may have had access to higher lifetime earnings and been able to avoid transitioning to Medicaid until later or not at all in their aging process. We do help clients to gain work experience / knowledge.	access to supported training is a barrier to a percentage of our customers.
g. employment services		Lack of living wage jobs. Lack of training and skills to pursue available jobs.	Lack of slots. We have a waiting list of our Senior Employment Program.	Significant	We help interested members of the senior population learn about employment options (which are extremely limited, including the Title V Senior Employment program and whenever the Initiative III supported employment services get off the ground).	access to supported training is a barrier to a percentage of our customers.
h. legal services			Lack of funding for robust legal services	Extreme	We have the Senior Legal Advice Clinic for elders over 60 so we can help them access this services. In a 2015 survey, 53% pay privately for legal services or information, 22% network with friends, family, or business associates, 21% do their own research on the internet or at the library, 13% contact O3A, 4% call a legal hotline, and 3% participate in O3A's senior legal advice clinics	
i. translation services		A lot of program materials are not translated...especially into languages other than spanish.		Average	We provide translation services as needed.	

In addition to provider perceptions of barriers to accessing needed care, OCH also asked provider organizations about surveys they do with their patients/clients and if they would be willing to share what they have learned with OCH. Of the 14 organizations (healthcare and CBO) responding to this question, the majority report conducting surveys but fewer than half said they are able to share results with OCH. (Table 15)

Table 15.

Does your organization do any surveys with your clients to collect input on:	Yes	Total	%
a. need for, access and barriers to health care services?	12	14	86%
b. need for, access and barriers to supportive services?	10	14	71%
If yes for either, are you able to share what you learned?	6	13	46%

Medicaid patient satisfaction input from the CG-CAHPS Patient Centered Medical Home survey from one FQHC identified a need for better access, “getting everyone seen as quickly as they want” and more provider time spent discussing health goals and worries/stress:

- less than half of respondents always get same-day responses during office hours
- 56% can get a routine appointment as quickly as needed
- 55% can get an urgent appointment as quickly as needed
- 62% said specific health goals were discussed
- 45% said staff asked about worries/stress

Medicaid client survey from one community behavioral health organization had the following average satisfaction scores (scale 1-5) among adult/child respondents:

- involvement in treatment planning 4.1/4.2
- useful skills learned 4.0/3.8
- received all services needed 4.2/4.0
- service location convenient 4.3/3.9

Client survey input from one OCH region AAA identified the following barriers:

- 1/3 reported experiencing isolation and/or other transportation issues, 6% can't get to the store
- 14% report that dental issues affect their ability to eat healthy food
- 11% can't afford a healthy meal, 10% report skipping buying food because of finances
- Many reporting "poor/bad" quality of life also report lack of access to transportation
- Most reporting good life quality also report they are able to drive themselves wherever they need to go

Medicaid Population Health Care/Access Needs and Current Provider Services Capacity

Table 16 summarizes identified health care/access needs derived from Medicaid beneficiary input and provider perceptions (column on left) and provider service capacity and availability to address needs (column on right). Notably, much of the need identified by the Medicaid population falls outside the doors of the clinical setting underscoring the critical importance of the partnerships between health care and community based organizations.

Table 16.

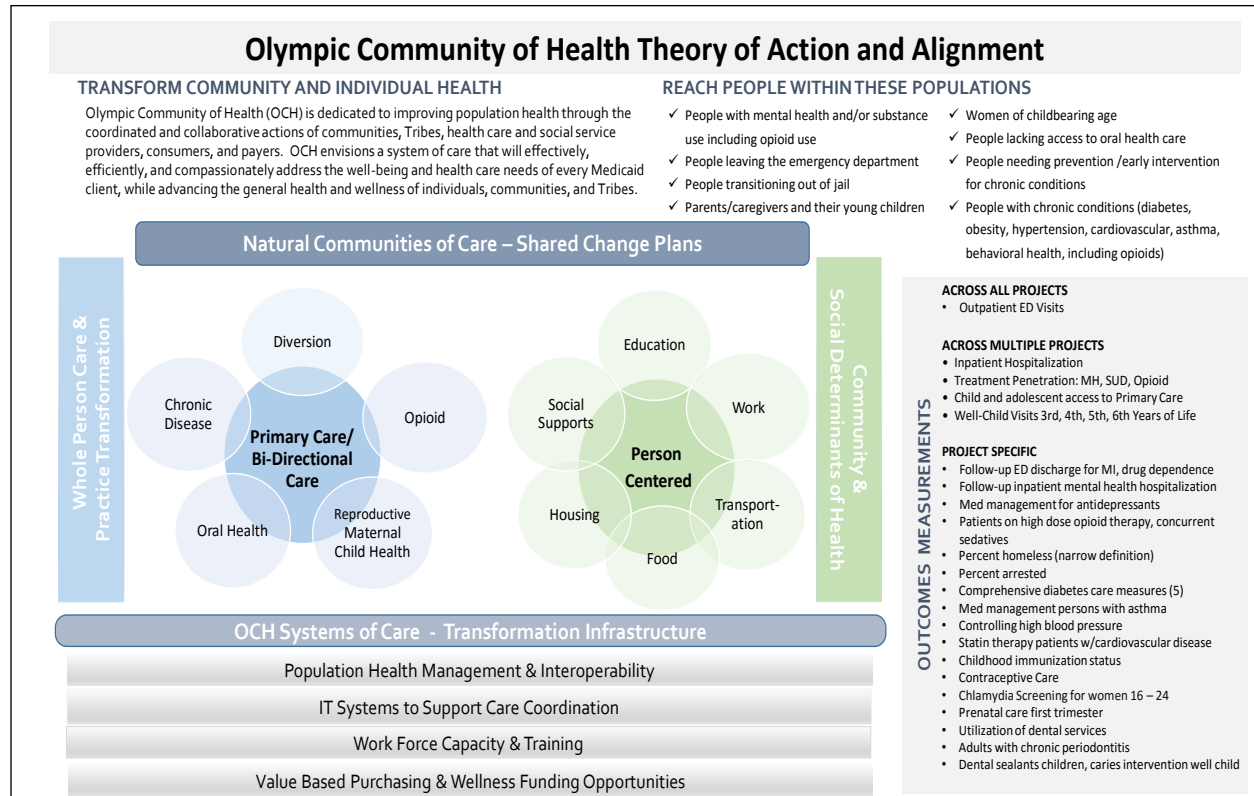
Identified Health Care or Access Need	Provider Service Capacity/Availability
Access to needed health care	OCH region has overall physician, primary care physician, ARNP, Mental Health and Dental provider rates below WA average - OCH region lacks provider capacity - across disciplines - to meet population demand. Next appointment wait times across disciplines reflect this. Identified workforce recruitment issues make response to identified need difficult and require creative, adaptive models. Not all providers will accept new clients and specialty care may be difficult to access. OCH region high rates of potentially avoidable and overall Emergency Department use – care that should be provided in a more appropriate setting.
Housing	OCH region has lack of safe and affordable housing, lack of income to support permanent housing, insufficient shelter space. The housing crisis has decreased the availability of affordable housing, which often means that people have to make choices between healthcare and other necessary expenses. Clients without sufficient housing makes it more difficult to find and serve them.
Transportation	OCH region has transportation deficits – need for transportation service options that are easy to use and don't take an entire day to navigate. Many AAA clients reporting "poor/bad" quality of life also report lack of access to transportation; most reporting good life quality also report they are able to drive themselves wherever they need to go.
Healthy Nutrition/Lifestyle	Individuals disengaged from providers, not perceiving the importance of health care/healthy behaviors. Need to spend more time planning for and working with patients on health/treatment goals and whole-person care and coordinating care/services with CBOs. Community service gaps: Healthier foods (fresh) are often the most expensive and not carried by most food banks, food banks limit access to a few times per month. Clients have obesity problems or lack knowledge about good nutritional practices.

THEORY OF ACTION AND ALIGNMENT STRATEGY

OCH Vision for a Transformed Health System

Olympic Community of Health (OCH) is dedicated to improving population health through 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 well-being and health care needs of every Medicaid client, while advancing the general health and wellness of all individuals, communities, and Tribes. (Figure 24, Attachment OCH-Theory of Action and Alignment - AttA)

Figure 24



Priorities Address Community Needs

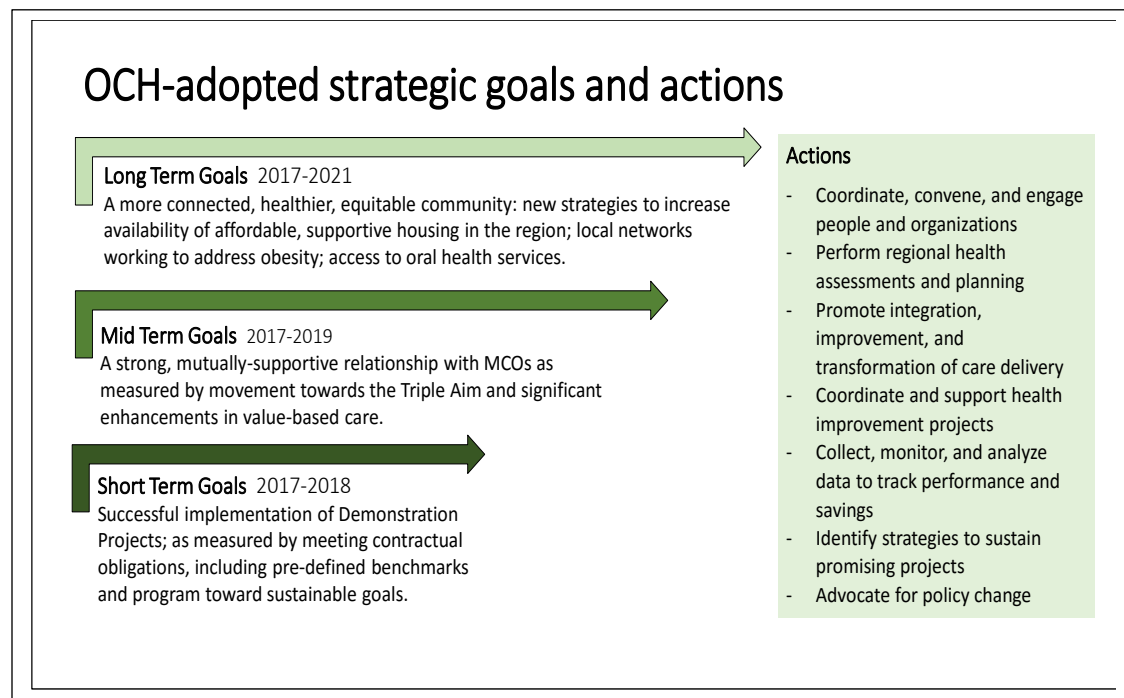
OCH priorities (Table 17) were determined by the Board of Directors following considerable review of joint public health/OCH supported regional needs assessments, health indicator data, on-line surveys, compilation of an extensive program and initiatives inventory, and including dialogue at 6 regional community forums beginning July 2015. The Board's decision was informed by a Regional Health Assessment and Planning Committee's review and recommendations. Assessments, surveys, program inventory, indicator data and forum content informing the priorities are available online at www.olympicCH.org.

Table 17. Regional Health Priorities

ACCESS	AGING	BEHAVIORAL HEALTH	CHRONIC DISEASE	EARLY CHILDHOOD
A continuum of physical, behavioral, and oral health care services are accessible to people of all ages and care is coordinated across providers.	Aging adults and their caregivers are safe and supported.	Individuals with behavioral health conditions receive integrated care in the best setting for recovery.	The burden of chronic diseases is dramatically reduced through prevention and disease management.	Children get the best start to lifelong health and their families are supported.
Progress on these priorities depends on improving health equity through SOCIAL DETERMINANTS – housing, education, workforce development, employment, transportation, safety, environmental conditions.				

Strategies Support Regional Health, Healthcare Needs, and Priorities

The region's selected priorities have driven the strategies OCH will employ to achieve short, mid-range, and long-term goals. (Figure 25)

Figure 25**Outcomes**

OCH is committing to projects that will address at least one of the above health priorities, will be sustainable by the end of the Transformation, and that partnering providers are willing to deliver. The Board, partners, and staff intentionally selected and designed projects to meet five core outcomes by 2021.

These outcomes were identified as necessary, intermediary steps to achieving the Triple Aim:

1. A more robust primary care delivery system
2. Integrated physical, behavioral and dental health services
3. Common data metrics and shared information exchange

4. Provider adoption of value-based payment contracts
5. Enhanced community-clinical linkages

Strategies

To achieve these outcomes and truly transform healthcare, OCH made two key strategic decisions. The first decision is to develop a theory of action that will facilitate practice transformation; recognizing that practices are transformed by *workflows* and *clinic redesigns*, and not by *projects*. Second, OCH will target infrastructure and capacity building investments in workforce and population health systems to directly address the five outcomes listed above.

Tactics

Several concurrent efforts are underway to operationalize these two strategies:

1. Coordinate planning and implementation by semi-autonomous Natural Communities of Care; allow NCCs to hone transformational activities, leverage shared assets, invest in social determinants of health, and target shared subpopulations in a way that meets local needs and honors existing relationships and initiatives.
2. Leverage matching dollars and resources within each NCC.
3. Encourage health equity by weighting DSRIP investments according to a community needs index and PRISM score.
4. Prepare providers for value-based contracting by aligning QIP incentives with metrics in VBP contracts or alternative payment model contracting. To the extent possible, select proxy measures for continuous monitoring and improvement that are already collected and reported by providers.
5. Facilitate strong provider-MCO partnerships that translate into successful VBP contracts and better health for patients.
6. Target major Medicaid providers for participation to make the largest possible impact.
7. Target smaller providers that are instrumental to the success of the transformation or have ability to impact hard-to-reach populations with disparities.
8. Minimize provider burden every step of the way.

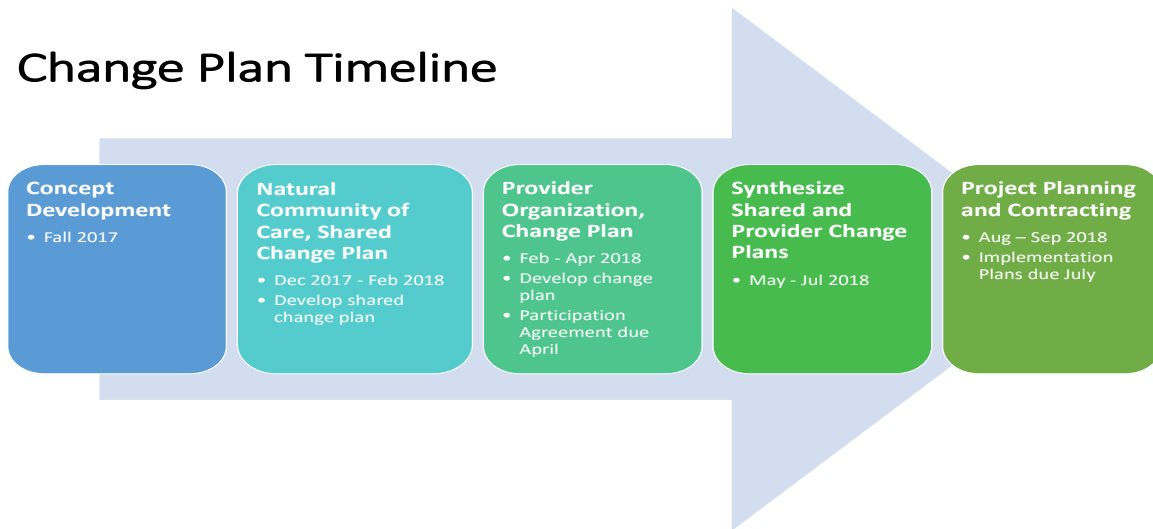
Change Plans Drive Transformation

Transformation will be accomplished through the Board's commitment to investing in Domain 1 strategies for population health/information technology, workforce capacity, fostering the shift to value-based payment models, and encouraging local collaborative agreements. OCH believes change begins at the local level, with people who know their communities best, and who will invest energy in activities that meet their community's health needs.

OCH will distribute to providers a catalogue of practice transformation strategies that are designed to move P4R and P4P metrics and milestones. OCH staff will support providers in customizing a change plan that fits their organization. Strategies may vary, and will include activities necessary to meet transformation measures such as workflow redesign, workforce capacity enhancements, new care coordination mechanisms, implementation of population health strategies, updated IT systems for improved provider communication, and engagement in value based purchasing contracts with MCOs. In many cases, these change plans will involve multiple clinical practices and service providers collaborating to leverage existing initiatives, and shared project goals. Final plans will be due by June 2018. (Figure 26)

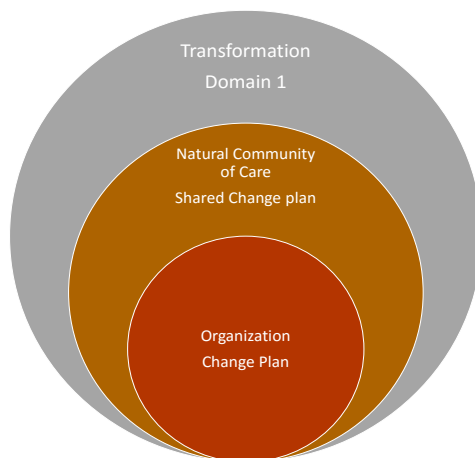
Figure 26

Change Plan Timeline



Recognizing that partners cannot work in isolation to achieve true transformation, OCH will convene partnering providers, clinical and non-clinical, serving a Natural Community of Care (NCC) to align strategies into a single shared change plan. (Figure 27) For the past year, partnering providers have had extensive conversations at OCH meetings and during the normal conduct of their work. Discussions as to how to best work together to meet OCH regional priorities, local priorities, and organization-level priorities for health transformation are well underway. In depth explorations have begun to identify access issues, improve care coordination, enhance community-clinical linkage such as referral management, address health equity and prevention, increase workforce capacity including training needs, share infrastructure, implement population health management, and prepare for value-based contracting. Change categories are being developed by OCH for each NCC to select from and guide NCC change plans. OCH will facilitate and incentivize collaborative arrangements between providers within the NCC, such as workforce and shared IT solutions, data-sharing agreements (DSA) and business associate agreements (BAA).

Figure 27



OCH Project Plan Portfolio	
Domain 2: Care Delivery Redesign	
<input checked="" type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input type="checkbox"/>	2C: Transitional Care
<input checked="" type="checkbox"/>	2D: Diversions Interventions
Domain 3: Prevention and Health Promotion	
<input checked="" type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input checked="" type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input checked="" type="checkbox"/>	3C: Access to Oral Health Services
<input checked="" type="checkbox"/>	3D: Chronic Disease Prevention and Control

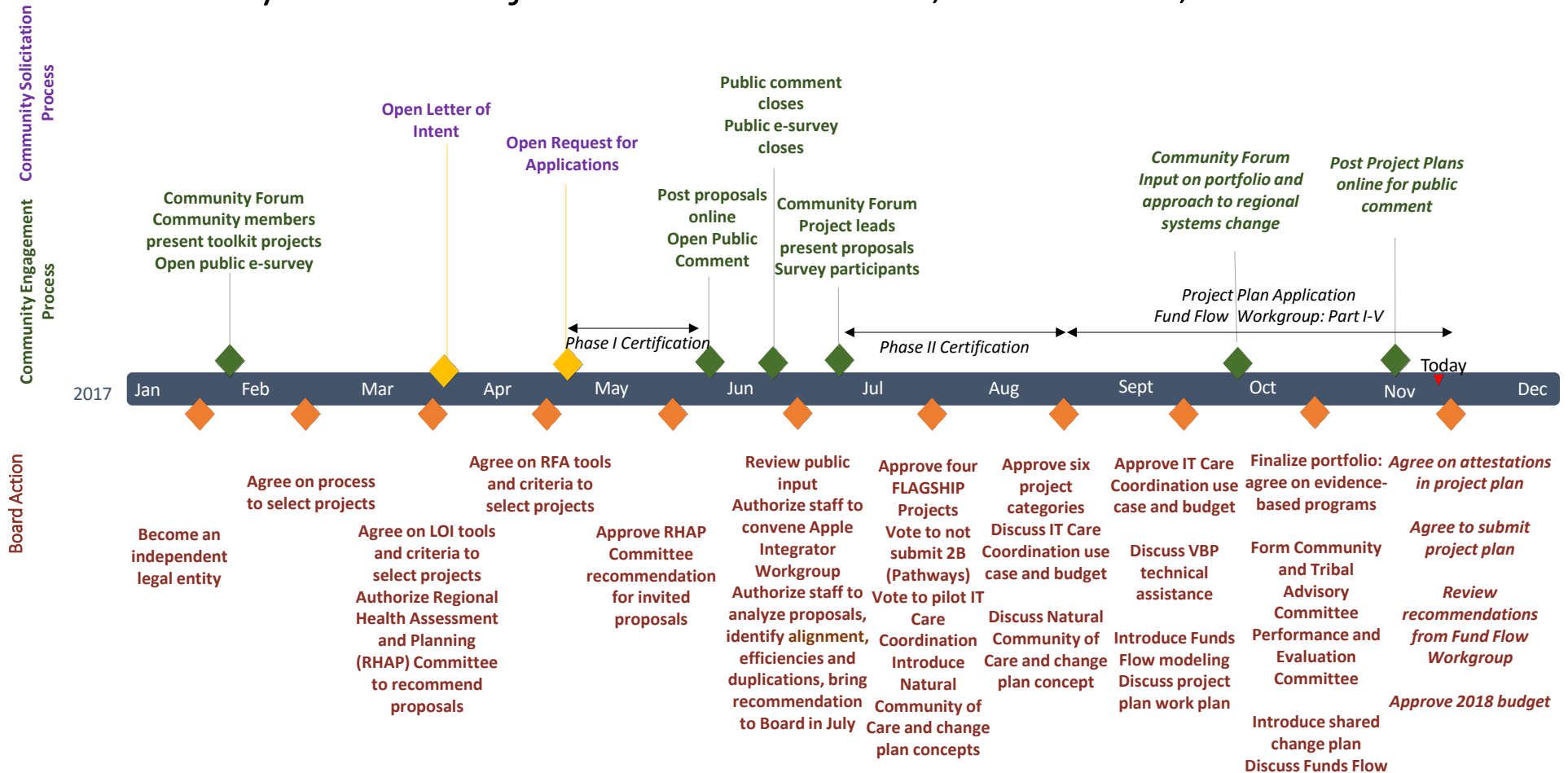
Project Selection Process

Figure 28 summarizes OCH's 12-month community process to arrive at the current selection of projects. During the Letter of Intent (LOI) and Request for Application (RFA) process, project applicants learned about the region-wide needs and priorities. Optional project selection 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.

Figure 28

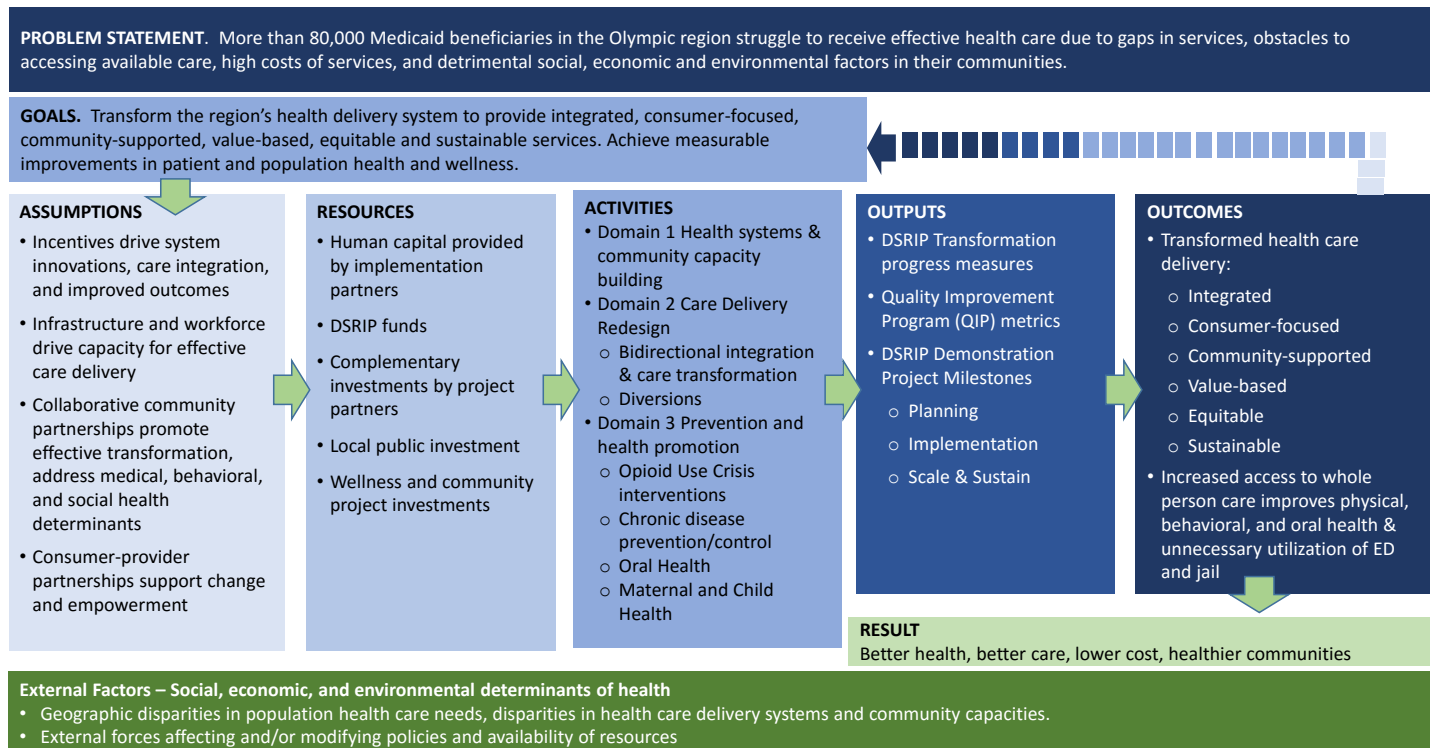
Summary 2017 Project Portfolio Plan, Selection, Timeline



The OCH vision for health system transformation arose from a population-based assessment. OCH engaged representatives from health care and social service providers, Tribes, interested community members and payers for inputs and guidance. Subsequently, OCH selected priorities that would best support individuals and communities in achieving the highest potential level of health and wellbeing. OCH priorities went beyond Medicaid and projects in the Medicaid Transformation Project (MTP) toolkit. For example, with a significantly larger population of older adults than other regions in the state, care and support for the aging population was among the top five priorities. OCH is committed to moving forward with projects that will improve the health and wellbeing of our communities, including access to oral health and support for early childhood, even when changes to funding allocations increase the level of challenge in doing so. OCH has developed a logic model representation of assumptions, resources, activities, outputs, and outcomes to illustrate the rationale in defining the problem the region wishes to resolve and the Medicaid Transformation goals we seek to achieve. (Figure 29, Attachment OCH-Theory of Action and Alignment - AttB)

Figure 29

Olympic Community of Health | Medicaid Transformation Logic Model



Shared Resources, Infrastructure and Interventions

OCH recognizes that Domain 1 infrastructure investments are among the most needed and valuable of interventions. Domain 1 investments can be applied regionally to achieve health transformation goals across the portfolio. Interventions and infrastructure investments will be informed by NCC shared change plans with select investments shared regionally to enhance capability in population health data systems and health IT, workforce capacity, and value-based payment (VBP) for sustainability (examples below). (Table 18)

Population health data systems and health IT

- Improved E-referral systems between organizations, sectors, and Tribes
- Improvements in care coordination/consent management provider communications, furthered through the OCH Care Coordination IT project
- Population health management to support VBP, including infrastructure and staffing that supports health analytics capacity and application of patient registries
- Sharing of IT infrastructure management and/or expertise in helping solve interoperability and other concerns among IT Directors of hospitals, FQHCs, CBHCs, payers

Workforce

- Provider and NCC determination of most needed workforce capacities
 - Currently identified workforce shortages exist in staffing for registered nurses, licensed social workers/ licensed mental health counselors, chemical dependency counselors, specific medical providers by location, and population health care managers
 - Identification of possible shared workforce staff such as diabetes educators, nurse care managers, community health workers, patient navigators, psychiatric ARNPs
 - Further implementation of telemedicine options, including telepsychiatry, through use of regional, state and national resources
- Increasing capacity for population health management
 - Exploration of shared population health care manager among providers either by clinical practice type, and/or geographic proximity among providers
 - Technical assistance to work with existing IT capacity to implement health registries, including workflow processes necessary to enter, analyze, use, and maintain registries
 - Training population analytic capability within care organizations to implement value-based care strategies such as condition-specific care coordination
- Cross training for excellence in primary care/bi-directional care (PCP, MH, SUD, and including dental prescribers) such as:
 - Technical assistance for deployment of collaborative care models and practice redesign, including at a minimum workflow processes, PDSA, QI projects and protected staffing time sufficient to engage in these activities
 - Training primary care professionals in standard behavioral health screens, behavioral health resources and referral options including treatment providers for MAT, medication and patient management
 - Training clinical and SDOH providers in ACES/NEAR Science, trauma-informed care, motivational interviewing, and principles of chronic care model
 - Training behavioral health professionals in co-occurring conditions: record and discuss vitals, review medication management at daily huddles, tools for patient self-management
- Preparing future 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. A co-occurring disorders curriculum for human services students has previously been developed and delivered.

- The 3CCORP team will work with the NW Family Medicine Residency to develop an OUD treatment toolkit.

Value Based Payment Education

- Webinars, seminars, technical assistance and other educational opportunities provided via state and national sources to prepare for VBP, and including regional information sessions
- Dialogue with OCH Board, providers and payers regarding how to move forward with VBP.
- Shared technical expertise opportunities to be made available through Managed Care Organizations.

Assessment

- For planning and decision-making OCH has created or accesses information through survey tools such as:
 - Value Based Payment (stat-generated VBP Action Survey)
 - Bi-directional integration (PCMH-A and MeHaf), TCPI survey, OCH hospital assessment
 - Health IT (collected by practice transformation hub, shared with OCH by providers)
 - Data and analytic assessments (OCH contracts with Kitsap Public Health District and Public Health Seattle-King County)
- Information is shared with Board and committees for planning and decision-making where appropriate.

Partnering Providers

- OCH is in the process of identifying partnering providers for each project. Most providers will participate in multiple projects, providing economies of scale and leveraging clinic redesign opportunities. Attachment OCH-Theory of Action and Alignment - AttC represents a preliminary assessment of engaged partners, cross-walked across the portfolio.

Table 18

Shared Resources, Infrastructure and Interventions across Project Categories						
	2A	2D	3A	3B	3C	3D
Foundational investments or infrastructure needs at the provider organization level to implement projects	Bi-Directional Integration	Diversion	Opioid Response	Oral Health Access	Reproductive, Maternal and Child Health	Chronic Disease Prevention and Control
Capacity Infrastructure Strategies						
Health information sharing (VBP) (PHS)						
Bricks and mortar						
Registries (VBP) (PHS)						
Risk stratification (VBP) (PHS)						
Operatories						
Referral Management (VBP)						
Analytics - Decision support technology (VBP) (PHS)						
Supplies						
Workforce Strategies						
Telehealth						
Population Health Analytics (VBP) (PHS)						
Cross training and redefine role						
New workforce						
Scope of practice (advocacy)						
Retraining/Certification/Uptraining						
Recruitment						
Retention						
Shared workforce						
Mobile workforce						
Virtual team-based care						
Curriculum development/support						
Connect to residency programs						
Transformation Strategies						
Patient Centered Medical Home (VBP) (PHS)						
Integrated, whole-person care						
Team-Based Care						
Care Management (VBP)						
Care Coordination incl. Referral Management (VBP) (PHS)						
Enhanced Access (VBP)						
Patient-Centered Interactions/Engagement (VBP)						
Organized, Evidence Based Care (VBP)						
Provider-Team/Patient Relationship (VBP)						
Empanelment (VBP)						
Quality Improvement Strategy/Workflows (VBP)						
Engaged Leadership						
Patient Outreach (VBP)						
VBP: Supports successful VBP contracting						
PHS: Supports development of high-functioning population health management system						

Moving Measures to Achieve Region-Wide Health Outcomes

OCH aligned each evidence-based program within each project category with the pay-for-reporting and pay-for-performance metrics in the MTP toolkit (Attachment OCH-Theory of Action – AttD through AttI). During the final OCH selection process, OCH evaluated the capacity to scale each project to move reporting measures and outcome metrics. One project was eliminated because it could not achieve this standard. Another project was rejected because the evidence-based program in the toolkit was unpalatable to partnering provider organizations. Based on preliminary analyses, the remaining six projects have the capacity to achieve reasonable movement of the measures based number of

individuals needed for 2% improvement over self (IOS) or to meet gap to goal (GTG) national benchmark. (Table 19) OCH will assist each provider organization in designing its change plan, and each NCC shared change plan, to ensure that tactics are identified to address each outcome metric.

Table 19

Toolkit Outcome Rates and Number of Individuals Needed for Improvement by Project Category					2A	2D	3A	3B	3C	3D	Statewide Accountability Measure
	OCH rate	State rate	# individuals needed for 2% improvement over self (IOS) or to meet gap to goal (GTG) national benchmark	IOS or GTG	Bi-Directional Integration	Diversion	Opioid Response	Oral Health Access	Reproductive, Maternal and Child Health	Chronic Disease Prevention and Control	
Antidepressant Medication Management - Acute Phase tx ¹	53%	52%	189	GTG	x						x
Antidepressant Medication Management - Continuation Phase tx ¹	36%	33%	258	GTG	x						x
Child access to Primary Care Practitioners, 12-24 months ¹	93%	94%	83	GTG	x					x	
Child Access to Primary Care Practitioners, 2-6 years ¹	84%	86%	692	GTG	x					x	
Child Access to Primary Care Practitioners, 7-11 years ¹	90%	91%	375	GTG	x					x	
Child/Adolescents' Access to Primary Care Practitioners, 12-19 yrs ¹	91%	90%	348	GTG	x					x	
Childhood Immunization Status ¹	10%	12%		GTG				x			
Chlamydia Screening in Women Ages 16 to 24 ²	56%	56%	285	GTG				x			
Comprehensive Diabetes Care: Blood Pressure Control					x					x	x
Comprehensive Diabetes Care: Eye Exam (retinal) performed ¹	29%	31%	861	GTG	x					x	
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)					x					x	x
Comprehensive Diabetes Care: Hemoglobin A1c Testing ¹	83%	84%	202	GTG	x					x	
Comprehensive Diabetes Care: Medical Attention for Nephropathy ¹	83%	86%	104	GTG	x					x	
Contraceptive Care – Most & Moderately Effective Methods ³	33%	31%	273	IOS				x			
Controlling High Blood Pressure					x					x	x
Dental Sealants for Children at Elevated Caries Risk - age 10-14	18%		28	IOS					x		
Dental Sealants for Children at Elevated Caries Risk - age 6-9	43%		33	IOS							
Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence - within 30 days ³	24%	28%		GTG	x						
Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence - within 7 days ³	16%	21%		GTG							
Follow-up After Hospitalization for Mental Illness - within 30 days ³	71%	70%		GTG	x						
Follow-up After Hospitalization for Mental Illness - within 7 days ³	60%	59%		GTG							
Inpatient Hospital Utilization Rate ²				IOS	x		x			x	
Medication Management for People with Asthma (5-64 Years) ¹	29%	28%	108	GTG	x					x	x
Mental Health Treatment Penetration (Broad Version) ²	44%	43%	357	IOS	x			x			x
Outpatient Emergency Dept Visit Rate per 1000 Member Months ¹					x	x	x	x	x	x	x
Patients on high-dose chronic opioid therapy (by varying thresholds)	20%		230	IOS			x				
Patients with concurrent sedatives prescriptions				IOS			x				
Percent Arrested ³	7%	7%	847	IOS		x					
Percent Homeless (Narrow Definition) ³	5%	5%	847	IOS		x					
Periodontal Evaluation in Adults with Chronic Periodontitis				IOS					x		
Plan All-Cause Readmission Rate (30 Days) ¹	14%	15%		GTG	x						x
Prenatal care in the first trimester of pregnancy ³	63%	65%		GTG				x			
Primary Caries Prevention Intervention as Part of Well/III Child Care as Offered by Primary Care Medical Providers	0.1%		108	IOS					x		
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)				IOS						x	
Substance Use Disorder Treatment Penetration ³	28%	27%	159	IOS	x			x			x
Substance Use Disorder Treatment Penetration (Opioid)				IOS	x						
Utilization of Dental Services by Medicaid Beneficiaries	30%		1997	IOS					x		
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life ¹	59%	61%	1600	GTG				x			x
Well-Child Visits in the First 15 Months of Life				GTG							

¹Healthier Washington Data Dashboard, Historical Toolkit Data, 9/1/2017² WA DSHS RDA, Historical Toolkit Data, 9/1/2017³ Not Specified in Historical Toolkit Data, 9/1/2017

For maximum efficiency and to increase the likelihood of region-wide success in moving the metrics, OCH is aligning target populations across the portfolio. (Table 20)

Table 20

Target Populations by Project Category		2A	2D	3A	3B	3C	3D
		Bi-Directional Integration	Diversion	Opioid Response	Reproductive Maternal and Child Health	Oral Health Access	Chronic Disease Prevention and Control
Beneficiaries	All Medicaid beneficiaries						
	Adult beneficiaries						
	Child beneficiaries						
	Older adult beneficiaries						
Care Setting	In Primary Care setting						
	In MH/SUD Treatment setting						
	Discharging from ED						
	Releasing from Jail						
	Children in school						
	Tribal clinics						
Geography	Entire OCH region						
	Residents of Port Angeles/Forks						
	Residents of North Kitsap						
	Residents of Jefferson County						
Other	Families/Parents/Caregivers/Partners						

Improving Region-Wide Quality, Efficiency and Effectiveness of Care Processes

OCH will assist providers in developing change plans, and aligning organization-level change plans with shared NCC change plans. OCH will integrate completed change plans into a regional project implementation plan (due DY2 Q3) in tandem with quality improvement plans (QIPs, due DY3 Q2). Metrics in the QIPs will be integrated into change plans, giving providers a clear understanding of reporting requirements and benchmarks to gauge performance. Change plans require regular reporting by provider organizations into an OCH data system. OCH will assess capacity at the provider level for data capture and reporting, offering technical assistance, training, coaching, and encouraging shared workforce capacity as necessary to assure success. To the extent possible, reporting will be tailored to what providers already report. *De novo* reporting requirements will be limited to “must haves” in order for OCH to be compliant with toolkit milestones and metrics. OCH will monitor data feeds to ensure quality, efficiency, and effectiveness of care processes. Each NCC may choose to have a single change manager, either employed by OCH or by collaborative agreement through a member of the NCC. Change managers will ensure progress towards the desired outcomes and to apply midcourse corrections as needed.

Advancing Health Equity in Communities

Because health is interconnected with social/economic factors, addressing these factors is foundational to making progress on strategic priorities. OCH has and will continue to use data to refine target populations to those subpopulations experiencing the greatest health disparities (OCH-Theory of Action – AttD-I). OCH is also incentivizing health equity by weighting DSRIP investments according to a community needs index and PRISM score.

OCH Integral to Regional Health System with Sustainable Business Model

OCH is the only not-for-profit entity dedicated to the vision of improving population health through the coordinated, collaborative actions of communities, Tribes, health care and social service providers, consumers, and payers in the Olympic region. OCH has already become the gathering place and vision holder for developing a system of care that addresses the well-being and health care needs of every person living within the Olympic region, while also aiming to advance the general health and wellness of communities and Tribes.

To achieve this vision, OCH programs are advanced by the 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 far beyond the Transformation.
- 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 realizes that its vision goes far beyond the Medicaid Transformation, and that its future organizational viability depends on growing a diversified funding portfolio, enlisting the support of people in OCH communities, and bringing their voice to the table to realize the vision for the region. OCH is planning to allocate \$1 million dollars of DSRIP funds over the course of the Transformation to support projects that address social determinants of health, and go upstream from the health care delivery system.

OCH's success with MTP will not only be measured by the performance of providers, it will be measured by the steady progress and continuation of the transformation over the next 20-30 years. Collaborative work with MCOs now, during the planning and development stage, is critical to ensure alignment with MCO/provider contracts after MTP, including transitioning towards Fully Integrated Managed Care and 90% value-based contracts. To this end, the OCH will coordinate technical assistance from MCOs to providers to prepare for value-based care.

There were no gaps or areas of improvement in OCH's Theory of Action section related to aligning ACH projects to existing resources and initiatives within the region identified by OCH Phase II Certification reviewers.

Theory of Action and Alignment Attachments

- A. *Required* OCH-Theory of Action and Alignment – AttA – Theory of Action and Alignment
- B. *Required* OCH-Theory of Action and Alignment – AttB – Transformation Logic Model
- C. *Required* OCH-Theory of Action and Alignment – AttC – Partnering Provider Matrix

- D. *Required* OCH- Theory of Action and Alignment– AttD – Bi-Directional At-a-Glance
- E. *Required* OCH- Theory of Action and Alignment – AttE – Diversions At-a-Glance
- F. *Required* OCH- Theory of Action and Alignment – AttF– Opioid At-a-Glance
- G. *Required* OCH- Theory of Action and Alignment – AttG– Reproductive Maternal and Child At-a-Glance
- H. *Required* OCH- Theory of Action and Alignment – AttH – Oral Health Access At-a-Glance
- I. *Required* OCH- Theory of Action and Alignment – AttI – Chronic Disease At-a-Glance

GOVERNANCE

Financial

The OCH Board of Directors (Board) has fiduciary responsibility over OCH, including the Medicaid Transformation Project (MTP). The Board reviews and approves the operating budget annually. The Board approves all DSRIP allocation methodology and budget development. Each year, the Board will approve the release of DSRIP funds to partnering providers and the OCH itself according to an agreed-upon allocation algorithm and timeline. Any increases or decreases to authorized allocation amounts greater than 10% require Board re-authorization

(See Funds Flow section for more details). Funds will be allocated based on each partnering provider's change plan, the Natural Community of Care's shared change plan, and an incentive algorithm developed by the Funds Flow Workgroup, and as approved by the Board. Each partnering provider organization will work with OCH to tailor a change plan to meet their infrastructure needs and planned transformation activities. OCH Finance Committee recommends financial policies, goals, and budgets that support the mission, values, and strategic goals of the organization. Finance Committee reviews the organization's financial performance against its goals and proposes major transactions and programs to the board. In addition to developing an annual budget, the committee tracks progress toward long-term financial goals that will provide for the sustainability of OCH. Finance Committee oversees annual financial audits as required by law and manages the selection of and relationship with the external auditor. A Fiscal Policies and Procedures Manual, approved by the Board, articulates internal controls by which OCH manages and oversees all revenue sources, including Design and Delivery System Reform Incentive Payment (DSRIP) Program funds.

What is a Natural Community of Care (NCC)?

An NCC is a community of resources and providers that serve the same population due to geographical proximity, natural referral patterns, and collaborative service agreements.

Clinical

Clinical expertise is leveraged through strong clinical representation on the Board and committees and through contracts with provider champions. Provider champions are providers with specific subject matter or technical expertise and training to advise specific projects or workflows. For example, a co-occurring disease specialist is assisting with the opioid response project. The Board adopted the Natural Communities of Care (NCC) concept, which allows for autonomy over care delivery redesign within the provider organizations of an NCC. An NCC is a community of resources and providers that serve the same population due to geographical proximity, natural referral patterns, and collaborative service agreements. Change plans will be developed both at NCC and organization levels. Leadership commitment to the change plan must be demonstrated to receive DSRIP incentives. Feedback from frontline providers and leadership will continue to be requested from each provider organization as clinic redesign tasks are developed. Based on nine months of active community input, the Board set the minimum allowable evidence-based programs (EBPs), desired outcomes, and strategic priorities for the MTP. Each NCC will create delivery systems for implementation. Expertise will be leveraged through Practice Transformation Hub Qualis Health assessments and the Transforming Clinical Practice (Pediatric) Initiative (TCPI). OCH manages contracts with subject matter clinical experts in opioid treatment, integration, and chronic disease.

Community

According to *Board Operating Procedures*, a form signed by all Board members, Board members are responsible for communicating with other members of their sector or Tribe to ensure effective

information flow and strong engagement on OCH matters. 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 solicit input and perspectives of organizations within their sectors and present information to the Board. Members report any substantive differences of opinion or disagreements within their sectors on decisions to the Board. In turn, members serve as spokespersons for the OCH and provide regular updates about OCH activities to organizations in their sector. These policies address lacking specificity related to how board members are engaging and communicating with their sectors found in Phase II Certification.

The Board has authorized staff to convene quarterly partner convenings of community partners, co-facilitated by Board and Committee members. The Board has also authorized the formation of a steering committee comprised of clinical and non-clinical partnering providers from each NCC. NCC provider and steering committee meetings will be as frequent as requested by partnering providers, likely frontloaded in 2018 during the planning phase. OCH will convene communities of practice (e.g., community health workers or decision support specialists) across the region and, where appropriate, across ACHs, to share best practices and host group trainings. Please refer to Community and Stakeholder Engagement and Input and Tribal Engagement and Collaboration for more details on OCH's process to engage the community and consumers.

The Board has authorized the development of change plans for each partnering provider organization. Change plans will include a description of how the provider organization plans to address health equity within their practice. OCH will offer trainings and webinars to support this goal. OCH is also incentivizing health equity by weighting DSRIP investments according to a community needs index, which accounts for health disparities across local communities, such as income, race, education, insurance coverage, and housing, and PRISM score.

In each Project Plan included in this proposal, OCH integrated results from categorical analyses identifying health disparities for each project area. These results will be used to focus providers on directing transformational activities on subpopulations experiencing health disparities. The "Project At-a-Glance" attachments in the Theory of Action and Alignment section represent an early approach toward this alignment.

Data

UCH governance decisions are driven by data. The Board is presented with data to inform decisions about project selection, target population, and provider selection. OCH will create a regional health data repository that will inform project planning and selection, as well as inform implementation and monitoring needs. OCH requested data from local social and healthcare providers as part of the project selection process and will incorporate provider self-assessments into change plans. The Board has approved formation of a Performance, Measurement, and Evaluation committee (PMEC). This committee will provide recommendations to the Board regarding assessment, measurement, monitoring, management, interoperability, security, and performance tracking.

Program Management and Strategy Development

UCH staff oversees day-to-day operations of the organization within the approved budget and strategic direction as approved by the Board of Directors. The Office/Administrative Coordinator is responsible for all human resources activities and recruiting new hires. Transformation work will occur in phases, beginning with engagement, then program planning, and finally implementation, continuous monitoring, and improvement. The changing scope requires a nimble staffing model that is lean and responsive to the changing needs of the MTP. To manage the speed and intensity of change, OCH is leveraging leaders from partnering organizations and consultants to assist as OCH moves from strategy and planning to implementation and reporting. These changes address the Phase II Certification finding

of a lack of specificity regarding points of accountability for recruitment and process.

Summary of Significant Changes

There has been one significant change on the governance structure since Phase II Certification: the dissolution of the Regional Health Assessment and Planning Committee, and the formation of two new committees, the Community and Tribal Advisory Committee (CTAC) and Performance, Measurement, and Evaluation Committee (PMEC). These changes resulted in revisions to OCH bylaws. The CTAC will consist of twelve to twenty community and tribal members. This committee is tasked with proactively engaging community-based organizations, Tribes, and beneficiaries of services to ensure that their voice guides and informs OCH decisions. The CTAC will provide recommendations to OCH including but not limited to project design and implementation, transparent communication strategies, regional whole-person health priorities, social justice, and health equity.

Change plans will also incorporate the change elements from PCMH-A, which means provider organizations are required to describe their plan for patient-centered interactions and engagement, as well as the provider-team-patient relationship.

Identified Areas of Improvement from Phase II Certification

The Phase II Certification called out lack of specificity related to how board members are engaging and communicating with their sectors. This concern is addressed in 1c above. Phase II certification also called out lack of specificity regarding points of accountability for recruitment and process for staffing and the opportunity to bolster the staffing model. Since Phase II Certification, OCH hired an Executive Assistant, Office and Administrative Coordinator and Clinical Transformation Manager in November. A Contracts and Compliance Coordinator, Communications Coordinator, and Assistant in will be hired in early 2018. Office and Administrative Coordinator is responsible for all human resources activities and recruiting new hires. The Board approves the annual budget which incorporates the planned staffing model for the coming calendar year.

Process for Ensuring Oversight of Partnering Provider Participation and Performance

OCH will hire a Compliance and Contract Coordinator to oversee change plan compliance and conduct site visits and performance audits annually and will charge a Compliance Committee to oversee this effort. Partners will receive additional support through a change manager, who will offer regular progress check-ins with participants within each Natural Community of Care. OCH Board will approve a mediation plan structure, dispute resolution policy, and grievance procedure to provide necessary processes for under-performance and non-compliance.

Governance Attachments

- A. *Required* OCH-Governance – AttA – Governance Structure

COMMUNITY AND STAKEHOLDER ENGAGEMENT AND INPUT

Solicitation of Input

OCH is dedicated to improving population health through the coordinated and collaborative actions of communities, Tribes, healthcare and social service providers, first responders, criminal justice, housing, consumers, and payers. Authentic, iterative, two-way conversations and knowledge exchange is key at every stage of the five-year transformation and beyond.

This section responds to areas for improvement identified in the Phase II Certification (P2C) review. Specifically, HCA requested OCH to provide clarity regarding meaningful community engagement and success with partnering providers beyond the opioid response project, and to address lack of specificity and logic regarding community engagement approaches and plans.

Since submission of P2C, OCH employed several strategies to improve outreach and to solicit genuine community connection around the Medicaid Transformation Project (MTP). These strategies include:

- Strengthening OCH's commitment to transparency.
 - Board of Directors (Board) meetings are open to the public, both in person and via Go-to-Meeting.
 - Board materials are posted on the [website](#) on average a week prior to the meeting
 - Public comment is welcomed and solicited at every board meeting.
 - OCH staff analyze, synthesize, and share public input results with the Board. Examples of this occurring recently include: public comment on OCH's request for proposals, which was open for 3 weeks; and public comment on the project plan drafts, which was open for 10 days. (Attachment OCH-Community and Stakeholder Engagement and Input – AttA)
- Providing multiple modes for broad community input.
 - Examples of posted materials for input on our website include solicitation during our request for proposals and during the draft project plan phase. (Attachment OCH-Community and Stakeholder Engagement and Input – AttB)
 - OCH has utilized several different surveys, developed by epidemiologists, to garner community input:
 - Posting of 10 different online surveys since November 2016, open for public comment between 2 weeks and 6 months; to date, the maximum response to a single survey was 477. (Attachment OCH-Community and Stakeholder Engagement and Input – AttC)
 - Advertised and held public informational webinars about Letter of Intent process and the form for project plan ideas. (Attachment OCH-Community and Stakeholder Engagement and Input – AttD)
 - Emailing of a Tribal survey to tribal partners on the project plan portfolio and health priorities in October 2017. (Attachment OCH-Community and Stakeholder Engagement and Input - AttE)
 - Distribution of survey to key Medicaid providers (including Tribal providers) in the region to solicit input on attribution, payer mix, and other data needed for the project plan in October 2017. (Attachments OCH-Community and Stakeholder Engagement and Input - AttF and AttG)
 - At our June 2017 partner convenings, collected and analyzed public input on each proposed project area. These results were presented at the August Board meeting and the September 2017 Convening. Survey results and meeting minutes posted

- online with Board materials. (Attachment OCH-Community and Stakeholder Engagement and Input - AttH)
 - Note cards were distributed at multiple Partners Convenings to allow participants to provide written input and questions. These were later transcribed and reviewed by staff to inform next steps. Participants were invited to provide contact information if they would like to be contacted personally following their input. (Attachment OCH-Community and Stakeholder Engagement and Input - AttI)
 - When asking for public input via the OCH website or e-survey, staff ensure the community receives multiple reminders of opportunity for input, including sending e-newsletter reminders to general listserv, targeted email campaigns to specific committees and Board participants, social media posts, and announcements at public meetings. Recipients are encouraged to recirculate surveys within their communities of practice. Staff attend numerous meetings in the region (existing community coalitions, boards, committees) and make announcements about opportunities to provide input to the OCH. (Attachments OCH-Community and Stakeholder Engagement and Input – AttJ and AttK)
- Engaging Medicaid consumers through various means.
 - The OCH Executive Director has convened one-one meetings with Medicaid consumers to solicit feedback on the MTPs.
 - The OCH Executive Director has attended two meetings with Medicaid consumer groups comprised of persons with severe mental illness and their family members, in addition to two meetings with FQHC boards, which have consumer members.
 - The OCH has issued targeted invitations to Medicaid consumers to participate in the opioid summit and partner convenings.
 - The Tribal liaison has been meeting and dialoging with tribal Councils of seven sovereign nations including clinic staff and tribal members during the past year.
 - The bi-directional system lead has met with two groups of concerned consumers about the access to care for Spanish-speaking individuals, specifically related to mental health care access and regarding services for pregnant/parenting mothers
- Responding directly to community input, concerns, and questions.
 - All partner meetings allow for question and answer times to address community comments and questions.
 - Concerns that are submitted in writing through notecards are reviewed by OCH staff. When appropriate, questions and responses are posted on the OCH website.
 - Input that was received on the draft project plans was provided to project leads for incorporation into project plans as appropriate. A tracking document was created to list each submission of public input as well as actions taken. Public comment on the project plans were shared with the Board ahead of submission. (Attachment OCH-Community and Stakeholder Engagement and Input - AttL)
 - Staff and board email addresses are listed on e-newsletters, allowing partners to directly contact to staff to raise issues and concerns.

Key Elements of Project Plan Shaped by Community Input

The OCH Project Plan has been developed over many months from several iterations of community engagement at varying times. All elements of the project plan in both Domain 1 and Domain 2 required community input. Specific examples include:

- The 3 County Coordinated Opioid Response Project Prevention Workgroup, which has

representation from all three counties, primary care, public health, Tribes, law enforcement, education, housing providers, and behavioral health, recommended the Six Building Blocks for Clinic Redesign and Improved Prescribing Practices to be implemented region wide. These recommendations have been incorporated into the design and planning of the change plans, and are foundational to transformation activities across projects moving forward.

- The Chronic Disease Prevention and Control Project Plan was developed collaboratively by all four hospitals, both FQHCs, two Tribes, all three local health jurisdictions, community-based organizations, two community behavioral health agencies, and the major primary and specialty providers in the region. Providers and community-based partners met several times to discuss feasibility, leverage existing opportunities, explore gaps in evidence-based services, and identify sub-groups most in need of self-management education and care coordination.
- Once the Board approved the six priority projects, based on recommendations from the multi-stakeholder RHAP committee, OCH convened weekly meetings with tribal partners, providers, community based organizations, content experts, and consultants to write the Project Plan collaboratively. Once each project plan was drafted, they were posted to the OCH website for stakeholder input, which was then incorporated into each plan. MCOs, community-based organizations, and providers offered suggestions and critiques to both Domain 1 and Domain 2 content. An example of a concern raised by a stakeholder related to the lack of emphasis on the critical role housing partners will play in reaching the triple aim as the projects roll out. This important input was subsequently addressed across the project plans.

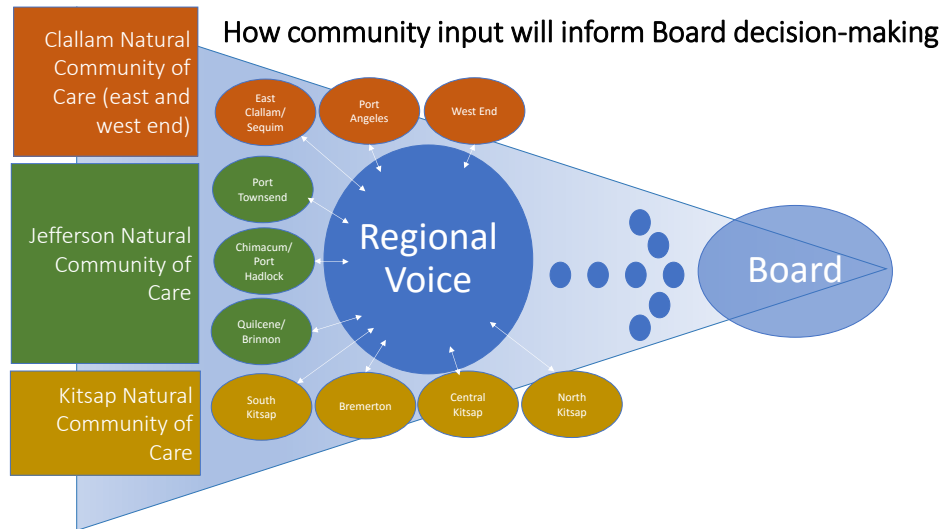
Continuous Future Engagement

One of the most important methods OCH will deploy moving forward is the development of the Board-approved Community and Tribal Advisory Committee (CTAC). The purpose of CTAC is to proactively engage community-based organizations, Tribes, and the beneficiaries of services to ensure that their voice guides and informs the decision making of the OCH. The CTAC will provide recommendations to the Board including but not limited to project implementation, transparent communication strategies, NCC shared change plans, regional whole person health priorities, social justice, and health equity. They will form a critical link to hard-to-reach consumers. The membership of CTAC will be comprised of community groups from under-represented populations or subgroups that experience health disparities. (Attachments OCH-Community and Stakeholder Engagement and Input - AttM and AttN)

The OCH will continue to engage the public directly through Partner Convenings, at least twice a year, an annual opioid summit, open Board meetings, NCC meetings, open webinars and learning collaboratives, and through the CTAC. If requested, the OCH will continue to host monthly meetings with Tribal partners.

At the NCC-level and individual practice level, consumer engagement will inform how OCH reaches hard-to-reach consumers, the development of shared change plans, OCH regional implementation plan, and ultimately OCH Board decision-making (Figure 30). This process is immortalized in the OCH bylaws: *The Board will charge the Community and Tribal Advisory Committee to proactively engage community-based organizations, Tribes, and the beneficiaries of services **to ensure that their voice guides and informs Board decisions.***

Figure 30: Community input informs Board decisions



NCCs will have quarterly strategy sessions, which will provide an opportunity for providers and partner affiliates to learn best practice strategies from each other regarding soliciting consumer engagement and methods to utilize consumer input to inform practice transformation. Providers and partners may invite consumers to participate in discussions around these practice transformations. Existing provider organization and MCO survey data on the Medicaid consumer experience will help inform these discussions.

Where possible, OCH will work with providers and affiliate partners to include within the change plans elements of engagement with consumers as a component of routine practice. It is anticipated that change plans will include transformational activities focused on improving patient-centered interactions, team-based care, and patient outreach – all areas that lend themselves to strategic consumer engagement. Practices may use as guiding principles the six components of the NIH Community Engagement Framework (2nd Edition) - outreach, consult, involve, collaborate, and shared leadership – to guide their change plan strategies.

Engaging Local Governments

Key local government agencies have been involved in the development of the OCH since inception. These include public health agencies from all three counties and County Human Services from all three (including County Commissioners). Kitsap Public Health District was the original backbone agency for OCH.

Local government agencies are well represented on the Board, and have a strong voice in the development of the OCH and the MTP. The following government agencies have seats on the Board:

- Tribal representative seats for each of the seven Sovereign Nations in the region.
- Public health, governed by a Board of Health comprised of elected officials
- Area agency on aging, a department of County government, governed by elected county commissioners
- Salish Behavioral Health Organization
- Public hospitals

There are also seats allocated to quasi-governmental agencies, including:

- Federally qualified health clinics
- Community Action Programs, which provide critical services addressing the social determinants of health, including housing
- Housing Authorities

At the committee level, there is broad government and quasi-government representation, including participation from County commissioners, public health, area agencies on aging, county departments, and Olympic Education Service District.

The Executive Director of OCH has engaged public hospital districts, boards of commissioners, and boards of health across the region through presentations at meetings. Additionally, the executive director sits on the executive committee for Salish Behavioral Health Organization with three county commissioners and an elected tribal representative, allowing for meaningful bidirectional communication between OCH and the BHO.

Addressing Areas of Improvement

Since OCH received feedback on its Phase II Certification regarding meaningful community engagement, the organization has intentionally addressed many of the issues raised, which have already been highlighted in this section. In addition to the above discussion, Table 21 identifies target consumer sectors and agencies OCH has prioritized to engage moving forward. Specific engagement strategies are also listed:

Table 21: OCH has identified engagement strategies for each target group

Target Group	Engagement Strategies
Elderly	Area Agency on Aging Advisory Council representation on CTAC
African American community	Faith-based organization self-identifying as having strong African American leadership and involvement on CTAC
Persons experiencing homelessness	Peninsula Housing Authority or other comparable agency representation on CTAC
Persons with severe mental illness or chemical dependency	NAMI Consumer Advocacy Group representation on CTAC; SBHO SUD Providers Group; Kitsap SUD Providers Group
Pregnant women and parents	Early Head Start/Head Start and maternal/child health non-profit (First Steps or other) representation on CTAC
Persons with disability	Developmental Disability Advisory Board representation on CTAC
Sovereign Nations	Refer to Tribal Engagement strategy
Government department of social services	Invite DSHS to NCCs
Immigrant communities	Immigrant advocacy group representation on CTAC

Attachments - Community and Stakeholder Engagement and Input

The attachments below signify robust public input into the OCH project selection and planning process; therefore all are categorized as *required*.

- A. OCH-Community and Stakeholder Engagement and Input – AttA – Screen Shot Soliciting Public Input I
- B. OCH-Community and Stakeholder Engagement and Input – AttB – Screen Shot Soliciting Public Input II
- C. OCH-Community and Stakeholder Engagement and Input – AttC – Workforce Survey
- D. OCH-Community and Stakeholder Engagement and Input – AttD – Informational Webinar
- E. OCH-Community and Stakeholder Engagement and Input – AttE - Tribal Survey
- F. OCH-Community and Stakeholder Engagement and Input – AttF - Provider Survey
- G. OCH-Community and Stakeholder Engagement and Input - AttG - Partner Survey
- H. OCH-Community and Stakeholder Engagement and Input – AttH - Community Survey Results
- I. OCH-Community and Stakeholder Engagement and Input - AttI - Comment Cards
- J. OCH-Community and Stakeholder Engagement and Input – AttJ – Request for Public Input on Project Plans
- K. OCH-Community and Stakeholder Engagement and Input – AttK – Request for Board Input on Project Plans
- L. OCH-Community and Stakeholder Engagement and Input – AttL – Public Comment on Project Plans
- M. OCH-Community and Stakeholder Engagement and Input – AttM – Community and Tribal Advisory Committee Charter
- N. OCH-Community and Stakeholder Engagement and Input – AttN – Community and Tribal Advisory Committee Membership

TRIBAL ENGAGEMENT AND COLLABORATION

Olympic Community of Health (OCH) benefits from a long history of engagement and partnership with Tribes in the region upon whose land OCH is located. There is a solid foundation of tribal engagement and partnership between the local health jurisdictions, provider organizations, and Tribes in the region that existed prior to the initiation of accountable communities of health and the Medicaid Transformation Project (MTP). This history laid the foundation for further collaboration in the development of the Regional Health Needs Assessment, identification of health priorities and health successes, and informed project selection and planning. In addition, the OCH Director of Community and Tribal Partnership has worked and partnered with Tribes in Washington State for nearly 30 years.

OCH is committed to the long-term process of engagement and partnership 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 (Board). The OCH bylaws address tribal representation on the Board. Six of the seven Tribes are active on the Board and one on the Executive Committee. Three Tribes provided tribal resolutions formally designating representation on the OCH Board (Attachments OCH-Tribal Engagement and Collaboration-AttA through AttC) and three Tribes provided letters of support for OCH's Phase II Certification application. OCH is committed to engaging the tribe that has not been active. OCH is collaborating with statewide partners to assist in outreach and will travel to the reservation for a meeting with tribal leaders.

Tribal and Indian Health Care Provider (IHCP) priorities in our shared region are being identified and incorporated into OCH work, including the MTP and project plan development in the following ways:

- Kitsap County is located on the territories of two of the tribes. One of these tribes was part of the identification of priorities for the Kitsap Community Health Assessment, which rolled up into the Regional Health Needs Assessment.
- While selecting projects, OCH convened monthly meetings with the regional tribes/IHCPs and representatives from the American Indian Health Commission of WA State (AIHC) and the Health Care Authority (HCA) Tribal Affairs Administrator. These meetings provided the opportunity for direct input from tribes as well as the opportunity to stay updated on statewide Tribal/Indian Health Care Provider (IHCP) activities and projects.
- The Director of Community and Tribal Partnership (DCTP) is a member of the Central Council of the Tlingit and Haida Indian Tribes of Alaska and an active member in the American Indian/Alaska Native (AIAN) communities in the OCH region. The DCTP met and spoke with six of the seven Tribes during the OCH Letter of Interest and Request for Application process to hear concerns that resulted in some early and important course corrections and educational opportunities for staff to improve collaboration going forward.
- OCH invited each of the seven tribes to all project plan development and writing retreats. At least one tribe participated in each project plan retreat and often multiple tribes participated. Tribes are partnering on each of the six projects either directly or by supporting the regional effort.
- OCH implemented a survey, "Tribal input for Olympic Community of Health Project Plans", with tribal partners in the region to directly document health priorities, health successes, and opportunities to better collaborate on the MTP. The survey and summary of survey responses are attached. (Attachments OCH-Tribal Engagement and Collaboration-AttD

through AttE). The top three health priorities are addressed in the OCH project plans: chronic disease management, substance abuse, and behavioral health integration.

- The OCH Director of Community and Tribal Partnerships (DCTP) attends and participates in statewide and regional Tribal/IHCP meetings, often as facilitator or presenter. This provides the opportunity to bring relevant information back to OCH and report key findings to inform the Board each month. Examples of meetings include: AIHC, monthly tribal /IHCP HCA meetings, Bree Collaborative Meetings; MH/CD meetings, SBHO Advisory meetings, and others.
- Qualis Practice Transformation Hub Practice Facilitator Coach is partnering with OCH and the tribes to perform assessments on interested tribal clinics. Two have been performed to date.
- Tribes are present at the quarterly OCH convenings where OCH activities are presented and feedback and input are solicited.
- At the request of the Tribes, the OCH executive director and DCTP engage in many conference calls and in-person meetings to discuss the MTP. This allows Tribes to make informed choices about if/how to participate and contribute.
- Tribes send representatives to OCH committee meetings (Regional Health Assessment and Planning 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.

The health priorities of the tribes have informed project selection and planning as described above. In addition:

- Two Tribes provided input into the structure of the change plans (see Theory of Action Section) to honor tribal sovereignty.
- Specific to workforce, several Tribes expressed an interest in autonomy in selecting, hiring, and managing the equivalent of a community health worker, which historically Tribes have termed “community health representatives”. Similarly, three Tribes have identified a dental hygiene workforce that is authorized to serve the AI/AN population, called dental health aide therapist (DHAT), as a priority.
- Two Tribes have expressed an interest in a jail re-entry program to be included in the OCH Diversion project plan.
- Tribes attend OCH project plan meetings and provide input into the crafting of the project plans.
- At least two tribes actively partnered in planning/writing for OCH Chronic Care, Reproductive and Maternal/Child Health, Opioid Response, Diversion, Bi-directional Integration, and Oral Access project plans.

In October of 2017, the Health Care Authority (HCA) approved setting aside MTP funds for tribal/IHCP specific projects. The DCTP has been actively engaged in this and forwards all relevant information, meetings, and materials to tribal partners to support keeping them informed and engaged. The

Tribal/IHCP protocol was submitted to CMS on November 6, 2017 and a response is expected from CMS no later than December 3, 2017. If approved, the timeline proceeds:

- ***IHCP Planning Funds Plan.*** No later than December 31, 2017, the tribes and IHCPs will submit to the state a consolidated IHCP Planning Funds Plan. Upon review and acceptance of the IHCP Planning Funds Plan, the state will issue \$5,400,000 out of Demonstration Year 1 incentive payment funds in accordance with the instructions received from the tribes and IHCPs.
- ***IHCP Projects Plan.*** No later than March 31, 2018, the tribes and IHCPs will submit to the state a consolidated IHCP Projects Plan, which will include both a statewide default project focused on statewide improvement of behavioral health for AI/AN and any additional projects that the tribes and IHCPs agree upon. Upon acceptance of the IHCP Projects Plan, the state will issue incentive payments upon achievement of the milestones in the IHCP Projects Plan in accordance with the instructions received from the tribes and IHCPs.

The DCTP is a member of the statewide tribal/IHCP workgroup to develop the necessary plans; the first workgroup meeting was held on November 14, 2017. The OCH supports the tribes in the region participating in tribal/IHCP specific MTP projects, OCH MTP projects, or a combination of them that meets the needs of tribal partners and communities.

Tribes are involved in OCH project selection and design and have been throughout the process. All draft project plans are distributed to the tribes and IHCPs for review and input. In addition, all information about tribal/IHCP specific protocols are distributed to tribal partners to ensure informed decision making about participation. As OCH transitions into planning and implementation, OCH will work with tribal leaders/IHCPs to invite perspectives from tribal partners regarding how the OCH and the MTP can serve, support, and benefit AIANs in our region.

There were no suggested improvements from Phase II Certification regarding tribal engagement and collaboration. Attached is the OCH policy, which was submitted in Phase II Certification and signed by the Board President (Attachment OCH-Tribal Engagement and Collaboration-AttF). However, the OCH is committed to continuous improvement processes including with tribal and IHCP partners. The OCH will continue to meet monthly with tribal partners during the planning, implementation, and scaling up phases of the MTP and in the broader scope of the work of the OCH over time. Finally, the OCH will explore with the leaders involved to date if and how we can engage the broader tribal member community in the OCH work.

Attachments – Tribal Engagement and Collaboration

- A. OCH-Tribal Engagement and Collaboration – AttA – Lower Elwha Resolution
- B. OCH-Tribal Engagement and Collaboration – AttB – Port Gamble Resolution
- C. OCH-Tribal Engagement and Collaboration – AttC – Suquamish Resolution
- D. OCH-Tribal Engagement and Collaboration – AttD – Tribal Survey
- E. OCH-Tribal Engagement and Collaboration – AttE – Tribal Survey Summary Results
- F. OCH-Tribal Engagement and Collaboration – AttF – OCH Tribal Collaboration and Communication Policy

FUNDS ALLOCATION**Funds Flow Oversight***Governance infrastructure*

The OCH Board of Directors (Board) has ultimate fiduciary responsibility for the planning, management and accounting of DSRIP revenues. Roles and responsibilities are as follows:

- The Board receives budget, accounting and financial management information, advice and guidance from the following advisory bodies and professional expertise.
- The Executive Committee discharges the responsibilities of the Board relating to the transaction of routine, administrative matters that occur between regularly scheduled Board meetings, prepare policy issues for full Board discussion and decision-making, and advise the Director regarding emerging issues, problems, and initiatives.
- The Finance Committee oversees all financial and accounting policies, procedures and practices to maintain and improve the organization's financial health and integrity. The committee applies an independent and agnostic approach to its oversight of the funds flow mechanics under MTP.
- The Funds Flow Workgroup was organized in August 2017 to develop allocation criteria, algorithms, timelines, and processes for allocating DSRIP revenue. The Workgroup includes representation from all counties in the region and one Tribe. Represented sectors include: hospital, tribal clinic, FQHC, public health, elected official, and MCO.
- In the next six months, the Board will organize a Compliance Committee, staffed by the contracts and compliance coordinator, to oversee the funds flow process. The purpose of this committee is to oversee the execution of and compliance with contracts with implementation partners.
- The Board selected an independent audit firm, DZA, to work with the Finance Committee and staff to ensure compliance with federal financial regulations and best accounting practices.

Collaborative process planning and decision-making

OCH is adhering to the following collaborative process to develop detailed funds flow policies and procedures for the management and allocation of DSRIP revenue:

- Beginning in September 2017, and continuing through the first quarter of 2018, OCH staff works with the Funds Flow Workgroup to develop allocation criteria, algorithms, timelines, and processes for allocating DSRIP revenue. The Board receives progress reports from the Workgroup throughout the development process.
- Between December 2017 and February 2018, OCH convenes providers and stakeholders within each Natural Community of Care (NCC) to review funds flow policies and procedures (allocation criteria, algorithms and timelines). An NCC is a community of resources and providers that serve the same population due to geographical proximity, natural referral patterns, and collaborative service agreements. The Workgroup collects feedback from these detailed review sessions to further refine its recommendations to the Board.
- Workgroup recommendations are reviewed by the Finance and Executive committees, and posted on the OCH website for public review, before final review and adoption by the Board.
- Funds Flow Management and Oversight Process
- OCH will rely on fully-documented collaborative agreements and contracts to govern the allocation of DSRIP revenue.
- Each NCC will have a collaborative agreement that outlines shared expectations for how incentives are earned and allocated to participating partners.
- Each partnering provider and community organization will have a contract with OCH that specifies the terms and conditions for participating in the MTP, performance reporting requirements, fund allocation criteria, shared responsibilities with other NCC partners and stakeholders, and procedures for dealing with grievances and resolving disputes.

Roles, responsibilities, and relationships: OCH governance and implementation partners

The Board is responsible for establishing the policies, procedures and requirements governing all MTP activities, including all aspects of allocating and accounting for earned DSRIP revenue to OCH partners. Partnering providers are responsible for fulfilling the terms and conditions set forth in their NCC's collaborative agreement, and their OCH contract, including the timely, complete and accurate reporting of all MTP activities. OCH anticipates the use of the following process to allocate all DSRIP funds earned by the regions during the MTP.

Each year the Board will approve the release of DSRIP funds to partnering providers and the OCH itself according to an agreed-upon allocation algorithm and timeline. The algorithm and timeline will be incorporated into contracts between the OCH and partnering providers. Any increases or decreases to authorized allocation amounts greater than 10% require Board re-authorization.

Staff will prepare reports for the Board that cross tabulate provider performance against the algorithm. Staff will recommend funds allocation based on this report. Staff recommendations may also include potential mediation or termination actions (see Monitoring and Continuous Improvement section of each Project Plan) for non-performing partners.

Following Board authorization, a designated OCH administrator will enter the Financial Executor portal to set up the funds transfer; a second administrator will verify the settings and approve the transfer. Discrepancies will be sent to the OCH Director of Administration and Financing for reconciliation. All discrepancies will be reported to the Compliance Committee (see below) within 2 business days to determine root cause and any whether any corrective action may be needed.

Stewardship and transparency of DSRIP funds

The OCH governance structure (see the response to governance above) provides oversight of all DSRIP revenue, independent auditing of financial transactions, and public reporting of OCH financial activity. In addition to the regular oversight activities, OCH will implement the following additional practices:

- At a minimum, the Board will receive a detailed program and financial reports on the status MTP activities, including detailed reports for each NCC. All MTP progress and performance reports will be posted to the OCH website and distributed to all Board members, participating partners, stakeholders, and interested stakeholders.
- At least once per year, OCH will conduct public forums in each NCC to share information on the progress of MTP activities, and receive feedback from community and tribal partners, consumers and stakeholders. OCH staff will report all contributions from these convenings to the Board, and post all feedback on the OCH website.
- At least once per year, OCH will convene all participating partners as a learning community to share lessons learned from MTP activities, identify successful practices, and brainstorm strategies to overcome obstacles to high performance.
- At Board meetings, OCH will provide time for public comment to receive “real time” feedback.

Significant changes since Phase II certification in funding, in-kind support, and internal financial tracking

Aside from the reduction in earnable DSRIP funds across the state, there have been no significant changes in state or federal funding or in-kind support to OCH since Phase II Certification. OCH added two categories to the financial tracking system to align with MTP activities: 1) Project Design Fund Categories: OCH Project Plan Development, Engagement, ACH Administration/Project Management, Information Technology, Health Systems and Community Capacity Building, Other, and 2) DSRIP Fund Category

Project Design Funds*Past, current, and projected use of Project Design Funds*

Between June and November 2017, Project Design funds were expended to support the development of the Project Plan Application. By the end of September, \$74,048 was expended for this purpose. Specifically, OCH engaged the following professional services to help plan and write the Project Plan Application:

- *Kitsap Public Health District (KPHD)* – provided analytics and evaluation to support selection, design, and monitoring of projects; Chronic Disease project plan
- *Walter Sive* – provided performance metric alignment and modeling, and data and monitoring system design
- *Rochelle Doan* – led bi-directional integration of care project plan
- *Jody Carona* – performed portfolio assessment and planning with hospital partners
- *Brian Burwell* – assisted in opioid treatment/prevention project plan

OCH engaged Rob Arnold to work towards interoperability between substance use treatment providers and primary care providers treating patients with opioid use disorder. OCH has expended \$5,000 of an authorized \$45,000 on this activity to date.

Beyond the Project Plan application, OCH budgeted 75% of Project Design funds to support administration and operations through 2023, 5% for consumer empowerment and policy advancement, 10% to improve care coordination through improvements in health information technology, and 10% to support change management within partnering provider organizations.

Funds Flow Distribution

OCH anticipated funds flow distribution (Please refer to OCH Workbook – Funds Distribution 1 & 2)

The following response describes OCH’s approach to allocating project incentive revenue to MTP use categories, and in turn, to itself, its participating providers and other partners. Consistent with OCH’s Theory of Action, these allocations are driven by a community-based focus on health care transformation.

Distribution of funds will be based on a dual-layered algorithm: based on potential earnings by each Natural Community of Care and each partnering provider organization. (Table 22) Columns A thru D in OCH’s incentive allocation approach (Table 22) have been reviewed conceptually by the Board with unanimous support. Each NCC will develop a shared change plan. Each partnering provider organization will develop a change plan that aligns with the NCC shared change plan. The amount of earnable incentives will depend, at least in part, on the transformational activities described in the two change plan documents and performance on quality improvement measures, to be determined and included in provider contracts. The algorithm criteria followed the following criteria: 1) data are available; 2) rationale and underlying drivers are transparent and reflective of real challenges and successes; 3) (for provider reporting) data are easy to compile and report to OCH, and 4) measures align with existing provider contracts and reporting responsibilities.

The funds flow allocations by use category reported in the Distribution 1 worksheet of the attached supplemental workbook are derived from Table 23, and redistributed to reflect the required use categories in the workbook. The funds flow allocations by organization type are reported in the Distribution 2 worksheet of the attached supplemental workbook and are derived from a modeled estimate of project plan revenue (Table 23), allocated to major types of participating organizations in DY2 (2018).

Table 22. OCH Incentive Allocation Approach

Potential Earnings by Natural Community of Care				Potential Earnings by Partnering Provider Organization		
A	B	C	D	E	F	G
# Medicaid beneficiaries in Natural Community of Care	PRISM Score	Community Needs Index	Baseline Allocation	# Outpatient claims/# unique beneficiaries/ attribution	Quality Improvement Measures (TBD)	Baseline self assessment factor

Funds Flow Design to date

OCH has adopted three CORE ASSUMPTIONS for modeling fund allocation:

1. OCH will earn 90% of potential Pay-for-Reporting. Budget (allocate) 90% as baseline payments to provider partners, and reserve (set aside) 10% for bonus allocations.
2. OCH will earn 25% of potential Pay-for-Performance incentives, and budget 100% earned incentives for bonus allocations.
3. All reserves and reinvestment pool incentives will be allocated as bonus (see definition of bonus below).

In October 2017, the Board agreed on DSRIP fund allocation drivers (Table 23) to ensure transparency of DSRIP funds allocations over the course of the Demonstration. This approach, recommended by the Funds Flow Workgroup, assigns proportions to each program component for each revenue category, and contemplates future investment in upstream prevention and wellness projects, depending on future cash flow estimates.

“Bonus” is the sum of Pay-for-Performance incentives (100%) and the set aside of Pay-for-Reporting (10%) incentives. Beginning in 2021, OCH expects to allocate Bonus payments to providers, and the OCH itself, consistent with terms of Demonstration participation contracts. The allocations will be spread across three years.

“Baseline” incentives are derived from 90% of earned Pay-for-Reporting incentives. Beginning in 2018, OCH expects to allocate Baseline incentives to providers over 5 years. Baseline allocations will be authorized as soon as (1) the Financial Executor confirms receipt of earned P4R incentives, and (2) OCH completes its internal performance review of partnering providers. Baseline allocations will occur at least two times per year to encourage providers to undertake transformation and integration activities.

Table 23. DSRIP Fund Allocation Drivers

Drivers for Funds Flow Allocation				
Program Components	Design	Project Plan	Baseline	Bonus
Change Plan Activities - Provider Payments			90.0%	85.0%
Capacity and Infrastructure				
Domain 1 Projects		75.0%		
IT Care Coordination	10.0%	5.0%	5.0%	
Advocacy and Empowerment	5.0%	5.0%		
Community Projects (SDOH, etc.)		5.0%		5.0%
Other Initiatives				
Upstream Prevention and Wellness			5.0%	
Reserves				5.0%
Operations & Administration (OCH)	75.0%	10.0%		5.0%
Provider-Based Project Management	10.0%			
Total Funds Flow Allocation	100.0%	100.0%	100.0%	100.0%

A few additional highlights describing OCH's funds flow approach:

- Incentives to cover OCH operations and administration are mostly drawn from Project Design Incentives (75%) for and Project Plan Incentives (10%).
- In DY 1 (2017), OCH is not allocating incentives to partnering providers. The only investment of DY 1 incentives outside of operations is to support the development of interoperability between substance use treatment providers and primary care providers.
- In DY 2 (2018) and DY 3 (2019), OCH is frontloading incentive allocations to prepare provider organizations for transformational activities.
- Between DY 2-5 (2018-2021), OCH is proposing to allocate \$3.3 million dollars towards Domain 1 activities, \$2.3 million of this investment will go straight to providers and \$1 million will be invested on behalf of providers and other project partners by OCH for regional Domain 1 investments, such as regional provider training in safe opioid prescribing (Six Building Blocks for Safe Opioid Prescribing).
- The largest category of incentives is quality incentive payments to providers and other partners, an estimated \$12.2 million between October 2018 and April 2023.
- Consumer empowerment is a priority; OCH will incentivize activities that will promote personal change to support healthier behaviors, so the impacts will continue beyond MTP.
- OCH funds flow modeling goes out to 2023, 2 years beyond MTP. Briefly, OCH estimates \$1.5 million in BONUS allocation and \$443,000 in BASELINE allocation in 2022 and 2023.
- During 2021 through 2023, OCH plans to ramp down its project management and administration, considerably.
- In 2021, OCH will consider possible creation of a wellness fund, contingent on the balance in the risk reserve and the overall success of MTP in the region.
- In 2023, OCH plans to transfer any balances in the reserve for contingencies to a wellness fund or to bonus payments to participating providers and other partners.
- Consistent with its conservative approach to financial planning and budgeting, OCH does not anticipate awards from the VBP incentive funds ("reinvestment" revenues). If earned, these revenues will be treated in the same manner as P4P incentives and reserved for bonuses, a wellness fund and reserves for operating contingencies.
- The counties in the Olympic region have opted out of the Mid-Adopter incentive program. As a result, the OCH budget does not include Managed Care Integration incentive funds.

ATTESTATIONS

OCH is not eligible for Managed Care Integration Incentive funds, so they are not included in the supplemental workbook or narrative and tables presented above.

Attest to whether all counties in the corresponding Regional Service Areas (RSAs) have submitted a binding letter of intent (LOI) to integrate physical and behavioral health managed care.

YES	NO
	X

Attest to whether the ACH region has implemented fully integrated managed care.

YES	NO
	X

If the ACH attests to having implemented fully integrated managed care, provide date of implementation.

DATE (month, year)	Not applicable
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If the ACH attests to not having implemented fully integrated managed care, provide date of projected implementation.

DATE (month, year)	January 1, 2020
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Attachments – Funds Allocation

Please refer to OCH supplemental workbook tabs Funds Flow Distribution-1 and Funds Flow Distribution-2 for projected funding by use category and organization type. *Required*

REQUIRED HEALTH SYSTEMS AND COMMUNITY CAPACITY (DOMAIN 1) FOCUS AREAS FOR ALL ACHS

Domain 1 Strategies

All selected projects under consideration will benefit from capacity building in the areas of workforce, population health management systems, and value-based payment readiness strategies. Table 24 shows capacity building alignment across all project areas. Each green cell indicates foundational infrastructure needs for at least one evidence-based strategy within that project. The categories in the left column are not mutually exclusive. They are interrelated with one another, value-based payment (VBP) contracting, and population health management systems. For example, investments in IT infrastructure to support registries and risk stratification will prepare an implementation partner for VBP contracting and require a specialized workforce to manage and operationalize these new systems. The networked nature of these inter-relationships is indicated by two parentheticals: “PHS” for population health systems and “VBP” for VBP contracting. (Table 24)

There are several capacity investments that would support all project areas: capacity infrastructure for health information sharing; development and management of tools such as registries and risk stratification; a decision-support technology that can assist with population health management and analytics; care coordination, including referral management; and patient outreach and engagement. These are indicated as a solid green bar across all projects. (Table 24)

The foundational investments or infrastructure needs identified in Table 24 will be incorporated into the change plan template (see Theory of Action Section) for each implementation partner and Quality Improvement Plan for each project. Some Natural Communities of Care (NCCs) are discussing sharing infrastructure such as technology and workforce. Therefore, the shared change plan may also address Domain 1 investment strategies.

What is a Natural Community of Care (NCC)?

An NCC is a community of resources and providers that serve the same population due to geographical proximity, natural referral patterns, and collaborative service agreements.

SECTION 1 -REQUIRED HEALTH SYSTEMS AND COMMUNITY CAPACITY
(DOMAIN 1) FOCUS AREAS FOR ALL ACHS

Olympic Community of Health

Table 24. Domain 1 Potential Strategies by Project Area

	2A	2D	3A	3B	3C	3D
Foundational investments or infrastructure needs at the provider organization level to implement projects	Bi-Directional Integration	Diversion	Opioid Response	Reproductive, Maternal and Child Health	Oral Health Access	Chronic Disease Prevention and Control
Capacity Infrastructure Strategies						
Health information sharing (VBP) (PHS)						
Bricks and mortar						
Registries (VBP) (PHS)						
Risk stratification (VBP) (PHS)						
Operatories						
Referral Management (VBP)						
Analytics - Decision support technology (VBP) (PHS)						
Supplies						
Workforce Strategies						
Telehealth						
Population Health Analytics (VBP) (PHS)						
Cross training and redefine role						
New workforce						
Scope of practice (advocacy)						
Retraining/Certification/Uprtraining						
Recruitment						
Retention						
Shared workforce						
Mobile workforce						
Virtual team-based care						
Curriculum development/support						
Connect to residency programs						
Transformation Strategies						
Patient Centered Medical Home (VBP) (PHS)						
Integrated, whole-person care						
Team-Based Care						
Care Management (VBP)						
Care Coordination incl. Referral Management (VBP) (PHS)						
Enhanced Access (VBP)						
Patient-Centered Interactions/Engagement (VBP)						
Organized, Evidence Based Care (VBP)						
Provider-Team/Patient Relationship (VBP)						
Empanelment (VBP)						
Quality Improvement Strategy/Workflows (VBP)						
Engaged Leadership						
Patient Outreach (VBP)						
VBP: Supports successful VBP contracting						
PHS: Supports development of high-functioning population health management system						

Value-Based Payment Strategies

OCH: Shift to VBP Sustains Transformation of Region's Projects

OCH Board of Directors (Board) supports investing in core health system capacities to transition the health delivery system to financial sustainability through alternative payment models, meeting the Healthier Washington goal of 90% of state payments tied to value by 2021. OCH regional activities build off of the State's Medicaid Value-Based Payment (MVBP) Action Team planning and implementation strategies to create a Regional VBP Transition Plan that will:

- identify implementation strategies to attain statewide VBP targets
- define a path toward a VBP Transition Plan reflective of readiness and implementation strategies for selected Domain 2 and 3 projects, including encouraging provider participation in annual statewide VBP surveys
- refine the Transition Plan as needed to achieve progress on annual targets necessary to meet 2021 Goal

Promoting the 2017 Provider VBP Survey

In support of the MVBP Action Team, OCH accepted the role of:

1. validating the level of VBP across the region;
2. supporting assessment of VBP across regional providers systems;
3. developing projects that will assist in implementation of taskforce recommendations;
4. disseminating state and regional efforts on VBP; and
5. disseminating learnings from VBP taskforce.

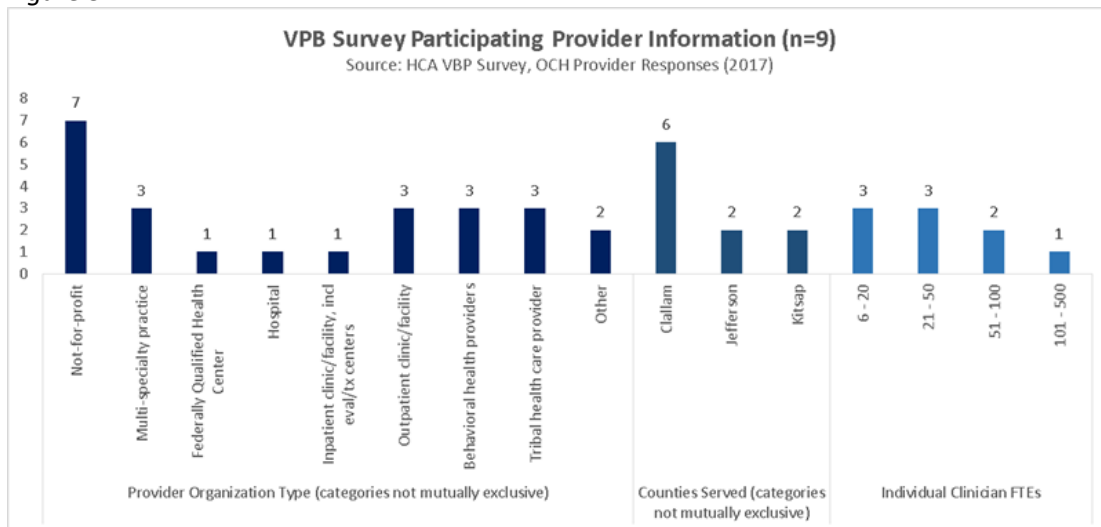
OCH Board members Joe Roszak, Karol Dixon, and Caitlin Stafford are participants in the MVBP Action Team and inspired staff to actively promote the 2017 Provider VBP Survey upon its release by HCA in July. OCH also requested to HCA that individual provider survey results be made available for regional analysis. Subsequently HCA inserted a question asking if providers would be willing to share their responses directly to their ACH and actively, repeatedly promoted it post release. OCH was able to review both the aggregate data provided by the HCA at end of survey and detailed responses from 10 provider organizations, included in our analysis below. (Figures 31-32) OCH will make available and discuss survey results on an annual basis with its Board and providers, with discussion of responses that might shape recommended actions to remain on target in achieving 90% of state payments tied to VBP by 2021.

In addition to Healthier Washington announcements regarding the survey, OCH encouraged provider participation during the open response period by emailing three separate messages directly to each provider, posting two web-based newsletter releases, posting information on the OCH website, and providing information and encouragement during OCH board meetings. Despite these efforts, provider response was somewhat lagging, which might be attributed to timing (late summer), survey fatigue, and unfamiliarity for some providers regarding VBP.

Current state of VBP among OCH providers

Aggregate results of the survey indicate participation by the following provider respondents:

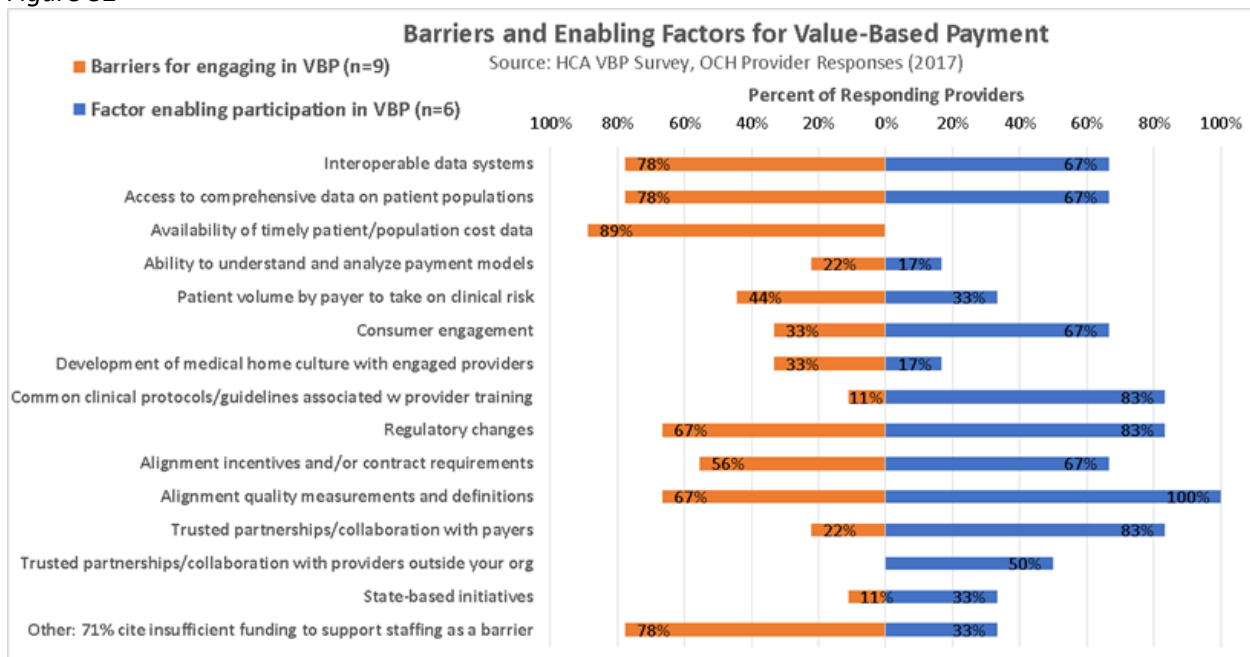
Figure 31



Respondents included many of our largest Medicaid providers, including both FQHCs, three of four of Community Behavioral Health Providers, and many of our large primary care practices. Three of seven Tribal nations within the OCH region responded.

The OCH Board has begun more in-depth conversations regarding VBP beyond the survey and the MVBP Action Team, and many partners had already been participating in state and national webinars regarding VBP. Information and Healthier Washington presentations were introduced to the Board and OCH Funds Flow Workgroup starting in August, and this information and the Workgroup discussions were shared with the Executive Committee and Board in September. Workgroup updates and new VBP information will continue to be discussed at each Board meeting.

Figure 32



The most concerning barriers (between 78% - 89%) included: insufficient funding to support staffing, availability of timely patient/population cost data, access to comprehensive data on patient populations, and interoperable data systems. Overcoming each these barriers will be critical to care management and care coordination, which is foundational to meeting VBP benchmarks. Secondary but important concerns (67% each) were alignment of quality measures and definitions, and regulatory changes.

Board discussions are consistent with the survey responses. Several providers already engage in VBP and are satisfied with the experience, though some note that VBP is a small subset of their overall reimbursement. Anecdotally, there appears to be a high level of anxiety about entering into alternative payment models, particularly among providers from Clallam County where managed care has not been introduced, and small, rural providers, where patient volume is low and administrative infrastructure is lacking.

The most favorable enablers were: alignment of quality measures and definitions (67%), trusted partnerships, and regulatory changes (56% each). OCH is committed to building and maintaining trust among partners over the course of the MTP, recognizing that trust is the foundation for both the difficult conversations ahead and for effective implementation that achieves the VBP goals.

The shift to VBP is in its early stages, and for respondents to the question regarding their experience with VBP, values ranged from Very Positive (4) to Neutral (1), Negative (1) and Not Applicable (3). Over the course of one year, the projected change in percent of revenue from volume-based to value-based payment was as follows: 25 – 50% = 1, 10 – 24% = 4, with 4 respondents indicating they anticipate their revenue from VBP will stay the same. It is unclear if these responses are representative of all providers in the region, and we expect to learn more over the course of the next six months.

Promoting VBP across all Projects

OCH is accountable to its partners and is therefore focusing transformational activities under the MTP on preparing providers to enter into, and succeed under, these new VBP contractual arrangements. This is reflected in OCH's focus on Domain 1 throughout this project plan proposal. (Table 25) Improved system interoperability and data analytics will improve care management and care coordination capacity, lower unnecessary utilization thus reducing costs, and improving patient management for improved health. Creating solutions to increase workforce capacity is vital to provide quality care to people in our region, particularly in rural, isolated areas.

Table 25. Building Infrastructure: OCH Approach to VBP Strategies in All Projects

	By OCH Project	Value-Add	
2 Care Delivery Redesign	2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	Better coordinated care More seamless access to care, across service type Better coordinated care across continuum of health, particularly for enrollees with complex health needs (Domain 1 – IT Care Coordination) Decreased unnecessary ED visits	Improved Quality & Reduced Costs Sustainability through VBP for all projects
	2D: Diversion Interventions	Increased access to primary care and social services, particularly for underserved populations Decreased unnecessary ED visits	
3 Prevention & Health Promotion	3A: Addressing the Opioid Use Public Health Crisis	Better coordinated care Improved opioid-related prevention, treatment and recovery supports Reduced opioid-related morbidity and mortality Decreased unnecessary ED visits	
	3B: Reproductive and Maternal/Child Health	Better coordinated care Increased access to high-quality reproductive health & children's services	
	3C: Access to Oral Health Services	Better coordinated care Increased access to oral health services Reduced incidence of oral disease Decreased unnecessary ED visits	
	3D: Chronic Disease Prevention and Control	Better coordinated care More integrated care Improved chronic disease management and control Decreased unnecessary ED visits	

OCH and the Pathway to VBP

OCH understands that its role is to help providers prepare for and ultimately succeed in providing value-based care. OCH business meeting and convenings regularly host frank, spirited, respectful discussions on this topic, allowing OCH to serve as educator, convener, advocate for practice transformation, and driver of sustainable reform. In September 2017, the OCH Board authorized a workgroup comprised of local providers and MCOs to agree on the following four foundational elements:

I. *Guiding principles*

- OCH does not interfere with MCO-provider contracting
- Great care is taken to avoid collusion; shared understanding of boundaries
- Efforts support sustainable transformation, clinical integration, and VBP contracting
- Share best practices
- Assumption: Current fee-for-service contracts do not align quality incentives.

II. *Definitions of success*

- Improved provider-MCO relationship with transparency
- Provider organizations are supported in transformation efforts
- MCOs hit VBP targets
- Providers hit VBP targets and earn incentives
- Transformation is sustainable
- Measurable health improvement
- Value-based care is the cultural norm

III. Role of OCH in the pathway to VBP

- Convener
- Facilitate assessments
- Aggregator and sharer of information, especially as it pertains to DSRIP investment needs
- Alignment for a regional strategy
- Monitor progress, facilitate mid-course adjustments

IV. Method of implementation

- Identify target organizations
- Iterative process to design and write action plans
- Piggy-back off current infrastructure between providers and MCOs
- Leverage/integrate existing organization-specific action plans into change plans
- Organize around Natural Communities of Care
- Offer workshops, webinars, and technical training, summits
- Continued partnership and dialogue with MCOs

Change Plans: OCH Strategy to Achieve VBP targets

Change plans are the OCH's lynchpin for achieving VBP benchmarks. Each NCC will agree on a shared change plan, a compact between the implementation providers that outlines shared strategies and collaborative agreements. OCH will facilitate arrangements between providers within the NCC, such as workforce and shared IT solutions, data-sharing agreements (DSA) and business associate agreements (BAA). Regional investments such as these, particularly if they are shared across provider organizations, are essential to helping providers achieve VBP targets.

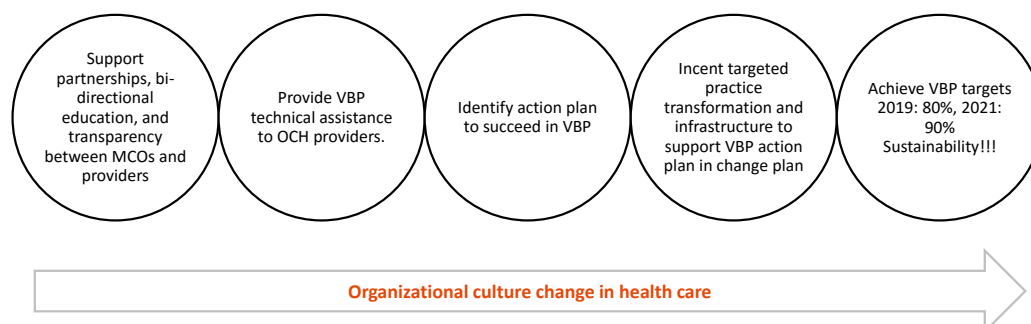
Each implementation partner will submit a change plan to OCH which outlines workflows and clinic redesign elements, and is aligned with the NCC's shared change plan. Change plans will be designed to accelerate practice transformation and integration, incentivizing strategies such as team-based care and care coordination, and tactics such as chlamydia screening, oral health screening, depression screening, and HbA1C control. The change plan will also incentivize workforce development, VBP contracting, and population health management. Provider reporting on change plan progress will highlight performance challenges or barriers to implementation early on, leaving more opportunity for course correction before the 2021 target.

All implementation partners will be asked to participate in a baseline assessment, which will include an assessment of workforce, population health systems, and change elements for PCMH-A, all integral to providing value-based care. The baseline assessment will be built into the change plan. This will help OCH target technical assistance, either externally, from MCOs or the Practice Transformation Hub, or by sharing best practices and lessons learned from other implementation partners in the region. OCH is actively talking with MCO partners on how and when to deliver technical assistance to providers.

Acknowledging the MCO's role in Medicaid health systems transformation beyond MTP, in May 2017 OCH scheduled five meetings between the OCH executive committee, executive director, and senior leadership of each MCO to discuss mutually beneficial VBP goals to sustain the transformation and a shared work plan to get there. From the outset, OCH has focused on sustainability and will not move forward with projects that cannot be sustained. Through change plans and a focus on sustainability, the stage is set for achieving the goal of 90% VBP by 2021. (Figure 33)

Figure 33

Value-Based Payment: OCH Pathway to 2021

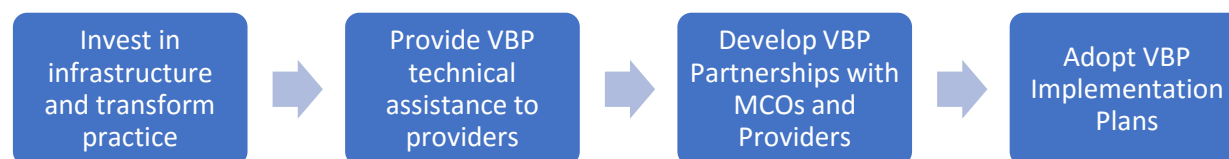


OCH is committed to helping implementation partners achieve their VBP benchmarks, thereby ensuring sustainable transformation. To these ends, OCH has taken the following actions:

- Sustainability was one of 10 required criteria in OCH project proposal selection.
- OCH prioritized evidence-based programs that support practice transformation, workforce development, and system redesign, as these are essential steps in achieving sustainable, value-based care. Examples of these include the extensive work throughout the region to achieve whole person integrated care through evidenced bi-directional care models.
- Because care management and care coordination are foundational to VBP, both are woven throughout the projects using population health management approaches.
- Staff analyzed inputs from project proposals (e.g., target population, budget) and the two required projects to identify and crosswalk potential alignments in workforce, VBP, transformation, and population health IT management.
- OCH research and planning efforts exposed the limited extent to which earnable DSRIP incentives will cover transformation costs; highlighting the importance of funds flow strategies the encourage performance and leverage direct investments by implementation partners.
- OCH recognizes the importance of the State Accountability Measures (SAM); therefore, the projects and programs were cross-walked to ensure alignment between project, project-specific metrics, and SAM metrics.

The OCH Board has been highly engaged in discussions regarding sustainability and alternative payment models. Many providers have taken advantage of VBP education offered through professional associations and learning collaboratives, Healthier Washington and Qualis webinars, AIMS Center tools. 2017 Board presentations have included review of OCH role in advancing VBP capabilities among providers, key elements for providers to ensure VBP infrastructure capabilities, reflection on an OCH pathway for VBP, and shared understanding of the underlying principles for successful VBP informing the OCH portfolio plan and project selection. These OCH assumptions for sustainable regional design include Domain 1, 2 and 3 strategies to set the stage for VBP. (Figure 34)

Figure 34



Workforce Strategies

Advancing statewide and regional innovations to develop workforce capacity

OCH workforce strategies provide a foundation of sustainable, community-based, and ultimately statewide delivery system transformation. OCH preliminary considerations and approaches to adapt workforce strategies across all selected projects can be seen in Table 24.

Identifying the OCH workforce

Administering payment and service delivery activities

OCH executive director, with HR and Manatt consultation and Board approval, assessed organizational staffing needs to support OCH functions under MTP, including supporting payment and service delivery transformation activities. DSRIP funding remains unstable, requiring OCH management to be nimble and adaptive to changing circumstances. The immediate goal is to "right size" the staff to meet the administrative needs of the MTP, while providing a certain level of competency for a subset of more technical and professional positions, such as the new Clinical Transformation Manager hired November 2017. In the short term, OCH will direct DSRIP investments to clinics to internalize change management to support MTP planning and ramp-up to implementation. Each NCC may choose to have a single change manager, either employed by OCH or by collaborative agreement through a member of the NCC. These conversations will occur during DY2 Q1.

Assessment of current workforce capabilities, capacity, and gaps

Preliminary considerations for strategies to achieve a transformed workforce were derived from the OCH process for developing elements essential to workforce planning. Consideration involved four elements:

1. Conducting a variety of needs assessment processes to assess workforce capacity needs and possible strategies;
2. synthesizing assessment findings to inform and support project planning;
3. leveraging partnerships during the shared change plan process - existing partnerships within the NCCs to identify workforce solutions and determine and prioritize which strategies to employ; and
4. engaging with training and education providers for new workforce preparation, up-training of existing workforce, and sharing of best practices.

During spring 2017, OCH requested information from collaborating partners during a letter-of-intent (LOI) and request-for-proposal (RFP) process for optional projects. Collected workforce information included current type and number of clinical and non-clinical employees. Budget line items included additional project workforce. This information helped inform planning of additional capacity and service gaps. Examples of requested additional workforce included community health workers, population health managers, health analysts, dental hygienists, and diabetes educator.

OCH entered into a collaborative agreement with Qualis to share data from Practice Transformation Hub assessments conducted with primary care and behavioral health providers. Providers were requested to share results with the OCH, with 24 participating sites to date. Assessments identified bi-directional care workforce needs.

Executive leadership from all four hospitals participated in an OCH hospital strategic alignment assessment. Hospitals identified a shared priority to implement bi-directional integration; however, workforce challenges seriously threaten the success of this endeavor. Identified behavioral health

workforce shortages included Psychiatrists/ARNPs, LCSWs and LMHPs, CDPs, and population health staff in analytics and care management. Project Plan 2A details potential workforce solutions toward implementing integration, such as increased capacity to employ population health strategies for care management; increased use of telehealth especially for behavioral health care; innovation in recruitment and retention such as increasing peer support networks in rural areas; sharing positions across agencies; redefining roles; practicing at top of license, advocating for changes in scope of practice; creating efficiencies in workforce hiring; virtual team based care and/or mobile workforces; and partnerships with educational institutions and residence programs for workforce preparation and uptraining of new or existing workforce.

Review of provider workforce rates per 100,000 population identifies significant disparities compared to the state average and within the OCH region. 2016 physical health provider workforce rates compiled by the University of Washington Center for Health Workforce Studies indicate that the OCH region has fewer physicians, primary care physicians and ARNPs compared to the state and a higher rate of RNs. Notably for physicians, county level rates identify differing levels of capacity by place – Jefferson has the lowest rate of physicians overall but has the highest rate of primary care. Kitsap has the lowest rate of primary care. Clallam has the highest rates of all physicians and primary care; however, these rates do not show the deep complexities related to accessing care in rural/isolated and low-resource communities. Additional provider data made available by HCA for mental health care providers (2015) and dental providers (2014), although not as recent, show Jefferson with high rates of mental health care providers and very low rates of dental providers. Clallam and Kitsap have mental health care provider rates below the state average. Clallam has a substantially higher dental rate compared to the region and state averages. (Table 26)

Table 26. Rate of Providers per 100,000 Residents

	Year	WA	Region	Clallam	Jefferson	Kitsap
All Physicians providing direct care	2016	229	170	189	145	168
Primary Care providing direct care	2016	81	67	83	87	60
Licensed ARNPs	2016	73	65			
Licensed RNs	2016	972	1007			
Mental Health Care Providers	2015	263	241	235	288	237
Dental Providers	2014	77	74	91	50	73

MD Source: Washington State's Physician Workforce in 2016, UW WWAMI AHEC & UW CHWS, accessed [here](#), November 2017.

ARNP/RN Source: Washington State Data Snapshot: Registered Nurses (RNs). UW CHWS & WCN. Accessed [here](#), November 2017.

MH, Dental Source: HCA AIM RHNI, 4.25.17

Review of sentinel health provider workforce data collected April-May 15, 2017 by the University of Washington Center for Health Workforce Studies identified two workforce issues from OCH area respondents (n=12). First, respondents cited exceptionally long vacancies for registered nurses (50% of respondents), mental health counselors, medical assistants and clinical social workers (25% of respondents). Drivers of long vacancies were insufficient qualified applicants and salary/wage/benefit issues. Second, there has been an increase in demand for several key positions: mental health counselors and registered nurses (33% of respondents), and clinical social workers and psychiatric aides (25% of respondents). Drivers of increased demand were high turnover and competition. OCH interprets

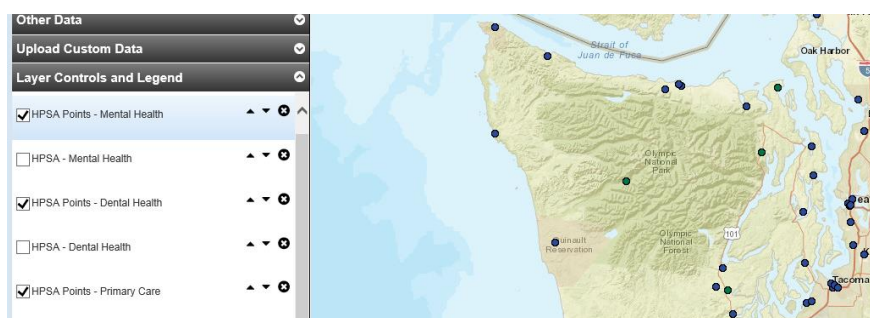
these data with caution due to uncertainty of representativeness of respondents and small sample size. (Washington State Health Workforce Sentinel Network, accessed [here](#), September 2017).

Washington's Behavioral Health Workforce Assessment identified key findings and recommendations at the state level, some of which are actionable at the OCH regional level. For example, there are barriers to behavioral workforce recruitment and retention; limited quality applicants, lack of professional development opportunities and access to education and clinical training; burdensome administrative requirements that compete with patient care; and low reimbursement rates. OCH's rural setting poses additional challenges. There are also challenges in education and training of evidence-based practices associated with integration of behavioral health with physical health care.

Potential recommendations to address these challenges include increased Medicaid reimbursement rates; expanded opportunities for programs that provide loan repayment; better leverage of telemedicine and telehealth; increased access to clinical training sites and residency opportunities; increased availability of quality clinical supervision; and increased resources for continuing education and training support (McCarty et al., Washington Behavioral Health Workforce Assessment: Input from Key Informants, accessed [here](#), November 2016)

Review of current HRSA designations for health professional shortage areas (HPSA) demonstrates workforce gaps across the OCH region. Primary care shortages exist for specific low-income population groups in Clallam and Kitsap, as well as for specific service areas in Clallam and Jefferson and in facilities in all three counties. Dental shortages exist for low-income population groups in the east side of Clallam County, the west side of the Olympic Peninsula, and in facilities in all Clallam and Kitsap counties. Mental health shortages exist for the entirety of all three counties and in facilities in Clallam and Kitsap counties. (Figure 35) (Data Warehouse, HRSA, accessed [here](#), November 2017)

Figure 35. OCH Region Health Professional Shortage Areas



Implementing an OCH Workforce Plan

The OCH will share the workforce capabilities, capacity, and gap identified by these various assessments to support individual provider and NCC change plans, helping draw connections, make linkages, and encourage collaborations and innovative responses to workforce opportunities and challenges. Change plans will reflect workforce planning aimed at organizational goals, which will align with OCH proxy measures and VBP benchmarks, aligning for maximum impact. OCH's preliminary approach to adopting workforce strategies across all projects is described below and within each Project Plan. Of note, the change plan process with partnering providers will define the final OCH Workforce Plan.

- *Innovations and Creative Staffing Solutions* - Examples: Shared workforce, telehealth, advocacy for policies/regulations supporting workforce solutions, shared recruiting strategies, mobile workforce, virtual team-based care,

- *New Workforce* - Examples: Population Health Analysts, Community Health Workers, Community Paramedics
- *Training* - Examples: Cross training, redefined roles, retraining/certification/uptraining, curriculum development/support, connection to residency programs
- *Utilization of Statewide Resources and Regional Resources* - Examples: align with Olympic Workforce Development Council's health care priority

Considerations and Prioritization of Statewide and Regional Innovations

OCH will continue to leverage opportunities to invest resources that ensure sustainable workforce capacity assessment and development, such as collaborative activities with Washington's statewide health workforce resources. (Table 27) OCH has strong connections with existing workforce initiatives and resources, and will continue to use these resources to leverage a workforce designed to support transformation activities. Priority considerations are workforce practice transformation that involve population health management, support integrated whole person care, further team-based care, use decision support, apply care management approaches, enhance care coordination for the overall population and target populations, and bring efficient, effective innovations to bear.

Table 27. Use of Existing Workforce Initiatives and Resources

Statewide Resources	OCH Linkage to State Resource	OCH Use of Resource
Workforce Training and Education Coordinating Board's Health Workforce Training Council	<p>Impact: Bi-Directional Care Board of Directors (BOD) member on Health Workforce Board Council – helps IDs needs, solutions for BH in Primary Care & CBHAs. Shares with OCH Board.</p> <p>Two BOD members are stakeholders for 2016/17 BH Workforce Report providing recommendations to stabilize and innovate BH workforce.</p> <p>Impact: All Projects Olympic Workforce Development Council staff on OCH Committees (OWDC); OCH Board member on OWDC.</p>	<p>Planning. Workforce Collaborations. Informs innovative approach to workforce strategies, especially bi-directional care implementation. Building local approach on BH Workforce Report. Supports strong relationship with OWDC (healthcare workforce a 2018 priority).</p>
	<p>Impact: All Projects OCH encourages providers to participate in the Health Sentinel Network, requests provider survey information be shared back to OCH.</p>	<p>Data for Clinical Workforce Planning. OCH TA compiles sentinel workforce data for review. OCH Board and staff use supply and demand data for forecasting, development of change plans.</p>
Healthier WA Practice Transformation Hub	<p>Impact: Bi-Directional Care, Opioid, Domain 1 <u>Qualis Health Coach Connector</u>: OCH promotes clinic assessment and coaching participation, Coach attends BOD meetings, OCH agreement with Qualis for aggregate data report of assessment results.</p>	<p>Assessment & Practice Transformation. Domain 1 IT Care Coordination <u>Qualis Health Coach Connector</u>: results shared with OCH for project planning. 24 respondents to date. <u>TCPI Practice Coach</u>: with clinic permission, results shared with OCH for project planning. 3 Kitsap clinics partner</p>

	<p><u>Pediatric TCPi Practice Coach</u>: OCH promotes clinic participation.</p> <p><u>TCPi Pediatric Care Coordination</u>: OCH staff and TCPi working together to map resources.</p> <p>Impact: Domain 1, All Projects</p> <p><u>HUB trainings & Resource Portal</u>: announcements made via OCH of training opportunities, resources.</p>	<p>for BH quality improvement</p> <p><u>Care Coordination resource mapping</u>, identification of gaps, possible solutions.</p> <p>Practice Training & Education.</p> <p>Webinars, web-based resources Portal, Conferences for Practice change, Team-based care, VBP, etc.</p>
AIMS Center	<p>Impact: Bi-Directional Care, Opioid, Chronic Disease</p> <p>Qualis Health Coach Connector shares information regarding AIMS Center with OCH PCP, BH practices</p>	<p>Practice Transformation.</p> <p>Practices utilize to design collaborative care approach, especially Team Based Care detailed on resource website.</p>
WA State DOH Workforce Supports	<p>Impact: All Projects</p> <p>OCH Board members (15) representing critical access hospitals, tribes, FQHC, CBHA, PCP practices in rural areas utilize the many services of State Rural Health Office. Providers have utilized DOH for Community Health Worker training and practice.</p>	<p>Data. Recruitment. Funding.</p> <p>Use Medical/BH/Dental Shortage Designation/ HPSA for funding opportunities, workforce planning. Direct recruitment (WRG). Visa Waivers, Natl Health Service Corp applications. Future use of Office of Health Professions for scope of practices, expertise.</p>
WA DOH Health Education Resource Exchange (H.E.R.E.)	<p>Impact: All Projects</p> <p>OCH Board member representing Public Health, familiar with and utilizes resources available via H.E.R.E., shares information with OCH.</p>	<p>Education. EBP for Health Promotion, Interventions.</p> <p>Clearinghouse for Clinical and SDOH information and resources at clinical and community level.</p>
Community Colleges & AHECs	<p>Impact: Bi-Directional, Opioid & All Projects</p> <p>Community Colleges-OCH partnership with Olympic College (OC) results in curricula re opioids. Past partnership with OC/CBHA for co-occurring disorders.</p>	<p>Educate Existing and New Workforce</p> <p>Partner with local community colleges for uptraining of existing workforce, curricula updates for new workforce. Partner in future with AHEC for primary care and rural health workforce recruitment and retention strategies.</p>

Population Health Management Systems:

OCH preliminary considerations and approaches to expand, use, support, and maintain population health managements systems across all projects can be seen in Table 24.

Working with partnering providers to identify and assess current population health systems

Prior to expanding upon, using, supporting or maintaining existing population health management systems across all selected projects, OCH will first finish our baseline assessment of these systems among provider organizations. Due to the cooperative relationship between OCH and Qualis Practice Transformation Hub, and OCH's commitment to provider engagement in the region, OCH has a near-complete baseline assessment of current HIT and population health management systems for all major Medicaid provider organizations in the region, and many of the smaller ones. Over the next few months,

during the planning and assessment period, OCH will complete its HIT/population health systems assessment for all partnering providers. This will be part of the workforce assessment described above.

To date, the Practice Transformation Coach provided by Qualis Health Hub performed an HIT assessment for 19 clinics and more assessments are planned. The HIT assessment includes EHR basics, such as name, vendor, and version; interfaces between the EHR and practice management; all other interfaces; uploads to the clinical data repository; and QI and IT workforce within each practice.

Based on our initial assessment, it is clear that OCH provider organizations have a track record of working collaboratively to leverage HIT capacity and infrastructure. For example:

- Three of the four community behavioral health agencies (CBHA) negotiated a joint contract with Valent, a behavioral health EHR company based out of Seattle, WA. The fourth CBHA is considering entering into this contract, which is centrally administered through mutual agreement by the CBHA in Kitsap County.
- In Clallam and Jefferson, two hospitals and a major primary care provider entered into a collaborative agreement with Providence to purchase the same version of EPIC. There are discussions to spread this opportunity to other interested FQHCs and tribal clinics.
- Pre-Manage system is used throughout the region by multiple types of provider organizations, including social service agencies through the Health Home Program. PreManage is an interoperable communication tool that provides real-time clinical visit history of patients and ensures that high-value clinical insights attach to the patient rather than to an otherwise disparate EHR system. Currently there is high penetration of PreManage among OCH primary care providers; OCH is exploring its use in behavioral health settings.
- A CBHA and FQHC are exploring Consent2Share as a potential platform to address barriers to health information exchange related to 42 CFR part 2 for shared patients.

Approach to working with partnering providers to support payment and service delivery transformation through population health systems

Moving forward, OCH will convene provider organizations in each NCC with MCOs to determine how to expand, use, support, and maintain population health management systems to support the transformational activities within the project areas. As described in the Theory of Action Section, the first phase of work, December to February, is the development of a collaborative shared plan. MCOs will be active participants in this process, helping to guide providers towards sound investments that would pay off through value-based contracts. One NCC has already begun informal discussions about leveraging their MTP Domain 1 investment to support a shared, population health management IT system.

Per the IT surveys listed, OCH providers identified a specific unmet need for a simpler, more cost effective and efficient way to coordinate care between organizations. The concern raised by OCH providers was that care coordination is done primarily by phone, fax and email, and lacks a tracking system to follow care outcomes. Without a proper, community-wide care tracking system, many patients fall through the cracks and opportunities for improved care are lost.

To address this issue, OCH providers came together and conceptualized a new care tracking system for managing “e-referrals” between each other. This new system would allow providers in the network to securely access the patient’s longitudinal health record, manage digital consents and communicate with other providers in the network to ensure “closed loop” workflow and communications.

OCH Board of Directors discussed at length the potential financial risks of investing MTP incentives into health information technology. To mitigate this risk, OCH will leverage existing cooperative arrangements and investments to work, on a case-by-case basis, towards a functional population health information system. To that end, the OCH Board authorized a pilot project called “IT Care Coordination.” This process uses a disruptive, data-driven innovation model that promotes cross organization collaboration, accountability and a shared view of patients and outcomes leveraging existing tools wherever possible. Problems are identified, then solved quickly and iteratively. Providers do not need to commit to a platform. OCH will iteratively test one prototype to the next, starting with the most minimally viable e-referral system. The goal is to keep the process lean and compact while reducing the barriers to effective provider engagement.

The first “use-case” for the pilot is to identify digital alternatives to paper referrals, paper consents, faxes and un-responded to phone calls between primary care medication-assisted treatment (MAT) prescribers and substance use treatment providers to improve handoffs, reduce duplication of work and missed opportunities while improving overall tracking of services. Within this use-case example, OCH has performed a preliminary provider assessment and is moving forward with a deeper evaluation of workflows and various IT platforms from a small group of “pilot” provider organizations: one federally qualified health center, 2 substance use treatment providers, 1 community behavioral health agency, 1 housing and social services organization, and 1 department of corrections.

Definition of success and approach to sustainability of advancements in population health systems

If successful, this pilot will be the first use-case towards developing a new OCH community “HealthIT Commons.” The new HIT Commons will be built on a cloud-based, low barrier, e-referral network system that allows all provider types to communicate with one another about shared clients and patients. This infrastructure would support all transformational activities across all project areas and providers, and would be supported as a public utility beyond MTP. Success is measured from three perspectives:

1. Community: Streamline clinical-community linkages, emphasizing social determinants of health, resulting in improved whole-person care
2. Provider: Reduce and streamline data entry steps and workload for improved cross organizational accountability and automate reporting for each patient referral
3. Consumer: Enhance the perception that “All my providers work together to take care of me and help me reach my goals”.

Health IT Commons is envisioned to operate like other public utilities and paid for with connection and usage fees. Co-development of this product with MCOs is essential. OCH views this platform as the stepping stone to deliver next generation, low cost services such as eConsults and remote monitoring. OCH will share learning and experience with other ACHs across WA State.



2A. Bi-directional Integration of Physical and Behavioral Health through Care Transformation

Project Plan

November 16, 2017

This document represents the foundational component of Olympic Community of Health's (OCH) portfolio for transforming the Medicaid delivery system in Clallam, Jefferson and Kitsap counties – bi-directional integration through care transformation.

The goal is to provide the right level of whole person care at the right place and right time. For most people, behavioral health concerns are identified in the primary care setting, where early intervention, treatments or referral can occur. For persons experiencing behavioral health problems, it means creating avenues so that there is no wrong door to prevention, early intervention, treatment, and recovery. For some, specialty behavioral health care, whether mental health or substance use disorder treatment, or both, is the path to recovery. OCH's approach to bi-directional integration facilitates a patient-centered approach to recovery.

Menu of Transformation Projects	
Domain 2: Care Delivery Redesign	
<input checked="" type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversion Interventions
Domain 3: Prevention and Health Promotion	
<input type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input type="checkbox"/>	3D: Chronic Disease Prevention and Control

PROJECT SELECTION AND EXPECTED OUTCOMES

Rationale for Selecting This Project

The OCH Regional Health Needs Assessment informed the top five health priorities for the region, with physical, behavioral and oral health access and behavioral health identified as two of five priority areas. (Table 1) Improving health equity by addressing the social determinants is the foundation to achieve all five priorities.

Table 1. Olympic Community of Health Regional Health Priorities				
ACCESS	AGING	BEHAVIORAL HEALTH	CHRONIC DISEASE	EARLY CHILDHOOD
A continuum of physical, behavioral, and oral health care services is accessible to people of all ages and care is coordinated across providers.	Aging adults and their caregivers are safe and supported.	Individuals with behavioral health conditions receive integrated care in the best setting for recovery.	The burden of chronic diseases is dramatically reduced through prevention and disease management.	Children get the best start to lifelong health and their families are supported.
Progress on these priorities depends on improving health equity through SOCIAL DETERMINANTS – housing, education, workforce development, employment, transportation, safety, environmental conditions.				

OCH's year-long prioritization process was informed by four factors: results of community assessments (including the three county public health departments' Community Health Assessments and local hospital Community Health Needs Assessments), stakeholder input on gaps and assets in our region, a health initiatives inventory, and finally, consensus on core data measures (Figure 1)

Figure 1

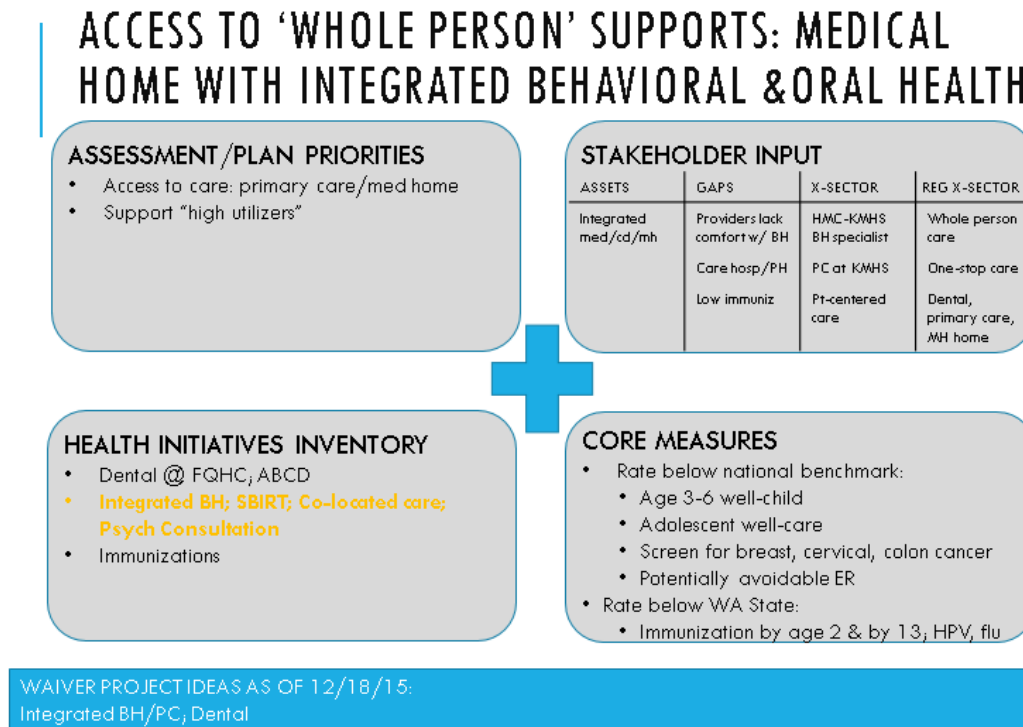


Figure 2

Justification: Prevalence of Mental Health (MH) and Substance Use Disorder (SUD)

Of the 84,459 Medicaid beneficiaries in the OCH region, over 20,000 have a mental health (MH) diagnosis (29%), nearly 10,000 have a substance use disorder (SUD) diagnosis (14%), and nearly 6,000 have co-occurring MH and SUD (9%). (Figure 2) (WA HCA AIM, Cat 1 Behavioral Health and Chronic Conditions, 09/29/17)

In the OCH region, MH, SUD, and co-occurring MH+SUD prevalence rates are similar across counties but vary across sub-groups. (Figure 3) For example: (WA HCA AIM, Cat 1 Behavioral Health and Chronic Conditions, 09/29/17)

- MH prevalence rates are higher among females, those age 30-59, American Indian/Alaska Native (AI/AN), White, Black, and disabled.
- SUD prevalence rates are higher among males, those age 20-59, AI/AN, White, Black, and disabled.
- Co-occurring MH+SUD rates are similar by gender, higher for those age 30-59, AI/AN, White, Black, and disabled.

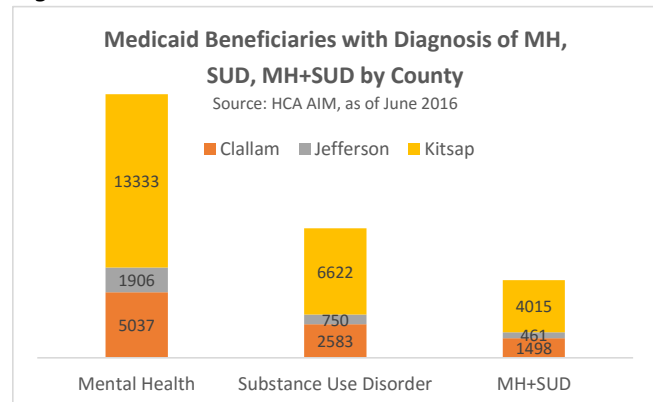
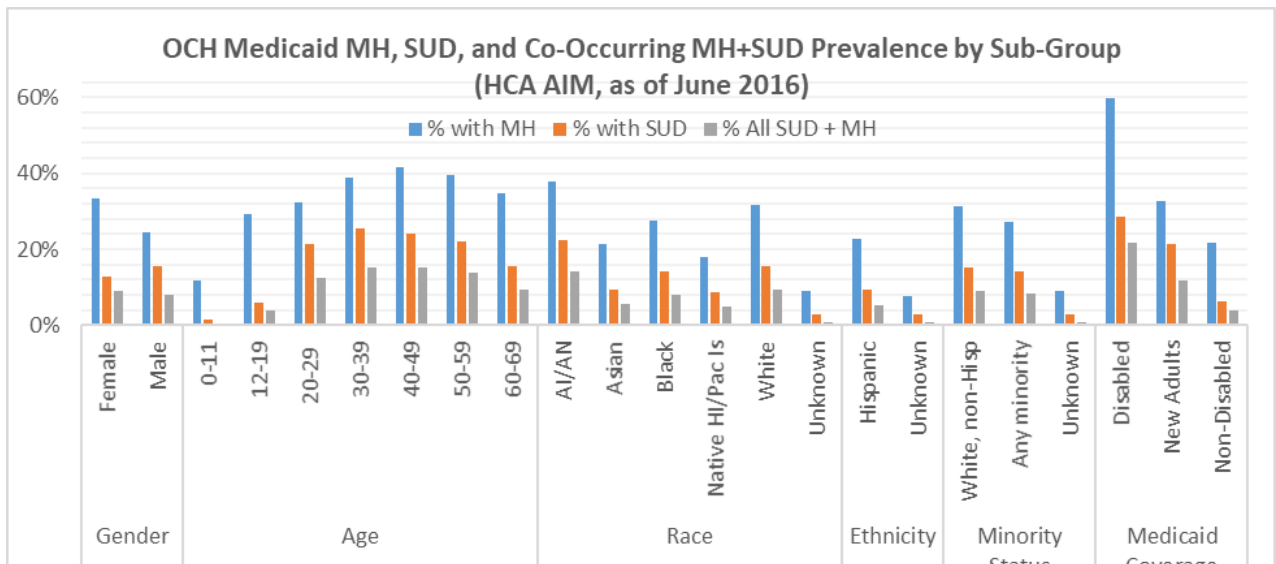


Figure 3

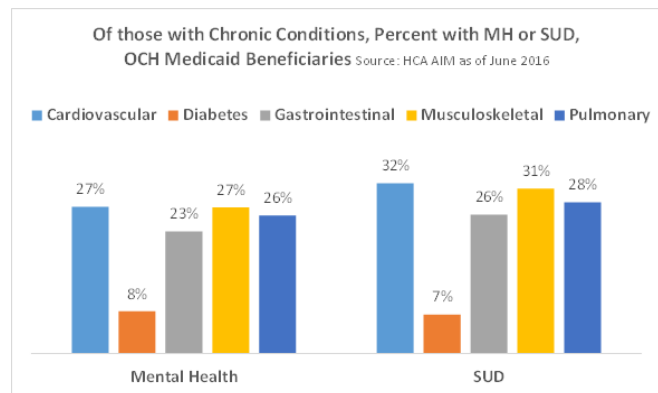


Justification: Comorbidities - physical health and behavioral health

An estimated 70% of primary care visits are related to psychosocial issues even though physical health is usually the primary visit reason. (APA Center for Psychology and Health, Briefing Series on the Role of Psychology in Health Care: Primary Care, accessed [here](#), January 2014) Moreover, the interaction between chronic diseases and unaddressed behavioral health issues has a substantial impact on overall health and wellness. (Figure 3)

Figure 4

In the OCH region, comorbid chronic disease and Behavioral Health (BH) is common and likely underreported. Around 1 in 4 (23-27%) Medicaid recipients with cardiovascular, gastrointestinal, musculoskeletal, or pulmonary disease has a mental health diagnosis and more than 1 in 4 (26-32%) with cardiovascular, gastrointestinal, musculoskeletal or pulmonary disease has a SUD. (Figure 4) (WA HCA AIM, Cat 1 Behavioral Health and Chronic Conditions, 09/29/17) Specific to primary care visits, it is unknown how much underreporting of BH diagnoses exists due to: inconsistent BH screening practices; inability to document same day physical health and BH encounters/claims for patients with co-morbidities; and/or unfamiliarity with referral for SUD treatment. (Figure 4) (WA HCA AIM, Cat 1 Behavioral Health and Chronic Conditions, 09/29/17)



Twenty percent of Medicaid beneficiaries in the OCH region have a mental health condition and at least one chronic physical health condition, 10% have a SUD condition and at least one chronic condition, and 7% have co-occurring MH and SUD conditions and at least one chronic condition. Of those with MH, SUD, or MH+SUD, the majority, between 7 and 8 out of 10, in each of those diagnostic groups also has at least one chronic condition. These BH patients with medical co-morbidities are among the most complex patients to treat, and have the highest rates of unnecessary ED utilization. (Figures 5 & 6) (WA HCA AIM, Cat 1 Behavioral Health and Chronic Conditions, 09/29/17)

Figure 5

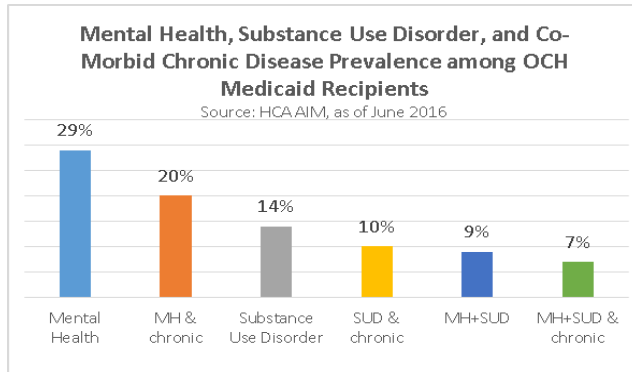
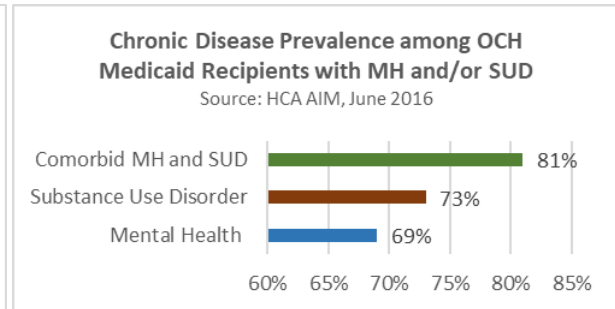


Figure 6

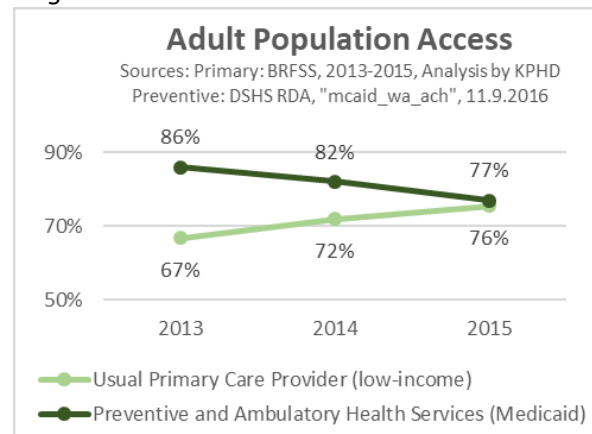


Justification: Access to care

Given the high rate of comorbid BH and chronic disease, co-location of primary care at specialty behavioral health settings with enhanced collaboration, or alternately, tightly coordinated, collaborative care with off-site primary care providers by specialty behavioral health providers, or co-located integrated care increases likelihood of access to and utilization of primary care for persons with MH and SUD.

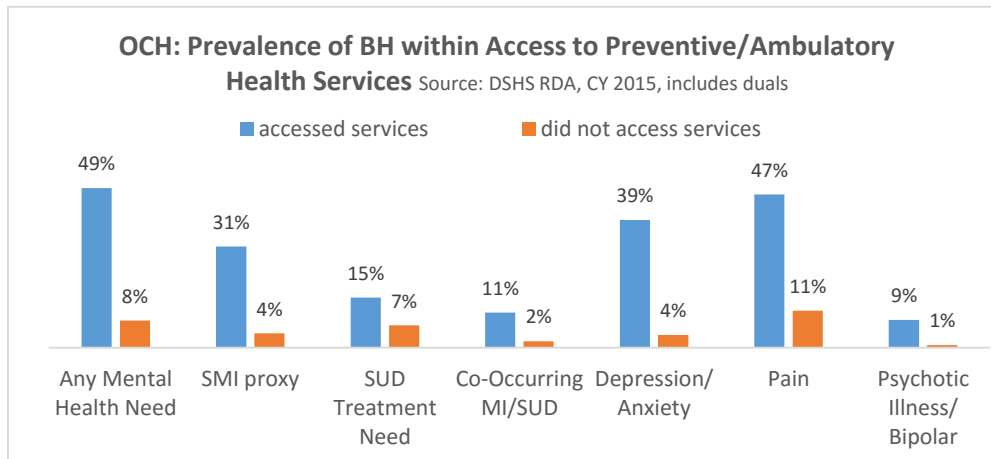
In the OCH region, 76% of low-income adults over the age of 18 reported having a usual primary care provider (BRFSS, 2013-2015, analysis by Kitsap Public Health District (KPHD)) and 77% of Medicaid beneficiaries accessed preventive and ambulatory health services in 2015. (WA DSHS RDA, "mcaid_wa_ach", 11/9/2016) Compared to 2013, more adults report having a usual provider; however, over the same timeframe, fewer have had a preventative visit. Despite these differences in trend, both access indicators demonstrate high rates of some level of engagement among most individuals. (Figure 7)

Figure 7



Of OCH Medicaid beneficiaries who have not accessed preventive/ambulatory health services, including "duals" or dually enrolled Medicare-Medicaid beneficiaries, a low proportion are individuals with BH conditions. This suggests that most individuals with BH conditions are engaged in at least some health service. The three groups with slightly higher prevalence rates among those not accessing services are individuals with pain, any mental health need, or SUD treatment need. (Figure 8) (WA DSHS RDA, "Meets_Std_ACH_Olympic", 10/30/2017)

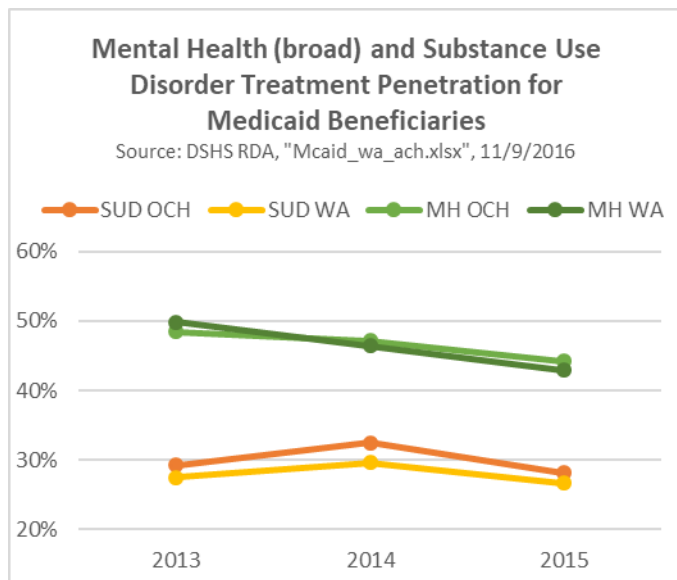
Figure 8



Penetration rates for MH and SUD are dependent on numerous factors, including an individual's choice not to engage in specialty behavioral health services. Consistent screening and identification of behavioral health issues in the primary care setting is a factor. Limited access to behavioral health care, especially in rural areas where workforce, transportation, and resources are insufficient, is also a factor.

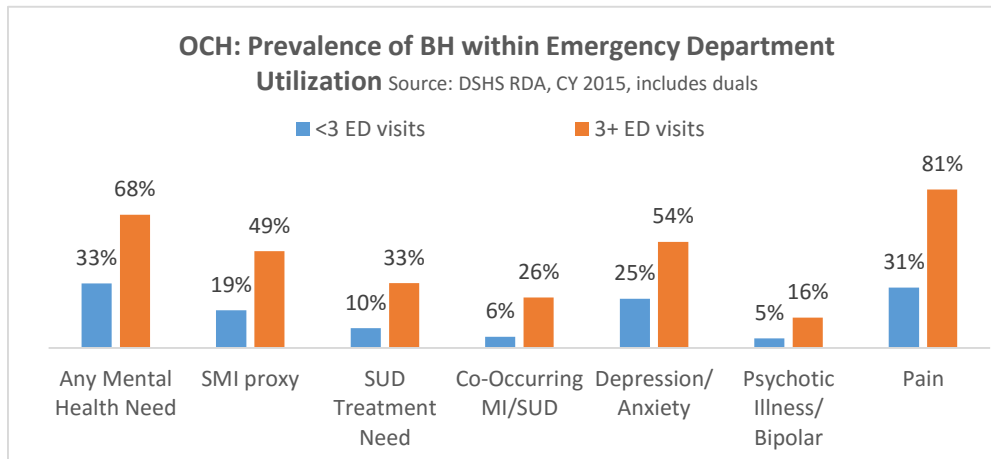
Figure 9

Justification: MH and SUD penetration rates
Adult MH and SUD penetration rates for OCH and the state are similar. The three-year trend is influenced by the influx of newly insured individuals under the Affordable Care Act. In 2016, nearly 8,000 OCH Medicaid beneficiaries had a SUD treatment need and 2,237 received treatment (28%); nearly 18,000 had a mental health service need and 7,904 received services (44%). (Figure 9) (WA DSHS RDA, "mcaid_wa_ach", 11/9/2016)



A high proportion of high utilizers of the emergency department (ED), defined as 3 or more visits, are Medicaid beneficiaries and duals with BH conditions. This suggests that individuals with BH conditions continue to inappropriately utilize the ED for care despite having access to health services as described previously. Among the ED high utilizers, 81% are individuals with pain, 68% with any mental health need, 54% with depression/anxiety and 49% with serious mental illness. (Figure 10) (WA DSHS RDA, "Meets_Std_ACH_Olympic", 10/30/2017)

Figure 10



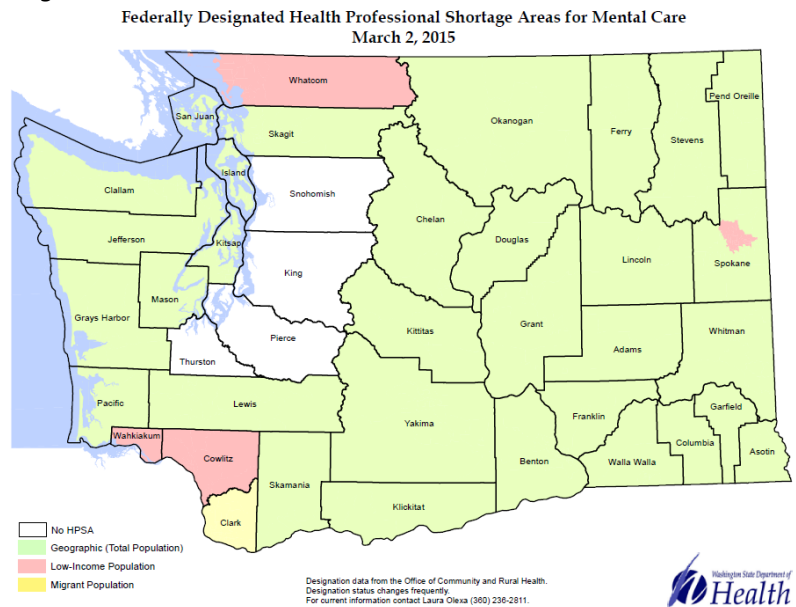
Interventions targeted towards high utilizers of the ED with co-occurring disorders have been shown to be effective. In acknowledgement of this, OCH is aligning strategies across the entire project portfolio to target this subpopulation, especially Diversion (2D), Opioid (3A), and Chronic Disease (3D). Success in reducing unnecessary ED utilization is hinged to accurate targeting of this subpopulation and deployment of appropriate evidence-based care coordination programs from primary care and behavioral health settings.

Justification: Workforce

The OCH region is a designated health professional shortage area for mental care. (Figure 11) (WA DOH, accessed [here](#), November 2015)

One-quarter of OCH area respondents (n=12) to a recent sentinel health workforce survey (4/1-5/15/2017) identified mental health counselors and clinical social workers as positions with exceptionally long vacancies, one-third identified demand increase for mental health counselors, and one quarter identified demand increase for clinical social workers. “Not enough qualified applicants” was cited as a reason for long vacancies and “high turnover” was the most commonly cited reason for increased demand (Washington State Health Workforce Sentinel Network, accessed [here](#), September 2017).

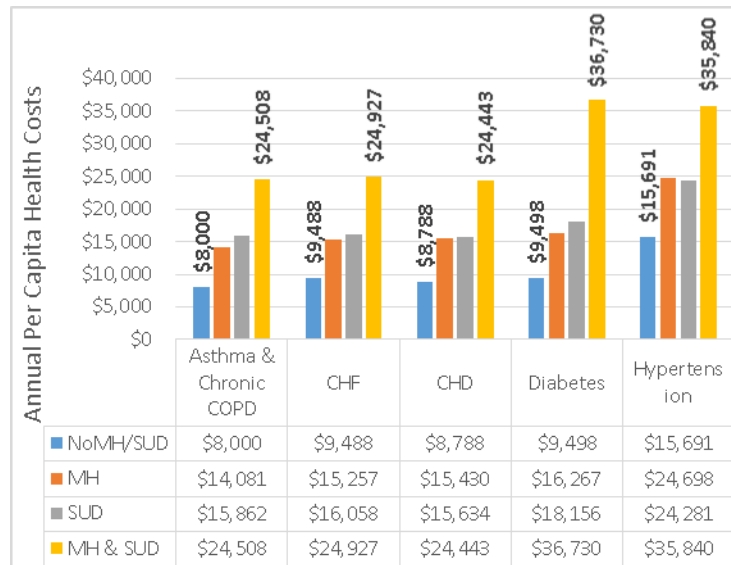
Figure 11



Justification: Cost and comorbidities
(Oss, M., How the 'superutilizer effect' has driven integrated care & changed the mental health landscape, accessed [here](#), May 23, 2017)

"Patients with serious mental illness (SMI) are vulnerable to a host of medical problems, and obstacles to health care can be overwhelming. Although chronic co-morbidity rates are far higher among patients with mental illnesses, these co-morbidities are far less likely to be diagnosed and treated adequately than in the general population. Few prevention or wellness interventions are targeted to the needs of SMI individuals with chronic physical problems, although interventions are available." (Gold et al. (August 2008), Primary care of patients with serious mental illness: your chance to make a difference, Vol. 57, No. 8: 515-525) Individuals with MH/SUD comorbidities experience gaps in care management, leading to avoidable utilization of expensive health care settings.

Figure 12



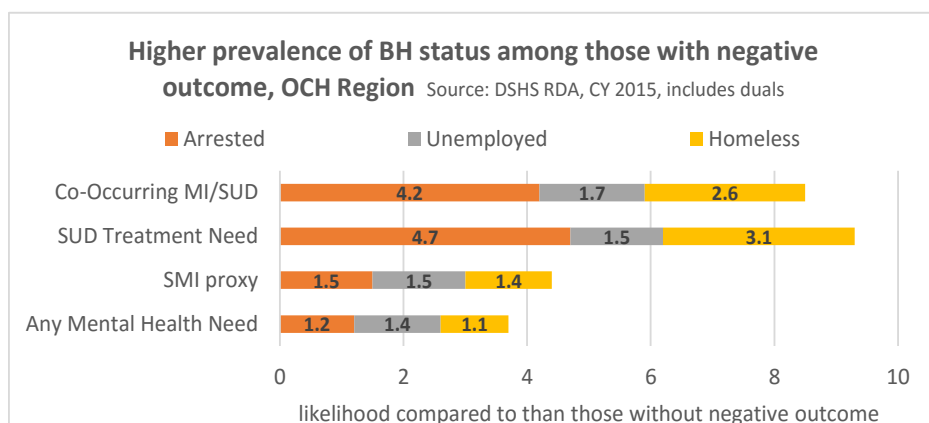
Health costs for individuals with chronic disease multiply substantially with the addition of comorbid MH and SUD, increasing cost by up to 200%. (Oss, M., How the 'superutilizer effect' has driven integrated care & changed the mental health landscape, accessed [here](#), May 23, 2017) Other cost research has shown a "cost offset of 20-40 percent for primary care patients who receive behavioral health services." (Collins et al., (2010), Evolving models of behavioral health integration in primary care, New York, NY: Milbank Memorial Fund) For mental health treatment the return on investment (ROI) is calculated as \$6.50 saved for every \$1 invested. (Unutzer et al., (2008), The Collaborative Care Model, Am J Managed Care, AIMS Center) For drug addiction treatment, the ROI is calculated as \$12 in savings related to health care and justice for every \$1 spent. (Figure 12) (National Institute on Drug Abuse, Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition), accessed [here](#), October 2017)

Justification: Lack of coordination among providers

Individuals struggling with economic distress and poverty, housing challenges and other social influences experience magnified adverse outcomes. People with serious mental illness are more likely to be unemployed, arrested, and/or face inadequate housing compared to those without mental illness. (Jones et al., (November 2004), Prevalence, severity, and co-occurrence of chronic health problems of persons with serious mental illness. Psychiatry Serv. 55 (11): 1250-1257)

Figure 13

Data from the WA State Department of Social and Health Services depicts the increase in risk for negative outcomes (arrest, unemployment, homelessness) among those with behavioral health conditions – especially for those with co-occurring MH/SUD and those with an SUD treatment need. (Figure 13) (WA DSHS RDA, “Meets_Std_ACH_Olympic”, 10/30/2017)



Coordination with Existing Efforts (Table 2)

While developing their shared change plan (see Theory of Action section), each NCC will ensure that the transformational activities fit within the existing services in the local community. OCH will ask providers to describe how activities expand upon, enhance, or complement existing delivery system transformational activities. As part of the contractual process, OCH will require an attestation from each organization: if the organization is funded by the U.S. Department of Health and Human Services, and if so, request the organization attest that the federally funded activities are not duplicative of the transformational activities proposed in the change plan.

Many existing efforts are already underway and can be expanded to new populations or brought to scale, such as:

- Substance Use Screening, Brief Intervention, Referral and Treatment (SBIRT) scaled to other providers
- PreManage - an interoperable communication tool that provides real-time clinical visit history of patients and ensures that high-value clinical insights attach to the patient rather than to an otherwise disparate EHR system- introduced to behavioral health providers
- Clinical training opportunities through project 3A (Opioid) for prescribing practices, chronic pain management, provider education and linkage to medication assisted treatment providers.

Coordination with the Practice Transformation Hub and Transforming Clinical Practice Initiative

Beginning in April 2017, OCH has conducted baseline self-assessments of each partnering provider organization to identify all current delivery system transformation activities. There are multiple primary care and specialty behavioral health providers engaged in various levels and types of bi-directional strategies, beginning over a decade ago. OCH has entered into mutual agreements with its Qualis/regional Department of Health (DOH) Practice Transformation Hub Coach and DOH HUB Pediatric Transforming Clinical Practice Initiative (P-TCPI) Coach to work with OCH staff and consultants, meet with executive leadership and conduct standardized baseline assessments (24 to date). This partnership has helped OCH capture bi-directional efforts for adult and pediatric practices. The attached report summarizes a Primary Care and a Behavioral Health self-assessment tool for 19 provider sites by type of provider site, current level of behavioral health integration across the region, tribal involvement, and substance use response. (Attachment: OCH-2A Bi-Directional Care-AttA-Assessment Report)

Coordination with hospitals

In addition, OCH engaged a healthcare facilities consultant to conduct hospital-based needs assessments to discern current level of engagement, initiatives, and anticipated level of participation in bi-directional care going forward.

Coordination with advancements towards fully integrated managed care

While advanced in clinical integration in many respects, the region is not an early- or mid-adopter of Fully Integrated Managed Care (FIMC). OCH understands the importance of facilitating dialogue with providers, SBHO, and MCOs to move toward financial integration by 2020. Coordination among providers and payers is particularly important as the SBHO moves transitions to a Behavioral Health-Administrative Services Organization (BH-ASO) and the region's SBHO-affiliated community mental health and substance use providers adapt to the emerging payment models. The transformation will be challenging given that the SBHO uses a sub-capitated payment model for contracted mental health providers and there is no managed care in Clallam County.

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Table 2. Coordinating Efforts: Currently Identified Assets and Gaps of OCH Providers

Provider Type	Assets Brought to Project	Initial Gaps Identified
Federally Qualified Health Centers (2 of 2)	Clinical Practice Transformation & Workforce <ul style="list-style-type: none"> Both are exemplar practice sites and sharing best practices Both engaged with Practice Transformation Hub Coaching Current provision of BH Services – Collaborative Care <ul style="list-style-type: none"> 1 fully integrated model 1 with co-located CBHA staff both provide Team-based care, using EBP both use standard screens, including SBIRT both have some coordination for social needs 1 is Hub for regional MAT, both prescribe MAT 1 has received AIMS grant to hire a licensed social worker, employed by FQHC 1 is adding second BHA employed licensed social worker to PC clinic team Both partner w/ local CBHA to coordinate care for SMI/SED pop. Population Health <ul style="list-style-type: none"> 1 has Population Health Management staff, EHR capable of creating registries, with some interoperability, use Consent2Share, EDIE/PreManage Value Based Payments <ul style="list-style-type: none"> 1 has some VBP contracts in place 	Clinical Practice Transformation <ul style="list-style-type: none"> 1 exploring siting of FQHC at CBHC Workforce <ul style="list-style-type: none"> Behavioral Health providers, especially ARNPs Tele-psych for rural areas or when diagnostics and medication management not available Population Health <ul style="list-style-type: none"> 1 seeking EHR more able to support integrated care, registries
Primary Care Providers <ul style="list-style-type: none"> 4 hospital-associated all ages, multiple sites; 6 independent all ages w/multiple sites; 4 pediatrics only 	Clinical Practice Transformation & Workforce <ul style="list-style-type: none"> Commitment to bi-directional care. All major Medicaid providers in region involved except 1. 6 engaged with Practice Transformation Hub Coaching 1 hospital associated provider collocates CBHA ARNP, BHP Multiple providers note team based care with EBP, use of Standard screening tools 2 hospital providers “umbrella”/affiliate with CBHA 1 hospital has strong focus opioid prescribing 1 independent provider organization notes use of pain contracts for opioid prescribing 3 Pediatric clinics working with Qualis/TCPI 2 Pediatric clinics working on QI project with CBHA/TCPI Population Health <ul style="list-style-type: none"> 3 hospital associated PCP practices on EPIC. Use EDIE/ PreManage, Direct Messaging 	Clinical Practice Transformation <ul style="list-style-type: none"> convene w BH & CBOs for coordination, integration Shorten BH referral wait time, higher in rural areas Seek 24-hour BH access including Saturday clinics, BH NH care, 24/7 phone/ in person Use of HealthLeads, PREPARE for social service care coordination, consider use of templates for EHR Workforce <ul style="list-style-type: none"> 1 new pediatric PCP provider currently filling positions 1 clinic IDs BH Provider need Population Health <ul style="list-style-type: none"> patient access to E HR registries pre-visit planning
Community Behavioral Health Agencies (4 of 4)	Clinical Practice Transformation & Workforce <ul style="list-style-type: none"> 1 provides multidisciplinary team care 2 have co-located primary care, 2 in process 1 has co-located dental services via FQHC All provide co-occurring SUD treatment 2 offer EBPs for patient chronic disease - 1 via 1422 Chronic Disease grant All are spokes for MAT All offer Intensive Care Coordination with Health care Providers, MCOs and social service providers Population Health <ul style="list-style-type: none"> 3 of 4 share same IT system and operations management; 1 in process to share same IT 	Clinical Practice & Workforce <ul style="list-style-type: none"> 2 CBHA working on co-located primary care, need facilities space and staffing model Housing availability/PSH Psychiatric prescribers, MAs, Licensed mental health professionals, substance use providers, registered nurses, Pop. health analytics, pop care mgr, nurse care manager Consider shared crisis functions across region Population Health <ul style="list-style-type: none"> Clarify 42 CFR in HIE at State level to ensure consistency

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	system; 1 uses EDIE system and will also move to PreManage	of application statewide
Substance Use Treatment Providers (4 to date) <i>Note: additional SUD assessments currently underway</i>	Clinical Practice Transformation <ul style="list-style-type: none"> Evidence based provision of care WHAM curricula for prevention and chronic disease offered by 1 provider Weekly sponsored family meeting, and only SUD related family group in region CDP attends drug court weekly to advocate for clients Coordination with FQHC MAT Program Champion clinicians from BHA coordination with SUD in Clallam county Active leadership and participation on OCH Opioid Abuse Work Groups 	Clinical Practice & Workforce <ul style="list-style-type: none"> Increase CDP workforce, and co-occurring capable Increase outreach capacity Clallam PCP access - 8 mo. wait Convene with PCPs & CBOs re collaboration SUD clients Care coordination with PCP Population Health <ul style="list-style-type: none"> Increased E HR capacity to support integration, patient tracking, registry capable
Hospitals (4 of 4)	Clinical Practice Transformation <ul style="list-style-type: none"> All committed to bi-directional care as priority All operate primary care practices; 1 co-locates CBHA LMHPs All partner with key organizations for prevention and care delivery 	Clinical & Workforce issues: <ul style="list-style-type: none"> Need physicians, RNs, Data analytics/population health manager or analyst (shared?), EPIC report writer, referral, care coordinators, CHWs Diabetes educator—regional? Licensure-allow MHPs in lieu of LCSWs. Also advocate scope of practice changes Training: clinical, MAT, RX management, chronic disease management data/analytics/report writing; integration up-training Practice transformation for chronic disease region-wide including complex patients Closing gap persons w/o PCP, high ED utilizers 24/7 crisis service management – 3 region-wide 1 needs more behavioral health staff, adults /pediatrics Population Health <ul style="list-style-type: none"> E HR data accessibility improvements System to track progress/ measure ROI chronic disease Value Based Payments <ul style="list-style-type: none"> Bring MCOs to table re risk stratification
Tribal Nations (2 of 7 to date)	Clinical Practice & Workforce <ul style="list-style-type: none"> All 7 tribes hold seats on Board, 3 active in sub-committees 2 committed to integrating health services with mental health and substance use services and facilities 1 convened integration team with shared mission for whole person care 1 with mental health and CDP clinicians housed on-site and developing integration model and plan for new shared EHR 1 developing integration model for MH clinician on-site with PCP 1 developing shared ROI for BH, SUD and PC 1 integrating MH team to CD services 2 Cross training staff Wellness options 1 team in AIMS Tribal Cohort Collaborative Care Model Learning Series 	Clinical Practice & Workforce <ul style="list-style-type: none"> Workforce: need medical director (1) cultural coordinator, case manager or care coordinator, QI director, population health analyst Population Health <ul style="list-style-type: none"> EHR capacity improvements, including 42 CFR clarity and improvements in ability for record sharing

Project Scope: Target Population, Partnering Providers, Level of Impact, And Health Equity

For a crosswalk of the anticipated project outcomes, target population, subpopulations, and disparities for each strategy, please refer to Table 4.

Target population and level of impact

The target population for bi-directional care is broad – acknowledging that behavioral health needs are endemic and that addressing these needs is a central tenet of whole person care. It also assumes that persons being treated in a specialty behavioral health setting with serious mental illnesses (SMI) and/or SUD, which are often co-morbid with chronic disease, would benefit from accessible primary care services, care management, and more intensive care coordination. The aim is to provide integrated care, defined as care that encompasses behavioral health needs as a natural element of quality care in the primary care setting, and care for persons with more intensive behavioral health needs. Thus, bi-directional care practice transformation benefits all persons across the lifespan, whether receiving care in a primary care medical home or through specialty behavioral health providers.

OCH providers will help determine how to achieve the highest impact within the populations they serve using the resources available to the region and within their practices. In their change plans, implementation partners will identify broad and targeted populations within their primary care or specialty behavioral health practice. This will allow them to leverage synergies across the portfolio of projects (e.g., opioid treatment and ED diversion). This individualized approach considers the complexity of the people served by each practice and maximizes existing workflows. Providers understand the importance of risk stratification and targeting interventions appropriately.

Nearly all primary care practices serving the Medicaid population during the assessment process have expressed a high degree of interest in bi-directional care, as have the region's community behavioral health providers, multiple substance use treatment providers, and several tribes. OCH is confident that all major Medicaid providers of primary care and behavioral health will engage in some degree of clinical bi-directional integration, either directly through the MTP, through their own parent company (for the larger health systems), or through other efforts such as TCPI.

Target populations:

1. All Medicaid beneficiaries eligible for Medicaid Services in primary care settings (a) broadly screened and b) with identified behavioral health concerns not requiring specialty behavioral health care
2. All Medicaid beneficiaries eligible for Medicaid Services in behavioral health settings (a) without a primary care medical home or b) without an annual PCP visit, or c) with complex comorbid conditions, or d) receiving care at hospital EDs, or e) at jail discharge

Note: Prevalence of behavioral health is higher among the following sub-groups in the OCH region, these groups are identified for specific consideration within the general target populations: (WA HCA, Cat 1 Behavioral Health and Chronic Conditions, 09/29/17)

- a. mental health diagnosis: females, age 30-59, AIAN, White, Black, and disabled.
- b. substance use disorder diagnosis: males, age 20-59, AIAN, White, Black, and disabled.
- c. co-occurring MH+SUD diagnosis: age 30-59, AIAN, White, Black, and disabled.

An estimated 60% of adults in the United States have experienced adverse life events that contribute to persisting physical health, mental health and addiction disorders; most are treated in primary care (National Council for Behavioral Health, Trauma-Informed Primary Care Initiative, accessed [here](#),

October 2017). OCH expects to reach an estimated 23,500 Medicaid lives by applying evidenced-based clinical practice changes and trauma-informed care across provider organizations, employing screens and treatment for behavioral health concerns, assuring workforce delivery capacity investing in population health technology, and driving value based payments to fully integrated care.

Evidence-based strategies

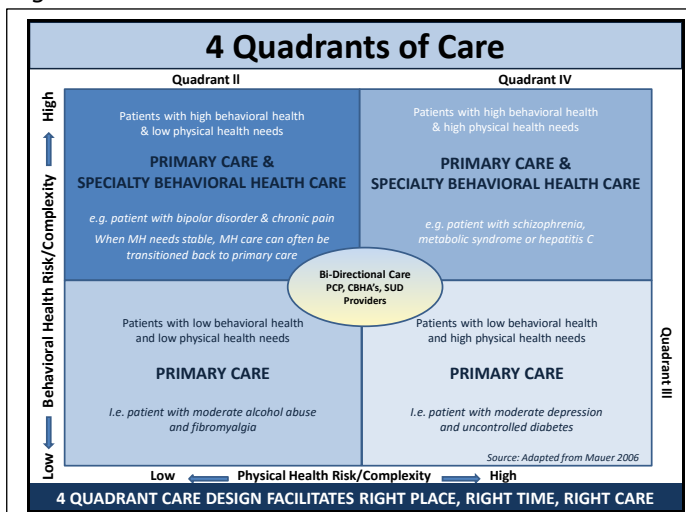
Partnering providers will select their preferred evidence-based integration model:

1. Increase availability of and access to behavioral health care provided in the primary care setting for patients of all ages either through the Bree Collaborative or Collaborative (Figure 14)

Care Model approach including:

- access to a patient centered medical home for integrated, whole person care;
- screening, early intervention, treatment and/or referral to specialty care;
- disease management, including for comorbid conditions; and
- care coordination for persons with comorbid conditions and/or social needs.

Figure 14



2. Increased access to primary care for patients of all ages in the specialty behavioral health setting who would not otherwise receive primary care except through their behavioral health provider. Primary care visits are facilitated through a) enhanced coordination and collaboration with primary care co-located at the behavioral health site, b) enhanced coordination and collaboration with off-site primary care by the behavioral health provider team, or c) co-located integrated care. Using the Collaborative Care approach, focus includes team based care for enhanced collaboration including:
 - annual visit/well check
 - visits for complaints/acute illness
 - management of chronic conditions, including chronic pain
 - chronic disease patient self-management education and programs
 - care coordination for persons with comorbid conditions and/or social needs.

Implementation partners critical to success (Table 3)

Adoption of bi-directional integration models by OCH clinical providers, both primary and specialty care, is critical to meeting outcomes across the portfolio. In primary care, the predominant focus is on identifying, treating, and/or referring adults and children with substance use, depression and anxiety diagnoses, using either the Bree and or the Collaborative Care Model. Screening for the most common behavioral health concerns will be incorporated into workflows. In the behavioral health specialty care setting, including community behavioral health and substance use providers, the focus is on strengthening the connection with primary care either through on-site co-location or via enhanced offsite care coordination guided by the Collaborative Care Model approach. In either setting, facilitating patient self-management by offering evidence-based strategies and programs is an OCH thread that weaves chronic disease prevention, education and behavior change (Project 3D), opioid use prevention and treatment (Project 3A), ED diversion (Project 2D), oral health access (Project 3C), and early identification and referral for behavioral health specialty care in children (Project 3B).

Partnership and collaboration across provider organizations within the NCC is the key to successful, bi-directional care. For example:

- Clallam County: North Olympic Healthcare Network partners with Peninsula Behavioral Health to co-

locate a behavioral health professional at the FQHC primary care site.

- Kitsap County: Kitsap Mental Health Services has primary care services co-located on its campus via CHI Franciscan Harrison Health Partners and via the local FQHC Peninsula Community Health Services (PCHS), including a PCHS dental clinic.

More examples of bi-directional partnerships are in place or being explored throughout the region. Each NCC has forged alliances with Emergency Medical Services, jails, law enforcement, courts, schools and early childhood service providers, housing providers, and public health – an acknowledgment that the intersection of these sectors is where care coordination is most needed. These NCC partners are accustomed to working together in their communities to identify and fill gaps in services, leveraging their individual resources and capacities. Often this naturally involves tribal partners, particularly in the area of chronic disease prevention and management, but also through the opioid project (3A). In anticipation of DY2, providers have begun strategizing how to leverage resources to improve access to quality patient care.

Health equity

The OCH will assure health equity is meaningfully addressed through the following:

- Ensure the funds flow formula incorporates the Community Needs Index and PRISM score.
- Seek to ensure each bi-directional care strategy addresses a health disparity, and work with partners to use data and evidence based practices tailored to identified subgroups specific to geography, cultural, ethnicity, gender, and/or diagnosis.
- Incorporate a commitment to partner with community-based and social service provider organizations that have legitimacy in the community/s they serve in the NCC shared change plan and/or implementation partner change plan. These include partnerships that address transportation, affordable housing, healthy food, prescriptions, medical or other supplies and others as indicated. For primary care practices, consider use of social determinants of health assessment for providers (e.g., HealthLeads, PRAPARE and PCAM).
- Ensure that culturally-relevant community resources for bi-directional care and associated chronic disease self-management are available at clinics across the region.
- Enhanced health literacy measures to ensure comprehension of health information.

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Table 3. OCH Partnering Providers: Bi-Directional Care

	Type of current BH partnership	Patient Centered Medical Home Primary Care Practices	Community Behavioral Health Agencies & Substance Use Treatment Providers	Type of current PC partnership
PROVIDERS BY NATURAL COMMUNITIES OF CARE (color coded)	Integrated	Peninsula Community Health Services (PCHS) (FQHC), 7 sites	Kitsap Mental Health Services (KMHS) (MH & SUD)	HHP & PCHS on site
	KMHS on site	CHI Harrison Health Partners (HHP) (hospital affiliated), 5 Kitsap sites	Kitsap Recovery Center (SUD)	PCP connection
	KMHS on site (6/18)	Northwest WA Family Residency Program	Westsound Treatment Center (SUD)	PCHS connection
	Exploring w/KMHS	Kitsap Medical Group, 3 sites	Agape (SUD)	
		North Kitsap Family Medicine		
	QI project KMHS	Kitsap Children’s Clinic		
	QI project KMHS	Silverdale Pediatrics Clinic		
	Exploring integration	Port Gamble S’Klallam Tribal Health Center	S’Klallam Recovery Center (BH)	Exploring integration
	DBH connection	Jefferson Healthcare Adult & Pediatric Clinics (Jefferson Healthcare hospital affiliated)	Discovery Behavioral Healthcare (DBH) (MH & SUD)	Exploring with JHC
			Safe Harbor Recovery (SUD)	
	PBHS on site	North Olympic Healthcare Network (NOHN) (FQHC)	Peninsula Behavioral Health Services (PBHS) (MH & SUD)	Exploring NOHN
		Olympic Medical Center Physicians (hospital affiliated)	Reflections Substance Use Treatment (SUD)	
		Olympic Medical Center Peninsula Children’s Clinic (hospital affiliated)	Cedar Grove Counseling (SUD)	
		Jamestown S’Klallam Clinic-Family Health Clinic	Olympic Personal Growth (SUD)	
	Integrated	Lower Elwha Tribal Health Center	Klallam Counseling Center (MH & SUD)	Integrated
		Bogachiel Clinic (Forks Community Hospital affiliated)	West End Outreach Services (MH & SUD)	
	Clallam Bay Clinic (Forks Community Hospital affiliated)			
SHARED ACROSS NCC	BEHAVIORAL HEALTH ORGANIZATION & MANAGED CARE ORGANIZATIONS Salish Behavioral Health Organization Amerigroup Community Health Plan of Washington Coordinated Care Molina United Health Care	CARE COORDINATION, SOCIAL SERVICE PARTNERS Housing: all counties Community Action Programs Food: all counties Law Enforcement, Justice, Fire, EMS: most jurisdictions all counties, some tribal Dental Providers: all counties Schools: Jefferson	WORKFORCE PARTNERS Olympic Workforce Development Council Olympic Community College	
Note: BH: Behavioral health; PC: Primary care; QI: Quality improvement				

Lasting impacts

Bi-directional care, when delivered according to evidence-based practice, will affect broad-reaching, system-wide transformation that will improve efficiency and quality of care. The impact of behavioral health practice transformation reaches the larger patient population, creating a spill-over effect beyond Medicaid and addressing the whole person health needs of people in our communities. By the end of the MTP, bidirectional design will impact:

- *Healthier communities* – Bi-directional clinic redesign will be embedded into a shared change plan of mutually reinforcing activities in each NCC. OCH will encourage providers to negotiate alignment with and support of the NCC shared change plan for their respective communities and with the SBHO and MCOs. NCC participants include primary care, hospital, specialty care clinical providers, law and justice, schools, tribes, and others working together to leverage resources and achieve

shared goals. Strategies will integrate new models of delivering care which will extend beyond Medicaid and will address the needs of the people of our communities.

- *Clinical practice transformation* - Clinic redesign in primary care and specialty behavioral health care through deploying the strategies above will lead to clinical integration that will continue beyond the MTP. Financial integration in 2020 will provide ongoing support for these clinical integration achievements. Practice consultation and coaching in evidence-based integration strategies will have lasting impacts, especially for smaller primary care practices or those new to providing on-site behavioral health services, and for SUD providers to strengthen connection with primary care.
- *Workforce* – The impacts of upfront investments to support provider organizations to recruit, hire, train, and license workforce will have lasting impacts. These may include adoption of new methods to deliver care (e.g., telemedicine) or use of shared staff across providers (e.g., diabetes or nurse educators). Incorporation of integrated care and trauma-informed care into the curriculums of local colleges will support gold-standard training for future class cohorts.
- *Population health management* - NCC collective investments could result in upfront commitments to provide population health IT capacity to provider organizations to manage the health of their patient population, overall and by targeted subgroups. This infrastructure support could improve communication between providers (specifically addressing 42 CFR part 2), improve care coordination, facilitate the use of registries and data analytics for population health management.
- *Value-based payments* - OCH will facilitate value-based payment (VBP) conversations, support VBP learning opportunities and discussions between providers, MCOs, the Salish Behavioral Health Organization (SBHO), and county commissioners. OCH and its partners will participate in strategies that help ensure sustainability of bi-directional care beyond the MTP. Preparing providers for the transition towards fully integrated managed care (FIMC) will be part of these discussions. OCH upfront investments to prepare for VBP are necessary to achieve FIMC in 2020. OCH will oversee deployment of technical assistance from MCOs to provider organizations to assist in mutually reinforcing strategies such as risk stratification, care coordination, and population health management.
- *Leveraging Natural Communities of Care for collective impact* - OCH will convene implementation partners within a Natural Community of Care (NCC) to align strategies into a single shared change plan. An NCC is a community of resources and providers that serve the same population due to geographical proximity, natural referral patterns, and collaborative service agreements. MCOs will collaborate in the development of all shared NCC change plans and will continue to work with partnering provider organizations as part of the provider-payer contractor process so that shared change plans are mutually supportive of metrics in MCO value-based contracts for sustainability. Bi-directional care strategies across implementation partners will be incorporated into provider-level change plans, aligning all partners and projects for maximum impact by focusing on target populations and investment areas. OCH will facilitate collaborative arrangements between providers within the NCC, focused on workforce and shared IT solutions, data-sharing agreements (DSA) and business associate agreements (BAA).

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Table 4. Bi-Directional Care: Strategies, Projected Outcomes, and Population Served

Strategies	Intermediary Milestone or Metric	Pay for Reporting Metrics	Payment for Performance Metrics	Evidence Base	Natural Community of Care	Target Population	Targeted Subpopulation	Year Est. # Served	Disparities
Support primary care partners adopting Bree Collaborative approach by facilitating practice transformation consultation, improved population health management capacity, shared strategies for sufficient and trained workforce, and furthering payment methodologies for sustainability to develop and maintain: 1. Integrated Care Team 2. Patient Access to BH as Routine Part of Care 3. Accessibility and Sharing of Patient Information 4. Practice Access to Psychiatric Services 5. Operational Systems and Workflows to Support Population-Based Care 6. Evidence-Based Treatments 7. Patient Involvement in Care 8. Data for Quality Improvement	<i>Natural Community of Care Collaborative Agreement in place</i> <i>Natural Community of Care shared change plan</i> <i>Partnering provider organization change plan</i> <i>Contract in place with OCH</i> <i>Monthly reports sent to OCH</i>	# of partnering PCPs who achieve special recognition / certifications / licensure (e.g., MAT) # of practices / providers implementing evidence-based approaches # of practices / providers trained on evidence-based practices: projected vs actual	Antidepressant Medication Management Child and Adolescents' Access to Primary Care Practitioners Comprehensive Diabetes Care: HbA1c Testing Comprehensive Diabetes Care: Medical attention for nephropathy	Bree Collaborative Behavioral Health Integration Report & Recommendations: http://www.breecollaborative.org/topic-areas/behavioral-health/	Clallam Jefferson Kitsap	All Medicaid beneficiaries in primary care	Medicaid beneficiaries with mental health and or substance use diagnosis Medicaid beneficiaries with chronic disease and at least 1 behavioral health comorbidity Medicaid beneficiaries in need of referral to specialty behavioral health care for treatment Medicaid beneficiaries with behavioral health diagnosis and 1) unnecessary use of ED for BH related visits; 2) at discharge from jail; 3) homeless or at imminent risk of homelessness	OCH Region: 17,000 <small>Source: DSHS RDA CY2015, any MH and any SUD treatment need, AAP %positive, age 20-64.</small>	Low income populations have higher incidence of mental illness, substance use and untreated chronic illnesses and including exacerbation of illnesses due to lack of or inadequate housing, transportation nutrition, lack of social support and isolation; and higher incidence of tobacco use and obesity, asthma, hypertension, diabetes, and cardiovascular disease.
Support primary care partners adopting Collaborative Care Model by facilitating practice transformation consultation, improved population health management capacity, shared strategies for sufficient and trained workforce, and furthering payment methodologies for sustainability to develop and maintain: 1. Patient-Centered Team Care / Collaborative Care 2. Population-Based Care 3. Measurement-Based Treatment to Target 4. Evidence-Based Care	<i>Proxy measures under development; will be selected to predict P4P metrics and/or desired outcomes for QIP; will be included in contracts</i>	% PCP in partnering provider organizations meeting PCMH requirements QIP Metrics Depression screening and follow up for	Medication Management for People with Asthma (5 – 64 Years) Mental Health Treatment Penetration (broad) Outpatient Emergency Department Visits per	Collaborative Care Model: http://aims.uw.edu/collaborative-care	Clallam Jefferson Kitsap	All Medicaid beneficiaries in primary care	Medicaid beneficiaries identified with mental health and or substance use diagnosis Medicaid beneficiaries with chronic disease and at least 1 behavioral health comorbidity Medicaid beneficiaries in need of referral to specialty behavioral health care for treatment Medicaid beneficiaries		Low income populations have higher incidence of mental illness, substance use and untreated chronic illnesses and including exacerbation of illnesses due to lack of or inadequate housing, transportation nutrition, lack of social support and isolation; and higher incidence of tobacco use and obesity, asthma, hypertension, diabetes, and cardiovascular

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5. Accountable Care	<i>and reported by partners.</i>	adolescents and adults	1000 Member Months				with behavioral health diagnosis and 1) unnecessary use of ED for BH related visits; 2) at discharge from jail; 3) homeless or at imminent risk of homelessness		disease.
Support behavioral health care partners adopting Milbank Report approaches, facilitating practice transformation consultation, improved population health management capacity, shared strategies for sufficient and trained workforce, and furthering payment methodologies for sustainability to develop and maintain: 1. Off-site, Enhanced Collaboration <i>or</i> 2. Co-located, Enhanced Collaboration 3. Co-located, integrated Either option 1, 2 or 3 will be supported by the OCH in applying core principles of the Collaborative Care Model.			Plan All-Cause Readmission Rate (30 Days) Substance Use Disorder (SUD) Treatment Penetration Comprehensive Diabetes Care: Eye Exam (retinal) performed Follow-up After Hospitalization for Mental Illness Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence Inpatient Hospital Utilization	Integrating Primary Care into BH Setting: What Works for Individuals with Serious Mental Illness, http://www.milbank.org/wp-content/files/documents/papers/Integrating-Primary-Care-Report.pdf .	Clallam Jefferson Kitsap	All Medicaid beneficiaries in mental health and/or substance use treatment setting	Medicaid beneficiaries receiving Mental Health and/or SUD specialty care services	OCH Region: 4,000 Source: DSHS RDA CY2015, Clients of State-Funded Alcohol or Drug Services (Age 18+), Risk and Protection Profile for Substance Abuse Prevention. 2,500 Source: Estimated 3.5% penetration of total Medicaid obtained in HCA AIM Cat 1 BH and CC, thru June 2016 CY2015,	Low income populations have higher incidence of mental illness, substance use and untreated chronic illnesses, including exacerbation of illnesses due to lack of or inadequate housing, transportation nutrition, lack of social support and isolation; and higher incidence of tobacco use, obesity, asthma, hypertension, diabetes, and cardiovascular disease.

IMPLEMENTATION APPROACH AND TIMING

Please refer to OCH Supplemental Workbook: 2A Implementation Approach

Resources to be deployed to partnering providers

The worksheet did not allow a way to address anticipated barriers to deploying resources to partnering providers, and OCH tactics for addressing each of them. (Table 5) Notably, all listed barriers below impact more than one project area and will therefore be addressed systematically across the MTP portfolio.

Table 5. Barriers to deploying resources and tactics to mitigate risks

Barriers or challenges to deploying resources to implementation partners	OCH tactics for addressing barriers or challenges
Administrative energy to manage sheer volume of change while conducting day to day operations	Organizational leaders involved in leading change, Natural Communities of Care determine what strategies to adopt and how to leverage resources, DSRIP funds support additional staff
Getting providers paid on time	Engage with financial personnel with each partnering provider organization to explain contracting and cash flow
Reporting and data exchange	Put data sharing agreements in place between the OCH and partnering providers
Underestimate financial costs to the organization	Build in contingency plans into contracts
Provider cannot hire the workforce in time to start implementation	Build in contingency plans into contracts; develop regional strategies for workforce recruitment
Insufficient IT systems to support integrated care. Limitations for communicating SUD information due to 42 CFR Part 2/ROI	Baseline assessment includes IT assessment; OCH assist in upfront infrastructure/IT investments. Seek State clarification on SUD ROI, increase use of EDIE/PreManage, Consent2Share, other options.
Inadequate workforce to conduct integrated care, population health informatics	OCH to facilitate shared workforce development opportunities and to help identify and support shared training needs across providers/affiliate partners, including through regional and NCC dialogue
Clinical practice transformation change is time consuming, challenges productivity	Qualis, TCPI, AIMS and OCH facilitated technical assistance to support practice consultation for quality improvements
Insufficient services capacity for referrals to be effective. This includes gaps in SUD treatment, BH "step down" facilities, affordable housing, and other social services	Inventory services gaps, including medical services for behavioral health (SBHO conducting), SUD inpatient/outpatient, BH facility gaps for treatment, step-down from intensive care, Permanent supported housing and other housing options. Advocate and seek funding to fill gaps.
State administrative codes – RCWs, WACs, Certification or other requirements that impede provision of bi-direction care	Identify administrative code barriers, present information to appropriate agency officials, work with professional organizations to advocate necessary changes to provision of integrated care.
No financial support for providers and OCH to move forward with Fully Integrated Managed Care (FIMC)	Engage HCA leadership to identify opportunities to support providers in their transition to FIMC

PARTNERING PROVIDERS

Partner Engagement Process and Commitment

Please refer to OCH Supplemental Workbook: 2A Partnering Providers. The list of partnering providers in the workbook is an initial list of partnering providers that have expressed interest in supporting the development and implementation of bidirectional care. Nearly all major Medicaid providers have been highly active participants in shaping the OCH project portfolio, including Bi-Directional Care. Participation has been a challenge for smaller SUD treatment providers; nonetheless many have been in communications with the Practice Transformation Hub coach to gauge willingness and readiness to participate. HCA provided data on the number of unique beneficiaries and claims among Medicaid covered lives which has been matched to the OCH implementation partner list. Based on a Number Needed to Treat analysis (see Theory of Action Section), OCH providers need to add access to mental health services to an additional 357 individuals and substance use treatment to 159 individuals to achieve a 2% improvement in these “gap to goal” measures. This is within reach because, at full capacity, an estimated 23,500 Medicaid beneficiaries (34% total OCH Medicaid population, all ages) will be reached by this project.

OCH will reach out to providers currently serving a significant number of Medicaid lives (Table 6), and all Tribes to participate in the change plan process development. A large proportion of AI/AN people are on Medicaid or uninsured, highlighting the considerable health and income disparities in these communities. OCH will provide technical assistance and DSRIP funding to all tribal health service providers to develop and implement a change plan tailored to both the Tribes needs and the goals of the MTP. NCCs may identify community-based organizations beyond this list and incorporate these agencies in their shared change plan and funds flow allocation.

Implementation partners have a historical commitment to serving the Medicaid population, and many have been involved in the portfolio selection process from the outset. This is evidenced by the constituencies of the OCH Board and Regional Health Assessment and Planning Committee, as well as the breadth of partnership commitments from the OCH RFA process. Leadership buy-in to the change plan for serving the Medicaid population and acceptance of Medicaid reimbursement levels is a contract requirement, with contracts a condition of receiving revenue incentives. Implementation partners must serve and disclose the number of Medicaid patients currently served, number attributed and payer mix. Implementation partners will need to commit to at least one bi-directional care model and to improving community health through the NCC shared change plan.

OCH is leveraging MCOs’ expertise in project implementation, encouraging and supporting VBP Technical Assistance from MCOs to provider organizations, MCO engagement in the change plan process, and provision of technical assistance for value based purchasing readiness through conferences, webinars and consultations. Partnership with MCOs will be critical to prepare providers for financial integration. MCOs bring expertise and lessons learned from early and mid-adopter regions.

Bi-Directional Integration of Physical and Behavioral Health Project Plan Olympic Community of Health
PARTNERING PROVIDERS

Table 6. Summary of implementation partners now serving a significant number of Medicaid lives

Patient Centered Medical Home Primary Care Practices	Medicaid Lives Served	NCC	Community Mental Health Agencies & Substance Use Treatment (Behavioral Health)	Medicaid Lives Served
Peninsula Community Health Services (FQHC)	13,770	Kitsap	Kitsap Mental Health Services (MH & SUD)	6615
CHI Harrison Health Partners (hospital affiliated)	10,825		Kitsap Recovery Center (SUD)	132
Northwest WA Family Residency Program			West Sound Treatment Center (SUD)	404
Kitsap Medical Group			Agape (SUD)	
North Kitsap Family Practice & Urgent Care	2,035			
Kitsap Children's Clinic	2,622			
Silverdale Pediatrics Clinic				
Port Gamble S'Klallam Tribal Health Center	765		S'Klallam Recovery Center (MH & SUD)	
Jefferson Healthcare Adult & Pediatric Clinics	4,598	Jefferson	Discovery Behavioral Healthcare (MH & SUD)	522
			Safe Harbor Recovery	199
North Olympic Healthcare Network (FQHC)	2,432	Clallam	Peninsula Behavioral Health Services (MH & SUD)	917
Olympic Medical Center Physicians	6,328		Reflections Substance Use Treatment (SUD)	
Olympic Medical Center Peninsula Children's Clinic	3,717		Cedar Grove Counseling (SUD)	
Jamestown S'Klallam Clinic – Family Health Clinic	2,252		Olympic Personal Growth (SUD)	
Lower Elwha Tribal Health Center	261		Klallam Counseling Services (MH & SUD)	
Bogachiel Clinic	1,831		West End Outreach Services (MH & SUD)	275
Clallam Bay Clinic				

SOURCE: HCA AIM, "Olympic ACH High Volume Provider Counts by Age", 10.27.2017

REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS

Numerous assets are in place that strengthen the successful employment of toolkit strategies designed to achieve whole person care, including but not limited to:

- A commitment by nearly all primary care practices accepting Medicaid to adopt either the Bree Collaborative or Collaborative Care approach to bi-directional care; two large primary care practices already have behavioral health professionals located at their clinics. Both federally qualified health clinics (FQHC) have behavioral health care staff integrated, one is fully integrated and employs these staff, another holds a contract with the local community behavioral health agency (CBHA). Two tribes are working to collocate their existing primary care and behavioral health services in closer proximity, and already share staff in the primary care setting.
- A commitment by all four community behavioral health agencies to either co-locate primary care on-site or to tighten care coordination with off-site primary care using a collaborative care approach. One has both primary care and dental onsite; one is exploring placement of a primary care provider (PCP) on its site through the local FQHC; one is working with its local hospital to determine possibility of collocating a PCP on CBHA premises, and placement of BH staff in primary care settings. One CBHA operates under the auspices of its local hospital.
- Seven substance use treatment providers are exploring how to best work with partner providers to ensure their clients in need of primary care and/or mental health services receive treatment, have an established medical home, and mutually employ care coordination to best support recovery.
- Tribes across the region are considering and or/implementing integrated care models, and planning discussions are underway to determine best approaches to integrate behavioral health.
- The OCH-led Three County Coordinated Opioid Response Project (3CCORP), initiated in 2016, has engaged multiple sectors across the three counties to create a shared, draft regional opioid response plan including prioritized strategies, benchmarks, and outcomes. Community investment in finalizing and implementing the plan is high. Tribal members, primary care providers (including medication-assisted treatment (MAT) prescribers), SUD providers, mental health providers, elected officials, law enforcement, fire/EMS, school personnel, criminal justice, hospital leadership, public health, Salish BHO, MCOs, and people in recovery are all among the over 100 individuals currently engaged in achieving 3CCORP vision. Shared goals to improve prescribing practices, increase number of waived MAT prescribers, and increase access to MAT treatment underscores the value of integrated care and strengthens alignment and coordination of care among PCP, SUD and MH providers. These providers represent the majority of Medicaid serving primary and behavioral health care practices in our region. Helping bridge differences in clinical culture with specific actions for shared practice improvements organically supports the overall shift to whole person, integrated care, and sets the stage for NCC change plans designed to support practice transformation and bi-directional care.
- SBHO and MCO active participation on the OCH Board and committees.
- Tables 6 through 9 in the Regional Health Needs Inventory Section list assets related to health care providers, social service providers and payers by service area; and number of beneficiaries served and number of claims by each major Medicaid provider, stratified by age and care setting (institutional or professional). OCH will be doing a deeper dive during the baseline assessment in DY1 Q4 and DY2 Q1.

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REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS

Table 7. Assets brought to project by provider type and Natural Community of Care

Provider Type	NCC	Assets Brought to Project	
Federally Qualified Health Centers (2 of 2)	Clallam Jefferson	Clinical Practice Transformation & Workforce <ul style="list-style-type: none"> Both engaged with Practice Transformation Hub Coaching Current provision of BH Services – Collaborative Care <ul style="list-style-type: none"> 1 fully integrated model 1 with co-located CBHA staff Both provide Team-based care, using EBP Both use standard screens, including SBIRT Both have some coordination for social services, networks 1 is Hub for regional MAT, both prescribe MAT Both partner w/ local CBHA to coordinate care for SMI/SED pop. 	Population Health <ul style="list-style-type: none"> 1 has Population Health Management staff, EHR capable of creating registries, interoperable with hospital, EDIE, measures reports Value Based Payments <ul style="list-style-type: none"> 1 has some VBP contracts in place
Primary Care Providers 4 hospital-associated all ages, multiple sites 6 independent all ages w/multiple sites 4 pediatrics only	All counties All counties Clallam Kitsap	Clinical Practice Transformation & Workforce <ul style="list-style-type: none"> Commitment to bi-directional care. All major Medicaid providers in region involved except 1. 6 engaged with Practice Transformation Hub Coaching 1 hospital associated provider collocates CBHA ARNP, BHP Multiple providers note team based care with EBP, use of Standard screening tools 2 hospital providers “umbrella”/affiliate with CBHA 1 hospital has strong focus opioid prescribing 1 independent provider organization notes use of pain contracts for opioid prescribing 3 Pediatric clinics working with Qualis/TCPI 2 Pediatric clinics working on QI project with CBHA/TCPI 	Population Health <ul style="list-style-type: none"> 3 hospital associated PCP practices on EPIC. Use EDIE/ PreManage, Direct Messaging
Community Behavioral Health Agencies (4 of 4)	All Counties	Clinical Practice Transformation & Workforce <ul style="list-style-type: none"> 1 provides multidisciplinary team care 2 have co-located primary care, 2 in process 1 has co-located dental services via FQHC All provide co-occurring SUD treatment 2 offer EBPs for patient chronic disease - 1 via 1422 ChD grant All are spokes for MAT All offer Intensive Care Coordination with Health care Providers, MCOs and social service providers 	Population Health <ul style="list-style-type: none"> 3 of 4 share same IT system and operations management; 1 in process to share same IT system; 1 uses EDIE system and will also move to PreManage
Substance Use Providers (5 to date)	Clallam Kitsap	Clinical Practice Transformation <ul style="list-style-type: none"> Evidence based provision of care WHAM curricula for prevention and chronic disease offered by 1 provider Weekly sponsored family meeting, and only SUD related family group in region CDP attends drug court weekly to advocate for clients Coordination with FQHC MAT Program Champion clinicians from BHA coordination with SUD in Clallam county Active leadership and participation on OCH Opioid Abuse Work Groups 	
Hospitals (4 of 4)	All Counties	Clinical Practice Transformation <ul style="list-style-type: none"> All committed to bi-directional care as priority All operate primary care practices; 1 co-locates CBHA LMHPs All partner with key organizations for prevention and care delivery 	
Tribal Nations (2 of 7 to date)	Clallam Kitsap	Clinical Practice & Workforce <ul style="list-style-type: none"> 2 committed to integrating health services with mental health and substance use services and facilities 2 with LCSW/MH in primary care 1 integrating MH team to CD services Cross training staff Wellness options 1 team in AIMS Tribal Cohort Collaborative Care Model Learning Series 	
Education & Workforce	All Counties	<ul style="list-style-type: none"> Community college willing to include integrated care, substance use in curricula Olympic Regional Workforce Development Council names health care workforce a priority 	
Social service providers & Community based organizations	All Counties	<ul style="list-style-type: none"> Strong CBHA, FQHC, hospital Linkages with housing, food, energy assistance, entitlements, employment, dental, long term care, children’s services and others in each NCC, generally through community based organizations and public entities. Strong connections demonstrated by participation in project portfolio development by CBOs in all counties, associated with basic needs and by public health, law enforcement, dentists, early childhood providers and others. Locally, these organizations have multiple shared clients and maintain collaborations and partner relationships. 	

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OCH implementation partners are committed to successful implementation and to long-term transformation of our system of care for persons with Medicaid coverage and for the whole population. While providers in the OCH region have a strong track record in clinical integration and commitment to bi-directional care, there are barriers to overcome to attain fully integrated managed care (FIMC) and meet all metrics.

Table 8. Barriers to improving outcomes and strategies to mitigate risks

Challenges or barriers to improving outcomes and lowering costs for target populations	Strategy to mitigate identified risks and overcome barriers
Lack of mechanism to leverage resources where multiple providers, clinical and social service, could benefit by setting shared goals, identifying and leveraging existing resources, using scarce resources to reach common measures.	<ul style="list-style-type: none"> • Creation of NCCs among partners. Charged to leverage resources within community (e.g., workforce, technology) • Change Plans to include in-kind contributions from each partner organization, including staff • Partner with existing collaborations; Leverage existing funding • Facilitate convenings within the NCC for best practices and new opportunities
Inadequate workforce capacity, especially for specialist positions, positions identified by sentinel network, rural geographies. Training needed to support whole person care models. Population based IT solutions lacking to support workforce communications, registries, measurements. <i>Note:</i> workforce especially challenging in more remote areas, affecting access to care	<ul style="list-style-type: none"> • Explore telehealth and virtual teams • Share IT solutions for population health management, both at PC and at CBHA, including registries, CFR 42 Part 2 solution. • Share BH and PCP staff more when colocated; population health nurse care manager, data analyst diabetes educator, others • Practice at top of license, advocate LMHP in lieu of LMSW. • Up-train all staff in integrated care practice, models, MI, TIC • Learn from partners using best practices, learning collaboratives, draw on tribes, CBHAs, for targeted chronic disease management
Lack of administrative and staff investment needed for sustained practice transformation, QI processes, workflow changes to support integrated care	<ul style="list-style-type: none"> • Require commitment to Change plans, assessments, milestones, monitoring, CQI- by provider, and NCC for reimbursement. • Provide technical assistance around lean or QI process • TA support, Hub and other expert consultation for practice transformation • Encourage provider organizations to innovate and course correct
Coordination of care between PC, MH, SUD. Target population is complex with multiple social determinants of health that cannot always be addressed without intensive care coordination and resources. Overcome low patient activation	<ul style="list-style-type: none"> • Improve HIE interoperability • Address 42 CFR Part 2 so mental health, substance use providers can readily share information using HIE. Legal decision with state of WA for 42 CFR Part 2; OneHealthPort work with state attorney; mutually agreed upon understanding to craft a data sharing matrix, clear policy outlining the authority for two organizations; draft template consent form; standard elements in an EHR and what they look like. • Employ team based care coordination for complex patients, high utilizers, including CHWs, Recovery Coaches, BH Peer Specialists, BA level Care Coordinators, Nurse Care Managers, LMHP, LMSW • Tailor the intervention to the patient • Advocate for health insurance, adequate housing, food/nutrition, other social services. • Patient self-empowerment options – ie chronic disease management, medication adherence. • Clinical knowledge of and application of motivational interviewing, trauma informed care • Effective care coordination for patients with complex needs
Lack of funds sufficient to effectively implement strategies	<ul style="list-style-type: none"> • Leverage resources among providers, clinical and social service. • Work with elected officials, associated staff to leverage state and local funds. • Seek additional funding, ie Social Investment financing, grants • Educate community about health, health care costs, options to impact

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	change
Getting caught up in the activities and losing sight of the “big picture”. Provider lack of confidence in sustainable implementation.	<ul style="list-style-type: none"> • Ensure processes are designed to support measures and milestones, with QI to ensure accountability and transformative practices focused on goals. • Place enough resources into the workforce, population health, financing infrastructure to launch and sustain the transformation through time.
Sustainability	<ul style="list-style-type: none"> • Provider risk effective innovations in bi-directional care will not be reimbursed by MCOs after Medicaid Waiver end.

MONITORING AND CONTINUOUS IMPROVEMENT

Monitoring Project Implementation

OCH will ensure timely and effective implementation through detailed planning, formation of Natural Community of Care (NCC) collaborative agreements, NCC steering committees, comprehensive baseline assessments and change plans. Change plans will outline a sequential, stepwise process, co-designed with the provider organization(s), to implement transformational activities.

In 2018, the biggest risk to implementation will be providers failing to meet reporting requirements. OCH will mitigate this risk by precisely noting reporting requirements in provider change plans, which will be developed in early 2018. We will also provide outreach and training on OCH's monitoring system (described below). Trainings will be in person and virtual, with materials specific to each project, and presentation on best practices for specific project measures. To the extent possible, OCH requirements for provider reporting will align with existing reporting requirements (e.g., HEDIS, Alternative Payment 4, and Apple Health Contracts). This will be a joint initiative with MCOs, strategically positioning providers to achieve VBP contract benchmarks.

Funding will flow to providers and affiliate partners upon completion of set milestones, as outlined in change plans. There will be fiscal consequences for lack of progress, as revealed by process and outcome measures. This will all be detailed in provider contracts.

Delays in implementation will be addressed by change managers, either employed by the provider organization or OCH. Change managers will identify cross-cutting implementation barriers among partnering provider organizations. In turn, they will not only make recommendations to address those barriers, but will also revise change plans appropriately.

Monitoring Continuous Improvement

OCH projects share common elements for monitoring and continuous improvement. To track progress, OCH will rely on a host of measures categorized (at its highest level) as follows: process measures, milestones and outcome measures. The latter two categories will include all toolkit required measures for determining project incentive payments. The first category (process measures), although not specified in the toolkit, is critical to ensuring OCH and partner organizations adopt best-practices both for projects and for Domain 1 activities. For the most part, the process measures will serve as real-time indicators.

OCH is planning to build a technology platform that can systematically manage all three categories of measures. The platform will also have enough descriptive context to guide partners and providers in the provision of information to send to OCH. The information coming from providers will primarily fall into our first two categories: process measures and milestones. Outcomes measures will be captured chiefly from existing reporting systems (e.g. Healthier Washington Dashboard, HCA-AIM reports, Washington Health Alliance Reports, DSHS reports, RDA reports, WSHA reports and others). The OCH platform will avoid the inefficiency and inaccuracy inherent in having providers entering data in multiple templates. OCH intends to use the platform for data aggregation and formatting to streamline the population of HCA required templates.

OCH's process measures are the lynchpin to ensuring OCH providers are on track to make the necessary progress expected under the Transformation. Simply put, outcome measures are too lagged and provide no insight into whether foundational operational front-line changes have been undertaken. Milestone

reporting, while providing a real-time sense of overall organizational change, still does not furnish a front-line view of how patient engagement may have changed.

OCH does not anticipate much resistance from partnering providers in providing requested information for tracking purposes. During OCH's letter-of-intent process (March to April 2016), when asked, "*Are you willing to provide project-specific data to OCH for tracking purposes?*" all partnering organizations agreed to send data to OCH for tracking purposes.

Identifying what is not working

OCH will form a steering committee for each NCC. The role of the committee is to oversee the work of the shared change plan, identify barriers, and collaboratively design solutions across sectors and Tribes. OCH staff will share learnings across NCCs, deploying technical assistance where appropriate. OCH will also deploy provider surveys, creating an anonymous vehicle for providers to provide feedback to the OCH.

OCH will hire a Compliance and Contract Coordinator to oversee change plan compliance, conduct site visits, and perform annual audits. OCH will form a Compliance Committee to oversee this effort. Partners will receive additional support through a change manager, who will offer regular progress check-ins with participants within each NCC. The OCH Board will approve a mediation plan structure and grievance procedure to provide necessary processes for under-performance and non-compliance.

The Performance Measurement and Evaluation Committee (PMEC) designs and reviews data submissions, interprets trends, and elevates red flags to the Board. The PMEC will swiftly identify issues regarding reporting, data quality, or failure to move metrics and offer counter-measure solutions where appropriate.

Each project implementation plan will include a go/no go decision midway through project implementation. If the work to that point has proven constructive with quantifiable evidence that the program will be both successful and sustainable, then the work will continue through the duration of the Transformation. Evidence that the program or elements of the program are not working will trigger a project plan modification request, specific to the root cause of the issue.

Bi-Directional integration project risks

Beyond the risk noted above of partners/providers not being set up to meet reporting requirements, OCH is mindful of the following specific risks with the Bi-Directional Integration project. We intend to devise focused monitoring mechanisms for these risks. This is only a sample of monitoring initiatives:

- Ineffective spreading of bi-directional care techniques to all clinic staff; effective implementation requires whole-clinic reorientation.
- Not-attempted or incomplete integration between currently selected behavioral health and primary care providers.
- Insufficient training and adoption of measurement-based behavioral health care, e.g. adoption of such measures as SBIRT, GAD-7, PHQ-9, etc.
- Ineffective development of behavioral health registries, thereby preventing robust stratification of behavioral health populations.
- Insufficient development of common platforms to capture leading indicators of behavioral health improvement among the population.

PROJECT METRICS AND REPORTING REQUIREMENTS

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
x	

RELATIONSHIPS WITH OTHER INITIATIVES

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
x	

PROJECT SUSTAINABILITY

The project supports sustainable health system transformation for people on Medicaid through development of sufficient infrastructure, workforce, and clinical practice transformation investments that will lead to successful value-based payment contracting for Medicaid providers beyond the Transformation. These transformations will outlive the MTP. Investments within the bidirectional integration project in infrastructure, capacity, workforce, and transformation, directly translate into the sustainable transformation components described in Section 1: Required Health Systems and Community Capacity (Domain 1) Focus Areas.

<i>Table 9. Driving towards sustainable capacity, infrastructure, workforce, and transformation strategies</i>	
Bidirectional Integration Project →→→→→→→→	Capacity Infrastructure Strategies
Through exploring technologies such as Pre-Manage or others to be determined	Health information sharing (VBP) (PHS)
To manage the subpopulation of people with co-occurring disorders and chronic disease(s)	Registries (VBP) (PHS)
To identify the subpopulation of highest risk patients	Risk stratification (VBP) (PHS)
To effectively refer patients for SUD treatment and/or MAT	Referral Management (VBP)
An analytic tool to facilitate internal evaluation and rapid-cycle testing of interventions	Analytics - Decision support technology (VBP) (PHS)
Bidirectional Integration Project →→→→→→→→	Workforce Strategies
Shared telepsychiatry or telepain	Telehealth
Training in trauma-informed care or clinical integration standards	Cross training and redefine role
Address professional workforce shortages needed for clinical integration such as psychiatric ARNP, RN, and LCSW	Recruitment
Bidirectional Integration Project →→→→→→→→	Transformation Strategies
Offering on-site behavioral health services in a patient's medical home	Patient Centered Medical Home (VBP) (PHS)
Doctors, social workers, nurses, mental health and SUD providers collaborating to provide whole person care	Team-Based Care
Patients receive the level and type of care they need in the venue that is most suited to their needs	Integrated, whole person care

Workforce and population-based management

Investments will support data systems and population based health approaches. Workforce strategies will increase use traditional and non-traditional solutions to increase workforce capacity for integrated primary care and behavioral health care delivery, for improved care coordination across systems, and for population health management. These strategies may include increased use of workforce/IT solutions through telehealth, and population health analytics/care managers, creative workforce teaming such as sharing specialty providers between agencies, virtual or mobile teams, advocating for efficiencies and reductions in barriers to practice due to regulatory requirements (e.g., scope of practice), length of time to achieve licensure, work with higher education, residency programs, and professional trainers for integrated curricula to prepare the new workforce and uptraining of existing

workforce, and use of state and regional workforce resources. Continued improvements in provider interoperability for data sharing and patient communications is a regional priority and necessary precursor to bi-directional care integration.

Managed care organizations

Over four years of the Transformation, providers can refine clinical processes and care coordination strategies to hit the targeted benchmarks for VBP incentives. By leveraging the collaborative structure of the NCC, together, providers from different sectors will benefit collectively by providing whole-person care for their population.

MCO and SBHO participation in developing change plans and participating in implementation of these projects will help providers engage with future value-based contracts. These contracts may include payment models that support integration of behavioral health staff in medical homes, co-location or integration of primary care providers with behavioral health specialty care, population health improvements and care coordination. To make practice transformation workflow and clinic redesign sustainable, OCH will encourage providers to partner with MCOs on MH and SUD treatment penetration rates, depression medication management, and reduction in ED and hospital utilization metrics as part of their VBP contracts.

Prevention and whole person care

Through this project, partnering providers will institute a comprehensive, whole-person approach to promoting and sustaining health for community members with mental health and/or substance use disorders and their families. By focusing on implementation across practices for improving screening, medication management and prescribing practices, and improving treatment and coordination of care for behavioral health concerns, providers will positively impact populations throughout the lifespan. In addition, this integrated approach promotes the linkage of health care and community based organizations, which will leave a sustaining impact on the entire region.

ATTACHMENTS

1. Bi-Directional Integration – Attachment A – Practice Assessments Report
2. *Required* OCH Supplemental Workbook: Tab 2A Partnering Providers
3. *Required* OCH Supplemental Workook: Tab 2A Implementation Approach

Olympic Accountable Community of Health

Assessment Data
(PCMH-A and MeHAF)

Summary of Regional Results
Final Report
November 1, 2017



Overview

The purpose of this report is to provide the Olympic Accountable Community of Health (OCH) with detailed results based on the administration and analysis of Patient-Centered Medical Home Assessments (PCMH-A) and Maine Health Access Foundation Site Self Assessments (MeHAF) conducted in the Olympic region. For questions concerning this report or its contents, please contact Maria Klemesrud (mariak@qualishealth.org) or Rick Helms (rickh@qualishealth.org).

The OCH engaged the Practice Transformation Support Hub and Qualis Health to provide technical support to practices in the counties of Clallam, Jefferson, and Kitsap, specifically administering and providing feedback of results from the PCMH-A and MeHAF instruments, which are tools for supporting and monitoring progress in primary care practice redesign and bidirectional behavioral health integration respectively. An initial administration of the PCMH-A and/or MeHAF instrument data and results are discussed herein for 19 primary care clinics and behavioral health agencies, which completed an assessment prior to October 20, 2017. Individual reports are shared with participating agencies with comparison against the regional scores.

The following practices engaged in the assessment process and their results are included in this report:

- Discovery Behavioral Health*
- Forks Hospital – Bogachiel Clinic*
- Forks Hospital – Clallam Bay Clinic*
- Harrison Health Partners - Family and Internal Medicine*
- Harrison Health Partners - Family Medicine and Dermatology
- Kitsap Medical Group – Bremerton*
- Kitsap Medical Group – Kingston*
- Kitsap Medical Group – Port Orchard*
- Kitsap Mental Health Services*
- Lower Elwha Tribe
- North Olympic Healthcare Network*
- Northwest WA Family Medicine Residency
- Peninsula Behavioral Health Services*
- Peninsula Children's Clinic
- Peninsula Community Health Services* (six sites participating**)
- Port Gamble S'Klallam Behavioral Health Center*
- Port Gamble S'Klallam Health Center*
- Reflections Counseling Services
- West End Outreach Services*

**Included in Interim Report*

***Seventh site is in Cascade Pacific Action Alliance and data not represented here.*

Please note: The data contained herein is blinded and does not explicitly identify individual practice scores. However, with the limited number of respondents reported, anonymity of individual clinics cannot be assured. Care should be taken when distributing this report if results are to remain blinded.

Assessment Tools

Patient-Centered Medical Home Assessment (PCMH-A)

The Patient-Centered Medical Home Assessment (PCMH-A) was jointly developed by the MacColl Center for Healthcare Innovation at the Group Health Research Institute and Qualis Health as part of the Safety Net Medical Home Initiative (SNMHI), a national demonstration project intended to support medical home transformation among practices serving vulnerable and underserved populations (www.safetynetmedicalhome.org). SNMHI sites included migrant and community health centers, residency clinics, private practices, and other facilities. The PCMH-A is based on a series of Change Concepts for Practice Transformation that comprises the technical assistance framework for the Practice Transformation Support Hub (see Appendix: Patient Centered Medical Home Assessment).¹

Qualis Health and the Practice Transformation Support Hub utilize the PCMH-A to gather data from primary care practices on transformation activities and readiness for behavioral health integration. The tool was determined to be the best of the available options for assessment because it is appropriate for primary care settings, has a scale that is sensitive to change over time, and provides information that serves as a helpful starting point for agencies creating action plans for implementing whole person care strategies.

The PCMH-A includes 36 items and eight sections each scored on a one to 12-point scale. Scores are divided into four levels, A through D. The overall score is the average of the eight subscale or Change Concept scores. For each of the items, *Level D* scores reflect absent or minimal implementation of the key change addressed by the item. Scores in *Level C* suggest that the first stages of implementing a key change may be in place, but that important fundamental changes have yet to be made. *Level B* scores are typically seen when the basic elements of the key change have been implemented, although the practice still has significant opportunities to make progress with regard to one or more important aspects of the key change. Item scores in the *Level A* range are present when most or all of the critical aspects of the key change addressed by the item are well established in the practice. Average scores for each Change Concept, and for all 36 items on the PCMH-A, can also be categorized as Level D through A, with similar interpretations; that is, even if a few item scores are particularly low or particularly high, on balance, practices with average scores in the *Level D* range have yet to implement many of the fundamental key changes needed to be a PCMH, while those with average scores in the *Level A* range have achieved considerable progress in implementing the key features of Patient Centered Medical Home, as described by the Change Concepts for Practice Transformation.

Summary scores for each Change Concept are computed based on the individual item scores in each section. The practice-specific Change Concept, or subscale score, is the average of the individual PCMH-A item scores for each Change Concept. A practice-specific overall score is the average of all eight subscale scores.

Maine Health Access Foundation Site Self-Assessment (MeHAF)

The Site Self-Assessment Plus (MeHAF) was developed by the Maine Health Access Foundation and is adapted from the assessment tools developed by the Robert Wood Johnson Foundation Diabetes Initiative, (www.diabetesinitiative.org) and the Assessment of Chronic Illness Care survey developed by the MacColl

¹Wagner EH, Coleman K, Reid RJ, Phillips K, Abrams MK, and JR Sugarman. "The Changes Involved in Patient-Centered Medical Home Transformation." *Primary Care: Clinics in Office Practice* 39(2) (2012): 241-259.

Center for Healthcare Innovation at the Group Health Research Institute (see Appendix: Maine Health Access Foundation Site Self-Assessment).

Qualis Health and the Practice Transformation Support Hub utilize the MeHAF to gather data from behavioral health agencies, as well as primary care practices that identify a readiness to focus primarily on bidirectional integration activities. The tool was determined to be the best of the available options for assessment because it is appropriate for primary care and behavioral health settings, has a scale that is sensitive to change over time, and provides concrete information which serves as a helpful starting point for agencies creating action plans for implementing integrated care.

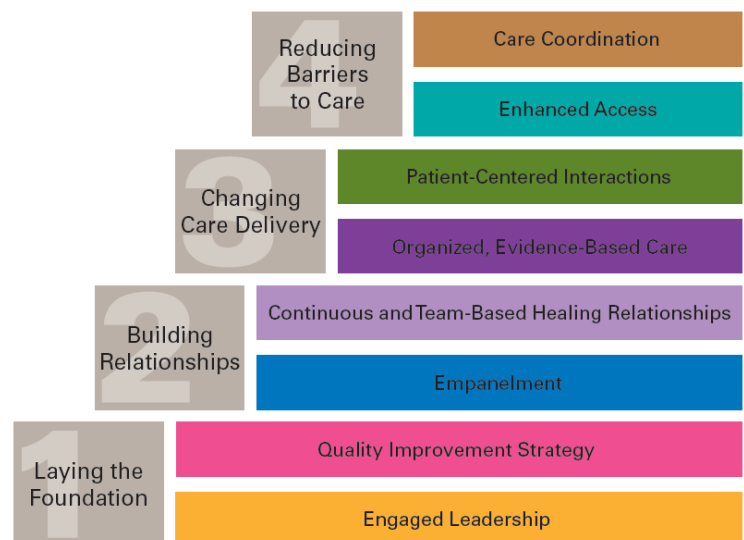
The MeHAF includes 21 items and is scored on a one to 10-point scale, broken into four levels. The assessment consists of two sections: *Integrated Services and Patient and Family-Centeredness* and *Practice/Organization*. Scores are divided into four levels to indicate an activity: 1) Does not occur or does not exist (Score: 1); 2) Is passive, sporadic, or occasional (Scores: 2, 3, 4); 3) Occurs at some levels or consistency (Scores: 5, 6, 7); 4) Occurs with regularity or is an essential function (Scores: 8, 9, 10).

The MeHAF does not group questions into composite areas or Change Concepts for score averaging. Qualis Health has presented data here mapping individual questions to each of the Change Concept key changes, while retaining the question-by-question responses.

Change Concepts for Practice Transformation

The Safety Net Medical Home Initiative developed a framework – The Change Concepts for Practice Transformation – to help guide primary care practices through the PCMH transformation process. "Change concepts" are general ideas used to stimulate specific, actionable steps that lead to improvement. Our framework includes eight change concepts in four stages:

- **Laying the Foundation:**
Engaged Leadership and
Quality Improvement Strategy
- **Building Relationships:**
Empanelment and Continuous and
Team-Based Healing Relationships
- **Changing Care Delivery:**
Organized, Evidence-Based Care and
Patient-Centered Interactions
- **Reducing Barriers to Care:**
Enhanced Access and
Care Coordination



The Change Concepts were derived from reviews of the literature and discussions with leaders in primary care and quality improvement. They have been most extensively tested by the 65 safety net practices that participated in the SNMHI, but are applicable to a wide range of practice types. They have also been adopted by other improvement initiatives nationwide.

Administration

The PCMH-A and MeHAF are administered by a practice facilitator (Connector/Coach), with a multidisciplinary group (e.g., physicians, nurses, medical assistants, residents, other operations staff, and administrators) to build consensus on each of the assessment questions in order to capture the perspectives of individuals with different roles within the practice and to get the best sense possible of “the way things really work” in a practice. Discussions occurring in the consensus building process provide opportunities to identify prospective areas for transformation. Each practice site completes an assessment, although multi-clinic systems are directed and supported by the same organizational leaders and policies, practice transformation occurs differently at separate clinic locations. Organizational leaders can compare PCMH-A and MeHAF scores and use this information to share knowledge and cross-pollinate improvement ideas across multiple sites.

The PCMH-A and MeHAF are self-assessment tools, which rely on an honest appraisal by a clinical team regarding their practice transformation progress and efforts. Inflation or deflation of scores can occur when questions are misunderstood or consensus is inadequately built among the team.

Summary of Results

PCMH-A

This report summarizes PCMH-A scores for practices in the Olympic Community of Health region that completed the assessment prior to October 20, 2017. This report presents the scores of 17 practices, each with an initial administration of the assessment (*see Figure 1*).

Care Coordination (Median 8.0)

Throughout the region, primary care clinics expressed difficulties getting timely behavioral health assistance for Medicaid patients with psychiatric concerns. Discussions with primary care practices indicate a thought that emergency room utilization is a result for those patients that are not proactive with mental health and substance use issues. Primary care providers share frustrated when patients return to their office in follow-up visits with continuous symptoms and complaints related to behavioral health. In addition, primary care providers report their offices serves as a revolving door of care and would like more resources to proactively treat chronic conditions including behavioral health. Health navigators and behavioral health providers have proven successful in filling some gaps and assisting patients with immediate needs that impact health, such as food, security, transportation and housing.

Continuous Team-Based Healing Relationships (Median: 10.3)

Primary care practices possess highly-engaged care teams, who work together to ensure patients get the best care possible. The majority of clinics reports operating with limited resources and under budgetary constraints; however, dedicated staff are available to assist patients. In observation, this often means medical assistants and nurses are working at the top of their license. Cross training is seen as an essential function based on workforce limitations and the transience of the workforce. Several clinics utilize a care team model and hold routine huddles, but many clinics report huddles are not always attended by primary care providers. Champion providers, RN, and MA/LPN teams report effective huddles.

Empanelment (Median: 6.8)

Clinics continually state a need to balance patient needs and empaneling patients. Issues of continuity of care were raised in multiple clinics, wanting to ensure patients continue to see the same provider. However, the need

of patients to be seen immediately or on short notice does not always allow this to occur. Practices voiced concerns over spending time on empanelment when these limitations exist. Approximately half of the patients are empaneled in practices, as some patients are not willing to see their empaneled provider. For example, a clinic may have a pediatrician seeing adult patients, as they were never transitioned to a new provider; the patients insist on seeing only this provider in the practice. Clinics say the reactive nature of medical practice is a barrier to empanelment.

Some rural practices have experienced provider turnover, which causes severe disruption to caseload and transitioning patients to new providers. Substance use providers in one county report Medicaid recipients often wait many months to be scheduled with a primary care provider. Registries for tracking behavioral health symptoms is a new concept to most primary care practices, and their electronic health records often do not have easy add-on templates for treatment-to-target interventions. Many clinics cannot afford the cost of adding features to electronic record systems.

Engaged Leadership (Median: 6.9)

Clinic staff voice that leaders are involved and embracing the idea of transformation and whole person care in theory, but not in actions across many clinics. The staff did not state that this is potentially a timing issue, with actions taking time to implement. Leaders consistently participated in assessment discussions and let their staff speak their minds openly, not driving the conversations. Some leaders stated frustration that administrative quality improvement activities don't transfer to clinic implementation and improvements in patient care, but also report understanding that internal quality improvement plans could be more effectively implemented. In the majority of clinics, leadership is supportive of protecting staff time for assessment and follow up activities with the Connector/Coach at the Practice Transformation Support Hub.

Enhanced Access (Median: 10.0)

Enhanced Access for many providers is not seen as a priority, but has been adopted by many practices. Providers often report being locked into short appointment times and longer-tenured providers being able to adjust their schedules for longer appointments as needed. Additional enhanced access planning is occurring in some clinics, with medical staff triaging patients appropriately. Additionally, several practices report the use of a "MyChart" feature with their records, allowing patients to communicate with providers directly.

Organizational Evidence-Based Care (Median: 9.0)

The majority of clinics assessed identify a high level of evidence-based care and practices. Several have moved to a huddle model of pre-visit planning, while others have concerns about time and productivity for implementing this step each day. However, those without huddles often report care as being more fragmented within their walls. Similarly, behavioral health measures are often measured but not tracked in any organized way. Primary care clinics report care plan development is common, but electronic records may not have capability of presenting care plans in a dashboard format.

Patient-Centered Interactions (Median: 7.7)

All practices surveyed have an awareness of the importance of patient-centered interactions and are interested in improving services to provide better care for patients. A majority of practices believe assessing patient and family values and preferences is done on an ad-hoc basis, and patient comprehension of verbal and written materials is assessed but more work is required to close the loop on evaluating health literacy for patient comprehension. Also, it is evident that the surveyed clinics are part of small communities and are passionate about serving their family, friends and neighbors. Additionally, rural clinics and tribal partners have consumers

working in the practices. However, the concept of patient/consumer voice may be foreign to several clinics assessed, especially related to having consumers as members of quality improvement teams.

Quality Improvement Strategy (6.5)

Most clinics have a quality improvement team that consists of managers and administrators and is not always communicating with staff delivering direct service to patients, so quality improvement efforts often do not translate into tests of change in patient care. Staff state that overall quality improvement strategies tend to be reactive in nature, and changes are made only when problems arise rather than a mindset of continuous quality improvement. Clinics with information technology support and highly-capable record systems perform at higher levels regarding quality and metrics.

It is often reported that productivity takes precedence over quality improvement activities. The most effective electronic health records among primary care providers are EPIC, NextGen and Athena. All clinics report optimizing their electronic health record would improve patient care but the expense of desired record systems and the technical staff to manage them is lacking. A concern among all providers is how to build behavioral health interfaces into records to capture population health information and tracking. Many providers utilize spreadsheets to begin registry tracking for PHQ-9 treatment to target and co-morbid conditions such as diabetes and asthma rather than modules in their systems. Clinics voice concern regarding the reliability of data when technology services are housed off-site and the difficulty and expense in building customized programs for registries to track high risk groups effectively.

MeHAF

This report summarizes MeHAF scores for practices in the Olympic Community of Health region which completed the assessment prior to October 20, 2017. This report presents the scores of five practices, each with an initial administration of the assessment (*see Figures 2-5*).

The highest median scores were: Linking to Community Resources (9.0) Social Supports (8.5), Patient Care that is based on (or informed by) best practice evidence for prescribing of psychotropic medications (8.5). The lower scoring areas include: To what degree are medical professionals currently available/accessible within your setting for warm hand-offs (3.5), Data systems/patient records (3.5), Level of integration, primary care and behavioral/mental health care (3.5) Physician, team and staff education and training for integrating care (3.0) Data Systems and Patient Records (3.5), and Funding Sources and Resources (2.5).

Laying the Foundation

Assessed clinics report leadership is invested, but line staff often feel pressure to make change while continuing day-to day work. There was not a majority of agencies and clinics providing dedicated time to quality improvement activities. Siloed settings in integrated systems due to concerns over confidentiality present a problem for continuous communication across the teams. Perceived legal constraints due to 42 CFR Part 2 and lack of interoperability between electronic health records makes it unsurprising that the category of Data Systems and Patient Records received a median score of 3.5. The region is considering how to improve this area through up-front release of information training for staff and programs such as PreManage, EDIE and Consent2Share. However, these programs may come costly or burdensome to implement, and if partnering agencies do not utilize their capabilities, it can become a waste of technology and money.

Funding Sources and Resources scored a median of 2.5, which is the lowest score in this assessment. Behavioral Health Agencies (BHAs) voiced they are being asked to serve the same clients with ever-decreasing funds. In

addition, agencies can be billed for out-of-region inpatient care for their Medicaid lives in exorbitant amounts. This fact alone can financially burden an already struggling BHA under the current payment methodology for behavioral health services. There is also speculation and stress from agency staff about financial integration and contracting with managed care organizations, as much is unknown at this point in time.

Building Relationships

Severe and persistent mental illness wrap-around services and care teams appear more effective with whole-person care, as they are involved in many aspects of clients' lives. Clients screened for short term care does not include intensive care management services, and integration efforts are limited in these settings. Behavioral health providers voiced difficulty in bridging the gap into primary care settings for their clients, as functional limitations may prevent them from being seen in traditional primary care settings.

Changing Care Delivery

Agencies report involving patients in care decisions and treatment in all behavioral health settings. Providers' engagement with integrated care "buy in" is moderately consistent, but with some concerns; some providers not fully implementing intended integration components. Additionally, agencies report utilizing evidence-based care for treatment of behavioral health conditions. Data systems and patient records are shared among providers on an ad hoc basis; multiple records exist for each client, no aggregate data used to identify trends or gaps. Funding resources is the lowest score on this assessment and not a surprise to anyone working in a behavioral health agency. This is due to a uncertain time of change with BHAs required to deliver the same care with limited resources.

Reducing Barriers to Care

Agency staff reports that relationships providers have with each other across care teams make the biggest difference in patient treatment. Relationship building between teams is seen as essential for building continuity of care for integration; it is not necessarily technical or formal integration efforts that are seen as successes. However, the lack of a feedback loop for referrals and coordination of care between providers of different types exists in many circumstances and improvements are recommended in this area. In more rural areas, there may not be providers that accept Medicaid and Medicare insurance for behavioral health and/or those that do are booked.

Behavioral Health Integration

Overall, primary care clinics voice concern in working directly with clients with severe and persistent mental illness, especially if these clients have a high functional impairment. This are typically the most common patients that are lost to care or unenrolled from primary care practice due to behavior issues or chronic no shows to appointment. In contrast, behavioral health clinicians have difficulty at times communicating with primary care providers on their client's behalf. Even in colocated sites, communication can be limited due to perception of adherence to information sharing rules (e.g. 42 CFR Part 2 and HIPPA). There is a lack of real time communication between primary care clinics behavioral health agencies (including both mental health and substance use disorder) to close referral gaps and often it is the decompensation of the patient that results in teams communicating about discharge plans. It is the innovative relationships developed between primary care and behavioral health teams that allow for higher levels of continuity of care for patients. Often, emergency room visits, hospitalizations, and discharge planning are at times the only communication primary care and behavioral health providers have with shared patients. However, without ongoing communication, the fragmented treatment cycle continues. Staff voiced in multiple clinics that building relationships is essential to

integration activities. However, there is considerable strength in engagement of the providers across the Olympic region and a desire to perform better for patient care.

Primary care staff report a possible high prevalence of co-occurring physical and mental health conditions in their patient population; however, these patients are often not severely impaired enough to screen into BHAs that accept Medicaid and do not have the financial ability or resources needed to access mental health services outside of the BHA system. Anecdotally, communities with wider gaps between the affluent and those with significant social determinates of health concerns is where integration seems to be struggling more.

Because of screening requirements of BHAs in the region, psychiatrists are often perceived as unwilling to manage medications of patients without a severe and persistent mental illness. Many clinics have integrated telemedicine to serve a wider range of patients and several employ a psychiatrist to share between primary care and behavioral health. Still others have built their own behavioral health program with clinicians and health navigators to route patients for psychiatric consultation. All groups of clinics have used innovative thinking in linking patients to whole person care in an environment of shrinking financial resources. Moderate psychiatric concerns, with limited effect on functionality, are often seen as an area where primary care providers should assist patients, whereas primary care providers may not yet be comfortable prescribing and providing care in this space.

Tribal Involvement

Tribal relationships are paramount to the success of the Olympic region in transforming care. Dialogue during the PCMH-A and MeHAF assessment process with Tribal members and care teams emphasized the importance of cultural awareness and appropriate treatment delivery, awareness of protecting patient information in a setting where Tribal members live and work in close proximity to their clinic, and the role of Tribal Elders and Tribal Governments in Sovereign Nations. In addition, trauma experienced by Tribal members, both individually and collectively, presents a requirement to ensure appropriate education and training are provided for all members of care teams.

The Port Gamble S'Klallam Tribe Health and Wellness Clinics as well as the Lower Elwha Tribal Health Clinic have partnered with the Practice Transformation Support Hub. Both groups have met consistently with the Connector/Coach and are actively practicing quality improvement activities across their agencies. With the support of the American Indian Health Commission, two Tribal Liaisons were recently hired and the Connector/Coach continues to work to assist with their efforts.

Substance Use Response

As a member of the OCH Demonstration Team, the Qualis Health Connector/Coach has participated with the Opioid Abuse Project in the Olympic region, and is a member of the Opioid Treatment Work Group. Many smaller substance use disorder (SUD) clinics participate in this group and voice concern about their ability to remain financially stable after the dissolution of the Behavioral Health Organization (BHO). Although practice transformation has engaged behavioral health and Tribal groups that include substance use treatment, it is the smaller, stand-alone SUD clinics that state concern about value based payment reform and the dissolution of the BHO. Rural SUD clinics report a multiple-month wait for their Medicaid clients to establish care and be seen by a primary care providers, as well as difficulty with real time communication with primary care and behavioral health clinicians. Significant dialogue occurred during the SUD assessments around tracking clients who no-

show for appointments, which is reportedly a common occurrence with a person experiencing a relapse. Advocacy, especially in drug court, and family-involvement efforts by SUD providers are perceived as high-value activities.

The most challenging culture shift for some chemical dependency counselors is the Medication-Assisted Treatment (MAT) model as an option of care for opioid abuse. Several chemical dependency counselors continue to hold to the belief that abstinence is best. It is through the Opioid Abuse Work Groups that dialogue and education is impacting treatment models and shifting the culture toward MAT as a treatment option, especially with seasoned medical doctors leading and participating on these teams and providing education and resources regarding a patient's choice to include medication assisted treatment in their recovery.

Without integration efforts with substance use disorder partners, primary care and behavioral health groups agree that consumers presenting with co-occurring disorders are the most difficult to successfully treat. Some primary care clinics state they have billed the SBIRT (screening, brief intervention, and referral to treatment) model for several years, while others are working to train their clinicians in this model. Within primary care practices, the implementation of conservative and more responsible prescribing practices, controlled substance contracts that include random urinalysis and use of the Washington Prescription Monitoring Program are the tools required to turn the tide on substance use epidemic. In addition, Olympic region leaders, with assistance from the Accountable Community of Health, are working hard to turn the tide on substance use, especially related to opioid abuse. The Olympic Accountable Community of Health regional team is currently in the drafting stages for a project plan to further address the opioid epidemic in the Olympic region under the Medicaid Transformation Demonstration.



Figure 1. PCMHA Summary

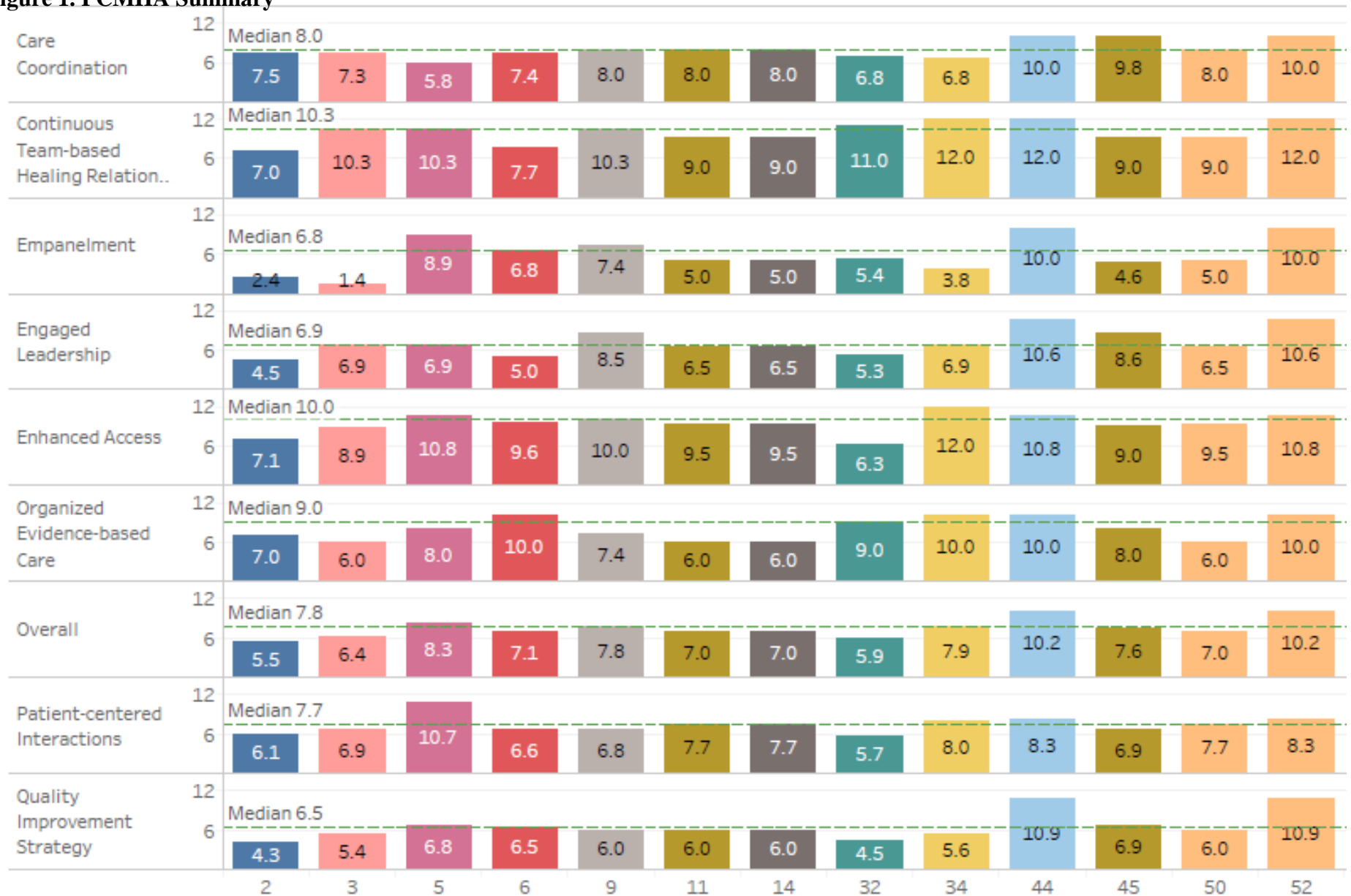


Figure 2. MeHAF Summary: Laying the Foundation

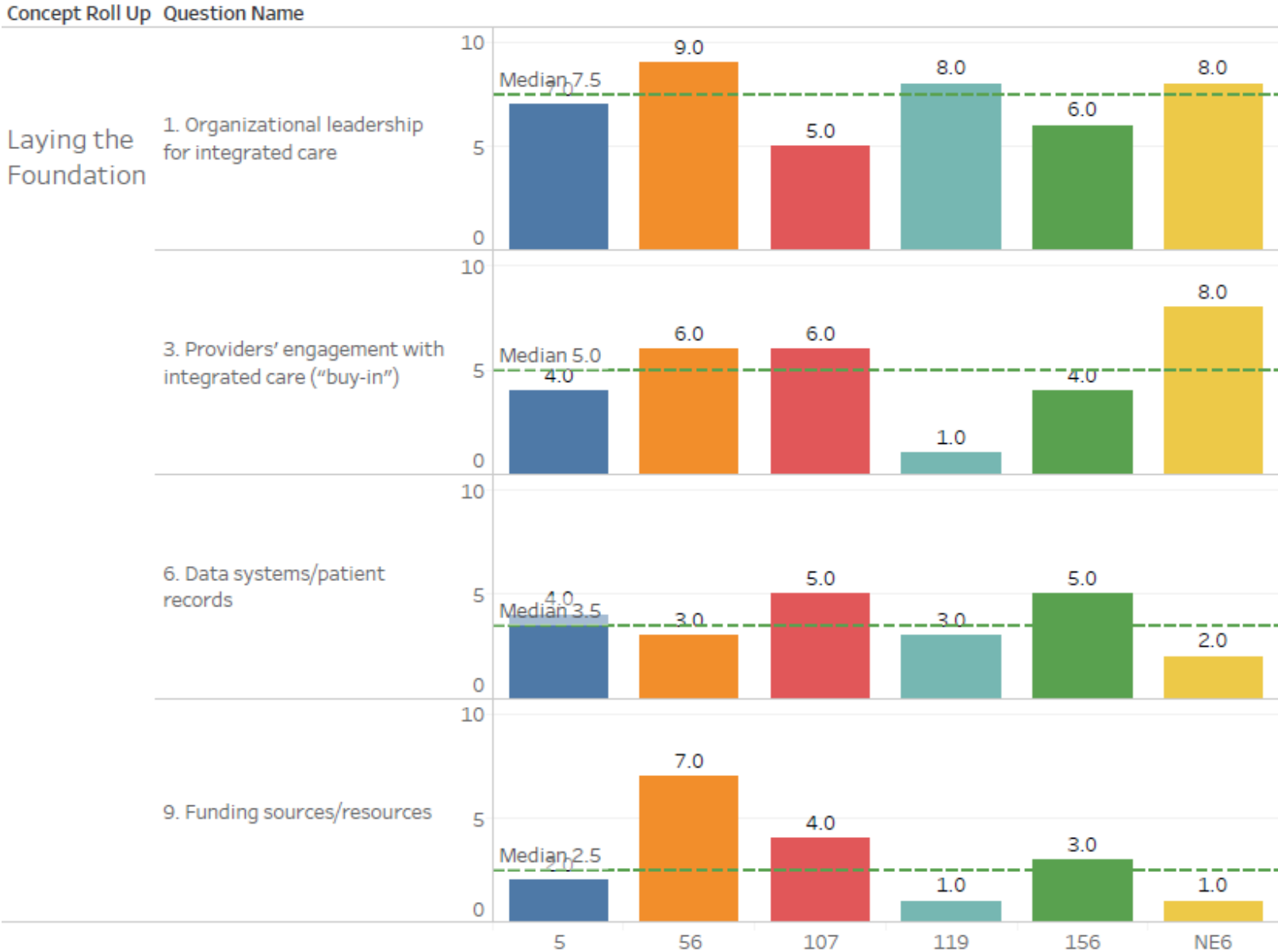


Figure 3. MeHAF Summary: Building Relationships

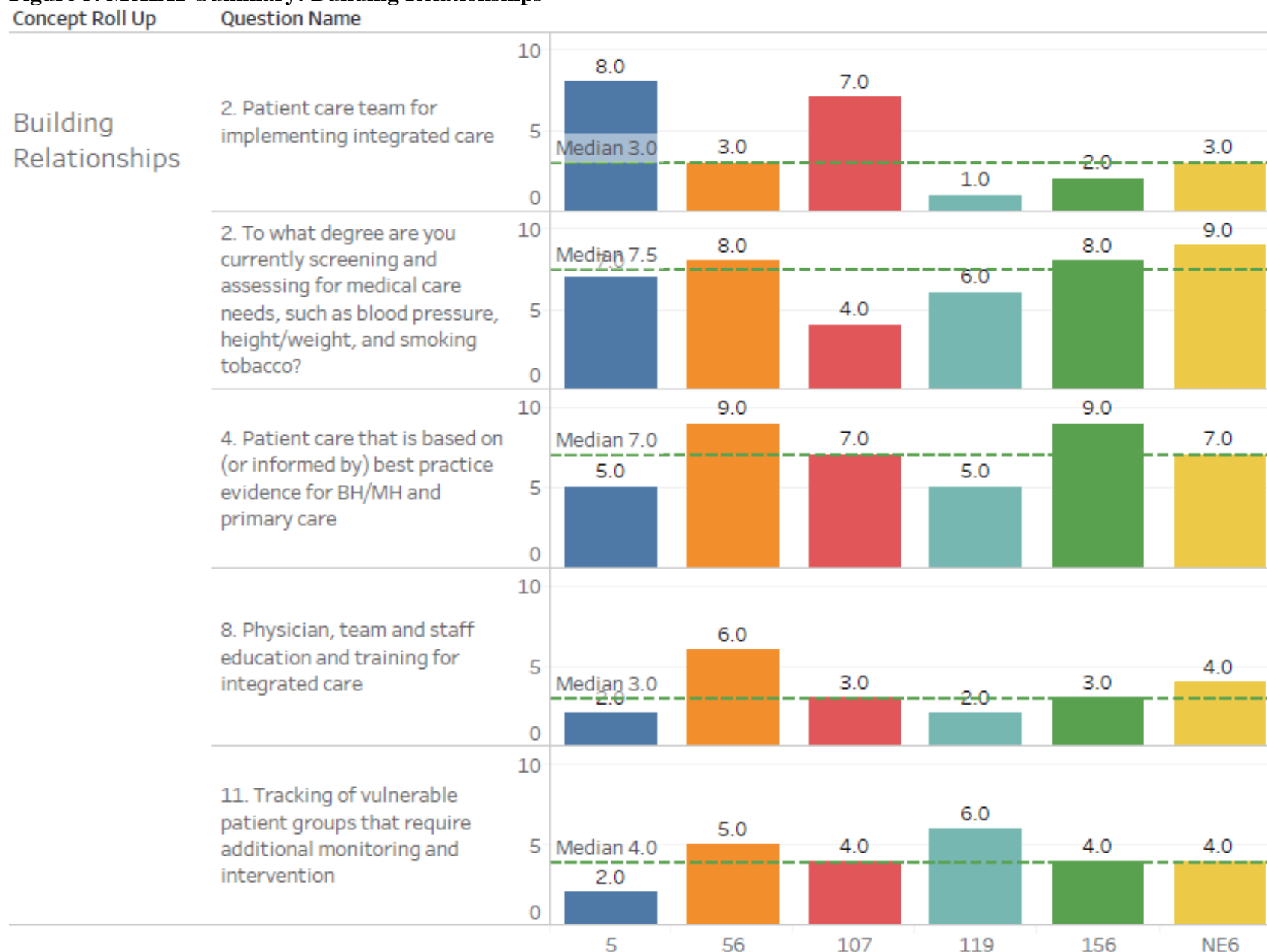


Figure 4. MeHAF Summary: Changing Care Delivery

Concept Roll Up Question Name

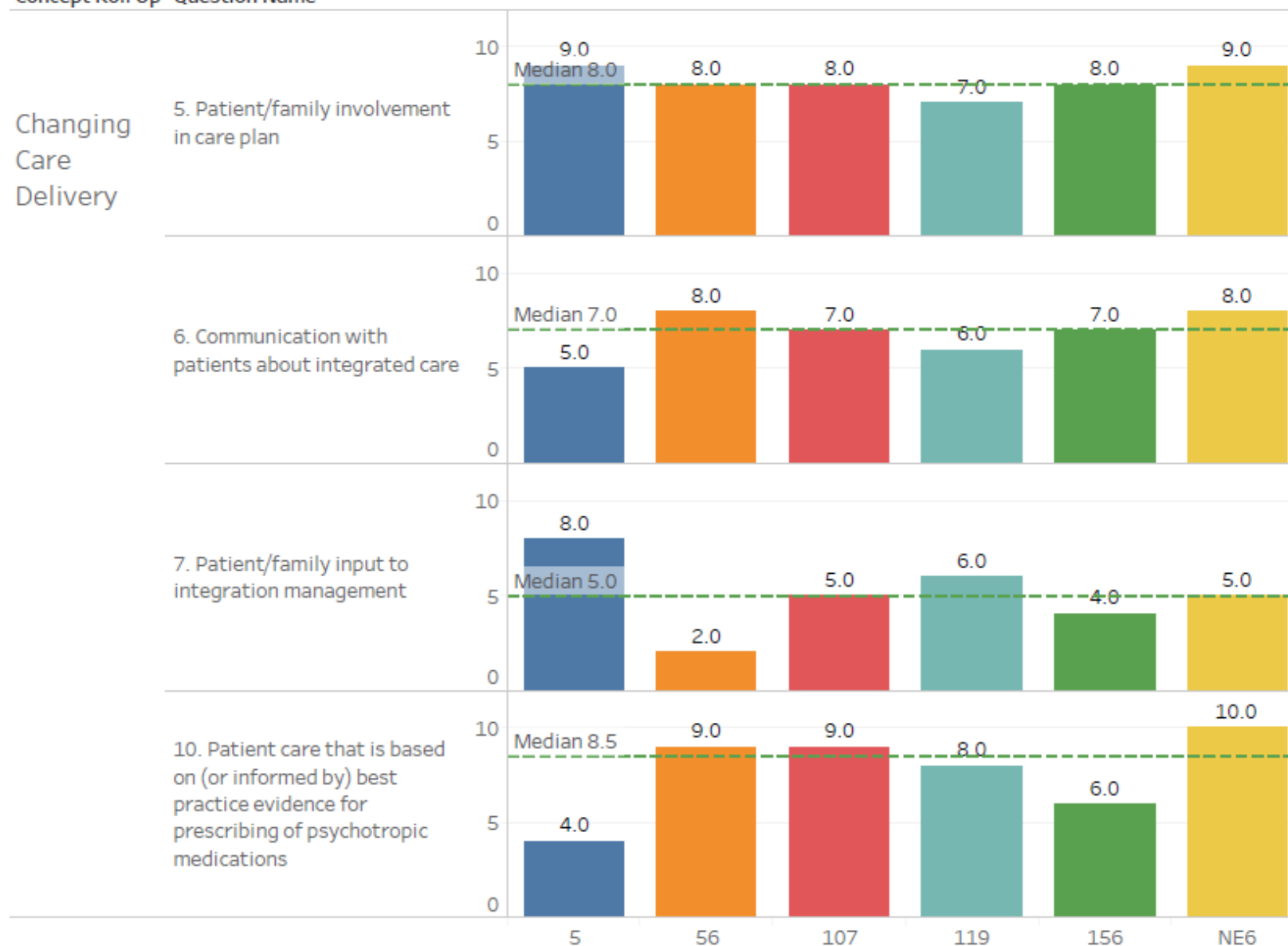


Figure 5. MeHAF Summary: Reducing Barriers to Care

Concept Roll Up Question Name





2D. Diversions Interventions

Project Plan

November 16, 2017

This document presents the Olympic Community of Health (OCH) project plan for Diversion Interventions. The region prioritized this project in recognition of the vulnerability of its target population of low-income individuals, the homeless, persons transitioning from jail settings, high utilizers of emergency services, and American Indian/Alaska Native (AI/AN) recipients of Medicaid. OCH also recognized the unavoidable fact that Kitsap County, the region's most populous county, ranks second in the state in emergency department (ED) utilization rates. Successful implementation of this project will make it possible to dramatically shift Medicaid investments upstream of the ED.

Diversion interventions align fully with the region's approach to transforming the Medicaid delivery system in Clallam, Jefferson and Kitsap counties. The evidence-based interventions integrate seamlessly with other projects in the portfolio, introduce opportunities to address social determinants, and provide ways to activate bi-directional integration.

Menu of Transformation Projects	
Domain 2: Care Delivery Redesign	
<input type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input type="checkbox"/>	2C: Transitional Care
<input checked="" type="checkbox"/>	2D: Diversions Interventions
Domain 3: Prevention and Health Promotion	
<input type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input type="checkbox"/>	3D: Chronic Disease Prevention and Control

PROJECT SELECTION AND EXPECTED OUTCOMES

Rationale for Selecting This Project

Prioritization of diversion strategies during the project planning period stemmed not only from Emergency Department (ED) utilization data, but also a wide variety of providers and affiliate partners who identified populations of concern in relation to the lack of a medical home. Individuals without a medical or behavioral health home do not have a usual place for care and the care they receive is often not coordinated. Individuals in this situation may rely on the hospital ED for services that would be more appropriately performed in other care settings. Inappropriate ED utilization is costly and inefficient.

Reducing high utilization requires improvements in systems of care coordination, patient engagement and activation, and access to primary care. This project addresses all three of these areas through two evidence-based approaches: 1) ER is for Emergencies and 2) Community Paramedicine. OCH is also considering two additional evidence-based approaches: 1) Law Enforcement Assisted Diversion and 2) Tribal Jail Re-Entry Program, pending further discussions within each Natural Communities of Care and with each Tribe. Target populations for diversion strategies include homeless persons, persons transitioning from jail settings, and in general, high utilizers of emergency services. Pending tribal interest, recipients of service may also include American Indian/Alaska Native (AI/AN) recipients of Medicaid.

The proportion of OCH low-income adults, many of whom are on Medicaid, with a usual primary care provider increased from 67% in 2013 to 76% in 2015. During the same period, the proportion of the OCH Medicaid population with access to preventive and ambulatory health services declined from 86% to 77% (WA BRFSS 2013-2015, analysis by Kitsap Public Health District (KPHD)). The OCH region has consistently higher ED utilization per 1000-member coverage months compared to WA State, and the most recently data available, 10/1/15-9/30/16, indicates a persistent trend with an OCH rate of 89 compared to WA at 68. (Assessment, Planning, Development, Evaluation (APDE) Division, Public Health Seattle King County (PHSKC), accessed [here](#), May 2017)

Figure 1

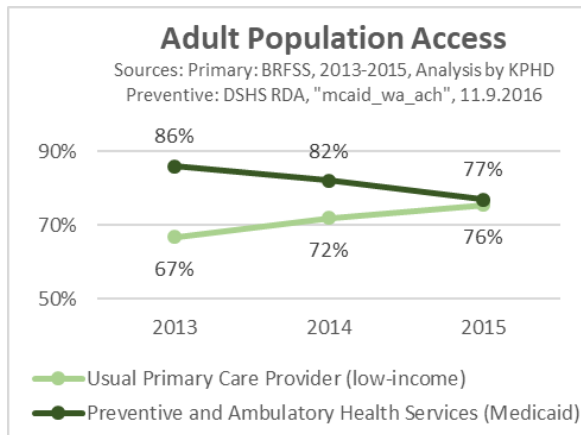


Figure 2

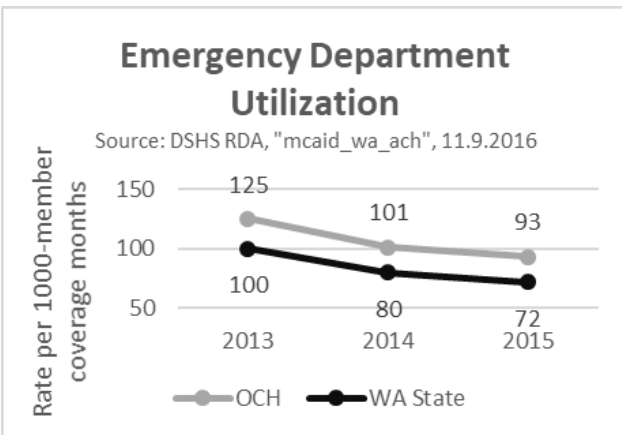
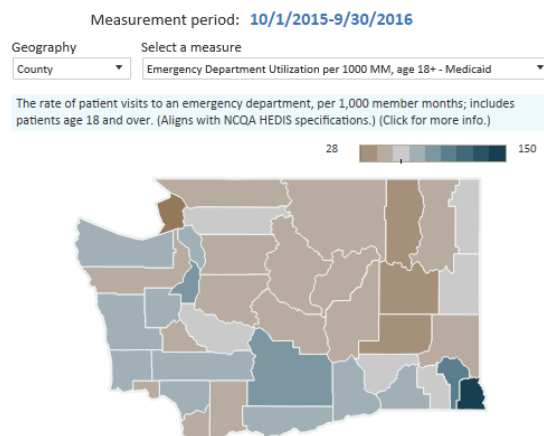
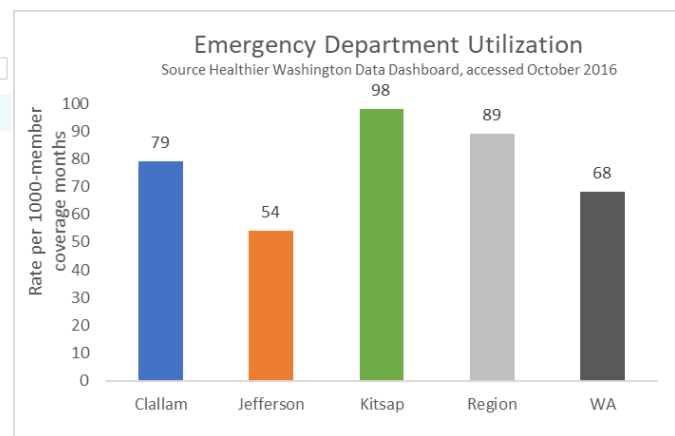


Figure 3



Source: Healthier Washington Data Dashboard, accessed October 2017

Figure 4



In the OCH region, Kitsap County has nearly two-thirds of the Medicaid lives and the highest overall ED visit rate. Notably, Kitsap has the second highest ED utilization rate in the State.

Coordination with Existing Efforts

Implementation partners in each Natural Community of Care (NCC) will work together to craft a shared change plan for the NCC, and then individual change plans for themselves. Plans will ensure that transformational activities fit within the existing services in the local community. An NCC is a community of resources and providers that serve the same population due to geographical proximity, natural referral patterns, and collaborative service agreements (see Theory of Action section). The shared change plan will align each organization's change plan within a shared set of strategies for the NCC.

For diversion strategies, there are a few existing programs and providers whose expertise can inform diversion implementation of transformational strategies within change plans. One example is Kitsap Connect – a care coordination program serving persons who are high utilizers of the ED stemming from complications of severe mental illness, chemical dependency, and homelessness. Peninsula Community Health Services, CHI/Harrison Medical Center, Kitsap Public Health, Kitsap Mental Health Services, and the county jail system work together to ensure the highest utilizers of costly health and social services are

connected to a medical home, housing, and behavioral health. Lessons learned from existing efforts will be shared across NCCs to help providers identify optimal transformation strategies, including a focus on community-clinical linkages and collective impact.

During the development of change plans, OCH will update the inventory of current delivery system transformation activities. OCH will perform a baseline self-assessment of each partnering provider, building on the regional inventory of initiatives last updated in March 2017, for a comprehensive list of all current and planned health improvement activities. OCH will ask providers to describe how the Medicaid Transformation Project (MTP) transformational activities will expand upon, enhance, or complement existing delivery system transformation activities. OCH will also assess gaps in community-clinical linkages at baseline, ensuring that change plans leverage rather than duplicate existing community efforts relevant to the success of the project.

As part of the change plan and contractual process, OCH will require an attestation from each organization that, if they are funded by the U.S. Department of Health and Human Services, federally-funded activities are not duplicative of transformational activities proposed in change plans.

Project Scope: Target Population, Partnering Providers, Level of Impact, And Health Equity (Table 1)

Scope of project

For details on the anticipated project outcomes, target population, subpopulations, and disparities for each strategy, please refer to Table 1. Strategies include ER is for Emergencies, and potentially LEAD and Jail Re-entry Tribal Program – all of which focus on connecting individuals to needed health and supportive services, including housing; and Community Paramedicine, which provides an alternate model of primary care provision in rural areas, where access to care is severely limited.

The primary goal of this project across strategies is to decrease unnecessary ED utilization by connecting high utilizers, or those at risk of poor utilization, to services such as primary care, behavioral health care, dental care, insurance enrollment services, and the coordinated housing intake system. Expected outcomes relate to the core component of ER is for Emergencies: the impact of connecting patients to a more appropriate care setting, such as a patient-centered medical home, and providing care coordination for high utilizers. The selected diversion strategies are expected to not only decrease unnecessary ED visits, but also reduce arrests, deaths due to opioid overdose, and homelessness, while increasing the benefits associated with having a patient-centered medical home, such as chronic disease education management and medication-assisted treatment for opioid use disorder.

LEAD and Tribal Jail Re-Entry have shown marked reductions in jail recidivism. LEAD has also shown dramatic decreases in ED utilization among those in the program.

Community paramedicine shows promise as a mechanism to expand the role of EMS providers in communities as well as address the shortage of primary care providers in rural settings. An initial analysis of a community paramedicine program in Snohomish county indicated that those who participated in the community paramedicine program had reduced costs associated with a reduction in unnecessary ED utilization (Fenn, R. Snohomish County Human Services Department, October 2015). In March of 2015, Washington State Senate passed [SB5591](#) that allowed emergency medical services to work more in community health by allowing assistance with referrals and education service programs. In April of 2017, the Senate passed [SB1358](#) allowing paramedics to bill Medicaid for services provided in the community.

Level of impact and target population

The target population for this project was selected based on the greatest potential level of impact and need in the community. Two-thirds of these are in Kitsap county, where the unnecessary utilization rate is 2nd highest in the state. The target population includes all Medicaid beneficiaries being discharged from the ED and released from jail. ER is for Emergencies has a large footprint, targeting patients who do not have a patient-centered medical home, in need of housing services, with a diagnosis of asthma, diabetes, hypertension, behavioral health disorder (emphasis on opioid use disorder diagnosis), or dental pain, or with a high recidivism rate, defined as ED visits ≥5/year or arrests ≥3/year. Community paramedicine has a smaller footprint and is therefore narrowly targeted to patients referred from partnering providers with chronic medical conditions such as chronic heart failure, chronic obstructive pulmonary disease, diabetes; and/or with complex behavioral health conditions.

At full capacity, an estimated 30,000 Medicaid beneficiaries (36% of total Medicaid population) will be reached by the diversions interventions proposed in this plan.

Implementation partners critical to success

Several partners are critical for this project to be successful, including: hospitals, primary care, community behavioral health agencies, community action agencies, area agencies on aging, fire and EMS, and tribal clinics. Community-based organizations that offer supportive services outside of the clinical delivery system are also critical as referral centers into a medical home and as collaborative partners in care coordination. If OCH moves forward with LEAD or a Tribal Jail Re-Entry Program, coordination with jails, law enforcement, and the criminal justice system will be essential. Partnering providers willing to participate and commit to a change plan are those that serve a significant number of Medicaid lives, particularly high ED utilizers, and all Tribes.

Health equity

Each diversion strategy is tailored to address health disparities within each subpopulation. Unnecessary use of the ED is itself a marker of poor health equity within the NCC and is indicative of underlying socio-economic disparities such as lack of health insurance, lack of access due to rural environments, homelessness, poverty, and transportation. Incarceration places individuals at risk of disruption in their health care engagement and can contribute to high utilization of the ED. Recently, [Senate Bill 6430](#) (July 2017) introduced a new process to suspend Medicaid for incarcerated individuals, rather than terminating Medicaid eligibility. MCOs receive a suspension eligibility notification for members meeting this criterion. Once a member has been released their Medicaid eligibility is reinstated and their coverage continues. The law also requires MCOs to provide transitional planning for incarcerated individuals for up to the first thirty (30) calendar days of incarceration, or as needed and upon the member's release. Several MCOs are developing pilots to optimize these new services. OCH will coordinate with MCOs in the region to leverage these activities with the new services planned under the diversion project.

Lasting impacts

The proposed diversion strategies integrate new models of delivering care that will extend beyond Medicaid and MTP, and will have a lasting impact on the people in our communities. At the individual patient level, individual care will stabilize over time as each person has a tailored connection to a medical home. At the provider level, strengthening of community-clinical linkages will form lasting referral relationships to ensure patients receive whole person supports as a natural outgrowth of their connection to care. These will include physical health, behavioral health support, housing linkage, and other critical social supports. Transformations within NCCs will result in a robust safety net to “catch” those most at risk of inappropriate use of the ED, including incarcerated individuals, persons struggling with homelessness, patients living in provider-shortage areas, etc.

- *Infrastructure and capacity building investments*
The project further supports sustainable health system transformation through investments in infrastructure, data systems, population health-based approaches, and workforce that will lead to successful value-based payment contracting for Medicaid providers beyond the MTP. Upfront investments support provider organizations to hire workforce and invest in population health IT capacity. Workforce strategies will provide training for community health workers, community paramedics, decision support teams for population health management, and contracting teams for training in payer billing and reporting.
- *Leveraging Natural Communities of Care for collective impact*
OCH will convene partnering providers within a NCC to align strategies into a single shared change plan. Recognition of the NCC is important as it brings attention to grassroots organizations and opportunities to champion projects borne of genuine community need.

Diversion strategies will be incorporated into change plans as transformation activities, and will be mutually supportive of the shared change plan and other projects. OCH will facilitate collaborative arrangements between providers within the NCC, such as data-sharing agreements and business associate agreements. By leveraging the collaborative structure of the NCC, together, providers from different sectors will benefit collectively by reducing unnecessary ED visits. OCH is developing an incentive allocation algorithm that incentivizes implementation partners within the NCC for reducing unnecessary ED use.

- *Value-based contracting*
MCOs will be collaborators in the development of all shared change plans and will continue to work with partnering provider organizations as part of the provider-payer contracting process. By including MCOs in the development process, MCOs can ensure that shared change plans are mutually supportive of the metrics in their value-based contracts. Provider organizations may use DSRIP incentive payments (see Funds Flow section) to deploy change management teams to oversee rapid-cycle testing feedback loops to refine diversion strategies until they are able to achieve their targeted benchmarks in their value-based payment contracts. Additionally, OCH will oversee deployment of technical assistance from MCOs to provider organizations to assist in mutually reinforcing strategies such as risk stratification, care coordination, and population health management.

OCH will engage with the Salish Behavioral Health Organization (SBHO) and MCOs regarding jail re-entry. Both are now contractually required to provide transition services for members. OCH will engage with MCOs and SBHO to identify opportunities to bring partners together to coordinate services for people leaving the jail, especially people with an opioid use disorder, because this is when they are most at risk for an overdose.

OCH will support Tribes preference for tribal encounter rates and reduced administrative burden, and advocate that Tribes be held harmless under new contracting mechanisms. OCH will encourage knowledge transfers between non-tribal and tribal provider organizations to share perspectives on MCOs as contracting partners.

2D. Diversions Interventions Project Plan
PROJECT SELECTION AND EXPECTED OUTCOMES

Olympic Community of Health

Table 1. Diversions Interventions: Strategies, Projected Outcomes, and Population Served

Strategies	Intermediary Milestone or Metric (toward desired outcome)	Pay for Reporting Metrics and Milestones	Payment for Performance Metrics	Evidence Base	Natural Community of Care	Target Population	Targeted Subpopulation	Estimated # Targeted per Year at Max. Capacity	Disparities
Connect individuals in emergency departments and jails to primary care, behavioral health care, dental care, the coordinated housing intake system, tailored, intensive case management programs	<p>Natural Community of Care Collaborative Agreement in place</p> <p>Natural Community of Care shared change plan</p> <p>Partnering provider organization change plan</p> <p>Contract in place with OCH</p> <p>Monthly reports sent to OCH</p> <p>Proxy measures under development; will be selected to predict P4P metrics and/or desired outcomes from QIP; will be included in contracts and</p>	<p>Report against QIP metrics</p> <p>Number of partners trained by selected approach / strategy: projected vs. actual and cumulative</p> <p>Number of partners participating and number implementing each selected approach / strategy</p> <p>% partnering provider organizations sharing</p>	<p>Outpatient ED Visits</p> <p>Percent Homeless</p> <p>Percent Arrested</p>	<p>ER is for Emergencies</p> <p>Law Enforcement Assisted Diversion</p> <p>Jail Re-Entry Tribal Program</p>	<p>Clallam Jefferson Kitsap</p>	<p>All Medicaid beneficiaries being discharged from the ED and released from jail.</p> <p>[NOTE: Medicaid benefit is suspended while incarcerated and is automatically reinstated within a day of release]</p>	<p>Patients who do not have a patient-centered medical home; in need of housing services; diagnosis of asthma, diabetes, hypertension, behavioral health disorder (emphasis on opioid use disorder diagnosis), dental pain; high recidivism (e.g., ED visits >=5/yr; arrests >=3/yr)</p>	<p>Estimated # served discharging from ED Clallam: 7,000 Jefferson: 2,000 <u>Kitsap: 20,000</u> TOTAL: 29,000</p> <p>Estimated # served released from jail Clallam: 900 Jefferson: 540 <u>Kitsap: 2,000</u> TOTAL: 3,440</p> <p>Estimated # served by Tribal Jail Re-Entry Program: 45</p> <p>[NOTE: Suquamish and Port Gamble S'Klallam Tribes with option to expand]</p>	<p>Unnecessary ED use is and of itself a marker of poor health equity; indicating underlying issues such as lack of health insurance or transportation, or poor health literacy.</p> <p>Persons incarcerated frequently have chronic medical, mental health and substance use disorders and are often frequent users of the ED. Approx. 60% of people in jail have a behavioral health diagnosis (SOURCE: conversation with Salish Behavioral Health Organization).</p>

2D. Diversions Interventions Project Plan
PROJECT SELECTION AND EXPECTED OUTCOMES

Olympic Community of Health

Community Paramedicine	reported by partners	information (via HIE) to better coordinate care % of partnering provider organizations with staffing ratios equal or better than recommended VBP arrangement with payments / metrics to support adopted model	Outpatient ED Visits	Community Paramedicine Model	Clallam	Medicaid residents of Port Angeles and Forks.	Patients referred from partnering providers with chronic medical conditions such as chronic heart failure, chronic obstructive pulmonary disease, diabetes; and/or with complex behavioral health conditions	Estimated # served: 360 <i>(240 in Port Angeles and 120 in Forks)</i>	Medicaid beneficiaries who are referred are more likely to have lack of a support network, lack of transportation, geographic isolation, financial barriers, or poor health literacy.
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IMPLEMENTATION APPROACH AND TIMING

Please refer to OCH Supplemental Workbook: 2D Implementation Approach

The worksheet did not allow a way to address anticipated barriers to deploying resources to partnering providers, and OCH tactics for addressing each of them. (Table 2) Notably, all listed barriers below impact more than one project area and will therefore be addressed systematically across the MTP portfolio.

Table 2. Barriers to deploying resources and tactics to mitigate risks

Barriers or challenges to deploying resources to implementation partners	OCH tactics for addressing barriers or challenges
Timely paying of providers	Engage with financial personnel with each partnering provider organization to explain contracting and cash flow
Insufficient IT systems to allow for population health management	Baseline assessment includes IT assessment; OCH assist in upfront infrastructure/IT investments; put data sharing agreements in place between OCH and partnering providers
Insufficient fiscal resources to support staffing and transformation needs	OCH help identify opportunities for sharing workforce and best practices across practices; encourage matching funds from partnering providers
Provider cannot recruit or retain the workforce to meet implementation demands	Build in contingency plans and incentives into contracts; develop regional strategies for workforce recruitment
Union issues	Allow each NCC to determine the employer for the new workforce; clarify scope of practice

PARTNERING PROVIDERS

Assurance of Serving the Medicaid Population

Please refer to OCH Supplemental Workbook: 2D Partnering Providers. The list of partnering providers in the workbook is an initial list of clinical and non-clinical partnering providers that have expressed interest in supporting the development and implementation of the diversion project. For this project to be successful, hospitals, primary care, community behavioral health agencies, community action agencies, area agencies on aging, fire and EMS, and tribal clinics must be committed partners. Based on a Number Needed to Treat analysis (see Theory of Action Section), OCH needs to decrease arrests and homelessness for 847 Medicaid beneficiaries in order to achieve a 2% improvement in these “gap to goal” measures. This is within reach because, at full capacity, an estimated 30,000 Medicaid beneficiaries (36% of total OCH Medicaid population) will be reached by this project.

OCH will reach out to providers who currently serve a significant number of Medicaid lives, and all Tribes, to participate in the change plan process development. As OCH explores LEAD or a Tribal Jail Re-Entry Program, coordination with jails, law enforcement, and the criminal justice system will be essential. Some of this already occurred during the OCH RFP process in spring, but more is needed. Tables 6 through 9 in the Regional Health Needs Inventory Section list assets related to health care providers, social service providers and payers by service area; and number of beneficiaries served and number of claims by each major Medicaid provider, stratified by age and care setting (institutional or professional). OCH will be doing a deeper dive during the baseline assessment in DY1 Q4 and DY2 Q1.

A large proportion of AI/AN people are on Medicaid, highlighting the considerable health and income disparities in these communities. OCH will provide technical assistance and DSRIP funding to all tribal health service providers to develop and implement a change plan tailored to both the Tribes’ needs and the goals of the Transformation.

Partner Engagement Process

Transformation work is not easy. Therefore, participating provider organizations are those with leadership and financial buy-in and those that commit to completing and following a change plan, sending regular data reports to OCH, performing continuous quality improvement cycles, and driving towards long term, sustainable transformation. OCH will work with Tribes to agree on a data sharing agreement on a case-by-case basis that acknowledges tribal sovereignty and protects tribal data.

Natural Communities of Care may identify community-based organizations beyond this list and incorporate these agencies in their shared change plan and funds flow allocation. This would enhance clinical-community linkages and begin to normalize social investment in health at the local level.

During the RFP process, OCH received multiple proposals in the diversion project category. For a list of all proposals that were received during the RFP process, including the formal commitments from partnering providers, please refer to <http://www.olympicch.org/medicaid-transformation-project.html>. A summary is presented below by proposal area within the diversion category:

- The proposal for ER is for Emergencies had formal written commitment from over 20 community partners, including both FQHCs, all five MCOs, two health systems, two behavioral health agencies, a community action agency and the regional workforce council.
- The proposal for community paramedicine had 17 partners with formal commitment across all three counties, including 1 tribal EMS partner and two hospital systems. This RFP was developed within the NW Regional EMS Council, which has broad participation.
- The proposal for LEAD was largely driven out of Clallam and Jefferson counties and had broad

support, including the Clallam prosecuting attorney's office, Port Angeles Police Department, Port Townsend Police Department, Sequim Police Department, and Suquamish Police Department. Community behavioral health agencies, federally qualified health care centers, one tribal clinics, and hospitals formally committed to this project.

MCO Expertise

MCOs are essential partner organizations and will be invited to collaborate in the development of the shared change plan. By including MCOs in the development process, MCOs can ensure that shared change plans are mutually supportive of metrics in value-based contracts. MCOs will also be able to provide technical assistance to provider organizations to help prepare them for value-based contracting and to leverage opportunities for the jail population out of [SB 6430](#). Additionally, MCO care coordinators will be invited to the table with local CHWs and community paramedics to ensure seamless coordination of care for high ED utilizers. Finally, each MCO has a member outreach platform, ranging from member portals, to text messaging and direct mail. OCH will work with the MCOs to leverage these platforms to ensure maximum potential in reaching the hard-to-reach subpopulations of high ED utilizers.

REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS

REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS

For this project to be successful, hospitals, primary care, community behavioral health agencies, community action agencies, area agencies on aging, fire and EMS, and tribal clinics must work together, leveraging their shared assets, to coordinate care for high utilizers of the ED. Together these organizations provide vital services to all Medicaid beneficiaries in the region. If OCH moves forward with LEAD or a Tribal Jail Re-Entry Program, coordination with jails, law enforcement, and the criminal justice system will be essential.

Several existing and planned assets will strengthen the diversion efforts in the region, including:

- Committed partnerships between provider organizations to serve this population (see Partnering Provider narrative)
- Health system leadership engagement and ultimate buy-in during project selection process
- Shared ED platform: All hospitals utilize the same Emergency Department Information Exchange (EDIE) system to collect data from all EDs visited by a patient, package that data into actionable insights, and then deliver those insights to ED clinicians via real-time notifications the instant they are needed.
- Shared communication platform: PreManage is an interoperable communication tool that provides real-time clinical visit history of patients and ensures that high-value clinical insights attach to the patient rather than to an otherwise disparate EHR system. Currently there is high penetration of PreManage among OCH primary care providers; OCH is exploring its use in behavioral health settings.
- Willingness to pilot co-location or embedding of one organization's workforce into another's clinical setting
- A fire district with chief and captain-level buy-in to pilot a community paramedic model, which is a complete paradigm shift from the current EMS care delivery model.

Tables 6 through 9 in the Regional Health Needs Inventory Section list assets related to health care providers, social service providers and payers by service area; and number of beneficiaries served and number of claims by each major Medicaid provider, stratified by age and care setting (institutional or professional). OCH will be doing a deeper dive during the baseline assessment in DY1 Q4 and DY2 Q1. The list of partnering providers is still under development; the final list will be developed within each Natural Community of Care. The strong working relationships between partnering organizations and precedence for regional partnerships is a tremendous asset for this project. Of note, tribal clinics are key partners and will be invited to engage in the shared change plan process within the Natural Communities of Care. A focus of future work will be greater inclusion and input from low-income housing and anti-homelessness campaigns in the region. This will be supported by the connections to local elected officials and social service organizations that have spearheaded such campaigns in the area.

There are several challenges or barriers to improving outcomes and lowering costs for the target populations through this project. The table below describes each challenge with a proposed strategy for mitigating the identified challenge. Notably, many of the listed barriers below impact more than one project area and will therefore be addressed systematically across the MTP portfolio.

Table 3. Challenges to improving outcomes and strategies to mitigate risks

Challenge or barrier to improving outcomes and lowering costs for the target populations through this project	OCH strategy for mitigating the identified risks and overcoming barriers
Space for new workforce	Mobile technology and innovative, collaborative

REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS

	agreements between partners to facilitate a different work environment
Insufficient funding available through MTP to support new workforce and transformational activities	Ask partnering providers to match or leverage existing resources and seek additional resources
Clinical practice transformation change is time consuming, challenges productivity	Deployment of a change manager workforce; support of internal QI teams; support from provider organization's leadership; Qualis, TCPI, AIMS and OCH facilitated technical assistance to support practice consultation for quality improvements
Change in scope of practice of new workforce	Allow each NCC to identify the employer of record for the new workforce; clarify scope of practice; advocacy with statewide associations
Community paramedicine is a paradigm shift for EMS providers	Train EMS in billing new Medicaid code; support shared learning opportunities with other community paramedicine programs in other ACHs
Sustainability	Work with providers, MCOs, HCA, and DSHS on billing the new community paramedicine benefit to make service sustainable; target workforce and infrastructure investments; coordinate with MCO and BHO on jail re-entry opportunities
Need to hire, train and supervise a new workforce	Support curricula development among higher education partners; offer special, regional trainings; support the formation of communities of practice for new workforce, especially for those working in typically high burn-out environments
Qualified workforce shortage, especially in rural areas	Deployment of a paraprofessional workforce in different environments to help coordinate care; explore options for shared workforce
The ability of a diversion program, even a successful one, to improve health for persons who are without housing or lack stable housing is severely compromised	<p>Advocate for sufficient needed "step-up" and "step down" facilities for persons with physical and/or behavioral health conditions who cannot be stable in their home environment. For all diversion program participants advocate for a safe, decent, affordable range of housing options including but not limited to permanent supported housing</p> <p>Coordinate with Initiative 3 of the MTP, supportive housing case management</p>

MONITORING AND CONTINUOUS IMPROVEMENT

Monitoring Project Implementation

OCH will ensure timely and effective implementation through detailed planning, formation of Natural Community of Care (NCC) collaborative agreements, NCC steering committees, comprehensive baseline assessments and change plans. Change plans will outline a sequential, stepwise process, co-designed with the provider organization(s), to implement transformational activities.

In 2018, the biggest risk to implementation will be providers failing to meet reporting requirements. OCH will mitigate this risk by precisely noting reporting requirements in provider change plans, which will be developed in early 2018. We will also provide outreach and training on OCH's monitoring system (described below). Trainings will be in person and virtual, with materials specific to each project, and presentation on best practices for specific project measures. To the extent possible, OCH requirements for provider reporting will align with existing reporting requirements (e.g., HEDIS, Alternative Payment 4, and Apple Health Contracts). This will be a joint initiative with MCOs, strategically positioning providers to achieve VBP contract benchmarks.

Funding will flow to providers and affiliate partners upon completion of set milestones, as outlined in change plans. There will be fiscal consequences for lack of progress, as revealed by process and outcome measures. This will all be detailed in provider contracts.

Delays in implementation will be addressed by change managers, either employed by the provider organization or OCH. Change managers will identify cross-cutting implementation barriers among partnering provider organizations. In turn, they will not only make recommendations to address those barriers, but will also revise change plans appropriately.

Monitoring Continuous Improvement

OCH projects share common elements for monitoring and continuous improvement. To track progress, OCH will rely on a host of measures categorized (at its highest level) as follows: process measures, milestones and outcome measures. The latter two categories will include all toolkit required measures for determining project incentive payments. The first category (process measures), although not specified in the toolkit, is critical to ensuring OCH and partner organizations adopt best-practices both for projects and for Domain 1 activities. For the most part, the process measures will serve as real-time indicators.

OCH is planning to build a technology platform that can systematically manage all three categories of measures. The platform will also have enough descriptive context to guide partners and providers in the provision of information to send to OCH. The information coming from providers will primarily fall into our first two categories: process measures and milestones. Outcomes measures will be captured chiefly from existing reporting systems (e.g. Healthier Washington Dashboard, HCA-AIM reports, Washington Health Alliance Reports, DSHS reports, RDA reports, WSHA reports and others). The OCH platform will avoid the inefficiency and inaccuracy inherent in having providers entering data in multiple templates. OCH intends to use the platform for data aggregation and formatting to streamline the population of HCA required templates.

OCH's process measures are the lynchpin to ensuring OCH providers are on track to make the necessary progress expected under the Transformation. Simply put, outcome measures are too lagged and provide no insight into whether foundational operational front-line changes have been undertaken. Milestone reporting, while providing a real-time sense of overall organizational change, still does not furnish a front-line view of how patient engagement may have changed.

OCH does not anticipate much resistance from partnering providers in providing requested information for tracking purposes. During OCH's letter-of-intent process (March to April 2016), when asked, "*Are you willing to provide project-specific data to OCH for tracking purposes?*", all partnering organizations agreed to send data to OCH for tracking purposes.

Identifying what is not working

OCH will form a steering committee for each NCC. The role of the committee is to oversee the work of the shared change plan, identify barriers, and collaboratively design solutions across sectors and Tribes. OCH staff will share learnings across NCCs, deploying technical assistance where appropriate. OCH will also deploy provider surveys, creating an anonymous vehicle for providers to provide feedback to the OCH.

OCH will hire a Compliance and Contract Coordinator to oversee change plan compliance, conduct site visits, perform annual audits. OCH will form a Compliance Committee to oversee this effort. Partners will receive additional support through a change manager, who will offer regular progress check-ins with participants within each NCC. The OCH Board will approve a mediation plan structure and grievance procedure to provide necessary processes for under-performance and non-compliance.

The Performance Measurement and Evaluation Committee (PMEC) designs and reviews data submissions, interprets trends, and elevates red flags to the Board. The PMEC will swiftly identify issues regarding reporting, data quality, or failure to move metrics and offer counter-measure solutions where appropriate.

Each project implementation plan will include a go/no go decision midway through project implementation. If the work to that point has proven constructive with quantifiable evidence that the program will be both successful and sustainable, then the work will continue through the duration of the Transformation. Evidence that the program or elements of the program are not working will trigger a project plan modification request, specific to the root cause of the issue.

Diversion project risks

Beyond the risk noted above of partners/providers not being set up to meet reporting requirements, we are mindful of the following specific risks with the Bi-Directional Integration project. We intend to devise focused monitoring mechanisms for these risks. This is only a sample of monitoring initiatives.

- Inadequate linkage between project initiatives and existing diversion initiatives among OCH providers.
- Among identified patients in need of medical home, not sufficient enough engagement to make the transition.
- Insufficient financial incentives (e.g. reimbursement to paramedicine providers for community health services) to affect material change in ER admissions.
- Inadequate health information exchange to facilitate coordination among emergency rooms.
- Insufficient access to and engagement with incarcerated Medicaid beneficiaries.

PROJECT METRICS AND REPORTING REQUIREMENTS

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
x	

RELATIONSHIPS WITH OTHER INITIATIVES

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
x	

PROJECT SUSTAINABILITY

The diversion project supports sustainable health system transformation for people on Medicaid through a newly trained workforce, advancement in population health systems, value-based contracts, new workflows in the ED and jail, and a culture paradigm shift for paramedics in the field. These transformations will outlive the MTP. Investments within the OCH diversion project in infrastructure, capacity, workforce, and transformation, directly translate into the sustainable transformation components described in Section 1: Required Health Systems and Community Capacity (Domain 1) Focus Areas.

Table 5. Driving towards sustainable capacity, infrastructure, workforce, and transformation strategies	
Diversion Project →→→→→→→→→→→→→→→→→→	Capacity Infrastructure Strategies
Through exploring technologies such as Pre-Manage or others to be determined	Health information sharing (VBP) (PHS)
To manage the subpopulation of high ED utilizers	Registries (VBP) (PHS)
To identify the subpopulation of high ED utilizers	Risk stratification (VBP) (PHS)
To effectively refer high utilizers to community providers	Referral Management (VBP)
An analytic tool to facilitate internal evaluation and rapid-cycle testing of interventions	Analytics - Decision support technology (VBP) (PHS)
Diversion Project →→→→→→→→→→→→→→→→→→	Workforce Strategies
Trained internal staff to perform rapid-cycle testing and evaluation	Population Health Analytics (VBP) (PHS)
Community health workers working in multiple settings and cross trained	Cross training and redefine role
Community health workers, community paramedics	New workforce
Community paramedics trained and licensed to bill for home visits	Retraining/Certification/Uptraining
Community health workers, community paramedics, case managers	Mobile workforce
Diversion Project →→→→→→→→→→→→→→→→→→	Transformation Strategies
Connect people to their patient-centered medical home	Patient Centered Medical Home (VBP) (PHS)
Community health workers in ED or jail setting, working with social workers and nurses to identify and connect patients to primary care	Team-Based Care
Law-enforcement assisted diversion and jail-re-entry are both types of case management for a small, targeted subset of individuals requiring intensive support services	Care Management (VBP)
Referral from ED, jail, or home to primary care, dental care, or other services	Care Coordination incl. Referral Management (VBP) (PHS)
MCOs and local care coordinators work together to identify the hard-to-reach population and connect to care	Patient Outreach (VBP)

VBP: Supports successful VBP contracting

PHS: Supports development of high-functioning population health management system

By strategically deploying DSRIP investments, provider organizations, both individually and in collaboration

with MCOs, can continuously refine the strategies listed above, increasing the likelihood of achieving contract benchmarks. MCO participation in developing change plans and participating in the implementation of these strategies will help ensure that future value-based contracts continue to reward providers for their hard work to divert unnecessary ED visits. For the diversion project, care coordination is the most powerful lever to reach this end and is therefore the focus of this project plan. Furthermore, by leveraging the collaborative structure of the Natural Community of Care, together, providers from different sectors will benefit collectively by reducing unnecessary ED visits.

In April of 2017, the Senate passed [SB1358](#) allowing paramedics to get reimbursed by Medicaid for services provided in the community. Part of OCH's strategy will be to train EMS in leveraging this new billing code for a sustainable revenue stream by the end of 2021.

Sustainability for this project is also feasible through [Senate Bill 6430](#). The law requires MCOs to provide transitional planning for incarcerated individuals for up to the first thirty (30) calendar days of incarceration, or as needed and upon the member's release. Several MCOs are developing pilots to optimize these new services. OCH will coordinate with the MCOs in the region to leverage these activities with the new services planned under the diversion project.

ATTACHMENTS

1. *Required* OCH Supplemental Workbook: Tab 2D Partnering Providers
2. *Required* OCH Supplemental Workbook: Tab 2D Implementation Approach

ATTACHMENTS – 2D DIVERSIONS INTERVENTION

3. OCH-Required Workbook Tab-2D Implementation Approach
4. OCH-Required Workbook Tab-2D Partnering Providers



3A. Addressing the Opioid Use Public Health Crisis

Project Plan

November 16, 2017

This document represents a vital component of Olympic Community of Health's (OCH) portfolio - addressing the opioid use public health crisis. Addressing this crisis was a priority for OCH well before it became a required project under Medicaid Transformation. OCH and its partners have been working on the region's opioid response for nearly 18 months, pioneering an approach that reflects our values, goals and collaborative focus. OCH will incorporate many of the processes and strategies developed in response to the opioid crisis to inform our approach to other projects in our portfolio.

Our vision is a region that engages all partners to practice region-wide safe opioid prescribing practices, improve care for chronic pain, improve access to the full spectrum of best practices for the treatment of opioid use disorder, prevent fatal opioid related overdoses, and ensure that our community is informed and educated.

The opioid crisis touches every person in our region. It will take every person in our region to solve it.

Menu of Transformation Projects	
Domain 2: Care Delivery Redesign	
<input type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversion Interventions
Domain 3: Prevention and Health Promotion	
<input checked="" type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input type="checkbox"/>	3D: Chronic Disease Prevention and Control

PROJECT SELECTION AND EXPECTED OUTCOMES

Rationale for Selecting This Project

Phase One

In July 2016, the Olympic Community of Health (OCH) Board of Directors (Board) and community members identified the opioid public health crisis as the most critical issue to be addressed in our region. OCH leveraged State Innovation Models (SIM) funding to implement Phase One of the Three County Coordinated Opioid Response Project (3CCORP) with the goals to:

- Convene a Steering Committee with representation from multiple sectors across the three OCH counties of Clallam, Jefferson, and Kitsap
- Identify and engage with Tribal and community partners
- Complete a high-level assessment of existing data and OCH-initiated surveys (targeting law enforcement, fire/EMS, primary care providers, social workers, substance use disorder (SUD) providers, and other relevant workforce members)
- Draft a regional opioid response plan (RORP)

The Steering Committee (SC) was convened in September 2016 and met five times over a five-month period to guide the assessment and drafting of the Regional Opioid Response Plan (RORP). See Table 1 for a list of 3CCORP SC and Workgroup members.

Phase One goals were met and concluded with an Opioid Summit on January 30, 2017. Participants included primary care providers (including medication assisted treatment [MAT] prescribers), SUD providers, mental health providers, elected officials, law enforcement, fire/EMS, school personnel, criminal justice, hospital leadership, public health, Salish BHO, people in recovery, and people with lived experience. At the Opioid Summit, initial survey results were presented. Additionally, a draft of the RORP was presented, which focuses on three goals and is aligned with the state plan.

The three goals in the RORP:

1. Prevention of opioid misuse and abuse, including among youth, primarily through improving prescribing practices and community education.
2. Improve access to the full spectrum of best practices for the treatment of opioid use disorder (OUD), including among pregnant and parenting women, primarily through increasing the number of waived primary care providers, increasing support for waived providers to increase the number of patients they can serve, aligning outpatient SUD providers and MAT prescribers to coordinate care, promoting regional efforts to introduce opioid treatment

programs (OTP), and promoting community education.

3. Prevent opioid overdose primarily through increasing the number of people trained to recognize and respond to an overdose, increasing the number of access points for naloxone, promoting safe storage and disposal of medicines, and promoting community education.

Phase Two

At the January Opioid Summit, approximately 75 community members signed up to work on one or more workgroups aligned with the regional opioid response plan goals. Each of the three workgroups is chaired by a 3CCORP Steering Committee member and have cross-county and cross-sector representation. Workgroups meet monthly to prioritize strategies toward each of the goals and to set benchmarks and timelines for the strategies. The Steering Committee continues to meet at least bi-monthly.

Table 1. Three County Coordinated Opioid Response Project Steering Committee & Workgroup Members

Opioid Project Committee	Co-Chair 1	Co-Chair 2	Provider Participation and Membership
Steering Committee	Public Health Officer (Clallam) and Frontline Primary Care Provider	Tribal Police Chief	Clallam County Public Health, Jefferson County Public Health, Kitsap County Public Health, Olympic Medical Center, Jefferson Healthcare, Discovery Behavioral Health, Peninsula Behavioral Health, Suquamish Police Department, Kitsap County Prosecutor, Clallam County Jail, Harrison Medical Center/ED, Salish BHO, Bremerton Fire, Olympic Educational Service District 114, Safe Harbor Recovery, Lived Experience, County Commissioner from each county
Treatment Workgroup	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
Prevention Workgroup	Public Health Officer (Kitsap)	CMO Medical Group	Olympic Medical Center, Makah Tribe, Kitsap Public Health, Coordinated Care, CHPW, Molina, Olympic College, UW ADAI/DOH, Port Gamble S'Klallam Tribe, Lower Elwha Tribe, OESD 114, Port Angeles Police Department, Port Angeles CAN, First Step Family Support Center, Forks Community Hospital, Jefferson Healthcare, North Olympic Healthcare Network, Amerigroup, Harrison Medical Center
Overdose Prevention Workgroup	Frontline Primary Care Provider	Tribal Police Chief	Makah Tribe, OLYCAP, PCHS Pharmacy, Port Angeles Police Department, Clallam County Health and Human Services, Molina, Kitsap Public Health, Olympic College, Kitsap Mental Health Services, Coordinated Care, Port Gamble S'Klallam Tribe, Clallam County Jail, First Step Family Support Center, West End Outreach Services, Suquamish Tribe Wellness Center, Amerigroup, North Olympic Healthcare Network

In addition to reviewing HCA and public health data (summarized below), OCH implemented 4 surveys:

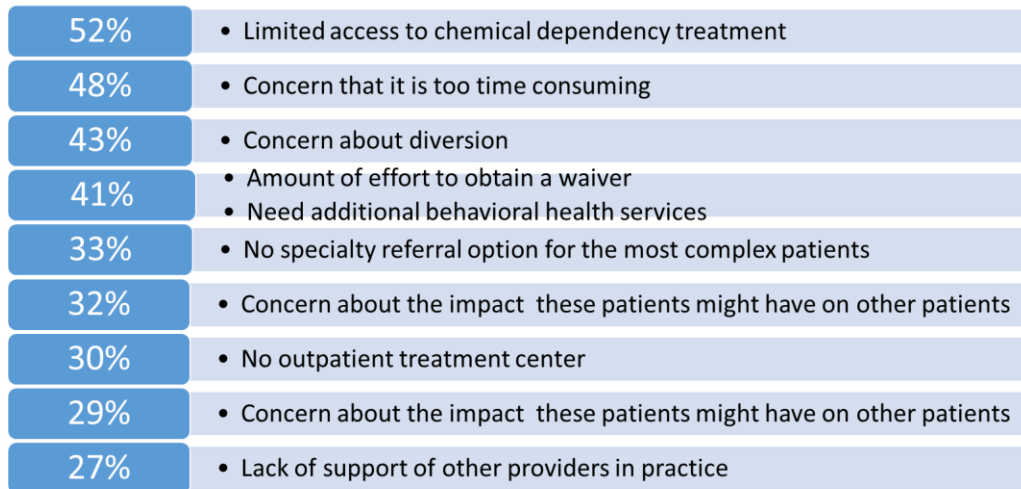
1. Healthcare providers - 75 respondents with representation from each county and 5 from Tribal clinics
2. Workforce, defined as those who most closely touch/work with people with OUD (e.g. SUD providers, behavioral health providers, social workers, care coordinators, and others) -477 respondents with representation from each county

3. Law Enforcement - 17 respondents with representation from each county
4. Fire/EMS - 7 respondents with representation from each county

Highlights: OCH Healthcare Provider Survey summary (N = 75)

Responses indicate that current MAT prescribers are not serving at their authorized capacity. Twelve of the seventy-five providers currently have a waiver to prescribe MAT; however, only ten are currently prescribing. Most respondents frequently identified barriers to prescribing MAT. (Figure 1)

Figure 1: Provider barriers to prescribing MAT



Highlights: OCH Workforce survey summary highlights (N= 477)

Of the 477 individuals who responded to the OCH workforce survey, 65% reported being very to extremely concerned about opioids in the work that they do. (Figure 2) The OCH workforce survey indicated that over half of respondents have tried to connect clients with opioid use disorder treatment and have experienced barriers. (Figure 3)

Figure 2: Workforce concern about opioids

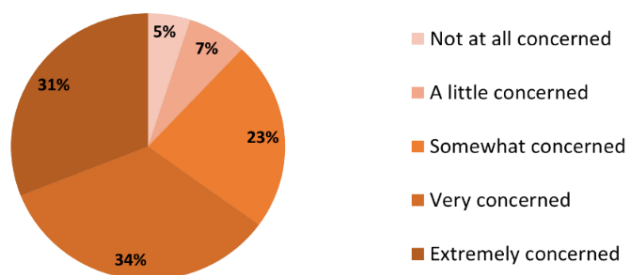


Figure 3: Barriers to accessing treatment



Since the release of the Medicaid Transformation Toolkit, OCH has held two regional partner convenings

to provide information about the eight project categories in the toolkit and to receive input and guidance about project selection priorities. Attendees were asked three questions:

- Will [the project] help?
- Will [the project] work?
- Is this important to people on Medicaid?

Regional partners scored the opioid project the highest in response to all three questions (yellow bars, Figures 4-6).

Figure 4

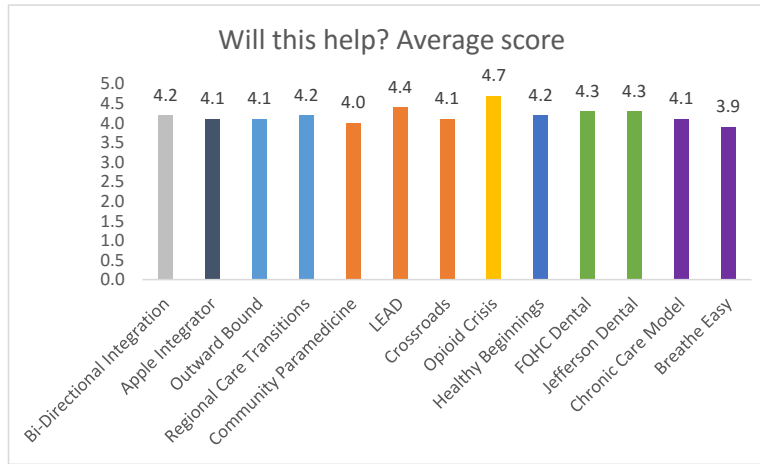


Figure 5

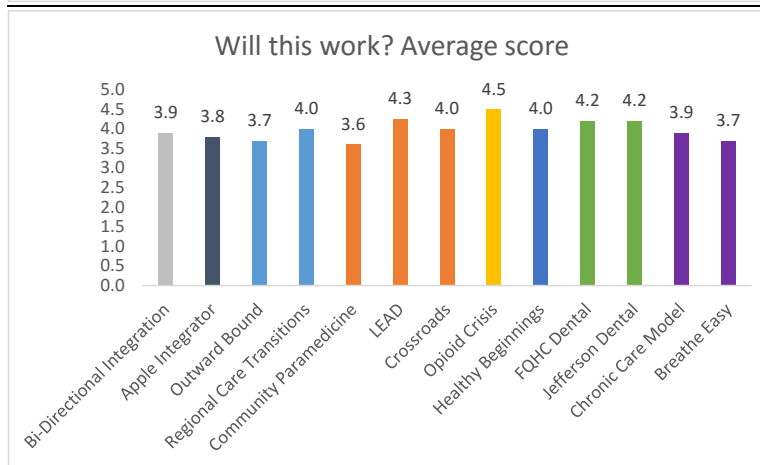
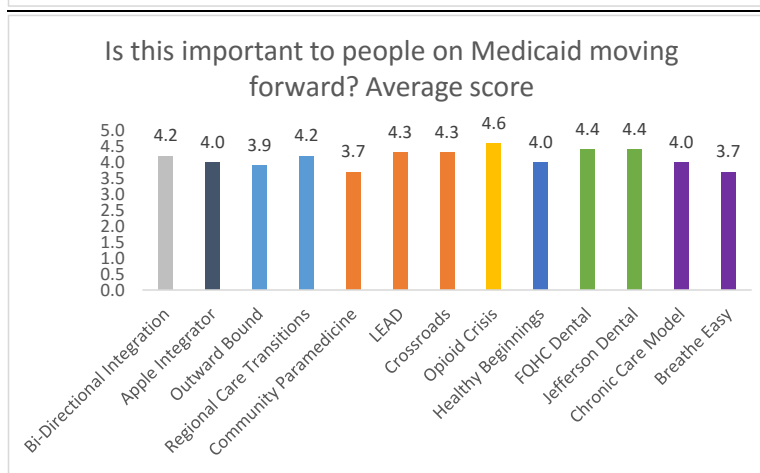


Figure 6



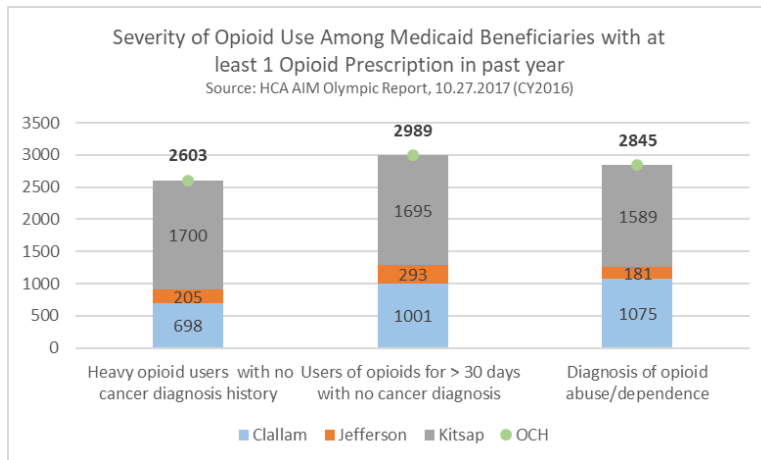
Regional Data in Support of the Opioid Project

The following section includes data from various sources to describe the prevalence of opioid use and prescribing, opioid-related events, harm reduction syringe exchange, as well as perceptions of use from youth and current users.

Medicaid beneficiary opioid data

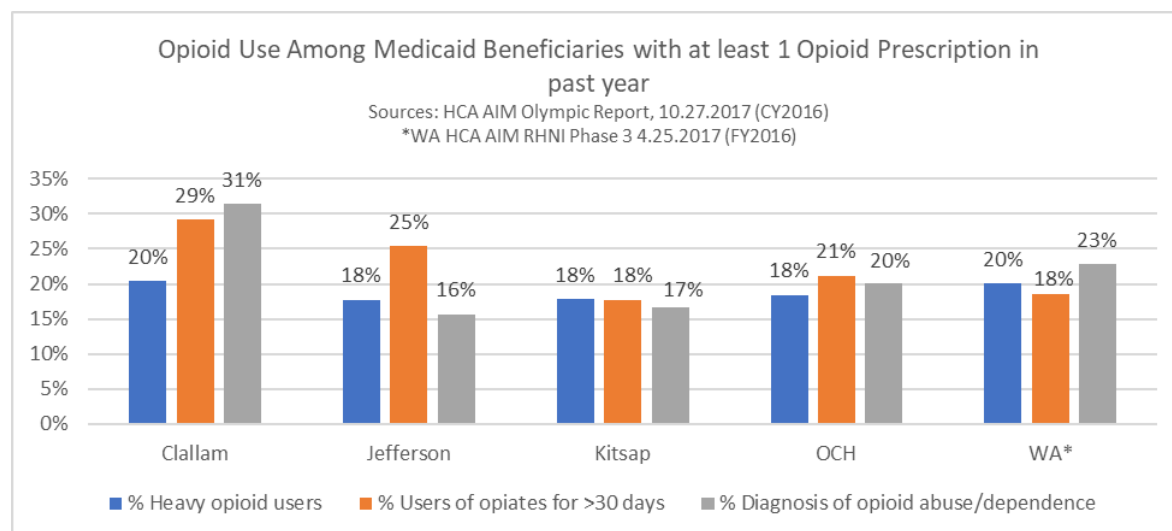
In the OCH region in 2016, there were approximately 84,000 Medicaid beneficiaries; 11,500 Medicaid beneficiaries had at least one opioid prescription, excluding individuals with a history of cancer. (HCA AIM RHNI Phase 3, 4.25 2017) Of those, about 2,600 were heavy users (average daily ≥ 50 morphine equivalency dose (MED)), nearly 3,000 were long-term users (>30 cumulative day supply) and 2,845 had been diagnosed with opioid abuse/dependence. (Figure 7) (HCA, AIM Olympic Report, 10.27.2017).

Figure 7



On average, 18% of Medicaid beneficiary opioid users are heavy users, ranging from 18-20% across the three counties, highest in Clallam. Twenty-one percent of opioid users have > 30 day prescriptions, with 18%, 25% and 29% in Kitsap, Jefferson and Clallam, respectively. 8% more opioid users in Clallam have been diagnosed with an opioid abuse or dependence in the past two years than the state average. (HCA, AIM Olympic Report, 10.27.2017). (Figure 8)

Figure 8



Of all OCH Medicaid beneficiaries with a diagnosis of abuse/dependence in the past two years, 16% receive MAT with buprenorphine, and 5% receive methadone (Figure 9). Compared to the Washington State average, the OCH region has more beneficiaries receiving MAT with buprenorphine and a much lower rate of beneficiaries receiving MAT with methadone.

Figure 9

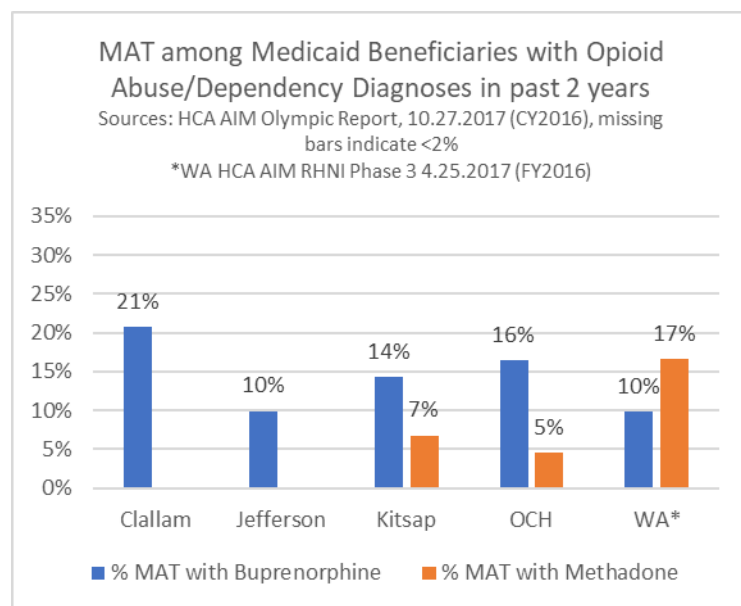


Table 2 includes sub-population prevalence estimates for both Washington and the OCH region. Orange shading indicates that OCH is worse when compared to the state for the same sub-population while green shading indicates that OCH is better; red font indicates highest groups within OCH sub-population category. Note that any cell with an * is suppressed due to counts below 10.

For heavy opioid users, OCH rates by gender, ages 0-49, and race are similar to the state; ages 50-59 and 60-69 are 2-4% above the state average. For chronic opioid users, OCH rates by gender, age 20-49, non-

Hispanic white, non-Hispanic black are similar to the state; age 50-59 and 60-69 and other race are 2-3% above the state; non-Hispanic AI/AN is 5% above the state average. For those receiving MAT with buprenorphine, OCH rates are better than the state for all sub groups except age 50-59, within OCH, rates are worse among older adults and non-Hispanic white. For those receiving MAT with methadone, OCH rates for all sub-populations are below the state average and there is little variation within OCH.

Table 2. Medicaid beneficiary opioid users by demographic groups

Source: HCA AIM RHNI Phase 3, 4.25.17		Medicaid Beneficiaries with an Opioid Prescription in past year				Medicaid Beneficiaries with an Opioid Abuse/Dependence Diagnosis in past 2 years			
		% Heavy Opioid Users		% Chronic Opioid Users		% Receiving MAT with Buprenorphine		% Receiving MAT with Methadone	
		WA	OCH	WA	OCH	WA	OCH	WA	OCH
Overall		20%	20%	18%	21%	10%	13%	17%	4%
Gender	Female	20%	19%	18%	21%	10%	13%	17%	5%
	Male	20%	21%	19%	20%	10%	12%	16%	4%
Age	0-9	0%	0%	1%	*	0%	*	0%	*
	10-19	17%	18%	1%	*	2%	*	*	*
	20-29	20%	18%	7%	7%	13%	16%	15%	4%
	30-39	20%	19%	17%	18%	13%	15%	19%	5%
	40-49	20%	19%	27%	28%	8%	11%	16%	4%
	50-59	21%	23%	36%	38%	5%	5%	16%	6%
	60-69	22%	26%	40%	42%	3%	*	18%	*
	70-79	17%	*	18%	*	*	*	*	*
	80+	16%	*	20%	*	*	0%	*	0%
Race / Ethnicity	Non-Hispanic White	20%	20%	22%	22%	10%	12%	17%	5%
	Non-Hispanic AI/AN	18%	18%	20%	25%	15%	21%	15%	*
	Non-Hispanic Black	20%	19%	15%	14%	4%	*	18%	*
	Hispanic	20%	19%	11%	12%	10%	*	14%	*
	Other/UNK	21%	20%	12%	15%	7%	10%	13%	*

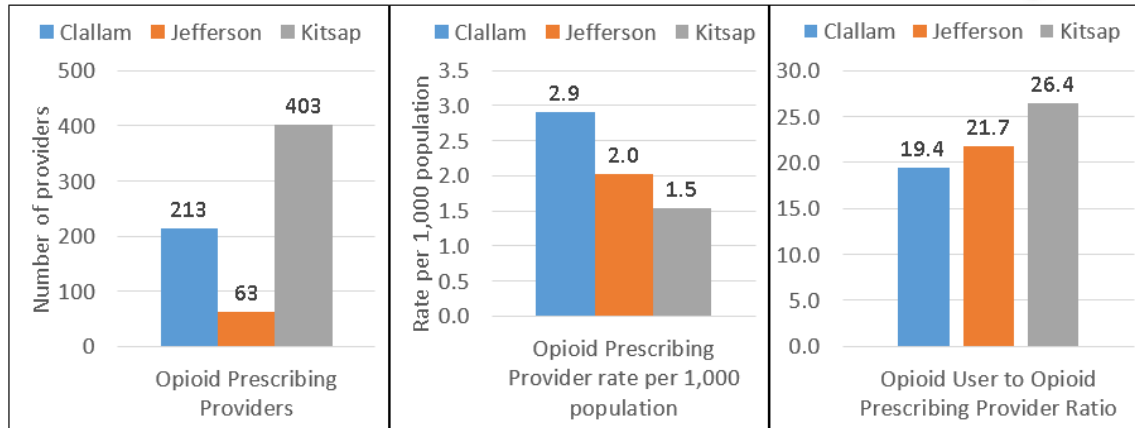
*Suppressed, n < 10

In 2015, there were nearly 700 Medicaid providers prescribing opioids in the OCH region; Clallam has the highest rate of opioid prescribers per population. The rate of opioid users per prescribing provider was highest in Kitsap. (Figure 10) (WA HCA, AIM Team, CY 2015)

Figure 10

Medicaid Providers Prescribing Opioids

Source: WA State Health Care Authority, AIM Team, CY 2015



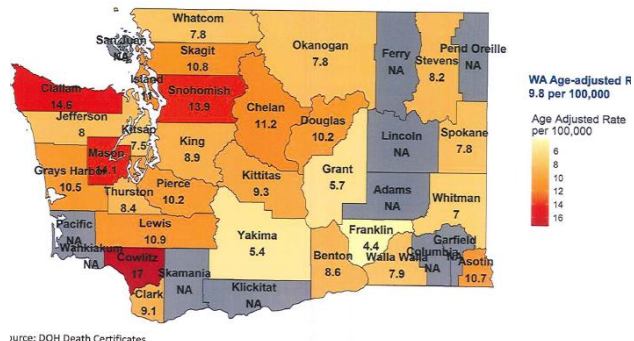
Includes opioid users with cancer diagnosis

General Population Opioid-Related Deaths, Hospitalizations, and ED Visits

Figure 11

Rates of Opioid Overdose Deaths* by County of Residence, 2011–2015

During 2011-15, Clallam County had the second highest age-adjusted opioid overdose death rate in Washington State. (WA State Department of Health (DOH), Death Certificate Database, analysis by Kitsap Public Health District (KPHD)) (Figure 11)



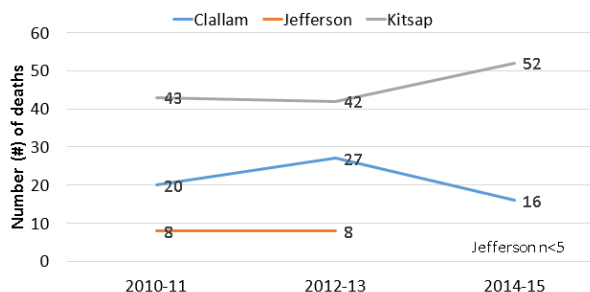
Source: DOH Death Certificates

Looking at two-year periods, opioid-related deaths (counts) appear to be decreasing from 2012-13 to 2014-15 in Clallam and Jefferson while increasing in Kitsap. (WA DOH Death Certificate Database, analysis by KPHD). From 2011 to 2015 Clallam County experienced the second highest rate of fatal opioid overdose in the state. (Figure 12) (WA DOH Death Certificate Database, analysis by KPHD)

Figure 12

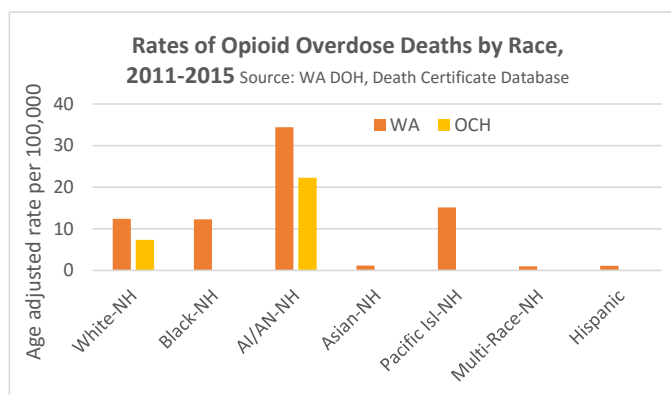
Opioid Related Deaths

Source: Death Certificate Database, WA State Dept. of Health, Center for Health Statistics. Analysis by Kitsap Public Health District



Opioid-related death rates by race/ethnicity highlight dramatic disparities – the death rate for AI/AN-non-Hispanic is three times higher than rate for White-non-Hispanic. Rates for other race groups in OCH are suppressed due to the small number of events. (Figure 13) (WA DOH Death Certificate Database, analysis by KPHD)

Figure 13



During 2011-15, similar to deaths, Clallam County had one of the highest rates of opioid-related inpatient hospitalizations. (Figure 14) The number of hospitalizations counts increased substantially in Clallam and Kitsap and have remained relatively unchanged in Jefferson. (Figure 15) (Comprehensive Hospitalization Abstract Reporting System, WA State Dept. of Health, Center for Health Statistics, Accessed in CHAT)

Figure 14

Rates of Opioid Overdose Inpatient Hospitalization* by County of Residence, 2011-2015

Source: Comprehensive Hospitalization Abstract Reporting System, WA State Dept. of Health, Center for Health Statistics. Accessed in CHAT.

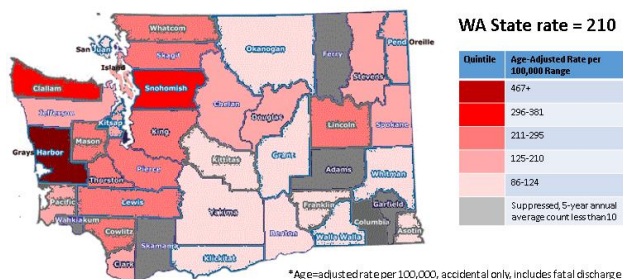
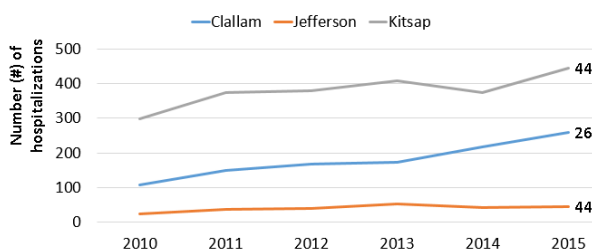


Figure 15

Opioid Related Inpatient Hospitalizations (accidental only, includes fatal discharge)

Source: Comprehensive Hospitalization Abstract Reporting System, WA State Dept. of Health, Center for Health Statistics.



Data from a new opioid dashboard produced by the WA DOH cannot be directly compared to the data presented above due to slight differences in definitions; however, it provides some data for 2016. Among OCH residents (unknown how many were Medicaid beneficiaries), there were 40 opioid-related deaths, 72 inpatient hospitalizations, and 176 emergency department visits. The distribution by county reveals disproportionately higher rates among Clallam residents (blue bars, 2.0-2.7 times higher than Kitsap) and Jefferson (orange bars, 1.5-2.3 times higher than Kitsap). (Figures 16-17) (Comprehensive Hospitalization Abstract Reporting System, WA State Dept. of Health, Center for Health Statistics, Accessed in CHAT)

Figure 16

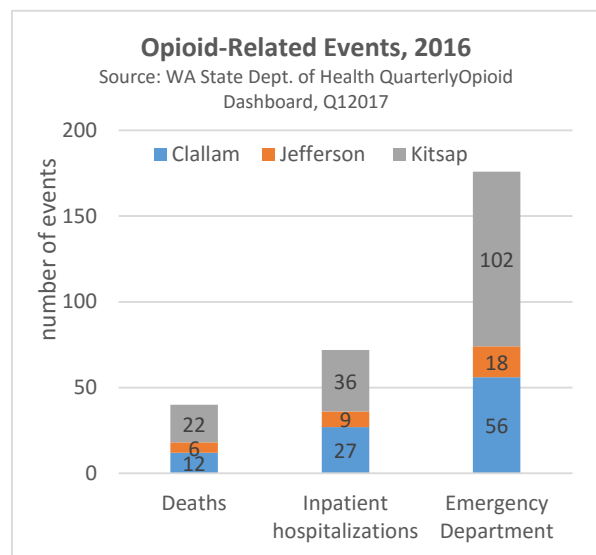


Figure 17

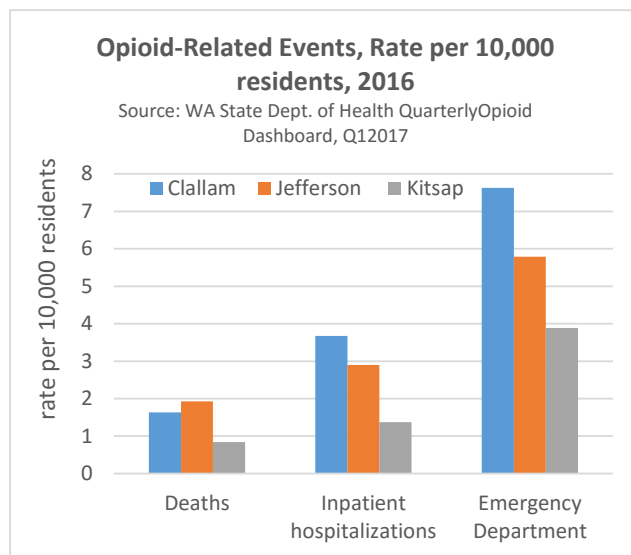
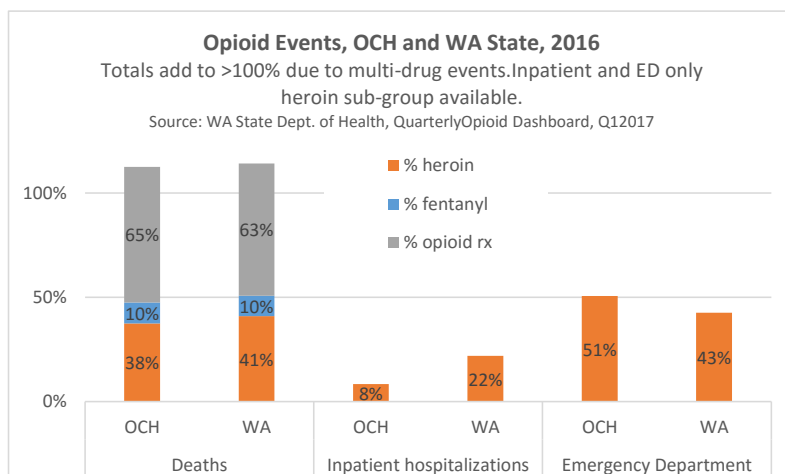


Figure 18

The proportion of opioid events among OCH residents involving heroin was about the same for deaths, lower for inpatient hospitalizations, and higher for ED compared to WA. Fentanyl and opioid prescription detail was only available for deaths and indicates a similar trend in the OCH region as compared to WA. (Figure 18) (WA State Dept. of Health Quarterly Opioid Dashboard, Q1 2017)



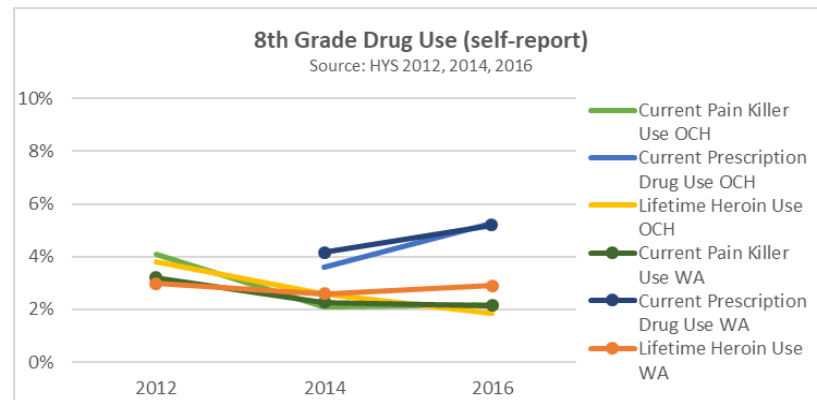
Youth drug use and perceptions of drug use

In 2016 among OCH youth, 1 in 20 eighth graders, 1 in 14 tenth graders and 1 in 12 twelfth graders reported using a prescription drug not their own in the past 30 days. One in 50 eighth graders, 1 in 35 tenth graders, and 1 in 20 twelfth graders reported ever having used heroin and having used pain killers

to get high in the past 30 days. (Figures 19-21) (Healthy Youth Survey (HYS), 2016)

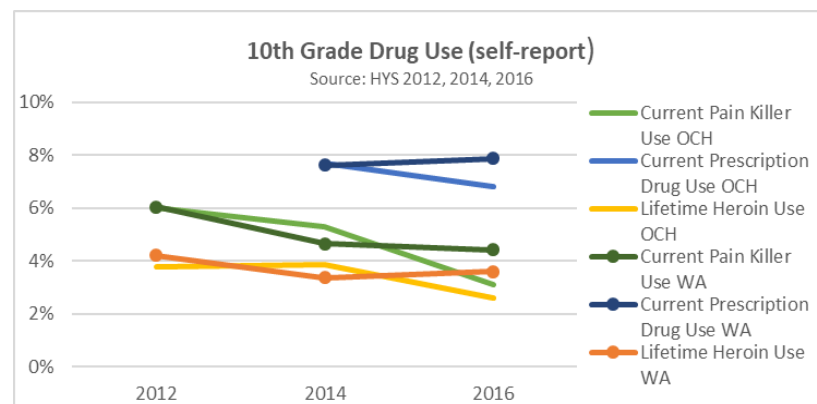
OCH 8th grade youth self-reported pain killer and prescription drug use are similar to rates in Washington State; however, lifetime heroin use was lower in the OCH region in 2016 compared to the state, and notably had been slightly higher in 2012. Eighth grade rates of prescription drug use are up slightly in 2016 compared to 2014, current pain killer use is unchanged and lifetime heroin use is down. (Figure 19) (HYS, 2012, 2014, 2016)

Figure 19



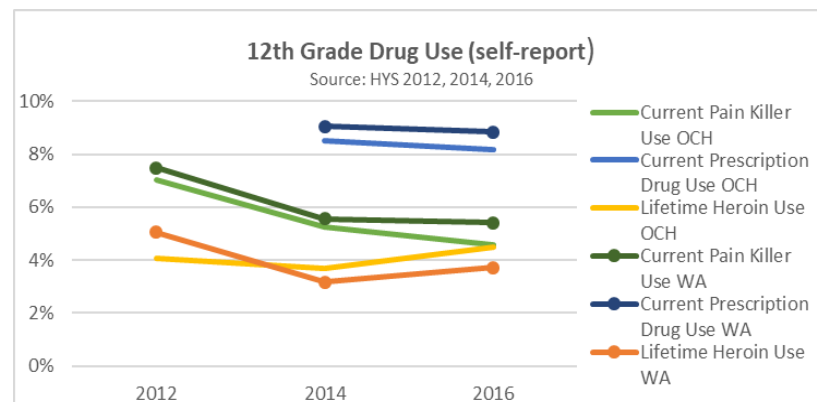
OCH 10th grade youth self-reported drug use is lower than rates in Washington State. All OCH rates are slightly lower in 2016 compared to 2014. (Figure 20) (HYS, 2012, 2014, 2016)

Figure 20



OCH 12th grade youth self-reported drug use is lower than WA for current pain killer and current prescription drug however, slightly higher than the state for lifetime heroin use. Both current painkiller and current prescription drug use rates are down slightly in 2016 compared to 2014 however lifetime heroin use appears to have increased slightly. (Figure 21) (HYS, 2012, 2014, 2016)

Figure 21



Note: Current prescription drug use question was not asked on Healthy Youth Survey 2012.

Figure 22

OCH student perceptions about drug use are similar to those among youth in Washington State, varying by about 2%. About 95% of students report their parents do not agree with youth prescription drug use; 85-91% report friends perceive prescription drug use is wrong (lower among older students), however, many fewer, about 70%, report perceiving risk from prescription drug use. (Figure 22) (HYS, 2016)

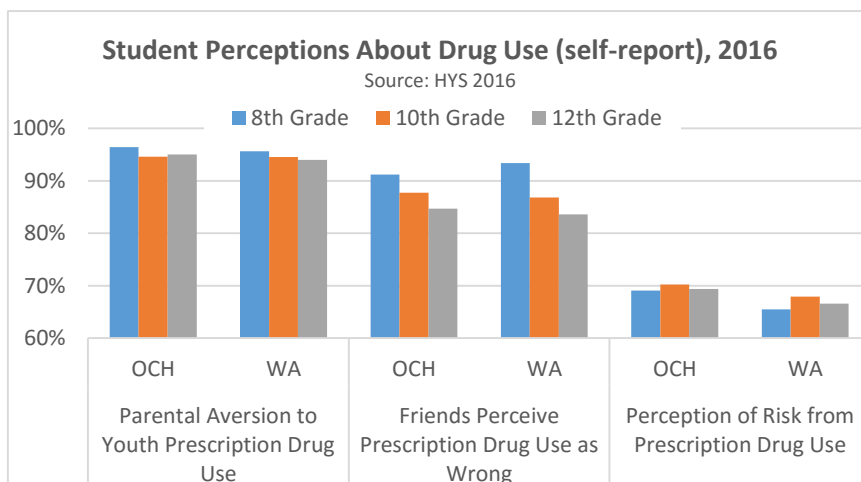
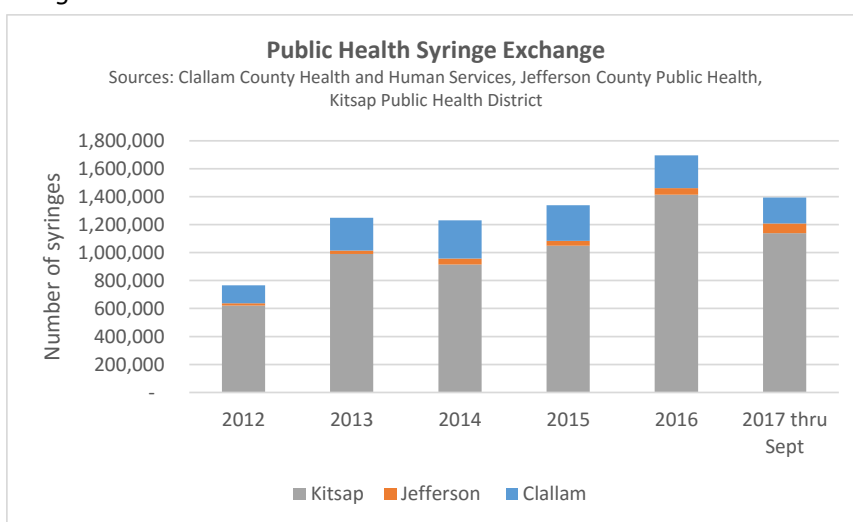


Figure 23

Syringe Exchange

The number of syringes exchanged in the harm reduction programs hosted by the three county public health agencies has steadily increased over time. This trend is expected to continue into 2017 based on extrapolation of existing data (Figure 23)



2015 Drug Injector Survey

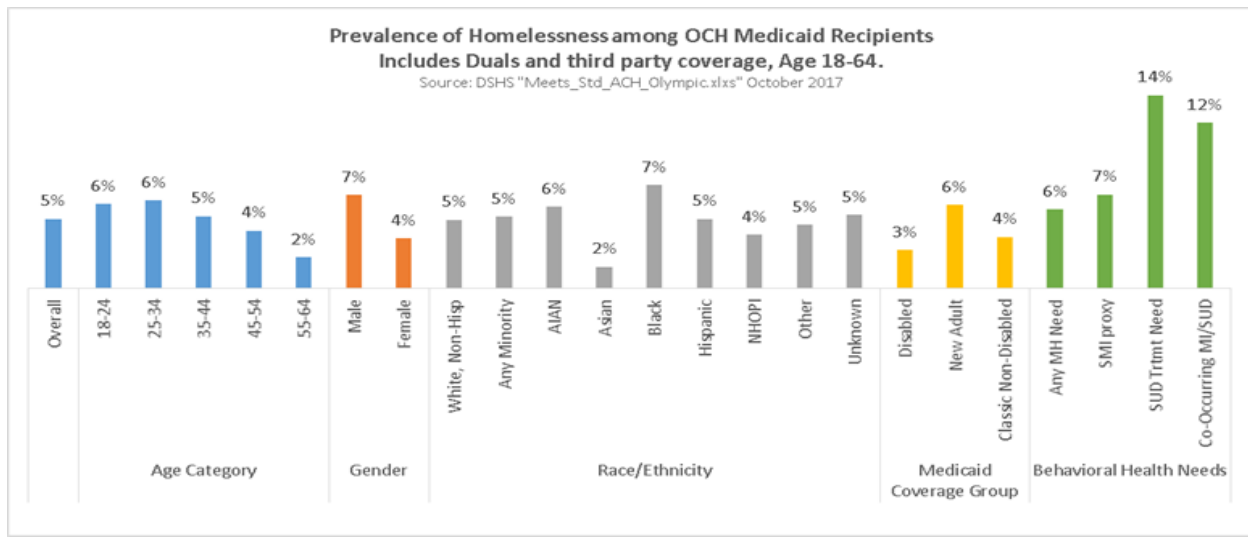
In 2015, researchers from the University of Washington Alcohol and Drug Abuse Institute (ADAI) surveyed clients of syringe exchange programs (SEPs) in Washington. Of the 1,036 valid responses, 66 were from Clallam, Jefferson, or Kitsap counties. Of interest to the OCH opioid response plan, regional responses: (Kingston & Banta-Green, Results from the 2015 Washington State Drug Injector Health Survey, UW ADAI, accessed [here](#), February 2016)

- 70% hooked on prescription opiates before using heroin (WA estimate: 57%)
- 68% main drug, heroin by itself (WA estimate: 69%)
- 52% witnessed an overdose, last 12 months (WA estimate: 54%)
- 22% overdosed at least once in the last 12 months (WA estimate: 23%)
- 46% had take-home naloxone kit, last 3 months (WA estimate: 30%)
- 52% very or somewhat interested in getting help to cut down or quit (WA estimate: 67%)
- 2 clients (3%) were currently in treatment (WA count: 133 WA or 13%)

Housing

OCH recognizes that progress depends on improving health equity through social determinates of health including housing, education, workforce development, employment, transportation, safety, and environmental conditions. In particular, the housing crisis throughout our State may compromise the ability of even the most successfully enacted prevention and treatment efforts to improve health for persons with OUD who are without stable housing. For many individuals with complex chronic health conditions, homelessness or housing instability can be the most significant barrier to health care access, often resulting in excessive use of expensive emergency department, inpatient treatment, and crisis services. For these individuals, supportive housing offers an evidence-based solution to improve health outcomes while reducing costs. Figure 24 clearly shows that Medicaid beneficiaries with substance use disorders suffer from homelessness at the highest rate.

Figure 24



Coordination with Existing Efforts

While developing their shared change plan (see Theory of Action section), each Natural Community of Care (NCC) will ensure that the transformational activities fit within existing services in the local community. The shared change plan will align each organization's change plan within a shared set of strategies for the NCC region.

During the development of change plans, OCH will update the inventory of current delivery system transformation activities. OCH will perform a baseline self-assessment of each partnering provider for a comprehensive list of all current and planned health improvement activities. OCH will ask providers to describe how the DSRIP transformational activities will expand upon, enhance, or complement existing delivery system transformation activities.

The current work of the 3CCORP Steering Committee and Workgroups will be integrated into the NCC change plans. There are currently approximately 100 community and Tribal members serving on the 3CCORP Steering Committee and Workgroups. (Table 1) They advise OCH about existing efforts and how best to support and coordinate. There are active collaborations and coalitions in each of the three

counties with either a specific focus on opioids or including opioid work as part of a broader healthcare focus. The 3CCORP director attends these meetings on a regular basis to provide updates and receive input about current efforts. The 3CCORP director is networked with colleagues at DOH, DBHR, HCA, ADAI, the American Indian Health Commission, and Tribes in the OCH region and attends meetings related to opioids on a regular basis. OCH to benefits from this statewide collaboration. An inventory is underway of relevant providers and community partners in the region to inform assessments of current services for community members and families who may be struggling with opioid use disorder. (Table 2)

As part of the change plan and contractual process, OCH will require an attestation from each organization that federally-funded activities are not duplicative of transformational activities proposed in change plans.

Table 3. Summary of the Initial Draft Assessment Plan

	3.a. Project activities	Naloxone survey	Resource list	Metric to improve	Workforce partner
1	Develop a current list of outpatient SUD providers (agencies) in the OCH region including name, address, county, contact person and contact information, and website if available (Jolene at SBHO might be able to help?).	X	X	X	X
2	Develop a current list of inpatient/residential SUD providers (agencies) in the OCH region including name, address, county, contact person and contact information, and website if available.	X	X	X	X
3	Develop a list of peer recovery support in the OCH region including name, address, county, contact person and contact information, and website if available.	X	X	X	X
4	Develop a current list of behavioral health providers (agencies) in the OCH region including name, address, county, contact person and contact information, and website if available.	X	X	X	X
5	Develop a current list of primary care providers who are waived to prescribe MAT and the number of patients that they are authorized to serve in the OCH region including name, address, county, contact person and contact information, and website if available.	X	X	X	X
6	Develop a current list of law enforcement jurisdictions in the OCH region including name, address, county, contact person and contact information, and website if available (Mike Lasnier might be able to help?).	X		X	X
7	Develop a current list of fire districts in the OCH region including name, address, county, contact person and contact information, and website if available.	X		x	X
8	Develop a current list of pharmacies in the OCH region including name, address, county, contact person and contact information, and website if available.	X	X	X	X
9	Develop a current list of jail facilities in the OCH region including name, address, county, contact person and contact information, and website if available.	X			X
10	Develop a current list of Emergency Departments (EDs) in the OCH region including	X		X	X

Project Scope, Partnering Providers, Expected Outcomes, and Target Population

Goal One: Prevention of opioid misuse and abuse by improving prescribing practices and community education

The OCH will support providers to improve prescribing practices, improve care for chronic pain, increase use of the Prescription Monitoring Program (PMP), improve identification of patients at risk for OUD and referral for appropriate assessment and treatment, improve care for complex patients, and standardize practices across the region. OCH is establishing a collaboration with the Office of Healthy Communities (OHC) at the Department of Health (DOH) to strengthen partnerships with pediatric providers to include improving prescribing for youth. According to the American Society of Addiction Medicine, in 2016, 80% of new heroin users started with misuse of prescription medicine. Goal One will be addressed primarily by:

1. Implementing the Six Building Blocks (6-BBs) model for clinic redesign in all three counties in the region. The 6-BBs are:
 - a. Leadership and consensus – build organization-wide consensus to prioritize safe prescribing practices; includes an initial clinic-wide self-assessment
 - b. Revise policies and standardize work – revise and implement clinic policies and define standard workflows for health care team members
 - c. Track patients on chronic opioid therapy (COT) – implement pro-active population management before, during, and between clinic visits for COT patients
 - d. Prepared, patient-centered visits – prepare and plan for clinic visits of all patients on COT to support care that is safe, appropriate, and empathic
 - e. Caring for complex patients – identify and develop resources and referrals for patients who develop complex opioid dependence
 - f. Measuring success – continues monitoring and improvement over baseline assessment and clinic QIP
2. Partner with the Washington State Medical Association, Washington State Hospital Association, Department of Health, and the Health Care Authority to distribute opioid prescribing variance reports that include feedback and comparison metrics, allowing prescribers to evaluate their practices relative to others in the state and update and improve their process with available information and training on the Washington State Agency Medical Director's (AMDG) prescribing guidelines.
3. Partner with dental providers and pain clinics to develop strategies to implement best practices such as the Bree Collaborative Dental Guideline on Prescribing Opioids for Acute Pain Management and the CDC Guideline for Prescribing Opioids for Chronic Pain, respectively.

"As a prescriber of acute pain post-surgery narcotics, I do not want to be the first contact that gets patients addicted to narcotics after acute surgical pain. My goal is to learn as much as possible about evidence based prescribing practices for acute pain opioids."

– OCH Healthcare Provider

Implementing the 6-BBs will also standardize use of the PMP, as well as familiarize providers with and increase utilization of the Washington State Agency Medical Directors Group (AMDG) Interagency Guideline on Prescribing Opioids for Pain, the Bree Collaborative Opioid Prescribing Metrics, the Bree Collaborative Dental Guideline on Prescribing Opioids for Acute Pain Management, the Coordinated Care Model, and the CDC Guideline for Prescribing Opioids for Chronic Pain across the OCH region.

Goal Two: Improve access to the full spectrum of best practices for the treatment of OUD including support for long-term recovery

Goal Two will be accomplished primarily through increasing the number of primary care providers who are waived to prescribe MAT, increasing support for waived providers to increase the number of patients they can serve, aligning outpatient SUD providers and MAT prescribers to coordinate care, supporting peer recovery support services, training providers to recognize patients at risk for OUD and feel confident to either treat or refer for treatment, and community education campaigns. The Bree Collaborative drafted the Opioid Use Disorder Treatment Report and Recommendations; once these are adopted they will inform treatment best practices in the OCH region. These findings will be reviewed by a sub-committee of local providers and adapted for the unique needs of the region.

The 3CCORP Treatment Workgroup will support Goal Two by:

1. facilitating training for becoming waived
2. collaborating with the regional Hub and Spoke system
3. collaborating with the regional community colleges to develop CEU-eligible training for chemical dependency providers (CDP) and chemical dependency professional trainees (CDPT) and the use of MAT for treatment of opioid use disorder
4. collaborating with the NW WA Family Medicine Residency to collaborate on curricula for residents to improve clinical care and coordination of treatment
5. seeking feedback of social service and agencies connected to the homeless population
6. facilitating quarterly county-level convenings of behavioral health providers and MAT prescribers and annual multi-disciplinary opioid summits
7. developing an IT solution for referrals and care coordination between organizations serving the same patients with OUD
8. working on educational campaigns about OUD and OUD treatment

OCH plans to collaborate with the Office of Healthy Communities at the DOH, OCH plans, to extend the project to pediatric providers. The OCH 3CCORP Treatment Workgroup has prioritized coordinating efforts with the Salish Behavioral Health Organization to bring an Opioid Treatment Program (OTP) to two locations in the OCH region as well as developing regional guidelines for coordinated care for OUD. Support has been offered by the Kitsap Provider's Group, a network of SUD treatment providers in the region that has provided annual regional trainings for 19 years, to partner for educational campaigns and convenings in the area. Fifty-two percent of respondents to the OCH Healthcare Provider survey stated that they did not have access to or know how to refer MAT patients to SUD services. OCH is currently creating a survey for SUD providers to identify barriers and challenges for those agencies in coordinating care. A recent report on the Washington State Medication Assisted Treatment – Prescription Drug and Opioid Project found that increasing access to MAT resulted in a decrease in illicit prescription opioid use, heroin use, methamphetamine use, and injection drug use rates; a decrease in alcohol and other drug use; a decrease in inpatient treatment and ED utilization; an increase in reported employment or school enrollment; an increase in accessing of outpatient services and treatment retention (Speaker et al., Washington State Medication Assisted Treatment - Prescription Drug and Opioid Addiction Project: Year One Performance, DSHS RDA, April 2017).

Goal Three: Prevent opioid overdose deaths

The 3CCORP Fatal Overdose Prevention Workgroup will support Goal Three by:

1. increasing the number of people trained to recognize an opioid overdose and respond appropriately through a “train the trainer” model

2. increasing the number of agencies dispensing naloxone with appropriate training, including the Good Samaritan Law
3. standardizing packaging and location of naloxone kits for homes and business (similar to AEDs)
4. increasing the number of first responders carrying naloxone
5. convening a bi-annual multidisciplinary summit including overdose prevention
6. increasing the number of emergency departments with protocols in place for opioid overdose (e.g., naloxone take-home co-prescribing based on risk)
7. tracking “lives saved” via ODMAP, EDIE, claims data, naloxone refills as potential proxies.
8. developing benchmarks and timelines to track in addition to those in the Toolkit.

3CCORP has been working closely with the ADAI as well as the teams from StopOverdose.org and the Center for Opioid Safety Education (COSE). This collaboration will support the work done in Goal Three.

Target population

The primary target populations are: (HCA RHNI Phase 3, 4.25.2017)

- Beneficiaries with a diagnosis of Opioid Use Disorder (OUD) and their families as well as beneficiaries not yet diagnosed with OUD (2,636 beneficiaries with diagnosis history of abuse/dependence)
- Beneficiaries without a cancer diagnosis with an opioid prescription in the last year (11,488)
- Beneficiaries without a cancer diagnosis who are chronic opioid users (2,385)
- Beneficiaries without a cancer diagnosis who are on high dose prescriptions (2,247)
- Beneficiaries who have presented to the ED with an overdose (176 in total population, count of visits not unique individuals)
- Beneficiaries under the age of 18 at risk for developing OUD (1,009 with a prescription in the last year, 167 high dose prescriptions)

The secondary target population is the broader community, both Medicaid and non-Medicaid, through:

- Education and prevention via educational/informational materials
- Reduction of diverted prescription opioids
- Reduction of improperly stored and disposed medicine

Partnering clinical providers include (Table 1):

- Primary care providers
- Dentists
- Outpatient and inpatient SUD providers
- Behavioral health providers
- Emergency Departments
- Hospitals and clinics
- Tribal clinics
- Salish Behavioral Health Organization

Non-clinical partners include:

- Law enforcement
- Elected officials
- Fire/EMS

- Schools
- Criminal justice
- Jail facilities
- Lived experience
- Housing
- Early Childhood
- Tribes

Equity

The opioid public health crisis touches every single person in our region in some manner. This issue is most prevalent in minority, low-SES communities, and frequently co-exists with other chronic health problems and homelessness. Promoting involvement of primary care in treatment for OUD increases the potential early detection/intervention of other health problems and intervening against other health disparities. Partnering with and expanding the reach of community health centers that have already specialized in these populations will further address health disparities and promote equitable care in the region.

In developing the goals and strategies of the regional opioid response plan, the Steering Committee and three workgroups bring their expertise about challenges and opportunities with regard to geography, diversity, access to housing and resources, levels of poverty, access to education, resources, and needs in the OCH region to address the crisis, improve outcomes, address equity, and lower costs. Rates of heavy and chronic opioid use and diagnosis of opioid dependence/abuse differs by race/ethnicity in the OCH region and rates of opioid overdose deaths differ by race/ethnicity in OCH and Washington State. (Figures 25-26) OCH is working closely with the Tribes in our shared region to support Tribal specific efforts in each of the communities and there is Tribal representation on Steering Committee and each of the three workgroups.

Figure 25

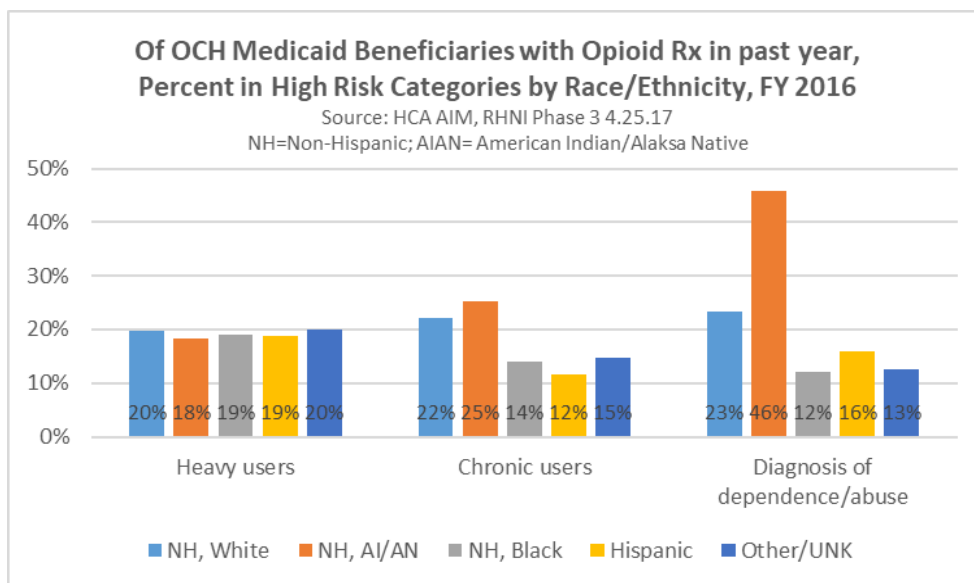
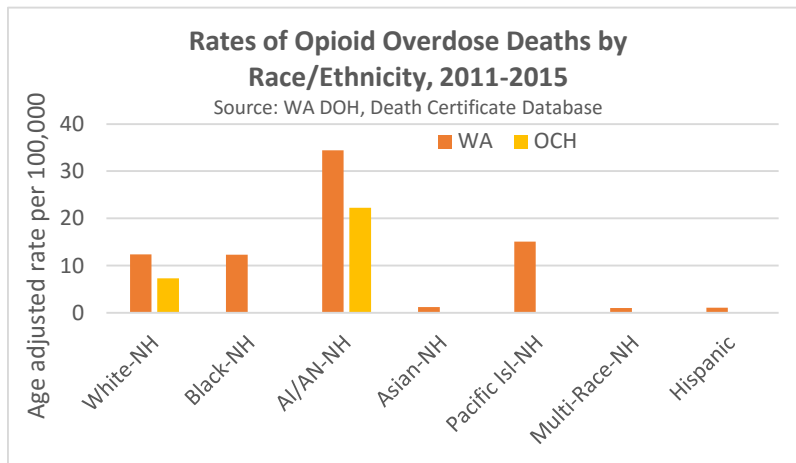


Figure 26



Lasting impacts

The proposed strategies integrate new models of delivering care as well as prevention that will extend beyond Medicaid and the MTP, and will address the needs of the people in the OCH community.

Infrastructure and capacity building investments

The project supports sustainable health system transformation through investments in infrastructure, data systems, population health-based approaches, and workforce. These investments will lead to successful value-based payment contracting for Medicaid providers beyond the MTP. Upfront investments support provider organizations to hire workforce, implement strategic clinic redesign to improve prescribing practices, and invest in population health IT capacity to manage the health of this population. Workforce strategies will provide training for primary care providers, SUD providers, behavioral health providers, law enforcement, fire/EMS, criminal justice, school-based staff, and those at risk for an overdose or for witnessing an overdose.

Leveraging Natural Communities of Care for collective impact

OCH will convene partnering providers within a Natural Community of Care (NCC) to align strategies into a single shared change plan to address the opioid crisis. An NCC is a community of resources and providers that serve a shared population due to geographical proximity, referral patterns, and collaborative agreements between providers. Recognition of the NCC is important as it brings attention to grassroots organizations and opportunities to champion projects borne of genuine community need.

Goals and strategies in the regional opioid response plan will be incorporated into change plans as transformation activities, and will be mutually supportive of the shared change plan of their NCC and across other projects. OCH will facilitate collaborative arrangements between providers within the NCC, such as data-sharing agreements and business associate agreements. By leveraging the collaborative structure of the NCC, providers from different sectors will benefit collectively by improving prescribing practices, improving access to the full spectrum of best practices for the treatment of opioid use disorder, aligning SUD providers and MAT prescribers to coordinate care, increasing the number of people trained to recognize and respond to an overdose, increasing the availability of naloxone, and reducing unnecessary ED visits. The increased connection and collaboration will also accelerate optimization of practice, as there will be a greater pool of practical experience to draw from. Consistent

with the OCH Theory of Action, we expect these activities to ultimately drive down overall costs and increase the effectiveness of care.

Value-based contracting

MCOs will be collaborators in the development of the shared change plan and will continue to work with partnering provider organizations as part of the provider-payer contracting process. By including MCOs in the development process, MCOs can ensure that shared change plans are mutually supportive of the metrics in their value-based contracts. Provider organizations may use their DSRIP incentive payments (see Funds Flow section) to deploy change management teams to oversee rapid-cycle testing feedback loops to refine diversion strategies until they are able to achieve their targeted benchmarks in their value-based payment contracts. Additionally, OCH will oversee deployment of technical assistance from MCOs to provider organizations to assist in mutually reinforcing strategies such as risk stratification, care coordination, and population health management.

OCH is collaborating closely with the Salish Behavioral Health Organization (SBHO) on 3CCORP. The SBHO already has fully capitated contracts for mental health in the region. These contracts will transfer from the SBHO to the MCOs in 2020, under fully integrated managed care.

OCH will support Tribes preference for tribal encounter rates and reduced administrative burden, and advocate that Tribes be held harmless under new contracting mechanisms. OCH will encourage knowledge transfers between non-tribal and tribal provider organizations to share perspectives on MCOs as contracting partners.

3A. Addressing the Opioid Use Public Health Crisis
PROJECT SELECTION AND EXPECTED OUTCOMES

Olympic Community of Health

Table 4. Opioid Response: Strategies, Projected Outcomes, and Population Served

Strategies	Intermediary Milestone or Metric	Pay for Reporting Metrics and Milestones	Payment for Performance Metrics	Evidence Base	Target Population	Targeted Subpopulation	Est. # per Year at Max Capacity	Disparities
Improved opioid prescribing practices	Natural Community of Care Collaborative Agreement in place	# and list of community partnerships	Patients on high-dose chronic opioid therapy by varying thresholds	Six Building Blocks for Safe Opioid Prescribing	All Medicaid beneficiaries with an opioid use disorder or at risk for developing an opioid use disorder and their families	Beneficiaries with a diagnosis of Opioid Use Disorder (OUD) and their families as well as beneficiaries not yet diagnosed with OUD	2636	The opioid public health crisis touches every single person in our region in some manner. This issue is most prevalent in minority, low-SES communities, and frequently co-exists with other chronic health problems and homelessness.
	Natural Community of Care shared change plan	# of health care providers, by type, trained on AMDG's Interagency Guideline on Prescribing Opioids for Pain	Patients with concurrent sedatives prescriptions	Washington State Agency Medical Director's (AMDG) prescribing guideline		Beneficiaries without a cancer diagnosis with an opioid prescription in the last year	11488	
	Partnering provider organization change plan	# of health care organizations with EHRs that newly provide clinical decision support for opioid guidelines	Patients with concurrent sedatives prescriptions	CDC Guideline for Prescribing Opioids for Chronic Pain		Beneficiaries without a cancer diagnosis who are chronic opioid users	2385	
	Contract in place with OCH			Bree Collaborative Opioid Prescribing Metrics		Beneficiaries without a cancer diagnosis who are on high dose prescriptions	2247	
	Monthly reports sent to OCH			Bree Collaborative Dental Guideline on Prescribing Opioids for Acute Pain Management		Beneficiaries who have presented to the ED with an overdose	176 (visits, not unique individuals)	
	Proxy measures under development; will be selected to predict P4P metrics and/or desired outcomes from QIP; will be included in contracts and reported by partners. Early planning from 3CCORP indicate the following QIP measures:	QIP Metrics		2017 WA State Interagency Opioid Response Plan				
				Center for Opioid Safety Education				
	Improved treatment for							

3A. Addressing the Opioid Use Public Health Crisis
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Increase in access to and utilization of full spectrum of opioid use disorder treatment	<p>chronic pain, including non-pharmacological interventions</p> <p>Increase in providers accessing and using PMP</p> <p>Increased awareness and education regarding OUD and OUD treatment</p> <p>Increase in coordination between primary care and behavioral health</p> <p>Increase in people trained to recognize and respond to an overdose</p> <p>Decrease in opioid related ED visits</p>	<p># and list of community partnerships</p> <p># and location of buprenorphine prescribers</p> <p># and location of MH/SUD providers delivering acute care and recovery services to people with OUD</p> <p># and type of access points for MAT</p> <p>QIP Metrics</p>	<p>Substance Use Disorder (Opioid) Treatment Penetration</p>	<p>Bree Collaborative Opioid Use Disorder Treatment Report and Recommendations</p> <p>2017 WA State Interagency Opioid Response Plan</p> <p>Center for Opioid Safety Education</p>		<p>Beneficiaries under the age of 18 at risk for developing OUD</p>	<p>1009 (children with prescription in previous 12 months; 167 with a high-dose prescription)</p> <p>SOURCE: HCA AIM Team</p>	
Prevent or intervene in opioid overdoses to prevent death	<p>Increase in health care providers' recognizing OUD and linking to appropriate treatment</p> <p>Decrease in fatal and non-fatal opioid related overdoses</p> <p>Increased access to naloxone</p>	<p># and list of community partnerships</p> <p># of EDs with protocols for overdose education and take-home naloxone for opioid overdose</p> <p># of local health jurisdictions / CBOs that received TA to organize or expand syringe exchange programs</p> <p>QIP Metrics</p>	<p>Outpatient ED Visits</p> <p>Inpatient Hospital Utilization</p>	<p>2017 WA State Interagency Opioid Response Plan</p> <p>Center for Opioid Safety Education</p> <p>StopOverDose</p>				

IMPLEMENTATION APPROACH AND TIMING

IMPLEMENTATION APPROACH AND TIMING

Please refer to OCH Supplemental Workbook: 3A Implementation Approach

PARTNERING PROVIDERS

Assurance of Serving the Medicaid Population

Please refer to OCH Supplemental Workbook: 3A Partnering Providers. This workbook contains an initial list of partnering clinical and non-clinical providers for the opioid response project. Clinical providers in the workbook represent those that collectively serve a significant portion of the Medicaid population. These providers have been very active in developing the opioid response project plan and will roll up into the regional Natural Communities of Care (NCC) to develop change plans to implement the opioid goals into the OCH project plan portfolio.

In addition to the partnering providers and community-based organizations who have been active on the 3 County Coordinated Opioid Response Project, OCH will reach out to Tribes and providers who currently serve a significant number of Medicaid beneficiaries to participate in the change plan process development. A large proportion of AI/AN people are on Medicaid. (Figure 26)

Partner Engagement Process

Transformation work is not easy. There is considerable risk and effort on the part of the providers and community-based organizations. Therefore, participating provider organizations and community-based organizations are those with leadership and financial buy-in and those that commit to completing and following a change plan, sending regular data reports to OCH, performing continuous quality improvement cycles, and driving towards long term, sustainable transformation. OCH will work with Tribes to agree on a data sharing agreement on a case-by-case basis that acknowledges tribal sovereignty and protects tribal data.

MCO Expertise

MCOs are essential partner organizations and been involved with 3CCORP to date. MCOs will be invited to collaborate in the development of the shared change plan. By including MCOs in the development process, MCOs can ensure that shared change plans are mutually supportive of the metrics in their value-based contract. MCOs will also be able to provide technical assistance to provider organizations to help prepare them for value-based contracting and to leverage opportunities for the jail population out of SB 6430. MCOs can help with outreach efforts to improve prescribing practices, improve access to best practice treatment for OUD, and prevent opioid related overdoses.

REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS

REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS**Assets**

As demonstrated by the cross-sector and cross-region membership, and active participation in the 3CCORP Steering Committee and Workgroups, the opioid project has considerable assets to support the success of the project. Additionally, for this project to be successful, organizations that serve the Medicaid population must leverage existing assets to provide enhanced access points for their patients and families. Collaboration between clinical and community providers will support the success of improved prescribing practices, improved access to best practices for OUD treatment. The 3CCORP project has illuminated existing provider networks and provided a platform for the development and strengthening of new connections.

Tables 6 through 9 in the Regional Health Needs Inventory Section list assets related to health care providers, social service providers and payers by service area; and number of beneficiaries served and number of claims by each major Medicaid provider, stratified by age and care setting (institutional or professional). OCH will be doing a deeper dive during the baseline assessment in DY1 Q4 and DY2 Q1.

The list of partnering providers is under development; the final list will be developed within each Natural Community of Care. Of note, tribal clinics are key partners and will be invited to engage in the change plan process within the Natural Communities of Care. A focus of future work will be greater inclusion and input from low-income housing and anti-homelessness campaigns in the region. This will be supported by the connections to local elected officials and social service organizations that have spearheaded such campaigns in the area.

The OCH is also collaborating with Qualis Health and the Office of Healthy Communities in the Department of Health to leverage primary/behavioral health care and pediatric care assessments and practice coaching for readiness for bidirectional integration and moving to a value-based payment structure. Inclusion of pediatric primary care and dentists addresses the alarming increase in risk for OUD in youth.

The history of the 3CCORP Steering Committee and three Workgroups over the past year demonstrates a strong working relationship between partnering organizations and the willingness to work regionally is a critical asset to the success of the opioid project plan and overall portfolio. OCH manages a Regional Health Inventory, a growing list of local health initiatives. Partnering provider organizations already bring multiple assets to this project.

Challenges

Addressing the opioid public health crisis is extremely challenging. There are several challenges or barriers to improving outcomes and lowering costs for the target populations through this project. Table 9 describes the anticipated barriers to deploying resources to partnering providers, and OCH tactics for addressing each of them. Notably, nearly all listed barriers below impact more than one project area and will therefore be addressed systematically across the MTP portfolio.

REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS

Table 9. Challenge to improving outcomes and strategies to mitigate risks

Challenge or barrier to improving outcomes and lowering costs for the target populations through this project	OCH strategy for mitigating the identified risks and overcoming barriers
Incorporating new workflows into primary care, which is already over tapped and inadequately reimbursed	Incorporate new service lines into existing workflows, leverage multi-disciplinary care teams, train in enhanced billing; implementation of nurse care-manager, case management models for addiction medicine to decrease burden on prescribers
Clinical practice transformation change is time consuming, challenges productivity	Built into the 6-BB model; deployment of a change manager workforce; support of internal QI teams; support from provider organization's leadership; Qualis, TCPI, AIMS and OCH facilitated technical assistance to support practice consultation for quality improvements
Integrated Care	Promoting better partnership between primary care and SUD/BH providers; development and implementation of evidence-based multi-disciplinary care for OUD; Working to improve effectiveness of outpatient withdrawal management via MAT & outpatient care for OUD, decreasing need for costly residential treatment; Quarterly multidisciplinary convenings of county providers and annual regional conference
State administrative codes – RCWs, WACs, Certification or other requirements that impede communication between SUD/BH and primary care providers for patients with OUD	Identify administrative code barriers, present information to appropriate agency officials, work with professional organizations to advocate necessary changes to provision of integrated care.
Improving health for persons who are without housing or lack stable housing is severely compromised	Advocate for sufficient needed “step-up” and “step down” facilities for persons with physical and/or behavioral health conditions who cannot be stable in their home environment. Advocate for a safe, decent, affordable range of housing options including but not limited to permanent supported housing. Coordinate with Initiative 3 of the MTP, supportive housing case management.
Sustainability	Regional implementation of the 6-BB model for clinic redesign and improved prescribing practices; county and region-level integration and coordination of behavioral health and primary care for treatment of OUD; standardization of overdose prevention response and naloxone kit storage; partner beyond clinical providers to include those that work with people with OUD including criminal justice, elected leaders, schools, fire/EMS, etc.; integrate population health management tools into workflows; invest in population health management IT infrastructure; track progress on moving VBP metrics related to prevention of opioid misuse and abuse, improved access to OUD treatment, and prevention of opioid related overdoses

MONITORING AND CONTINUOUS IMPROVEMENT

Monitoring Project Implementation

Implementation of the 6BBs ensures that monitoring and continuous improvement plans are in place. OCH will align the current work of the 3CCORP with the other projects in the portfolio and avoid delays in implementation through detailed planning, formation of Natural Community of Care (NCC) collaborative agreements, NCC steering committees, comprehensive baseline assessments and change plans. Change plans will outline a sequential, stepwise process, co-designed with the provider organization(s), to implement transformational activities.

In 2018, the biggest risk to implementation will be providers failing to meet reporting requirements. OCH will mitigate this risk by precisely noting reporting requirements in provider change plans, which will be developed in early 2018. We will also provide outreach and training on OCH's monitoring system (described below). Trainings will be in person and virtual, with materials specific to each project, and presentation on best practices for specific project measures. To the extent possible, OCH requirements for provider reporting will align with existing reporting requirements (e.g., HEDIS, Alternative Payment 4, and Apple Health Contracts). This will be a joint initiative with MCOs, strategically positioning providers to achieve VBP contract benchmarks.

Funding will flow to providers and affiliate partners upon completion of set milestones, as outlined in change plans. There will be fiscal consequences for lack of progress, as revealed by process and outcome measures. This will all be detailed in provider contracts.

Delays in implementation will be addressed by change managers, either employed by the provider organization or OCH. Change managers will identify cross-cutting implementation barriers among partnering provider organizations. In turn, they will not only make recommendations to address those barriers, but will also revise change plans appropriately.

Monitoring Continuous Improvement

OCH projects share common elements for monitoring and continuous improvement. To track progress, OCH will rely on a host of measures categorized (at its highest level) as follows: process measures, milestones and outcome measures. The latter two categories will include all toolkit required measures for determining project incentive payments. The first category (process measures), although not specified in the toolkit, is critical to ensuring OCH and partner organizations adopt best-practices both for projects and for Domain 1 activities. For the most part, the process measures will serve as real-time indicators.

OCH is planning to build a technology platform that can systematically manage all three categories of measures. The platform will also have enough descriptive context to guide partners and providers in the provision of information to send to OCH. The information coming from providers will primarily fall into our first two categories: process measures and milestones. Outcomes measures will be captured chiefly from existing reporting systems (e.g. Healthier Washington Dashboard, HCA-AIM reports, Washington Health Alliance Reports, DSHS reports, RDA reports, WSHA reports and others). The OCH platform will avoid the inefficiency and inaccuracy inherent in having providers entering data in multiple templates. OCH intends to use the platform for data aggregation and formatting to streamline the population of HCA required templates.

OCH's process measures are the lynchpin to ensuring OCH providers are on track to make the necessary progress expected under the Transformation. Simply put, outcome measures are too lagged and provide

no insight into whether foundational operational front-line changes have been undertaken. Milestone reporting, while providing a real-time sense of overall organizational change, still does not furnish a front-line view of how patient engagement may have changed.

OCH does not anticipate much resistance from partnering providers in providing requested information for tracking purposes. During OCH's letter-of-intent process (March to April 2016), when asked, "*Are you willing to provide project-specific data to OCH for tracking purposes?*", all partnering organizations agreed to send data to OCH for tracking purposes.

Identifying what is not working

OCH will form a steering committee for each NCC. The role of the committee is to oversee the work of the shared change plan, identify barriers, and collaboratively design solutions across sectors and Tribes. OCH staff will share learnings across NCCs, deploying technical assistance where appropriate. OCH will also deploy provider surveys, creating an anonymous vehicle for providers to provide feedback to the OCH.

OCH will hire a Compliance and Contract Coordinator to oversee change plan compliance, conduct site visits, perform annual audits. OCH will form a Compliance Committee to oversee this effort. Partners will receive additional support through a change manager, who will offer regular progress check-ins with participants within each NCC. The OCH Board will approve a mediation plan structure and grievance procedure to provide necessary processes for under-performance and non-compliance.

The Performance Measurement and Evaluation Committee (PMEC) designs and reviews data submissions, interprets trends, and elevates red flags to the Board. The PMEC will swiftly identify issues regarding reporting, data quality, or failure to move metrics and offer counter-measure solutions where appropriate.

Each project implementation plan will include a go/no go decision midway through project implementation. If the work to that point has proven constructive with quantifiable evidence that the program will be both successful and sustainable, then the work will continue through the duration of the Transformation. Evidence that the program or elements of the program are not working will trigger a project plan modification request, specific to the root cause of the issue.

Opioid project risks

Beyond the risk noted above of partners/providers not being set up to meet reporting requirements, we are mindful of the following specific risks with the Addressing the Opioid Use Public Health Crisis project. We intend to devise focused monitoring mechanisms for these risks. This is only a sample of monitoring initiatives.

- Insufficient real-time feedback loops on key processes that attest to success of 6-BBs implementation.
- Too slow an increase in the number of waived providers prescribing MAT.
- Insufficient insight into barriers to provider referral to SUD services and, thus, not explicit enough counter-measures that can be monitored.
- Insufficiently detailed and timely sharing of best treatment practices; thus, hindering spread and improvement of patient health.
- Inadequate number of step-up and step-down facilities to serve need.

PROJECT METRICS AND REPORTING REQUIREMENTS

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

1. *Reporting semi-annually on project implementation progress.*
2. *Updating provider rosters involved in project activities.*

YES	NO
x	

RELATIONSHIPS WITH OTHER INITIATIVES

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.
- Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.
- If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.

YES	NO
x	

PROJECT SUSTAINABILITY

The narrative below provides the high level, cross project description. It is important to note that on October 7, 2016, Governor Inslee launched Executive Order 16-09 “Addressing the Opioid Use Public Health Crisis”. EO 16-09 describes the state of the opioid crisis in Washington State and directs state agencies under his authority to work with local public health, Tribal governments, and other partners to implement the state opioid response plan.

The opioid project supports sustainable health system transformation for people on Medicaid through a newly trained workforce, advancement in population health systems, value-based contracts, new workflows, and clinic redesign. These transformations will outlive the MTP. Investments within the OCH opioid project in infrastructure, capacity, workforce, and transformation, directly translate into the sustainable transformation components described in Section 1: Required Health Systems and Community Capacity (Domain 1) Focus Areas.

<i>Table 10. Driving towards sustainable capacity, infrastructure, workforce, and transformation strategies</i>	
Opioid Project →→→→→→→→→→→→→→→→	Capacity Infrastructure Strategies
Through exploring technologies such as Pre-Manage or others to be determined	Health information sharing (VBP) (PHS)
Increase utilization of PMP; clinic-managed OUD registries	Registries (VBP) (PHS)
To identify those in need of MAT treatment or at risk of OUD	Risk stratification (VBP) (PHS)
To effectively refer people with OUD between the BH and primary care setting	Referral Management (VBP)
An analytic tool to facilitate internal evaluation and rapid-cycle testing of interventions	Analytics - Decision support technology (VBP) (PHS)
Increase Naloxone/Narcan distribution and access sites	Supplies
Opioid Project →→→→→→→→→→→→→→→→	Workforce Strategies
Opportunities such as Telepain or ECHO	Telehealth
Trained internal staff to perform rapid-cycle testing and evaluation	Population Health Analytics (VBP) (PHS)
Training for improved prescribing practices, increased ability to recognize and treat/refer for treatment patients with opioid use disorder, increased number of MAT prescribers and support networks (e.g. Nurse Care Managers), increased experience for SUD providers to support MAT in outpatient treatment,	Cross training/ Retraining/ Certification/Uptraining

increased number of people trained to recognize and appropriately respond to opioid overdoses, increase in safe medicine storage and disposal, coordination of care among clinical and non-clinical providers and partners, trauma-informed care, and population health management.	
Opioid Project →→→→→→→→→→→→→→→→	Transformation Strategies
Whole person care provided by the patient's medical or behavioral health home	Patient Centered Medical Home (VBP) (PHS)
BH and primary care providers coordinating care for people with OUD	Team-Based Care
New workflows to effectively identify, treat, and refer patients with OUD in the clinic setting	Quality Improvement Strategy/Workflows (VBP)
Referrals and information sharing between BH and primary care providers	Care Coordination incl. Referral Management (VBP) (PHS)

Managed Care Organizations

MCO participation in developing change plans and participating in implementation of these projects will help clinical and non-clinical providers engage with future value-based contracts that may include improved prescribing, improved access to best practice OUD treatment, and prevention of fatal opioid related overdose health-focused projects.

To make this workflow and clinic redesign sustainable, OCH will encourage providers to partner with MCOs on including opioid prescribing, treatment, and overdose metrics as part of their VBP contracts. By doing this, providers will be able to receive incentives for improvement in these outcomes.

Prevention and Whole Person Care

Through this project, partnering providers will institute a comprehensive, whole-person approach to promoting and sustaining health for community members with chronic pain and/or opioid use disorder and their families. By focusing on implementation across practices for improving prescribing practices, improving treatment and coordination of care for OUD, and preventing opioid overdoses, providers will positively impact populations throughout the lifespan. OUD often impacts young adults, and increasing the potential to successfully intervene and connect these individuals to health services has the potential for dramatic impacts in health problems and service utility across the lifespan. In addition, this approach promotes the linkage of health care and community based organizations, which will leave a sustaining impact on the entire region, regardless of coverage or targeted population.

Fundamentally, OCH views this project as both critical and cross-cutting. Opioids touch every provider, sector, and community member.

ATTACHMENTS

ATTACHMENTS

1. *Required* OCH Supplemental Workbook: Tab 3A Partnering Providers
2. *Required* OCH Supplemental Workbook: Tab 3A Implementation Approach



3B. Reproductive and Maternal and Child Health

Project Plan

November 16, 2017

Setting the course for health equity and disease prevention begins by investing in the health of men, women, babies and young children. In the Olympic Community of Health region, providers and partners share a deep concern for disparities low-income families experience in reproductive health care access and low adherence to recommended well-child care, including immunizations and well-child visits.

The following project proposal for Reproductive, Maternal, and Child Health highlights how providers will integrate the CDC Recommendations for Preconception Health and Health Care as transformational strategies within their clinical workflows, including coordinated referrals with maternal and early child health community programs. This is augmented by purposeful incorporation of strategies to improve well-child visit completion across the three counties. As this work becomes fully realized in the region, we will benefit from marked improvements in reproductive and child health indicators, setting the stage for a healthier community in the future.

Menu of Transformation Projects	
Domain 2: Care Delivery Redesign	
<input type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversions Interventions
Domain 3: Prevention and Health Promotion	
<input type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input checked="" type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input type="checkbox"/>	3D: Chronic Disease Prevention and Control

PROJECT SELECTION AND EXPECTED OUTCOMES

Rationale for Selecting This Project

In the Olympic Community of Health region, there are over 33,000 children receiving Medicaid (Healthier Washington Data Dashboard, accessed October 2017), nearly 15,000 women of reproductive age (HCA AIM RHNI Phase 3, 4.25.2017), and over 1,600 babies born to women receiving Medicaid (DSHS First Steps Database, accessed October 2017). For each of these populations, access to recommended preventive health care services falls short. For this reason, strategies and activities related to reproductive and maternal and child health have been a part of our region's strategic priorities (Table 1) since OCH began three years ago. The goal within this priority is to ensure children get the best start to life and families are supported. OCH's prioritization of this area was informed by four factors: results of community assessments (including the three county public health departments' Community Health Assessments and local hospital Community Health Needs Assessments), stakeholder input on gaps and assets in our region, a health initiatives inventory, and finally, on core data measures. (Figure 1)

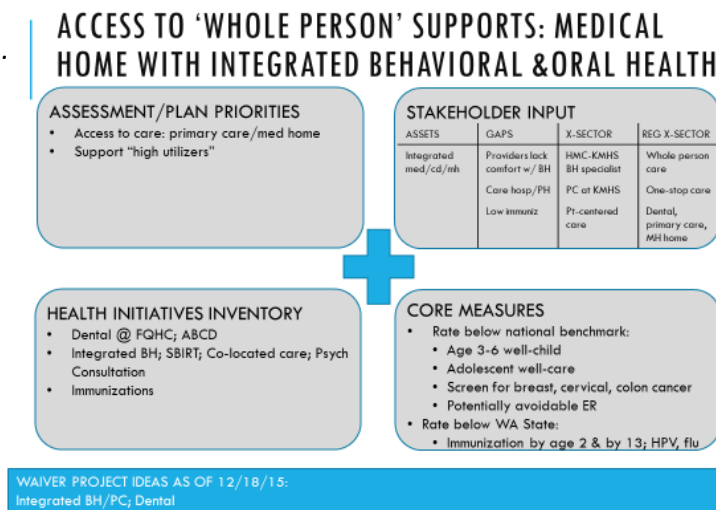
By deploying, *CDC Preconception Health and Health Care*, an evidence-based program, OCH will promote health for women pre/peri/post-conception and help create healthy environments where children can thrive and receive the developmental care they need.

Table 1. Olympic Community of Health regional health priorities and strategies

ACCESS	AGING	BEHAVIORAL HEALTH	CHRONIC DISEASE	EARLY CHILDHOOD
A continuum of physical, behavioral, and oral health care services is accessible to people of all ages and care is coordinated across providers.	Aging adults and their caregivers are safe and supported.	Individuals with behavioral health conditions receive integrated care in the best setting for recovery.	The burden of chronic diseases is dramatically reduced through prevention and disease management.	<u>Children get the best start to lifelong health and their families are supported.</u>
Progress on these priorities depends on improving <u>health equity</u> through SOCIAL DETERMINANTS – housing, education, workforce development, employment, transportation, safety, environmental conditions.				

This project promotes OCH's value of health equity and access to care for all. Change plans include a commitment to partner with community-based organizations whose services address the social determinants of health and prevention, including issues such as housing, employment, health care utilization, access to healthy foods, and health education. To promote further health equity within this strategy, OCH will focus training efforts on counseling patients on contraceptives that are best for them and ensuring that a full range of contraceptives are available to patients, so they can have quicker access to the contraceptive that they choose. Where needed, providers will be trained in trauma-informed practice as part of the OCH's commitment to addressing the social determinants of health. Figure 1 highlights the placing of child health and reproductive health as an important component of whole person supports, where medical, behavioral, and oral health are integrated to promote wellness.

Figure 1.



Our regional data related to this project's outcome metrics further justifies the need to employ project interventions. Reproductive health indicators (Figure 2 and Table 2) include chlamydia screening, access to long-acting reversible contraception (LARC), and early prenatal care rates – all lower than the state average. Note that while LARC is no longer a pay-for-performance metric, it is one of several types of contraception that feeds into two of the pay-for-performance metrics related to this project and is therefore included and tracked. Data on the other types of contraception, such as oral contraceptives, are not available.

To address these gaps, OCH will focus on the CDC Preconception Health and Health Care checklist.

Figure 2

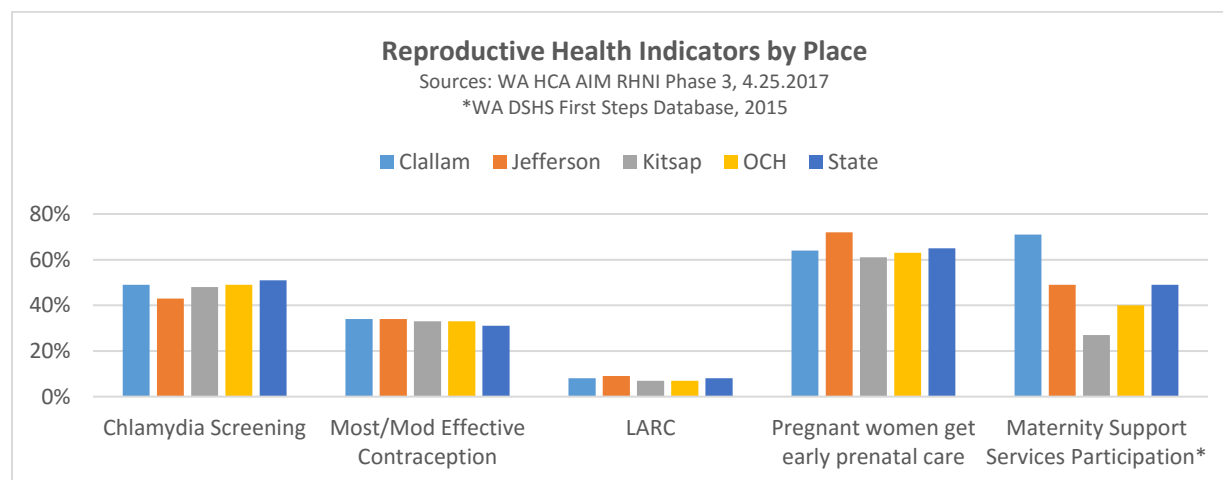
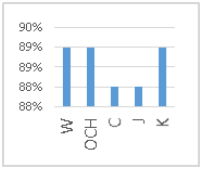
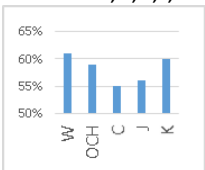
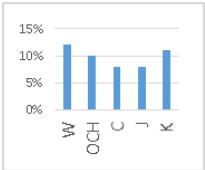


Table 2. Reproductive Health Indicator Disparities

Indicator	Geographic Disparity	Sub-population Disparity
Chlamydia Screening	All counties below WA; Jefferson 5-6% below Clallam& Kitsap	No data
Most/Moderately Effective Contraception	All counties slightly above state average; for post-partum women, region is below state average	Post-partum women below state average: W: 41%; R: 37%; C: 39%; J 40%; K 36%
Long-Acting Reversible Contraceptive (LARC)	Kitsap (and regional average) slightly below state average; for post-partum women, region is below state average	Post-partum women, regional average and Clallam and Kitsap below state average: W: 16%, R: 9%, C: 9%, J: 16%, K: 9%
Pregnant women get early prenatal care	Region average below WA; Kitsap lowest	No data
Maternity Support Services Participation rate	Kitsap 44% lower than Clallam and 22% lower than Jefferson and WA	No data
Note: W- Washington State, R- OCH Region, C- Clallam County, J- Jefferson County, L- Kitsap County		

Child health indicator regional data (Table 3) indicates that while nearly 9 in 10 children access primary care, only 6 in 10 children 3 to 6 years of age receive regular well-child checks. Once in the clinic, children receive the indicated care and screenings as part of the well-child check. This project will address low rates of completion of well-child visits.

<i>Table 3. Child Health Indicators</i>				
Indicator	Rates	Rates by place	Geographic Disparity	Sub-population Disparity
Children access primary care (all ages)	W: 89% R: 89% C: 88% J: 88% K: 89%	% bars: W,R,C,J,K 	None	Range across race groups: 86-91%; Range by age group: 12-24 months= 94% 25 mths-6 years: 86% age 7-11= 91% age 12-19= 90%
Well Child Visits age 3-6	W: 61% R: 59% C: 55% J: 56% K: 60%	% bars: W,R,C,J,K 	Clallam and Jefferson rates below Kitsap and WA average	Range across race groups 49-62% Rates vary greatly: One Kitsap FQHC reports 75% within one MCO; 981 well child visits in August 2017 alone
Child Combo 10 Immunizations	W: 12%; R: 10%; C: 8%; J: 8%; K: 11%	% bars: W,R,C,J,K 	All counties below WA; Clallam and Jefferson lowest	No data

Note: W- Washington State, R- OCH Region, C- Clallam County, J- Jefferson County, L- Kitsap County

Coordination with Existing Efforts

While developing their shared change plan, each Natural Community of Care (NCC) will ensure that the transformational activities fit within the existing services in the local community. Please refer to the Theory of Action section for details on this process. In short, the shared change plan will align each organization's change plan within a shared set of strategies for the NCC region.

For this project, OCH will coordinate with Kitsap Strong, a community initiative to improve the health and well-being of all children, families, and adults in Kitsap, to provide education and training in NEAR sciences (Neuroscience, Epigenetics, ACEs and Resilience) and trauma-informed practices to partnering provider organizations.

During the development of change plans, OCH will update the Regional Health Inventory, an inventory of current health improvement transformation activities. OCH will perform a baseline self-assessment of each partnering provider and affiliate partners, building off the regional inventory of initiatives last updated in March 2017, for a comprehensive list of all current and planned health improvement activities. OCH will ask providers to describe how the DSRIP transformational activities will expand upon, enhance, or complement existing delivery system transformation activities. OCH will also assess gaps in community-clinical linkages at baseline, ensuring that change plans leverage rather than duplicate

existing community efforts relevant to the success of the project.

As part of the change plan and contractual process, OCH will require an attestation from each organization that if they are funded by the U.S. Department of Health and Human Services that the federally-funded activities are not duplicative of the transformational activities proposed in the change plan.

Project Scope: Target Population, Partnering Providers, Level of Impact, And Health Equity

For details on the anticipated target population, subpopulations, and disparities for each strategy, please refer to Table 4.

Scope of project

The primary goal of this project is to improve the reproductive health of women, men, and couples, with a focus on the period before conception and between conception. The secondary goal is to increase awareness of the need for well-child checks, improve the referral processes into providers for these visits, and create provider learning collaboratives to enhance trauma-informed care and patient outreach and engagement. While this project is targeted at the Medicaid population, clinic redesign, workforce development, and outreach and engagement will spill over into all populations served by partnering providers.

The primary expected outcomes for this project are improved access to sexual and reproductive health care, resulting in enhanced access to contraception, sexually transmitted infection screening and treatment, and prenatal care, postnatal care, perinatal mental health treatment and supports, addiction treatment for pregnant women, and positive birth outcomes for mom and baby. The secondary expected outcomes are increased rates of well-child visits, which will result in increases in childhood immunizations, chronic disease education and management.

This project will employ two evidence-based strategies:

1. CDC Recommendation for Preconception Health and Health Care

- Individual Responsibility Across the Life Span: Each woman, man, and couple should be encouraged to have a reproductive life plan.
- Consumer Awareness: Increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts.
- Preventive Visits: As a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risk and improve pregnancy outcomes.
- Interventions for Identified Risks: Increase the proportion of women who receive interventions as follow up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact).
- Interconception Care: Use the interconception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (e.g., infant death, fetal loss, birth defects, low birthweight or preterm birth).
- Pre-Pregnancy Check-Ups: Offer, as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy.

- Health Insurance Coverage for Women with Low Incomes: Increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and preconception and interconception care.
 - Public Health Programs and Strategies: Integrate components of preconception health into existing local public health and related programs, including emphasis on interconception interventions for women with previous adverse outcomes.
 - Research: Increase the evidence base and promote the use of evidence to improve preconception health.
 - Monitoring improvements: Maximize public health surveillance and related research mechanisms to monitor preconception health
2. Coordinated, targeted outreach and engagement to increase well-child visits
Evidence for this program is provided by Peninsula Community Health Services. This strategy increases awareness of the need for well-child checks, improves referral processes into providers for visits, and creates provider learning collaboratives to increase well-child visits. Several evidence-based tactics include:
- Coordinate outreach with MCOs through direct mail, email, phone campaigns, and texts
 - Increase marketing and uptake of a patient portal; patient scheduling through portal
 - Deploy community health workers to contact patients to schedule visits
 - System wide, targeted outreach and engagement to coincide with school year milestones, such as matriculation and school athletics
 - Population health management systems track well-child visits
 - Table at school health/wellness fairs
 - Coordinate mobile clinic scheduling days with schools
 - Leverage veterans and therapeutic drug court to schedule well-child visits
 - Strengthen clinical-community linkages with schools, especially Head Start program

Level of impact and target population

The target population for this project was selected based on the greatest potential level of impact and need in the community. The region's Medicaid population has low participation essential wellness services such as early prenatal services, maternity support services, STI prevention, contraceptive care, and well-child visits. The target population includes women and men of reproductive age and their partners, all sexually active men and women, all pregnant women, all women following labor and delivery, all men and women during assessment visit, and children 0 to 6 years old and their parents or caregivers. The targeted subpopulation includes women and men classified as high-risk through provider intake and assessment and children attributed to a provider organization who have not had a well-child check.

At full capacity, an estimated 28,000 Medicaid beneficiaries (34% of total Medicaid population) will be reached by the two evidence-based strategies proposed above.

Health equity

As mentioned above, this project promotes health equity and access to care for all. Pregnant women on Medicaid are more likely to have financial barriers to receiving quality, person-centered care as compared to women on commercial insurance. Furthermore, there is little access to affordable sexual and reproductive health care for low income men and women, particularly in the rural, geographically isolated subareas of the region. The rate of well-child visits varies by 27%, between 49%-62%, across race groups. This is an indication of major barriers to access for certain subpopulations.

Implementation partners critical to success

The following partners are critical for this project to be successful: primary care, sexual and reproductive health providers, pediatrics, and tribal clinics. This project also requires strong community-based partners to serve as referral centers, such as public health, schools, community action agencies, and community organizations that serve low income families. These partners also offer critical programs that strengthen family stability – including programs like Nurse Family Partnership, Parents as Teachers, Early Head Start, Head Start, housing placement, and connection with social services. The final partner list for this and all projects will be formalized prior to submission of the implementation plan.

Lasting impacts

The proposed strategies integrate new models of delivering care that will extend beyond Medicaid and the Transformation and will address the needs of the people in our communities.

- *Infrastructure and capacity building investments*

The project supports sustainable health system transformation through investments in infrastructure, data systems, population health-based approaches, and workforce that will lead to successful value-based payment contracting for Medicaid providers beyond the Transformation. Upfront investments support provider organizations to train workforce to provide different types of contraception, including LARC, and offer trauma-informed care to their patients. Investments also support population health IT capacity to identify high-risk patients in need of these services and track them over time, and offer training for decision support teams to assist providers in population health management.

- *Leveraging Natural Communities of Care for collective impact*

OCH will convene partnering providers within a Natural Community of Care to align strategies into a single shared change plan. Reproductive and maternal and child health strategies will be incorporated into change plans as transformation activities, and will be mutually supportive of the shared change plan. OCH will facilitate and incent collaborative arrangements between providers within the Natural Community of Care, such as data-sharing agreements (DSA) and business associate agreements (BAA). Of vital importance for the success of this project is establishing a strong referral base from community-based organizations into primary care and pediatrics for well-child visits. Once these referral pathways are established and supported with BAAs and DSAs, they will continue beyond the life of the Transformation. Equally important will be systematic referral of patients to community programs that support the outcomes of this project, including Nurse Family Partnership, Early Head Start, Head Start, and Parents as Teachers.

- *Value-based contracting*

Well-child visit benchmarks are in value-based contracts between MCOs and providers, a pass through from the contract between MCOs and HCA. There is a shared interest between OCH, MCOs, and HCA to move this metric. MCOs will be collaborators in the development of all shared change plans and will continue to work with partnering provider organizations as part of the provider-payer contracting process. By including MCOs in the development process, MCOs can ensure that shared change plans are mutually supportive of the metrics in their value-based contracts. Over the Transformation, provider organizations may use their upfront DSRIP incentive payments (see Funds Flow section) to deploy change management teams to oversee rapid-cycle testing feedback loops to refine diversion strategies until they are able to achieve

their targeted benchmarks in their value-based payment contracts. Additionally, OCH will oversee deployment of technical assistance from MCOs to provider organizations to assist in mutually reinforcing strategies such as risk stratification, patient outreach, care coordination, and population health management.

OCH will support Tribes preference for tribal encounter rates, MCO incentives, reduced administrative burden and will advocate that Tribes be held harmless under new contracting mechanisms. OCH will encourage knowledge transfers between non-tribal and tribal provider organizations to share perspectives on MCOs as contracting partners.

3B. Reproductive Maternal and Child Health Project Plan
PROJECT SELECTION AND EXPECTED OUTCOMES

Olympic Community of Health

Table 4. Reproductive, Maternal, and Child Health: Strategies, Projected Outcomes, and Population Served

Strategies	Intermediary Milestone or Metric (toward desired outcome)	Pay for Reporting Metrics and Milestones	Payment for Performance Metrics	Evidence Base	Natural Community of Care	Target Population	Targeted Subpopulation	Estimated # Targeted per Year at Max. Capacity	Disparities
10 preconception health and health care recommendations to improve the health of women, men, and couples, before conception of a first or subsequent pregnancy	<p>Natural Community of Care Collaborative Agreement in place</p> <p>Natural Community of Care shared change plan</p> <p>Partnering provider organization change plan</p> <p>Contract in place with OCH</p> <p>Monthly reports sent to OCH</p> <p>Proxy measures under development; will be selected to predict P4P metrics and/or desired outcomes from QIP; will be included in contracts and reported by partners</p>	<p>Report against QIP metrics</p> <p>Number of partners trained by selected model / approach: projected vs. actual and cumulative</p> <p>Number of partners participating and number implementing each selected model / approach</p>	<p>Mental Health & Substance Use Treatment Penetration</p> <p>Childhood Immunization Status</p> <p>Contraceptive Care – Postpartum</p> <p>Chlamydia Screening in Women Ages 16 to 24</p> <p>Outpatient ED Visits</p> <p>Contraceptive Care – Most & Moderately Effective Methods</p> <p>Prenatal care in the first trimester of pregnancy</p> <p>Well-Child Visits in the First 15 Months of Life</p>	CDC Pre-conception Health and Health Care	Clallam Jefferson Kitsap	<p>Women and men of reproductive age and their partners</p> <p>All sexually active men and women</p> <p>All pregnant women</p> <p>All women following labor and delivery</p> <p>All men and women during assessment visit</p>	Women and men classified as high-risk through provider intake and assessment.	<p>15,000 women</p> <p>5,000 men</p> <p>1,500 pregnant women</p>	<p>Pregnant women who are Medicaid beneficiaries are more likely to have financial barriers to receiving quality, person-centered care as compared to women on commercial insurance.</p> <p>There is little access to affordable sexual and reproductive health care for low income men and women, particularly in the rural, geographically isolated subareas of the region.</p>

3B. Reproductive Maternal and Child Health Project Plan
PROJECT SELECTION AND EXPECTED OUTCOMES

Olympic Community of Health

Federally qualified health center collaborates with Medicaid Managed Care Organizations to perform targeted outreach and engagement to shared Medicaid clients receive well-child checks.			Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life Well-Child Visits in the First 15 Months of Life	Peninsula Community Health Services well-child visit incentive program		Children ages 0 to 6 years and parents/caregivers	Children attributed to a provider organization who have not come in for a well-child visit.	1,500 babies 5,000 children	The rate of well-child visits varies by 27%, between 49%-62%, across race groups. This is an indication of major barriers to access for certain subpopulations.
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IMPLEMENTATION APPROACH AND TIMING

Please refer to OCH Supplemental Workbook: 3B. Implementation Approach

The worksheet did not allow a way to address anticipated barriers to deploying resources to partnering providers, and OCH tactics for addressing each of them. These challenges and tactics are presented in Table 5 below. Notably, many listed barriers below impact more than one project area and will therefore be addressed systematically across the MTP portfolio.

Table 5. Challenges to deploying resources and tactics to address them

Barriers or challenges to deploying resources to implementation partners	OCH tactics for addressing barriers or challenges
Timely paying of providers	Engage with financial personnel with each partnering provider organization to explain contracting and cash flow
Insufficient IT systems to allow for population health management	Baseline assessment includes IT assessment; OCH assist in upfront infrastructure/IT investments; put data sharing agreements in place between OCH and partnering providers
Insufficient fiscal resources to support staffing and transformation needs	OCH help identify opportunities for sharing workforce and best practices across practices; encourage matching funds from partnering providers
Provider cannot recruit or retain the workforce to meet implementation demands	Build in contingency plans and incentives into contracts; develop regional strategies for workforce recruitment

PARTNERING PROVIDERS

Assurance of Serving the Medicaid Population

Please refer to OCH Supplemental Workbook: 3B Partnering Providers. The list of partnering providers in the workbook is an initial list of clinical and non-clinical partnering providers that have expressed interest in supporting the development and implementation of the reproductive, maternal and child health project.

For this project to be successful, primary care, sexual and reproductive health providers, pediatrics, and tribal clinics. This project also requires strong community-based partners to serve as referral centers, such as public health, schools, community action agencies, and community organizations that serve low income families. Based on a Number Needed to Treat analysis (see Theory of Action Section), OCH providers need to perform an additional 285 chlamydia screenings and provide access to effective contraception to an additional 273 women to achieve a 2% improvement in these pay-for-performance measures. This is within reach because, at full capacity, an estimated 28,000 Medicaid beneficiaries (34% of total Medicaid population) will be reached by the two evidence-based strategies proposed above.

OCH will reach out to providers who currently serve a significant number of Medicaid lives, and all Tribes, to participate in the change plan development process. Though American Indians and Alaskan Natives make up just 2% of the OCH's population (Washington Dept. of Health, CHAT, accessed October 2017), they comprise 6% of the OCH's Medicaid population (Healthier Washington Data Dashboard, accessed October 2017). Disproportionate representation of minority populations such as this highlight the considerable health and income disparities in these communities.

Transformation work is not easy. There is considerable risk and effort on the part of the providers. Therefore, participating provider organizations are those with leadership and financial buy-in and those that commit to completing and following a change plan, sending regular data reports to OCH, performing continuous quality improvement cycles, and driving towards long term, sustainable transformation. OCH will work with Tribes to agree on a data sharing agreement on a case-by-case basis that acknowledges tribal sovereignty and protects tribal data.

MCOs will collaborate in the development of the shared change plan and will continue to work with partnering provider organizations as part of the provider-payer contracting process. By including MCOs in the development process, MCOs can ensure that shared change plans are mutually supportive of the metrics in their value-based contract. MCOs will also be able to provide technical assistance to provider organizations to help prepare them for value-based contracting and to bill for new MCO benefits, such as the new jail population benefit. MCOs can help with outreach efforts to improve well-child visit rates.

REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS

REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS**Assets**

For this project to be successful, organizations that provide reproductive, maternal, and child health services for the Medicaid population must leverage existing assets to provide enhanced access points for their patients. Collaboration between clinical and community providers to increase the number of well-child visits is also vital.

Tables 6 through 9 in the Regional Health Needs Inventory Section list assets related to health care providers, social service providers and payers by service area; and number of beneficiaries served and number of claims by each major Medicaid provider, stratified by age and care setting (institutional or professional). OCH will be doing a deeper dive during the baseline assessment in DY1 Q4 and DY2 Q1.

The list of partnering providers is still under development; the final list will be developed within each Natural Community of Care. Of note, tribal clinics are key partners and will be invited to engage in the change plan process within the Natural Communities of Care. Two Tribes have indicated a willingness to partner in this project area. The strong working relationships between partnering organizations and precedence for regional partnerships is a tremendous asset for this project.

As part of the regional Olympic-Kitsap Early Learning Coalition, Kitsap Public Health District, Jefferson Public Health Department, Nurse-Family Partners Community Advisory Board, Port Gamble S'Klallam Tribe, Kitsap Community Resources, and First Step have strong existing relationships and are active partners in exploring ways to streamline referrals from the clinical setting into existing evidence-based practices such as Early Head Start, Nurse Family Partnership, Parents as Teachers. MTP provides the perfect opportunity to formalize these referral patterns and convene partnering providers within each NCC to work through potential barriers to community-based services and supports.

Peninsula Community Health Services, in collaboration with MCOs, have employed innovative outreach strategies resulting in improvements to well-child visit completion. OCH will leverage the lessons learned from their success to inform strategies that other providers may choose to include in their change plans. Kitsap Strong, an existing community initiative aimed at improving the health and well-being of all children, families, and adults in Kitsap, is a strong existing asset for this project. OCH has entered discussions with Kitsap Strong to provide the following supports to the region:

1. Assessment to determine the need for NEAR sciences (Neuroscience, Epigenetics, ACEs and Resilience) and trauma-informed care training to partnering provider organizations
2. NEAR Training throughout region; tailoring training for specific health care sectors
3. Trauma Informed Care Training - potentially creating certified trainers throughout region to support sustainability and ongoing work with health professionals/clinics
4. Community of practice development, dependent upon interest from health partners - Kitsap Strong staff will organize, coordinate, & facilitate a community of practice across region or within each county, to develop a strong network of support and create a "brave space" for providers to be vulnerable and honest about successes and challenges in providing trauma-informed care

3B. Reproductive Maternal and Child Health Project Plan

Olympic Community of Health

REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS

OCH manages a growing list of local health initiatives called the Regional Health Inventory. The table below shows multiple existing assets, in the form of programs, projects, training, and initiatives. Through the shared change plan and change plan process, OCH will facilitate clinical-community linkages to these programs:

Table 7

County (ies)	Tribal Nation (s)	Initiative Name	Brief Description including patient population	Target Population	Goal	Lead Org
Kitsap		Family Medicine Residency	Residency will train 8 Drs per year (24 residents total) & serve vulnerable populations	vulnerable populations, esp. in Bremerton	increase access to primary care, obgyn, medication-assisted treatment for addiction	CHI Harrison Hospital
Jefferson		Increase immunization	CHIP priority implementation - JCPH & JHC partnership	Children	Increase immunization rates & on-time rates	Jefferson Public Health
Clallam		Immunization clinics		Forks, PA, Sequim		Clallam Health and Human Services
Clallam		Circle of Security Postpartum Depression Groups	group for perinatal depression	All women in Clallam Co	identify & support women experiencing PPD & refer to needed services	First Step
Clallam, Jefferson, Kitsap	Port Gamble S'Klallam, Lower Elwha S'Klallam	Maternity Support Services, Infant Case Management	Services for pregnant women & early postpartum (RN, RD, BHW, CHN) case management for high risk families 2m to 1 yr	low income 200% poverty families on Medicaid who are pregnant or have a child under 1 year	Health pregnancy, Healthy birth, Health child, maternal mental health, infant mental health	First Steps FSC, Kitsap Public Health, Jefferson Health Dept, Lower Elwha Port Gamble Tribe
Kitsap	Port Gamble S'Klallam	Home Visitation	ages 2-5 home visits connection to resources, parenting	parents of children ages 2-5 yrs	increase parenting skills & support	Port Gamble S'Klallam Tribe
Clallam, Kitsap	serves tribal clients from multiple tribes on Olympic Peninsula	Parent Child Assistance Program (PCAP)	Program works with pregnant & parenting women with addiction issues	women either pregnant or with child under 3 who has addiction issues (current)	help mothers get clean & sober & stay clean & sober, help rebuild structures in their lives, reduce subsequent pregnancies where child is impacted by prenatal substance abuse	First Step FSC - Clallam, Agape - Kitsap
Clallam, Jefferson, Kitsap	Yes	Women, Infants, Children (WIC)	low-income pregnant and post-partum women and their children			Clallam: CCHHS; Jefferson: JCPH; Kitsap: KCR
Jefferson		School based health clinics	Reproductive health services, Mental Health & Substance abuse disorder	Medicaid eligible children and families (if eligible)	Improved health, reproductive exams and education, etc. Reduced anxiety, alcohol and drug assessments	Jefferson Co. Public Health
Jefferson/Kitsap	Port Gamble S'Klallam Tribe	Nurse Family Partnership	Nurse home visits for 1st time parents/low income pregnant women for child's 1st year of life	Low income first time pregnant women	Healthy pregnancy, improved child health and development, increased self sufficiency	Jefferson Co Public Health
Kitsap, Clallam		Prenatal Care Assistance Programs	Serves mothers who use alcohol and other substances during pregnancy with intensive case management and home/community based services	Low income mothers with an addiction disorder	reduce incidence of substance use in subsequent pregnancies, increase mothers length of sobriety	University of WA- Fetal alcohol and drug unit
Clallam		Olympic Peninsula Healthy Community Coalition	Implement policy and environmental change around healthy eating and active living	Preschool through seniors	Initiate community-based policies that help in decreasing and/or preventing chronic disease in our county	Olympic Peninsula Healthy Community Coalition

REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS

Challenges

Below are several challenges to improving outcomes and lowering costs for the target populations through this project and an early assessment of ways to mitigate issues that may arise. Success in addressing these challenges requires continuous performance monitoring and application of plan-do-study-act techniques to resolve them.

Table 8. Challenge to improving outcomes and strategies to mitigate risks

Challenge or barrier to improving outcomes and lowering costs for the target populations through this project	OCH strategy for mitigating the identified risks and overcoming barriers
Primary care integration creates untenable new work flows for medical providers	Revise internal work flows to eliminate steps causing excessive strain on work flows; train in how to maximize reproductive, maternal, and child health billing opportunities (e.g., enhanced reimbursement for LARC)
Insufficient community-based resources to manage referrals from primary care for mothers who qualify for community programs	OCH will convene Natural Community of Care providers to facilitate work arounds and identify opportunities to leverage resources to expand existing programs and coalitions
Change management	Deployment of a change manager workforce; support of internal QI teams; support from provider organization's leadership
Unable to sustain new workflows	Train providers in LARC insertion and trauma-informed care; integrate population health management tools into workflows; invest in population health management IT infrastructure; track progress on moving VBP metrics related to reproductive, maternal, and child health project in VBP contracts
Fragmented clinic-to-community referral systems for local MCH programs	Work with existing coalitions and partners to develop agreed upon guidelines for referral of patients to supportive preconception, interconception, pregnancy and child health programs
Failure to hit well-child visits metric, which is central to sustainability through value-based contracting	Enhance strategies to increase well-child visits, leverage other Projects, such as Diversion and Oral Health, and partnerships with community-based service providers to increase referrals providers accepting new appointments for well-child visits.

MONITORING AND CONTINUOUS IMPROVEMENT

Monitoring Project Implementation

OCH will ensure timely and effective implementation through detailed planning, formation of Natural Community of Care (NCC) collaborative agreements, NCC steering committees, comprehensive baseline assessments and change plans. Change plans will outline a sequential, stepwise process, co-designed with the provider organization(s), to implement transformational activities.

In 2018, the biggest risk to implementation will be providers failing to meet reporting requirements. OCH will mitigate this risk by precisely noting reporting requirements in provider change plans, which will be developed in early 2018. We will also provide outreach and training on OCH's monitoring system (described below). Trainings will be in person and virtual, with materials specific to each project, and presentation on best practices for specific project measures. To the extent possible, OCH requirements for provider reporting will align with existing reporting requirements (e.g., HEDIS, Alternative Payment 4, and Apple Health Contracts). This will be a joint initiative with MCOs, strategically positioning providers to achieve VBP contract benchmarks.

Funding will flow to providers and affiliate partners upon completion of set milestones, as outlined in change plans. There will be fiscal consequences for lack of progress, as revealed by process and outcome measures. This will all be detailed in provider contracts.

Delays in implementation will be addressed by change managers, either employed by the provider organization or OCH. Change managers will identify cross-cutting implementation barriers among partnering provider organizations. In turn, they will not only make recommendations to address those barriers, but will also revise change plans appropriately.

Monitoring Continuous Improvement

OCH projects share common elements for monitoring and continuous improvement. To track progress, OCH will rely on a host of measures categorized (at its highest level) as follows: process measures, milestones and outcome measures. The latter two categories will include all toolkit required measures for determining project incentive payments. The first category (process measures), although not specified in the toolkit, is critical to ensuring OCH and partner organizations adopt best-practices both for projects and for Domain 1 activities. For the most part, the process measures will serve as real-time indicators.

OCH is planning to build a technology platform that can systematically manage all three categories of measures. The platform will also have enough descriptive context to guide partners and providers in the provision of information to send to OCH. The information coming from providers will primarily fall into our first two categories: process measures and milestones. Outcomes measures will be captured chiefly from existing reporting systems (e.g. Healthier Washington Dashboard, HCA-AIM reports, Washington Health Alliance Reports, DSHS reports, RDA reports, WSHA reports and others). The OCH platform will avoid the inefficiency and inaccuracy inherent in having providers entering data in multiple templates. OCH intends to use the platform for data aggregation and formatting to streamline the population of HCA required templates.

OCH's process measures are the lynchpin to ensuring OCH providers are on track to make the necessary progress expected under the Transformation. Simply put, outcome measures are too lagged and provide no insight into whether foundational operational front-line changes have been undertaken. Milestone reporting, while providing a real-time sense of overall organizational change, still does not furnish a

front-line view of how patient engagement may have changed.

OCH does not anticipate much resistance from partnering providers in providing requested information for tracking purposes. During OCH's letter-of-intent process (March to April 2016), when asked, "*Are you willing to provide project-specific data to OCH for tracking purposes?*", all partnering organizations agreed to send data to OCH for tracking purposes.

Identifying what is not working

OCH will form a steering committee for each NCC. The role of the committee is to oversee the work of the shared change plan, identify barriers, and collaboratively design solutions across sectors and Tribes. OCH staff will share learnings across NCCs, deploying technical assistance where appropriate. OCH will also deploy provider surveys, creating an anonymous vehicle for providers to provide feedback to the OCH.

OCH will hire a Compliance and Contract Coordinator to oversee change plan compliance, conduct site visits, perform annual audits. OCH will form a Compliance Committee to oversee this effort. Partners will receive additional support through a change manager, who will offer regular progress check-ins with participants within each NCC. The OCH Board will approve a mediation plan structure and grievance procedure to provide necessary processes for under-performance and non-compliance.

The Performance Measurement and Evaluation Committee (PMEC) designs and reviews data submissions, interprets trends, and elevates red flags to the Board. The PMEC will swiftly identify issues regarding reporting, data quality, or failure to move metrics and offer counter-measure solutions where appropriate.

Each project implementation plan will include a go/no go decision midway through project implementation. If the work to that point has proven constructive with quantifiable evidence that the program will be both successful and sustainable, then the work will continue through the duration of the Transformation. Evidence that the program or elements of the program are not working will trigger a project plan modification request, specific to the root cause of the issue.

Reproductive, Maternal and Child Health project risks

Beyond the risk noted above of partners/providers not being set up to meet reporting requirements, we are mindful of the following specific risks with the Bi-Directional Integration project. We intend to devise focused monitoring mechanisms for these risks. This is only a sample of monitoring initiatives.

- Inadequate increase in well-child visits, one of the key approaches of VBP
- Inadequate increase in outreach and engagement with women of child-bearing age and, thus, not enough adoption of patient reproductive life plans
- Stalled development of patient portals
- Inadequate increase in clinic to community referrals, whereby primary care and pediatric providers can be assured of wrap-around care and services for at-risk patients.
- Inadequate spread of best practices developed by Peninsula Community Health Services for well child visits

PROJECT METRICS AND REPORTING REQUIREMENTS

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
x	

RELATIONSHIPS WITH OTHER INITIATIVES

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
x	

PROJECT SUSTAINABILITY

The reproductive maternal and child health project supports sustainable health system transformation for people on Medicaid through a newly trained workforce, advancement in population health systems, value-based contracts, and new workflows primary care. These transformations will outlive the MTP directly translate into the sustainable transformation components described in Section 1: Required Health Systems and Community Capacity (Domain 1) Focus Areas.

<i>Table 9. Driving towards sustainable capacity, infrastructure, workforce, and transformation strategies</i>	
Reproductive Maternal and Child Health→→→→→	Capacity Infrastructure Strategies
Identify patients at risk of or with diabetes, hypertension, behavioral health issues important to reproductive health	Risk stratification (VBP) (PHS)
To ensure patients receive evidence-based community maternal and child health programs that promote reproductive health and child wellness	Referral Management (VBP)
An analytic tool to facilitate internal evaluation and rapid-cycle testing of interventions	Analytics - Decision support technology (VBP) (PHS)
Reproductive Maternal and Child Health→→→→→	Workforce Strategies
Training internal staff to perform rapid-cycle testing and evaluation	Population Health Analytics (VBP) (PHS)
As needed, train clinical providers and support staff in life course approach to reproductive health; maximizing each patient interaction to promote reproductive wellness	Cross training and redefine role
Hire and train CHWs	New workforce
Up-training for nurses and other clinicians in care coordination	Retraining/Certification/Uptraining
Shared training in NEAR sciences and trauma-informed practices to partnering provider and affiliate organizations	Shared workforce
Reproductive Maternal and Child Health→→→→→	Transformation Strategies
Focus on pre-conception and inter-conception health; access to contraception tailored to the unique needs of each patient	Patient Centered Medical Home (VBP) (PHS)
Focus on intersection of behavioral health and reproductive health	Integrated, whole-person care
Strengthening and standardizing linkages to community programs that help to improve maternal and child health outcomes	Care Coordination incl. Referral Management (VBP) (PHS)
Providers support patients in development of their individualized reproductive life plan	Patient-Centered Interactions/Engagement (VBP)
Enhanced rapid quality improvement processes incorporated within Change Plans	Quality Improvement Strategy/Workflows (VBP)
All levels of leadership take ownership of transformations based on CDC recommendations for pre-conception and inter-conception care	Engaged Leadership
Coordinated patient outreach plans between MCOs, CBOs, and providers to increase completion of well child visits	Patient Outreach (VBP)

VBP: Value-based payment

PHS: Population health systems

Prevention and Whole Person Care

Through this project, partnering providers will institute a comprehensive, whole-person approach to promoting and sustaining health for children, people of child-bearing age and their families. By focusing on implementation across practices for both preconception care and better referrals into well child visits, providers will positively impact populations early on in life or before birth. In addition, this approach promotes the linkage of health care and community based organizations, which will leave a sustaining impact on the entire region, regardless of coverage or targeted population.

Integration at the provider level of the CDC recommendations will promote sustained positive outcomes for the individual patient because men and women are empowered to take individual responsibility for planning of their reproductive health across the life course. Normalizing the self-management of reproductive health, with an emphasis on proactivity, will help change norms around seeking of preventive care for men and women throughout their lives. Sustainability at the practice level – whether primary care, Planned Parenthood, or specialty environments – will stem from the incorporation of the CDC recommendations into standard practice, thereby becoming a staple to how men and women of reproductive age receive care.

The CDC recommendations emphasize how important public health and community-based programs which emphasize interconception care, particularly for women with previous adverse outcomes. As providers and public health/community partners systematize bi-directional referrals, patients will receive wrap around care that addressing their whole person health needs as well as socio-economic issues. These referral relationships will help sustain program outcomes beyond the MTP.

Workforce and Population-Based Management

The project supports sustainable health system transformation for people on Medicaid through supporting infrastructure and workforce investments that will lead to successful value-based payment contracting for Medicaid providers beyond the Transformation. Investments will support data systems to identify and manage subpopulations of patients in order to better coordinate their care. For maternal, child, and reproductive health, this includes care coordination software that triggers reminders for STI screening or wellness checks. Workforce strategies, such as training providers to be able to provide the spectrum of contraceptive choices to their patients, will create a newly trained workforce better able to manage their patient population and offer patient-centered care. Over the four years of the Transformation, providers can continually refine processes through rapid cycle testing to hit the targeted benchmarks for VBP incentives.

Managed Care Organizations

MCO participation in developing change plans and participating in implementation of these projects will help clinical and non-clinical providers engage with future value-based contracts that may include reproductive, maternal, and child health-focused projects.

To make this workflow and clinic redesign sustainable, OCH will encourage providers to partner with MCOs on including contraceptive care or reproductive health metrics as part of their VBP contracts. By doing this, providers will be able to receive incentives for improvement in these outcomes. A reduction in births, a possible result of this transformation, would result in a loss in revenue for hospitals. MCOs can provide a gap-fill incentive that would phase down over the course of the Transformation to ease hospitals into reduction of birth-related revenue.

ATTACHMENTS

1. *Required* OCH Supplemental Workbook: Tab 3B Partnering Providers
2. *Required* OCH Supplemental Workbook: Tab 3B Implementation Approach



3C. Access to Oral Health Services

Project Plan

November 16, 2017

Oral disease is a preventable chronic disease plaguing lower income families in the Olympic region, which suffers from the worst access to oral health services in the state - 22% below the state average. The consequences of not addressing the oral health access issue extend beyond physical health and into social justice – it has significant impacts on peoples’ lives. Adults with rampant tooth decay have a harder time finding employment. Children with untreated tooth decay struggle in school. Olympic Community of Health enthusiastically supports this project - to begin to address this critical dental access need in our communities.

The fragmentation of our health care system has been a long-standing barrier to improving health at a patient and a community level, oral health in particular. The Community of Health will begin to overcome that barrier in oral health access, through collaborative planning, innovative partnerships, and ultimately more effective and efficient use of resources. A variety of committed community partners have found common cause in this intractable problem, and the innovative strategies and non-traditional partnerships emerging from this call to action inspires confidence that we are setting our region on the path to improved oral and overall health.

Menu of Transformation Projects	
Domain 2: Care Delivery Redesign	
<input type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversion Interventions
Domain 3: Prevention and Health Promotion	
<input type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input checked="" type="checkbox"/>	3C: Access to Oral Health Services
<input type="checkbox"/>	3D: Chronic Disease Prevention and Control

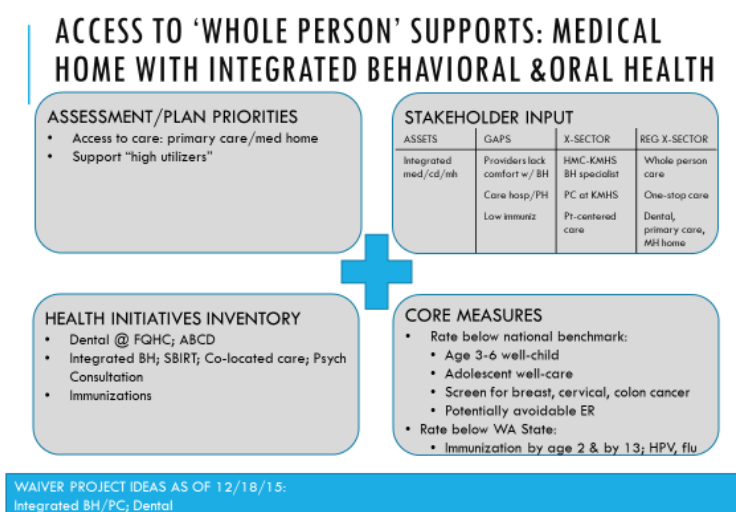
PROJECT SELECTION AND EXPECTED OUTCOMES

Rationale for Selecting This Project

The OCH Regional Health Needs Assessment informed the top five health priorities for the region, with oral health access identified as one of five priority areas. (Table 1) The goal within this priority is to improve access to oral health as a critical component of a continuum of integrated and coordinated care. OCH's prioritization of oral health was informed by four factors: results of community assessments (including the three county public health departments' Community Health Assessments and local hospital Community Health Needs Assessments), stakeholder input on gaps and assets in our region, a health initiatives inventory, and finally, consensus on core data measures. (Figure 1)

Table 1. Olympic Community of Health Regional Health Priorities				
ACCESS	AGING	BEHAVIORAL HEALTH	CHRONIC DISEASE	EARLY CHILDHOOD
A continuum of physical, behavioral, and <u>oral health</u> care services is accessible to people of all ages and care is coordinated across providers.	Aging adults and their caregivers are safe and supported.	Individuals with behavioral health conditions receive integrated care in the best setting for recovery.	The burden of chronic diseases is dramatically reduced through prevention and disease management.	Children get the best start to lifelong health and their families are supported.
Progress on these priorities depends on improving <u>health equity</u> through SOCIAL DETERMINANTS – housing, education, workforce development, employment, transportation, safety, environmental conditions.				

Figure 1



The need for expanded oral health services in the OCH region is compelling. OCH has extremely poor access to oral health services, 22% below statewide averages. Jefferson County has the 3rd lowest all-age use rate (access) among the 39 counties in Washington, Clallam is 6th lowest and Kitsap ranks 28th (Table 2) (*Arcora Foundation, Utilization of Dental Services by Users' Region & Age, 4/5/2017*). Access issues in the region are pervasive across all age groups and counties.

Table 2. Medicaid Dental Services Utilization in OCH Area: 2016

Geographic Area	All Ages Combined			Under Age 20			Age 21+		
	# Eligible	Users	Use Rate	# Eligible	Users	Use Rate	# Eligible	Users	Use Rate
Clallam	25,252	7,333	29.0%	10,500	4,279	40.8%	14,754	3,036	20.6%
Jefferson	9,216	2,154	23.4%	3,113	1,386	44.5%	6,103	768	12.6%
Kitsap	65,378	20,248	31.0%	27,349	12,974	47.4%	38,030	7,274	19.1%
OCH Region	99,846	29,735	29.8%	40,962	18,639	45.5%	58,887	11,078	18.8%
Statewide			38.2%			56.3%			22.1%

(*Arcora Foundation, Utilization of Dental Services by Users' Region & Age, 4/5/2017*)

The root cause of the access problem is a lack of Medicaid provider capacity compared to statewide levels (Table 3). While total providers per Medicaid dental user are 5% below statewide averages, providers per eligible person are 35% lower than the state average. Total provider capacity cannot absorb any increase in demand. Further, FQHC provider capacity is low relative to the State. In Washington, there are 2,974 users per eligible FQHC provider while in the OCH region the comparable figure is 5,547, an 87% difference. Nearly all the FQHC capacity, except for a single provider in Clallam County, is in Kitsap County. The northern part of Kitsap County remains largely underserved. The lack of FQHC capacity reflects the history and geography of the region. While Peninsula Community Health Services (PCHS) has roots dating back to 1987, North Olympic Healthcare Network (NOHN) in Clallam County is a new FQHC (2015) and Jefferson County has no FQHC. The term "user" below means that an eligible Medicaid patient has at least one Medicaid dental claim in the previous year. The term "provider" below means any provider who billed Medicaid in 2016 for a dental claim. The term "other Medicaid providers" refers to any non-FQHC dental provider billing Medicaid. (*Arcora Foundation, Utilization of Dental Services by Users' Region & Age, 4/5/2017*)

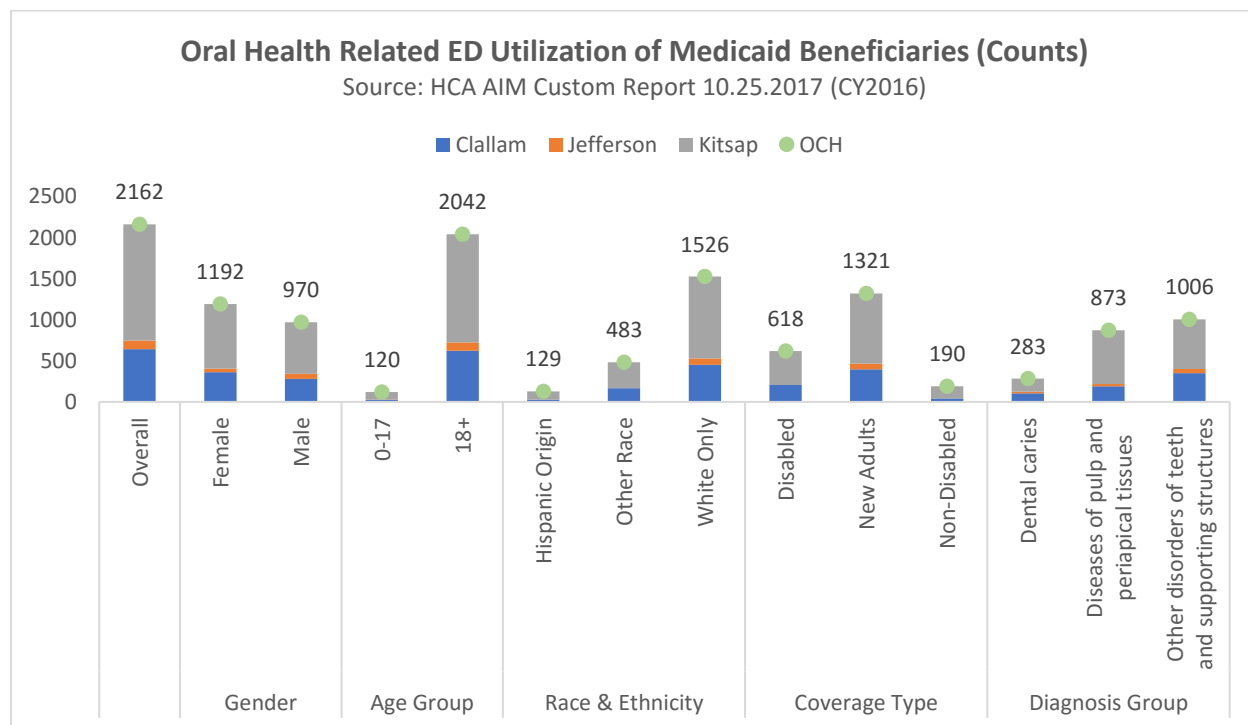
Table 3. OCH Medicaid Dental Provider Supply: 2016

COLUMN	A	B	C	D	E	F	G	H	I	J	J	L
Geographic Area	2016 Population	# Medicaid Eligibles	# Medicaid Users	# Medicaid Providers	# FOHC Medicaid Providers	# Other Medicaid Providers	Medicaid Eligibles per Participating Provider	Medicaid Users per Participating Provider	Medicaid Eligibles per Participating FOHC Provider	Medicaid Users Participating FOHC Provider Per	Medicaid Eligibles per Participating "Other" Provider	Medicaid Users per Participating "Other" Provider
How to use numbers in columns A-F to calculate numbers in G-L:							B/D	C/D	B/E	C/E	B/F	C/F
CLALLAM	73,410	25,252	7,333		1				25,252	7,333		
JEFFERSON	31,090	9,216	2,154		0				NA	NA		
KITSAP	262,590	65,378	20,248		13				5,029	1,558		
OCH REGION	367,090	99,846	29,735	109	18	91	916	273	5,547	1,652	1,097	327
STATEWIDE	7,183,700	2,114,778	807,366	3,108	711	2,397	680	260	2,974	1,136	882	337

(Arcora Foundation, Utilization of Dental Services by Users' Region & Age, 4/5/2017)

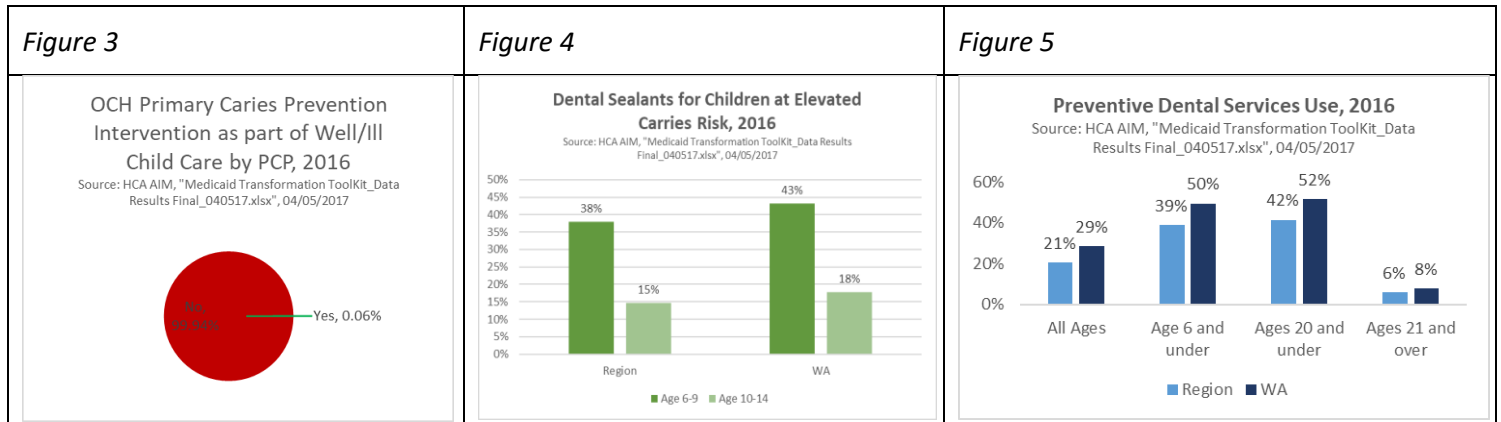
Figure 2 illustrates the number and percentage of emergency department visits related to oral health issues, likely stemming from inability to access care in the appropriate setting due to the inadequate access and capacity described above. The majority of visits are among adults, with over half from the new Medicaid adult population.

Figure 2



The OCH region has a critical opportunity to establish a lifelong trajectory for good oral health among our youngest residents – the most recent data indicate that little or no primary caries prevention interventions are happening (or being billed) as part of primary care visits. (Figure 3) Fewer than 1 in 2 children ages 6-9 and 1 in 5 children ages 10-14 at elevated risk for caries are getting dental sealants.

(Figure 4) The OCH lags the state average in dental services use for all ages with the largest gaps for those under 20. (Figure 5) (WA HCA AIM, "Medicaid Transformation Toolkit Data Results Final_040517.xlsx", 4/05/2017)



Coordination with Existing Efforts

While developing their shared change plan (see Theory of Action and Alignment section), each Natural Community of Care (NCC) will ensure that transformational activities fit within the existing services in the local community. An NCC is a community of resources and providers that serve the same population due to geographical proximity, natural referral patterns, and collaborative service agreements. The shared change plan will align each organization's change plan within a shared set of strategies for the NCC region.

OCH already has a solid understanding of existing efforts to increase access to dental care for the Medicaid population.

- The coordinator for Access Baby to Child Dentistry (ABCD) is in close contact with OCH and has the same regional service area.
- Efforts are underway in all three counties for capital expansion projects, pending state budget approval.
- Partnerships have been formed between federally qualified health clinics (FQHC) and dental residency programs and community behavioral health clinics to increase access points.
- Tribal efforts to train and hire a specialized workforce called dental health aide therapists (DHAT)

OCH is invested in seeing these efforts succeed, as they are foundational to the sustainability of dental services for the Medicaid population in the region. The activities described in this plan will dovetail nicely into these efforts because they consist of a swift increase in capacity (dental van) and clinic redesign (oral health integration in primary care), which are not current initiatives. The coordination of these transformational activities throughout the region will be mutually supportive of existing initiatives, as lessons and resources are shared across providers.

During the change plan process, OCH will ask providers to describe how the Medicaid Transformation Project (MTP) transformational activities will expand upon, enhance, or complement existing delivery system transformation activities. OCH will also assess gaps in community-clinical linkages at baseline, ensuring that change plans leverage rather than duplicate existing community efforts relevant to the success of the project.

As part of the change plan and contractual process, OCH will require an attestation from each organization that if they are funded by the U.S. Department of Health and Human Services that the federally-funded activities are not duplicative of the transformational activities proposed in the change plan.

Project Scope, Partnering Providers, Expected Outcomes, Target Population and Equity

For details on the anticipated project outcomes, target population, subpopulations, and disparities for each strategy, please refer to Table 4.

The primary goal of this project is to increase access to oral health services through primary care and mobile services for the region's Medicaid population. Expected outcomes include increased utilization of dental services by Medicaid beneficiaries, increased periodontal evaluation and ongoing care in adults with chronic periodontitis, increased dental sealants for children, and decreased ED visits attributed to dental issues.

Implementation partners critical to success

Key partners are organizations that have committed to implement the selected strategies (see Partnering Providers section). These partners have been active during project planning and include FQHCs, rural health clinics (RHC), tribal clinics, and public health. Public health is a key partner due to overlapping strategies with school-based clinics and chronic disease planning efforts. Primary care and pediatric practices will also be engaged as either sites for the mobile dental van or to integrate oral health into wellness visits. Arcora Foundation staff have been and will continue to be close partners to help align and strategize OCH efforts with national best practices to ensure long term, sustainable transformation.

Target population and level of impact

The primary target population for these strategies are all Medicaid enrollees who are not currently accessing dental services or who are accessing primary care in an FQHC, RHC, or pediatric setting. Within that overall framework, the following demographics are of strategic interest:

- Persons living in rural areas
- Children needing sealants
- Adults with periodontal disease
- Adult diabetics
- Pregnant women

Oral health access is one issue that impacts all Medicaid adults, regardless of race or income. These target populations identified above represent the most critical needs and where there will be the biggest, long term impact. Notably, while this project is targeted at the Medicaid population, these strategies spill over into all populations served by partnering provider organizations.

OCH selected a mobile dental van as an evidence-based toolkit strategy for this project. This strategy addresses the dispersed nature of the population in which a permanent, capital-intensive dental site may not be financially feasible. Additionally, this strategy reflects the collaborative culture fostered by OCH. The mobile van will also serve to address health equity, as rural residents are extremely underserved for their oral health needs, and these areas also struggle with transportation limitations, food deserts, and a high rate of poverty.

Integrating oral health prevention interventions such as oral exams, oral health education, and fluoride varnish into primary care visits, including well-child visits, and into school-based clinics is a key strategy of this project. This will greatly increase the percent of children and adults who receive caries prevention interventions, sealants, and are referred for restorative dental services. These services will expand as the mobile dental van ramps up capacity. Each county was successful in advocating for an oral health expansion project in the state budget; therefore, capacity will continue to accelerate, and ultimately be sustained upon completion and operationalization of these capital projects.

Given the limited financial resources available to OCH providers for this project category, the set of selected strategies is a starting point towards oral health systems integration and transformation. For the MTP, OCH is prioritizing access over delivery system performance improvement - metrics on which OCH providers are already performing generally above statewide averages.

OCH intentionally selected strategies that are mutually supportive of strategies across all MTP project areas. Specifically, project 3A, the opioid response project, is impacted by dental prescribing practices; project 3D, chronic disease prevention and control, is compounded by prevention and management of oral disease; and project 3B, reproductive, maternal, and child health, will increase well-child visit rates where children will now also receive oral screening, education, and referral to dental care.

If successful, together these strategies have the potential to provide oral health access to 7,000 new Medicaid beneficiaries, bringing the total number of Medicaid beneficiaries with access to dental services to nearly 37,000. This would raise the regional all-age use rate to 37%, a 23% increase by the end of the MTP period, bringing OCH in line with statewide access levels. Based on a Number Needed to Treat analysis (see Theory of Action Section), OCH needs to increase utilization of dental services for 1,997 Medicaid beneficiaries to achieve a 2% “improvement over self” in that measure. This goal is far lower than our estimated target of 7000. At the end of MTP, access will continue to improve with the continued ramp-up of capital expansion projects and a newly trained and deployed workforce.

Equity

Oral health access is one issue that impacts all Medicaid adults, regardless of race or income. The mobile van will increase access for rural, isolated populations, who are burdened with higher rates of poverty, co-occurring diagnoses, and multiple chronic diseases. The van will also offer services to traditionally vulnerable populations: pregnant women, institutionalized elderly, and children. Oral health integration will focus on populations with highest need and potential benefit from oral health access: pregnant women, adults with diabetes, and children.

Lasting impacts

The proposed diversion strategies integrate new models of delivering care that will extend beyond Medicaid and MTP, and will have a lasting impact on the people in our communities.

- *Infrastructure and capacity building investments*

Once built, the infrastructure and capacity remain in place - new fixed capacity in Kitsap and Jefferson as well as mobile capacity for the whole region. Essentially, the selected oral health strategies are front-end investments which can and will be sustained through fees-for-services billing, dental managed care, rural health systems financing, or value-based contracts, once the initial investments are capitalized and operational staff hired and trained. What has been needed in this region to solve oral health access is the MTP and collaborative planning, which has been fostered by OCH with capital provided through outside private and State funding.

- *Leveraging Natural Communities of Care for collective impact*
OCH will convene partnering providers within an NCC to align strategies into a single shared change plan. Oral health access strategies will be incorporated into change plans as transformation activities, and will be mutually supportive of the shared change plan. OCH will facilitate collaborative arrangements between providers within the NCC, such as data-sharing agreements (DSA) and business associate agreements (BAA). For example, a BAA allow referral to the mobile dental van from different agencies and a DSA will be needed to allow the transfer of the clinical record from the dental van back to primary or pediatric care. Once these referral pathways are established and supported with BAAs and DSAs, they will continue beyond the life of the MTP.
- *Value-based contracting*
MCOs will be collaborators in the development of all shared change plans and will continue to work with partnering provider organizations as part of the provider-payer contracting process. By including MCOs, and eventually a dental MCO, in the development process, MCOs can ensure that shared change plans are mutually supportive of the metrics in their value-based contracts. Provider organizations may use DSRIP incentive payments (see Funds Flow section) to deploy change management teams to oversee rapid-cycle testing feedback loops to refine diversion strategies until they are able to achieve their targeted benchmarks in their value-based payment contracts. Additionally, OCH will oversee deployment of technical assistance from MCOs to provider organizations to assist in mutually reinforcing strategies such as risk stratification, care coordination, and population health management.

3C. Access to Oral Health Services Project Plan
PROJECT SELECTION AND EXPECTED OUTCOMES

Olympic Community of Health

Table 4. Access to Oral Health Services: Strategies, Projected Outcomes, and Population Served

Strategies	Intermediary Milestone or Metric	Pay for Reporting Metrics and Milestones	Payment for Performance Metrics	Evidence Base	Natural Community of Care	Target Population	Targeted Subpopulation	Est. # per Year at Max Capacity	Disparities
Mobile Van - Full service van planned including both restorative and preventive dental services	<p>Natural Community of Care Collaborative Agreement in place</p> <p>Natural Community of Care shared change plan</p> <p>Partnering provider organization change plan</p> <p>Contract in place with OCH</p> <p>Monthly reports sent to OCH</p> <p>Purchase and outfit a mobile dental van</p>	<p># of partners / providers implementing the evidence-based approach</p> <p># of partners / providers trained on evidence-based approach: projected vs actual and cumulative</p> <p># of Medicaid beneficiaries served: projected vs actual and cumulative</p> <p>QIP Metrics</p>	<p>Utilization of dental services by Medicaid Beneficiaries</p> <p>Periodontal evaluation in adults with chronic periodontitis</p> <p>Outpatient Emergency Department visits</p> <p>Dental sealants for children at elevated risk</p>	<p>National maternal and child health resource center provides a manual to guide planning and implementation of mobile dental units and portable dental care equipment for school-age children, which could be adapted for adults.</p>	Clallam Jefferson Kitsap	Adults and children on Medicaid without or with limited dental access	Children in school; Elderly in skilled nursing or assisted living facilities; Referrals from primary care providers in the three counties for their patients who do not have access to dental services	1,000	<p>The mobile van will increase access for rural, isolated populations, who are burdened with higher rates of poverty, co-occurring diagnoses, and multiple chronic diseases.</p> <p>The van will also offer services to traditionally vulnerable populations: pregnant women, institutionalized elderly, and children.</p>
Expand use of integration of dental services in medical primary care settings	<p>Proxy measures under development; will be selected to predict P4P metrics and/or desired outcomes from QIP; will be included in contracts and reported by partners</p>		<p>Utilization of dental services by Medicaid Beneficiaries</p> <p>Outpatient Emergency Department visits</p> <p>Dental sealants for children at elevated risk</p> <p>Primary caries prevention intervention as part of well-child visit with PCP</p>	<p>Oral Health in Primary Care: integrating oral health screening, assessment, intervention, and referral, into the primary care setting</p> <p>oral health screening, assessment, intervention, and referral, into the primary care setting.</p>	Clallam Jefferson Kitsap	Adults and children on Medicaid during primary care visit	Patients screened by primary care providers: emphasis on pregnant women, children, and adults on Medicaid	1,000	<p>Integration will focus on populations with highest need and potential benefit from oral health access: pregnant women, adults with diabetes, and children.</p>

3C. Access to Oral Health Services Project Plan
PROJECT SELECTION AND EXPECTED OUTCOMES

Olympic Community of Health

Develop new dental FQHC site in North Kitsap (est. operational date: 2019)			Utilization of dental services by Medicaid Beneficiaries		Kitsap	Adults and children on Medicaid in North Kitsap	Priority populations include patients without dental access	3000 (assumed 2 dentists and 1 RDH)	The two regions identified for capital expansion projects have extremely poor access to dental services, among the lowest in the state. These are rural, isolated settings, with high rates of poverty and poor transportation infrastructure.
Develop new dental RHC site in Jefferson County (est. operational date: 2020)			Periodontal evaluation in adults with chronic periodontitis		Jefferson	Adults and children on Medicaid in Jefferson County	Priority populations include children, pregnant women, and people with diabetes.	1400 (assumed 1 dentist and 1 RDH)	
Support and expand DHAT workforce for tribal clinics			Outpatient Emergency Department visits	Alaska Dental Health Aide Program	Tribes expressing an interest in exploring further:	AI/AN people served by tribal clinics	Same	250	AI/AN born today have a life expectancy that is 4.4 years less than the U.S. all races population (73.7 years to 78.1 years, respectively) and continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases (IHS.gov, April 2017)
			Dental sealants for children at elevated risk						
			Primary caries prevention intervention as part of well-child visit with PCP		Jamestown S'Klallam				
					Lower Elwha Klallam				
					Port Gamble S'Klallam				
Offer preventive dental services to school-based clinics - Begin in Jefferson County (Port Townsend and Chimacum) with potential expansion to Clallam County			Dental sealants for children at elevated risk	SEAL AMERICA: The Prevention Invention, 2016. A manual for provider dental sealants in school-based settings.	Jefferson, possibly scaled to Clallam in later years	Children in school	Same	300 (assumes 1 provider to apply sealants; excludes children served by dental van)	Children living in rural settings are more likely to live in families experiencing lack of transportation, geographic isolation, financial barriers, or poor health literacy.
			Utilization of dental services by Medicaid beneficiaries						

IMPLEMENTATION APPROACH AND TIMING

Please refer to OCH Supplemental Workbook: 2C Implementation Approach

The worksheet did not allow a way to address anticipated barriers to deploying resources to partnering providers, and OCH tactics for addressing each of them. These are presented in Table 5 below. Notably, all listed barriers below impact more than one project area and will therefore be addressed systematically across the MTP portfolio.

Table 5. Challenges to deploying resources and tactics to address them

Barriers or challenges to deploying resources to implementation partners	OCH tactics for addressing barriers or challenges
Timely paying of providers	Engage with financial personnel with each partnering provider organization to explain contracting and cash flow
Report and exchange of data	Put data sharing agreements in place between the OCH and partnering providers
Underestimation of financial costs to the organization	Build contingency plans into contracts
Barriers to hiring workforce in time to start implementation	Build contingency plans into contracts; develop regional strategies for workforce training or sharing
Purchasing and purposing mobile dental van	During shared change plan process, gather commitments from partnering providers to host venues for van; support development of business plan; build in lost revenue into funds flow modeling
DHAT legislation restricts training venue to Alaska and patient population to AI/AN	Collaborate with North Sound ACH, Arcora Foundation, Tribes, and Native Dental Therapy Initiative Project Director Northwest Portland Area Indian Health Board to identify efficiencies in training, leverage funding, and advocate for fewer restrictions

PARTNERING PROVIDERS

Assurance of Serving the Medicaid Population

Please refer to OCH Supplemental Workbook: 3C Partnering Providers. The list of partnering providers in the workbook is an initial list of partnering providers that have expressed interest in supporting the development and implementation of oral health access. OCH will continue to reach out to providers who currently serve a significant number of Medicaid lives, and all Tribes, to participate in the change plan process development. Based on a Number Needed to Treat analysis (see Theory of Action Section), OCH needs to increase utilization of dental services for 1,997 Medicaid beneficiaries in order to achieve a 2% “improvement over self” in that measure. This goal is far lower than our estimated target of 7000.

A large proportion of AI/AN people are on Medicaid, highlighting the considerable health and income disparities in these communities. Currently tribal clinics are listed as partnering providers. OCH will engage with each Tribe individually to determine if a change plan is mutually desirable. For this project, several tribal clinics already implement oral health screenings and education as part of primary care; therefore, OCH may ask these clinics to help share best practices across the region. Tables 6 through 9 in the Regional Health Needs Inventory Section list assets related to health care providers, social service providers and payers by service area; and number of beneficiaries served and number of claims by each major Medicaid provider, stratified by age and care setting (institutional or professional). OCH will be doing a deeper dive during the baseline assessment in DY1 Q4 and DY2 Q1.

Partner Engagement Process

The organizations that expressed an early commitment during the RFA process in April/June 2017 to directly implement the selected strategies include the two FQHCs and the rural health system in Jefferson county. Since then, several major primary care providers in Clallam county have committed to integrating oral health screening and education into their workflows and change plans. Large primary care and pediatric practices have been engaged as either sites for the mobile dental van or to integrate oral health into wellness visits.

Public health and schools are key partners due to overlapping strategies with school-based clinics and chronic disease planning efforts. Area Agencies on Aging will play a role in targeting the mobile dental van to increase access to seniors.

There are three important partners not included Partnering Providers Implementation Tab for this project:

1. Arcora Foundation staff have been and will continue to be close partners to help align and strategize OCH efforts with best practices across the state and country to ensure long term, sustainable transformation.
2. United Way Kitsap County runs Access to Baby and Child Dentistry (ABCD) for the region. OCH plans to partner with the ABCD project coordinator around engagement activities to increase access points for children.
3. Northwest Portland Indian Health Board runs a Native Dental Therapy Initiative Project. OCH has already begun to partner with the project director regarding DHATs.

MCO Expertise

MCOs will collaborate in the development of the shared change plan and will continue to work with partnering provider organizations as part of the provider-payer contracting process. By including MCOs in the development process, MCOs can ensure that shared change plans are mutually supportive of the metrics in their value-based contract. MCOs, particularly the dental MCO if one has been selected, will also be able

to provide technical assistance to provider organizations to help prepare them for value-based contracting and dental managed care; which is gaining momentum and may become a new reality before the end of the MTP.

REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS

REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS

For this project to be successful, organizations that provide or manage primary care and oral health services for the Medicaid population must leverage existing assets to provide enhanced access points for their patients. The strong working relationships between partnering organizations and shared understanding of the oral health access crisis in the region are tremendous assets for this project. Table 7 below summarizes key community sectors and anticipated contributions of each.

Table 7. Community assets

Type of OCH provider or other organization involved with oral health strategies	Assets brought to OCH Oral Health Access Project
<u>Peninsula Community Health Services</u> <ul style="list-style-type: none"> 4 current dental locations 8 dentists & 4 RDHs FQHC status New location planned with 3 providers 	<ul style="list-style-type: none"> Dental management expertise and infrastructure Anticipated new N. Kitsap site Willingness to sponsor dental mobile van Leadership skills & collaborative approach Capital expansion for dental in N Kitsap, \$500,000 Willingness to test dental/primary care integration
<u>Jefferson Health care</u> <ul style="list-style-type: none"> Multiple medical clinics & service lines in Jefferson County 	<ul style="list-style-type: none"> Collaborative approach to other in-county organizations and to other regional providers Willingness to enter dental care realm Capital for new clinic, \$1,000,000 Acquired dental rural health clinic payment rate Explore the option of providing services in school-based clinics
<u>North Olympic Healthcare Network</u> New, large FQHC in Port Angeles	<ul style="list-style-type: none"> Capital for new clinic, \$610,000 Interest in dental access Willing to collaborate as does not have internal dental expertise
<u>Managed Care Plans</u> The region's five health plans as well as Delta Dental may ultimately help to reorganize and better manage results from delivery system There may be a single or multiple dental MCOs within the timeframe of the MTP. If so, they will also be involved.	<ul style="list-style-type: none"> Expertise with and infrastructure to support population health management Incentives to foster medical and dental integration Care management and other infrastructure
<u>Port Gamble S'Klallam Tribe</u> Tribal health clinic in Little Boston, co-located in the norther part of Kitsap County	<ul style="list-style-type: none"> Hiring a DHAT to serve the community Considering training a second DHAT
<u>Philanthropy:</u> Arcora Foundation	<ul style="list-style-type: none"> Expertise Financial resources Staff time to devote to planning Knowledge of innovation across the State
<u>Jamestown S'Klallam Tribe</u> A tribal health clinic in Blyn, WA, service over 10,000 patients each year	<ul style="list-style-type: none"> Planning DHAT capability

REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS

Existing efforts on which this project builds:

- Kitsap County: PCHS has co-located oral health services on the Kitsap Mental Health Services campus, adding a dentist and an RDH. There are plans to open a new location in North Kitsap, adding 7 chairs, 2 dentists and 1 RDH.
- Jefferson County: Jefferson Healthcare, a comprehensive rural health system, is on the cutting edge of finding new ways to deliver oral services to rural communities in the state. Their model co-locates dental services within the rural health clinics (RHC). Legislative authorization for rural health clinic payment rates for dental services as well as capital for the start-up of a dental clinic is secured. This will be the first such RHC in the State and has great promise of serving as a model for other rural areas.
- Clallam County: A firm plan for use of the capacity expansion funding does not yet exist for Clallam. In acknowledgement of the strong need, the FQHC in Clallam County, North Olympic Healthcare Network (NOHN) recently put in place a collaborative arrangement with a local dental clinic, Irwin Dental Clinic. Irwin Dental Clinic has a general resident dentistry program. This program has agreed to take referrals from NOHN Medicaid patients. Over the course of the MTP, through regional convening of partners, OCH will encourage and support collaborative efforts to assist Clallam in their expansion plans, leveraging assets in Kitsap and Jefferson counties.
- Regional: OCH operates within the ancestral lands of seven Tribes. Tribal partners have begun planning for a new type of provider, a DHAT, or Dental Health Aid Therapist, which will expand provider capacity to AI/AN populations. Additionally, a mobile dental van is only sustainable if operated through an FQHC. PCHS has stepped forward to explore this option on behalf of the region, as a stop gap until other expansion activities are completed.

Challenges and strategies to overcome them

Table 8 below identifies several challenges to improving outcomes and lowering costs for the target populations through this project and an early assessment of ways to mitigate issues that may arise. Success in addressing these challenges requires continuous performance monitoring and application of plan-do-study-act techniques to resolve them. Notably, many of the listed barriers below impact more than one project area and will therefore be addressed systematically across the MTP portfolio.

Table 8. Challenges and strategies

Challenge or barrier to improving outcomes and lowering costs for the target populations through this project	OCH strategy for mitigating the identified risks and overcoming barriers
Cannot attract enough new patients to fill the new capacity created by RHCs and FQHCs	Highly unlikely given critical capacity shortage. However, if an issue, outreach and inreach strategies to find and link patients to care will need to be designed and executed
Insufficient funding available through MTP to support new workforce and transformational activities	Ask partnering providers to match or leverage existing resources and seek additional resources
Clinical practice transformation change is time consuming, challenges productivity	Revise internal work flows to eliminate steps causing excessive strain on work flows; train in how to maximize dental billing opportunities; deployment of a change manager workforce; support of internal QI teams; support from provider organization's leadership; Qualis, TCPI, AIMS and OCH

REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS

	facilitated technical assistance to support practice consultation for quality improvements
Failure to hit measure related to unnecessary ED utilization metric	Create a more explicit connection between community health workers in ED (see Diversion Project Plan), and/or IT e-referral system (see Domain 1) to connect patients in the ED for a dental reason with a dental site accepting referrals
Mobile Van does not attract enough patients to be financially viable	(1) Add new sites and adjust scheduling (2) Add outreach activities to add patients (3) Add connector activities to assure patients make appointments
Mobile Van is too costly to operate relative to service volumes using the Van	Adjust service mix to reduce variable cost of operation; seek grants to “retire” any remaining fixed costs in the operating structure.

MONITORING AND CONTINUOUS IMPROVEMENT

Monitoring Project Implementation

OCH will ensure timely and effective implementation through detailed planning, formation of Natural Community of Care (NCC) collaborative agreements, NCC steering committees, comprehensive baseline assessments and change plans. Change plans will outline a sequential, stepwise process, co-designed with the provider organization(s), to implement transformational activities.

In 2018, the biggest risk to implementation will be providers failing to meet reporting requirements. OCH will mitigate this risk by precisely noting reporting requirements in provider change plans, which will be developed in early 2018. We will also provide outreach and training on OCH's monitoring system (described below). Trainings will be in person and virtual, with materials specific to each project, and presentation on best practices for specific project measures. To the extent possible, OCH requirements for provider reporting will align with existing reporting requirements (e.g., HEDIS, Alternative Payment 4, and Apple Health Contracts). This will be a joint initiative with MCOs, strategically positioning providers to achieve VBP contract benchmarks.

Funding will flow to providers and affiliate partners upon completion of set milestones, as outlined in change plans. There will be fiscal consequences for lack of progress, as revealed by process and outcome measures. This will all be detailed in provider contracts.

Delays in implementation will be addressed by change managers, either employed by the provider organization or OCH. Change managers will identify cross-cutting implementation barriers among partnering provider organizations. In turn, they will not only make recommendations to address those barriers, but will also revise change plans appropriately.

Monitoring Continuous Improvement

OCH projects share common elements for monitoring and continuous improvement. To track progress, OCH will rely on a host of measures categorized (at its highest level) as follows: process measures, milestones and outcome measures. The latter two categories will include all toolkit required measures for determining project incentive payments. The first category (process measures), although not specified in the toolkit, is critical to ensuring OCH and partner organizations adopt best-practices both for projects and for Domain 1 activities. For the most part, the process measures will serve as real-time indicators.

OCH is planning to build a technology platform that can systematically manage all three categories of measures. The platform will also have enough descriptive context to guide partners and providers in the provision of information to send to OCH. The information coming from providers will primarily fall into our first two categories: process measures and milestones. Outcomes measures will be captured chiefly from existing reporting systems (e.g. Healthier Washington Dashboard, HCA-AIM reports, Washington Health Alliance Reports, DSHS reports, RDA reports, WSHA reports and others). The OCH platform will avoid the inefficiency and inaccuracy inherent in having providers entering data in multiple templates. OCH intends to use the platform for data aggregation and formatting to streamline the population of HCA required templates.

OCH's process measures are the lynchpin to ensuring OCH providers are on track to make the necessary progress expected under the Transformation. Simply put, outcome measures are too lagged and provide no insight into whether foundational operational front-line changes have been undertaken. Milestone reporting, while providing a real-time sense of overall organizational change,

still does not furnish a front-line view of how patient engagement may have changed.

OCH does not anticipate much resistance from partnering providers in providing requested information for tracking purposes. During OCH's letter-of-intent process (March to April 2016), when asked, "*Are you willing to provide project-specific data to OCH for tracking purposes?*", all partnering organizations agreed to send data to OCH for tracking purposes.

Identifying what is not working

OCH will form a steering committee for each NCC. The role of the committee is to oversee the work of the shared change plan, identify barriers, and collaboratively design solutions across sectors and Tribes. OCH staff will share learnings across NCCs, deploying technical assistance where appropriate. OCH will also deploy provider surveys, creating an anonymous vehicle for providers to provide feedback to the OCH.

OCH will hire a Compliance and Contract Coordinator to oversee change plan compliance, conduct site visits, perform annual audits. OCH will form a Compliance Committee to oversee this effort. Partners will receive additional support through a change manager, who will offer regular progress check-ins with participants within each NCC. The OCH Board will approve a mediation plan structure and grievance procedure to provide necessary processes for under-performance and non-compliance.

The Performance Measurement and Evaluation Committee (PMEC) designs and reviews data submissions, interprets trends, and elevates red flags to the Board. The PMEC will swiftly identify issues regarding reporting, data quality, or failure to move metrics and offer counter-measure solutions where appropriate.

Each project implementation plan will include a go/no go decision midway through project implementation. If the work to that point has proven constructive with quantifiable evidence that the program will be both successful and sustainable, then the work will continue through the duration of the Transformation. Evidence that the program or elements of the program are not working will trigger a project plan modification request, specific to the root cause of the issue.

Oral Health project risks

Beyond the risk noted above of partners/providers not being set up to meet reporting requirements, we are mindful of the following specific risks with the Bi-Directional Integration project. We intend to devise focused monitoring mechanisms for these risks. This is only a sample of monitoring initiatives.

- Insufficient adoption by primary care providers of processes to ensure population gets better dental care.
- Economic factors (e.g. insufficient demand, low or non-existent reimbursement) do not enable a self-sustaining mobile dental unit.
- Outreach is not effective enough to ensure full utilization of the mobile dental unit and thus, there is too little improvement in oral health.
- Not enough tribes adopt or deploy enough resources to leverage the Dental Health Aide Therapists program.
- No MCO can provide a dental plan that is self-sustaining.
- Inadequate exchange of PHI among providers.

PROJECT METRICS AND REPORTING REQUIREMENTS

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
x	

RELATIONSHIPS WITH OTHER INITIATIVES

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
x	

PROJECT SUSTAINABILITY

The proposed strategies in this project plan add dental capacity to the existing delivery system that will extend beyond the Medicaid population, addressing the needs of people in the OCH region well beyond the MTP. Once built, the capacity remains in place - new fixed capacity in Kitsap and Jefferson as well as mobile capacity for the whole region. Essentially, the selected oral health strategies are front-end investments which can and will be sustained by fees-for-services, dental managed care, rural health systems financing, or value-based contracts, once the initial investments are capitalized and operational staff hired and trained. What has been needed in this region to solve oral health access is collaborative planning, which has been fostered by OCH with capital provided through private and State funding in addition to DSRIP funding.

Investments within the oral health access project in infrastructure, capacity, workforce, and transformation, directly translate into the sustainable transformation components described in Section 1: Required Health Systems and Community Capacity (Domain 1) Focus Areas.

Table 9. Driving towards sustainable capacity, infrastructure, workforce, and transformation strategies	
Oral Health Access Project →→→→→→→→→→→→	Capacity Infrastructure Strategies
To identify the target population of primary care patients for oral health screenings and referral (e.g., pregnant women, children, diabetics)	Risk stratification (VBP) (PHS)
To effectively refer primary care patients to the dental van; patients in the ED for dental diagnosis to a dental provider	Referral Management (VBP)
Oral Health Access Project →→→→→→→→→→→→	Workforce Strategies
The dental team for the mobile van will need operational planning and will likely lose money at the start while logistics are managed. Without MTP funding, this learning phase would not be possible.	Mobile workforce
Primary care providers are trained to do oral screening, and trained how to bill MCOs for this services	Training
Oral Health Access Project →→→→→→→→→→→→	Transformation Strategies
Oral health screening, education and referral become a stable workflow within the primary care setting	Integrated, whole person care
Referral from ED or primary care to dental care or dental van	Care Coordination incl. Referral Management (VBP) (PHS)
Mobile dental van and increased referrals; eventually capital expansion projects	Enhanced access

Prevention and whole person care

Through this project, partnering providers will institute a comprehensive, whole-person approach to promoting health for their patients and families. Oral health disease is the largest completely preventive, infectious disease in the United States. By increasing access to preventive oral health services, this project will have a positive impact on populations throughout the life course.

Leveraging Natural Communities of Care for collective impact

OCH will convene partnering providers within a NCC to align strategies into a single shared change plan. Oral health strategies will be incorporated into change plans as transformation activities, and will be mutually supportive of the shared change plan. OCH will facilitate collaborative arrangements between providers within the NCC, such as data-sharing agreements (DSA) and business associate agreements (BAA). Of vital importance for the success of this project is establishing a strong referral base to the mobile dental van and back to primary care. Once these referral pathways are established and supported with BAAs and DSAs, they will continue beyond the life of the Transformation.

MCO participation in developing change plans and participating in implementation of these projects will help providers engage with future value-based contracts that may include oral health integration metrics. It is becoming more and more likely that MCOs will begin managing financial claims for dental services, beyond ED claims, in the coming years, starting with a few pilot projects as early as 2018. If this moves forward, providers in the OCH region will be well positioned to be even more successful under value-based contracts with MCOs. This is especially relevant since the interventions proposed in this plan lend themselves very well to value-based contracting.

ATTACHMENTS

ATTACHMENTS

1. *Required* OCH Supplemental Workbook: Tab 3C Partnering Providers
2. *Required* OCH Supplemental Workbook: Tab 3C Implementation Approach



3D. Chronic Disease Prevention and Control Project Plan

November 16, 2017

The burden of chronic disease is pervasive in the Olympic Community of Health region, and is disproportionately borne by certain sub-populations, including American Indians/Alaskan Natives, low-income communities, and persons suffering from behavioral health issues. Practice transformation within the primary care and mental health environments, strengthening of community-clinical linkages, and leveraging existing expertise and resources within the region will help reduce morbidity and mortality stemming from diabetes, cardiovascular disease, hypertension, and asthma.

Our vision is to become a region where every person at risk of or diagnosed with a chronic disease receives team-based care in a medical home that is linked to tailored disease self-management community-based interventions. The Olympic Community of Health region will reduce the burden of chronic disease through collective application of the evidence-based chronic care model and National Heart, Lung, and Blood Institute Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma across a wide variety of clinical and affiliate partners.

Menu of Transformation Projects	
Domain 2: Care Delivery Redesign	
<input type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversions Interventions
Domain 3: Prevention and Health Promotion	
<input type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input checked="" type="checkbox"/>	3D: Chronic Disease Prevention and Control

PROJECT SELECTION AND EXPECTED OUTCOMES

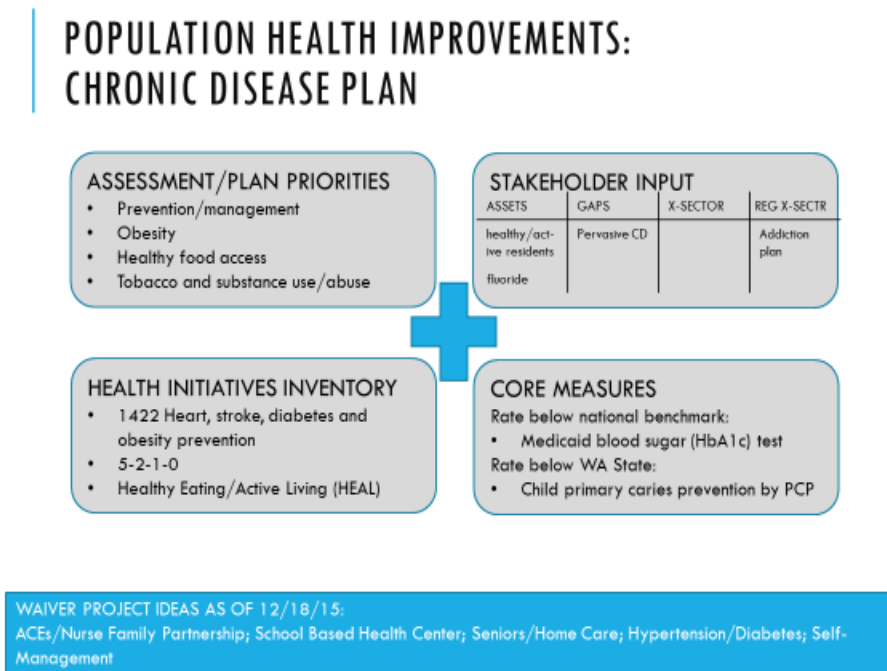
Rationale for Selecting This Project

The OCH Regional Health Needs Assessment (RHNA) informed the top five health priorities for the region, with Chronic Disease Prevention identified as one of those five priority areas. (Table 1) The goal within this priority is to reduce the burden of chronic disease through prevention and disease management. OCH's prioritization of chronic disease prevention was informed by four factors: results of community assessments (including the three county public health departments' Community Health Assessments and local hospital Community Health Needs Assessments), stakeholder input on gaps and assets in our region, a health initiatives inventory, and finally, consensus on core data measures. Figure 1 below summarizes these inputs

Table 1. Olympic Community of Health Regional Health Priorities

ACCESS	AGING	BEHAVIORAL HEALTH	CHRONIC DISEASE	EARLY CHILDHOOD
A continuum of physical, behavioral, and oral health care services is accessible to people of all ages and care is coordinated across providers.	Aging adults and their caregivers are safe and supported.	Individuals with behavioral health conditions receive integrated care in the best setting for recovery.	The burden of chronic diseases is dramatically reduced through prevention and disease management.	Children get the best start to lifelong health and their families are supported.
Progress on these priorities depends on improving <u>health equity</u> through SOCIAL DETERMINANTS – housing, education, workforce development, employment, transportation, safety, environmental conditions.				

Figure 1

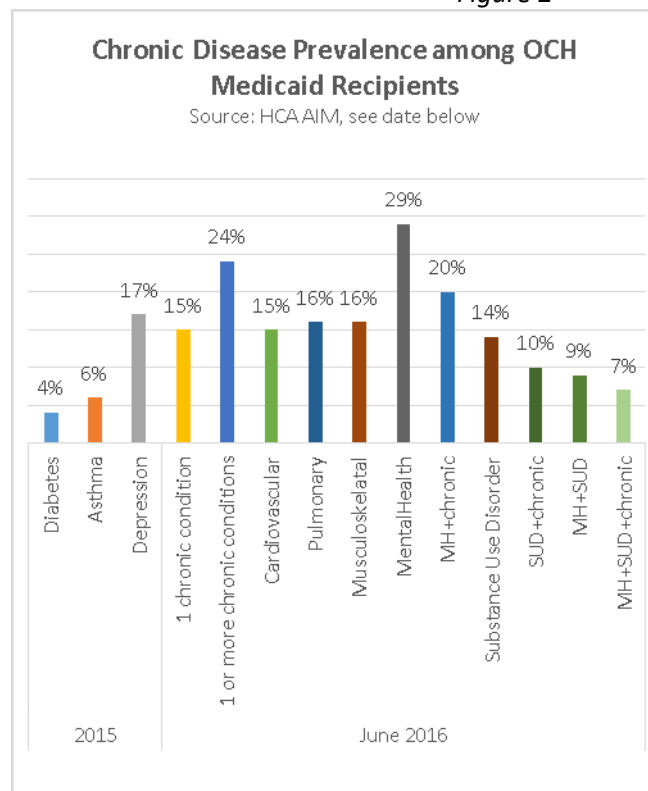


Chronic disease rates among adult residents of the region are high, and rates among low income populations are disproportionately higher. Among low-income OCH region residents, over 40% self-report ever being told they have high blood pressure, over 30% report being obese, about 15% report ever being told they have diabetes, and over 10% report ever being diagnosed with cardiovascular disease. (BRFSS, 2011-2015 (High BP 11,13,15), analysis by Kitsap Public Health District (KPHD)) Low income adults also report low rates of physical activity: about 1 in 4 report no daily leisure time activity and over half report less than 1 hour of daily activity despite an official recommendation of one hour or more. (BRFSS, 2011-2015, analysis by KPHD)

Chronic disease prevalence based on data provided by the WA Health Care Authority from claims and encounters indicates nearly 1 in 4 recipients has at least one chronic condition. Prevalence by disease type ranges, notably over 17,000 or 1 in 5 recipients has both a mental health and at least one chronic condition. (Figure 2) (WA HCA AIM, Cat 1 Behavioral Health and Chronic Conditions, 9/29/2017)

Across OCH counties, rates of chronic disease are relatively comparable, varying by a few percentage points at most.

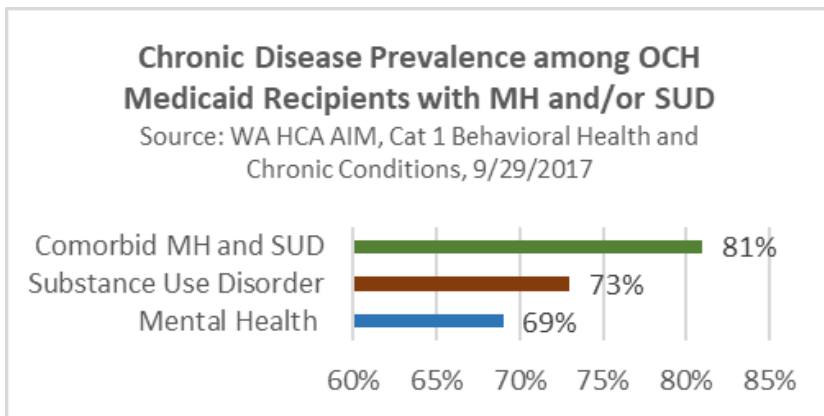
Figure 2



American Indian/Alaska Natives (AI/AN) have the highest rates of mental health concerns (MH) (38%), substance use disorder (SUD) (23%), and comorbid MH+SUD (14%). Chronic disease rates are 2.5 to 13 times higher among those with the Medicaid coverage group of 'disabled' compared to non-disabled. (WA HCA AIM, Cat 1 Behavioral Health and Chronic Conditions, 9/29/2017)

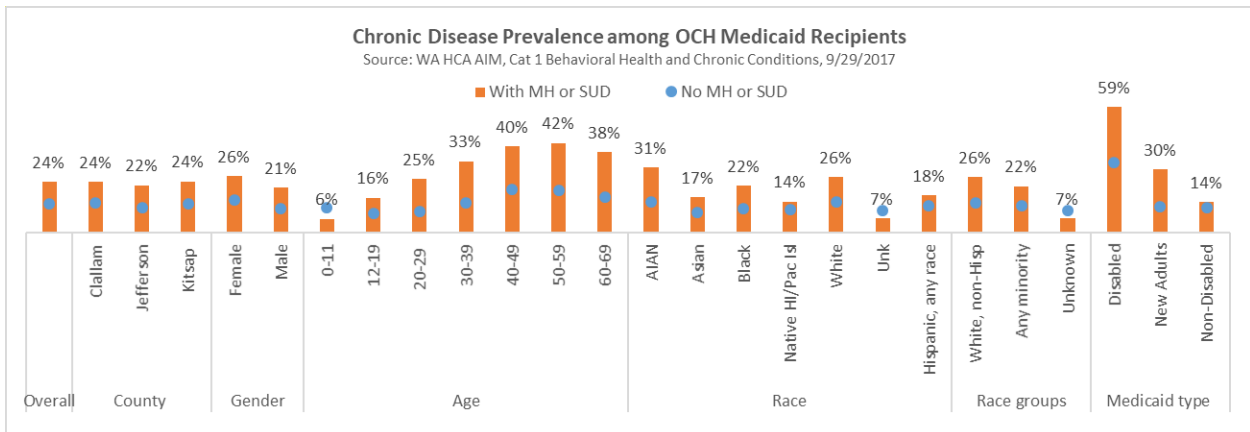
Prevalence of chronic conditions among those with MH, SUD or both is high. Between 7 and 8 out of 10 Medicaid recipients with comorbid or standalone MH or SUD diagnoses also have at least one chronic condition. (Figure 3) (WA HCA AIM, Cat 1 Behavioral Health and Chronic Conditions, 9/29/2017)

Figure 3



Medicaid recipients in the OCH region with a MH or SUD diagnosis have at least a two-fold increased rate of chronic disease compared to those without MH or SUD. (Figure 4)

Figure 4



The following data highlight the asthma burden among OCH Medicaid beneficiaries:

- Asthma rates among all Medicaid beneficiaries in the OCH region range from 3% among children under age 18 to 6% among adults age 18 and older. (HCA AIM RHNI Phase 3, 4/25/17)

Patients from four local service providers:

- The two federally-qualified health clinics (FQHCs) in the region serve over 1,500 patients with asthma, 8.1% of almost 20,000 patients served. As with diabetes and cardiovascular disease, persons with mental illness experience a disproportionate burden of asthma.
- 35% of the 600 children and 11% of the 4,500 adults served by Kitsap Mental Health Services

(KMHS) had an asthma diagnosis.

- Kitsap County Aging and Long Term Care reports that 21% of individuals over the age of 18 years that met nursing home level of care and chose to reside in community had diagnosed asthma, accounting for about 22 patients on any given day (Area Agency of Aging, 2017).

Coordination with Existing Projects in Region

Partners have selected the Chronic Care Model and National Heart, Lung, and Blood Institute Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma (EPR-3) to guide practice transformation around the management of diabetes, cardiovascular disease, hypertension, and asthma. In order to leverage existing efforts and avoid duplication of services, providers and community partners will utilize the OCH-developed Regional Health Needs Inventory, which tracks ongoing efforts within the region around chronic disease prevention. Existing efforts include regional offerings of chronic disease self-management (including Wisdom Warriors) and Diabetes Prevention Programs (DPP), primarily through community-based organizations and Tribal clinics. KMHS utilizes Whole Health Action Management (WHAM), an approach to chronic disease management designed specifically for persons diagnosed with mental illness and/or substance use. The three public health departments in the region have collaborated around policy, systems, and environmental changes to improve access to healthy eating and active living through local coalitions. One of our region's FQHCs, Peninsula Community Health Services (PCHS), is a leader in hypertension management and already employs key strategies within the chronic care model. The OCH is in a unique position to build from existing community-clinical linkages and partner expertise in chronic disease prevention.

Each partnering provider practice will participate in a baseline assessment of chronic illness care, focused on the following transformational strategies within the model:

- Organization of the healthcare delivery system
- Community Linkages
- Self-management support
- Decision support
- Delivery system design
- Clinic information systems

For providers specifically interested in asthma management, baseline assessments will include status in relation to the four components of asthma management in the EPR-3:

- Measures of Asthma Assessment and Monitoring
- Education for Partnership in Asthma Care
- Control of Environmental Factors and Comorbid Conditions that Affect Asthma
- Managing Asthma Long-Term

Practices will have tailored change plans derived from results of their baseline assessments.

Transformations within practices stemming from application of the chronic care model can be applied to any chronic disease of interest to the practice, including pre-diabetes, diabetes, hypertension, cardiovascular disease, and cancer. In the management of asthma, the core chronic care model strategies can be combined with the recommendations of EPR-3.

Project Scope: Target Population, Partnering Providers, Level Of Impact, And Health Equity

For details on the anticipated project outcomes, target population, subpopulations, and disparities for each strategy, please refer to Table 3.

Scope of project and target population

Providers and community partners intending to participate in this project serve about 60,000 unduplicated patients. An estimated 11,880 Medicaid lives per year (about 23% of the adult Medicaid population) comprise the adult target population for the chronic care model project. Partners committed to improving identification and management of asthma will serve a target population of at least 2,700 adults and children (based on current number of patients diagnosed with asthma within two federally qualified health centers (FQHC) and one community behavioral health agency (CBHA)).

Providers may choose to target sub-populations which experience a higher level of chronic disease burden, including

- Persons with depression and anxiety diagnoses
- Persons with severe mental illness and/or substance use disorder
- AI/ANs, who have higher risk of chronic illness than other minority groups
- For asthma: focus on children and older adults

Implementation partners critical to success

Success of the chronic care model centers stems from the intentional integration of the essential elements of health care system redesign that encourage high-quality chronic disease care. Central to the model's success is the strengthening and formalizing of community-clinical linkages that allow for increased disease self-management. To that end, partnering providers and community-based non-profit and government agencies are critical to the success of this project. Table 1 identifies key partners engaged in both the EPR-3 project and the chronic care model thus far (this list may expand depending on community-clinical linkage needs that arise during program planning and implementation).

Table 2: Current partners in the EPR-3 project and the chronic care model

Provider Partners and Community Behavioral Health Centers	Community-based and public service organizations	Managed Care Organizations/Payers
Bremerton Fire Department	Bremerton Housing Authority	Amerigroup
Cedar Grove Counseling	Clallam County Health and Human Services	Community Health Plan of Washington
Forks Community Hospital/Clinics	Jefferson County Public Health	Coordinated Care
CHI Harrison Hospital, Health Partners and Medical Residency	Kitsap Area Agency on Aging	Molina
Jefferson Healthcare	Kitsap Community Resources	United Health Care
Jamestown S'Klallam Family Health Clinic	Kitsap County Human Services	Salish Behavioral Health Organization
Kitsap Medical Group	Kitsap Public Health District	
Kitsap Mental Health Services	OlyCAP	
North Kitsap Family Medicine	Olympic Area Agency on Aging	
North Olympic Healthcare Network	Olympic Workforce Development Council	
Olympic Medical Group	Project Access NW	
Peninsula Behavioral Health Services	YMCA of Pierce and Kitsap Counties	
Peninsula Community Health Services		
Port Gamble S'Klallam Tribe Health Center		

Level of Impact

Several important considerations contributed to the OCH Board selecting the chronic care project as a flagship project of the organization – a core project that will ultimately transform regional health systems to reduce costs and improve health outcomes. These include:

- A compelling case for the need of improved chronic disease identification and management through the RHNA and provider self-report
- Enthusiasm of several health and social service providers across the region in investing in the chronic care model and EPR-3, as evidenced by the submission of two robust regional project applications representing a collaboration of providers
- Recognition that among eligible demonstration projects, the chronic disease prevention and control project was among those most likely to result in reduced emergency department utilization and hospitalizations
- Recognition that the chronic care model elements strengthen the provision of integrated and whole person care within the primary practice setting
- Alignment with the OCH's intention to engage evidence-based practices that meaningfully strengthen community-clinical linkages
- Promising results of a similar project piloted at KMHS, where team-based care, connection to disease self-management programs, enhanced clinical information systems, and integrated care were engaged to result in improved chronic disease management among persons with mental illness and/or substance use disorder

Health Equity

The OCH will assure health equity is meaningfully addressed through the following:

- Incorporating the Community Needs Index and PRISM Score within the Funds Flow Formula - These allow for risk burden to be assessed and acknowledged across provider practices.

- Whenever possible, using evidence based practices that are tailored to specific subgroups where health disparities exist - An example includes referring patients with mental illness and chronic disease to a WHAM program, which is designed to empower persons with mental illness to self-manage chronic disease. Another example is referring patients who affiliate with a tribal nation to Wisdom Warriors, a chronic disease self-management program designed for tribal members.
- Incorporating within provider level change plans the commitment to partner with community-based and service organizations to address socioeconomic barriers that influence health and well-being. These include partnership around patient transportation, housing, access to healthy foods, necessary household items, etc.
- Utilizing community health worker and peer navigators as a trusted link from clinic to community and vice versa.
- Ensuring that culturally-relevant community resources for chronic disease self-management are available and linked to clinics across the region.

Lasting Impacts

The formal integration of elements of the chronic care model and EPR-3 into primary care practices' daily workflows, decision support structures, electronic medical records, and team-based approaches to care will provide the foundation for sustained transformation. Further, the OCH has designed provider change plans to allow for practices to optimize the benefits of transformations across projects – that is, incorporation of the chronic care model elements will allow for lasting impacts in bidirectional integration, enhanced oral health access and reproductive/maternal and child health efforts. Change plans will further benefit all providers and patients within the practice, regardless of Medicaid status.

Sustained transformations will also stem from the following:

- Workforce development enhances, particularly uptraining of staff and the sharing of highly trained staff (such as nurse case managers) between practices
- Upfront investments in population health informatics, including enhancements to electronic health information systems
- Learning collaboratives within Natural Communities of Care (NCCs) which allow for shared problem-solving, identification of promising practices, and finding of efficiencies across practices and within the community. See Theory of Action for more information on NCCs.
- Ongoing technical assistance to providers to prepare for value-based purchasing

Table 3 below summarizes strategies and metrics for the chronic disease prevention work.

Table 3. Chronic Care Project: Strategies, Projected Outcomes, and Population Served

Strategies	Intermediary Milestones/ Metrics	Pay for Reporting Metrics/ Milestones	Pay for Performance Metrics	Evidence Base/Best Practice	Natural Community of Care	Target Population	Target Sub-population	Est. # Targeted per Year	Disparities
Organization of the Healthcare Delivery System Community Linkages Self-management support Decision support Delivery system re-design Clinic information systems	Securing regional licensing for DPP and CDSM Natural Community of Care Collaborative Agreement in Place Partnering provider organizations change plan Contract in place with OCH Monthly reports sent to OCH Proxy measures under development; will be selected to predict P4P metrics; will be included in contracts and reported by partners	# of health care providers trained in appropriate blood pressure assessment practices # of new / expanded nationally recognized self-management support programs (e.g., CDSMP, NDPP) # of partners participating / implementing each selected model / approach # of partners trained on selected model / approach: projected vs actual and cumulative # of home visits for asthma services, hypertension % of patients provided with automated blood pressure monitoring equipment QIP Metrics	Child and Adolescents' Access to Primary Care Practitioners Comprehensive Diabetes Care: HbA1c Testing Comprehensive Diabetes Care: Medical attention for nephropathy Outpatient Emergency Department Visits per 1000 Member Months Statin Therapy for Patients with Cardiovascular Disease (Prescribed) Comprehensive Diabetes Care: Eye Exam (retinal) performed Inpatient Hospital Utilization	Chronic Care Model, DPP, WHAM, CDSM/ Wisdom Warriors	Clallam, Jefferson, Kitsap	Adult Medicaid beneficiaries	Persons with mild mental health issues; Persons with severe mental illness and/or substance use disorder; persons with CHF; AI/AN	11,880	AI/AN have highest rate of behavioral health and comorbid mental health and SUD 70-80% of Medicaid recipients with MH or SUD also have at least one chronic condition Medicaid recipients in OCH with MH or SUD diagnosis have at least 2-fold increased rate of chronic disease compared to those without MH/SUD Low-income adults report low rates of physical activity
Asthma assessment and monitoring; Education for partnership in asthma care;	Natural Community of Care Collaborative Agreement in Place Partnering provider organizations change plan	% of documented, up-to-date Asthma Action Plans # of home visits for asthma services, hypertension	Medication Management for People with Asthma (5 – 64 Years)	National Heart, Lung, and Blood Institute Expert Panel	Clallam, Jefferson, Kitsap	Adult and child Medicaid beneficiaries	Persons w/ severe mental illness and/or substance	2,700	Persons with SUD and MH have higher disease burden with asthma 6% fewer non-free and reduced lunch

3D. Chronic Disease Prevention and Control Project Plan
PROJECT SELECTION AND EXPECTED OUTCOMES

Olympic Community of Health

Control of environmental factors and co-morbid conditions that affect asthma; Managing asthma long-term (including use of EPA Asthma Environmental Checklist)	<p>Contract in place with OCH</p> <p>Monthly reports sent to OCH</p> <p>Proxy measures under development; will be selected to predict P4P metrics; will be included in contracts and reported by partners</p>			Report 3: Guidelines for the Diagnosis and Management of Asthma			use disorder; AN/AI; Children; Older adults; smokers	<p>OCH students in 8, 10, and 12 grade combined (20%) have been diagnosed with asthma than free and reduced lunch students (26%) (HYS 2016)</p> <p>Adult females in Jefferson and Kitsap have statistically significant higher prevalence of asthma than males (BRFSS, 2011-2016, analysis by KPHD)</p> <p>Low income adults in Jefferson and Kitsap have statistically significant higher prevalence of asthma than non-low income adults (BRFSS 2011-2016, analysis by KPHD)*</p> <p>*Note: Annual household income less than \$35,000. Eligibility for Medicaid is equal or less than 138% of poverty; a family of four earning \$33,948 in 2017.</p>
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IMPLEMENTATION APPROACH AND TIMING

Please refer to OCH Supplemental Workbook: 3D Implementation Approach

The worksheet did not allow a way to address anticipated barriers to deploying resources to partnering providers, and OCH tactics for addressing each of them. These are presented in Table 4 below. Notably, all listed barriers below impact more than one project area and will therefore be addressed systematically across the MTP portfolio.

Table 4. Anticipated barriers to deploying resources to partnering providers and associated solutions

Barriers or challenges to deploying resources to implementation partners	OCH tactics for addressing barriers or challenges
Insufficient IT systems to allow for population health management	Baseline assessment includes IT assessment; OCH assist in upfront infrastructure/IT investments
Providers not currently linked to community resources	OCH link providers to existing community based programs in chronic disease self-management, including DPP, CDSM, Wisdom Warriors, WHAM
Inadequate workforce to conduct care coordination, population health informatics	OCH help identify shared training needs across providers/affiliate partners and arrange for shared workforce development opportunities
Insufficient fiscal resources to support staffing needs	OCH help identify opportunities for sharing highly trained workforce across practices
Practice Transformation time-consuming and challenging	Qualis provide on-going technical assistance tailored to change plans
Union issues	Allow each NCC to determine the employer for the new workforce; clarify scope of practice
Focus on highest risk sub-populations stretch provider resources	OCH assist providers in developing robust community-clinic referral management systems across NCC

PARTNERING PROVIDERS

Assurance of Serving the Medicaid Population

Please refer to OCH Supplemental Workbook: 3D Partnering Providers. The list of partnering providers in the workbook is an initial list of clinical and non-clinical partnering providers that have expressed interest in supporting the development and implementation of the chronic disease project. For this project to be successful, the major Medicaid providers must be willing partners. Based on a Number Needed to Treat analysis (see Theory of Action Section), OCH providers need to perform an additional 861 retinal eye exams in diabetics and 202 HbA1c testing to achieve a 2% improvement in these “gap to goal” measures. This is within reach because, at full capacity, an estimated 60,000 Medicaid beneficiaries, about 12,000 adults, will be reached by this project and the major Medicaid providers are fully engaged. Table 5 represents the main providers in our region and the number of Medicaid lives each serve.

Table 5. Major Medicaid providers in the OCH region and number of lives served

Provider Partners	Medicaid Lives Served
Forks Community Hospital/Clinics	705
Harrison Health Partners and Medical Residency	10,825
Jefferson Healthcare	1,116
Jamestown S’Klallam Family Health Clinic	2,252
Kitsap Mental Health Services	6,615
North Olympic Health Network	2,232
Olympic Medical Group	6,328
Peninsula Behavioral Health Services	917
Peninsula Community Health Services	12,425
Port Gamble S’Klallam Tribe Health Center	765

(SOURCE: unduplicated counts from HCA AIM for 2016)

All identified partners either serve on the OCH Board, at which the decision to select the Chronic Disease Management project as a top priority for the organization was made, and/or they individually identified this project as a priority for their own practice. Each of these providers will complete a baseline assessment to inform their change plan.

Assurance of serving the Medicaid population

Two of the participating partners are federally qualified health clinics, so their core mission is service to the Medicaid population. All partners that enter into a change plan will be contractually obligated to serve the Medicaid population in order to receive revenues, and only partners who already serve the Medicaid population will be eligible for change plans.

Partner engagement process

Clinical and community-based partners have been extensively engaged in the selection of the Chronic Care Model and EPR-3 as critical projects for the region. Eleven clinical and behavioral health providers and 15 community partners were included as key partners under the chronic disease management project in the Request for Application process that the OCH facilitated to solicit project applications from the region. In addition to designing the RFA process to engage a broad base of stakeholders in program design, the OCH has been intentional about provider and affiliate partner involvement through a variety of means, including:

- The Regional Health Assessment and Planning Committee of the OCH Board, which had 27

participating members representing: primary care providers, tribal clinics, Area Agencies on Aging, Human Services, federally qualified health clinics, public health departments, hospitals, community mental health agencies, educational services districts, emergency medical services, workforce development councils, community action programs, managed care organizations and tribes. This committee was convened in 2016 and was responsible for designing and leading the early project selection process. In mid-2017, the RHAP committee presented the OCH Board a portfolio of recommended project based on their careful review of the Regional Health Needs Assessment and the project applications.

- The Partner Group, which represents an expanded range of organizations and community members committed to improving health in the region. This Group meets 2-4 times per year and has been integral in the development of the Regional Health Needs Inventory, which includes a catalog of existing programs and resources related to chronic disease management in the region.
- Moving forward, change plans will include clinical-community linkage strategies critical to success in meeting chronic disease management metrics. Value-based care will necessitate these linkages, and funds flow will be linked to effective collaboration between providers and affiliate partners.

MCO expertise

Managed care organizations played a central role in identifying chronic disease management as a high priority project for our region. The OCH has already begun meeting with MCOs to discuss aligning value based care with model benefits and how these will best align with the chronic care model elements. Each care plan will include engagement with interested MCOs, where MCOs are expected to play a role in providing technical assistance for value based purchasing readiness. MCOs will also work with providers and affiliate partners to ensure there is adequate alignment with existing MCO service lines, including care coordination.

REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS**OCH and Partner Assets**

Several existing and planned assets will strengthen the chronic disease management efforts in the region, including:

- OCH's RHNA and Regional Health Inventory, which frame the application of the project plans to the unique needs of the region
- Strong working relationships between tribes and public health and precedence for regional partnerships through mutual aid agreements between sovereign nations and public health departments
- Thoughtful engagement throughout the project planning process of a wide variety of clinical and affiliate partners, as well as a variety of rural and urban partners
- Existing evidence-based and promising practice self-management services by affiliate organizations, including tailored programs such as Wisdom Warriors and WHAM
- Past regional experience involving several partners (public health in all 3 counties, Kitsap Mental Health, tribal clinics, Peninsula Community Health Services, local free clinics, the YMCA of Pierce/Kitsap County, and housing authorities) in chronic disease prevention and management through funding from the Centers for Disease Control and CMS
- Existing models of integrated care tied to improved chronic disease management, including multi-disciplinary team-based care at Kitsap Mental Health
- Partners with expertise in components of the chronic care model and innovation around chronic disease management, including Peninsula Community Health's Million Hearts program (nationally lauded)
- Subject matter expertise of tribal partners in the management of chronic disease and the role community health representatives and peers play in this work
- Change plans to require in-kind contributions from each partner and affiliate organization as part of contracting
- Planned sharing of skilled workforce and trainings across the region. Shared staff positions across agencies may include Diabetes Educators, Population Health Nurse Managers, and Community Health Workers
- Data analytics and epidemiologic expertise of public health partners

Barriers to Improving Outcomes and Lower Costs

Although not exhaustive, planning partners have identified the following potential barriers to improving outcomes and to lowering costs in implementing strategies to mitigate chronic disease. (Table 6)

REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS

Table 6. Challenges to improving outcomes and strategies to mitigate risks

Challenge or barrier to improving outcomes and lowering costs for the target populations through this project	OCH strategy for mitigating the identified risks and overcoming barriers
Focus on highest risk sub-populations a stretch to provider resources	OCH assist providers in developing robust community-clinic referral management systems across NCC
Cost of Diabetes Prevention Program can be prohibitive to patients	Ensure patients have several options for community-based chronic disease self-management, including WHAM, Wisdom Warriors, Stanford CDSME; negotiate coverage of DPP with MCOs
Integration of Chronic Care Model elements potentially time-consuming and challenging	Qualis provide on-going technical assistance tailored to change plans
Lifestyle changes needed to improve chronic disease outcomes are very complex	OCH will assist providers in ensuring workflows include planned patient accountability for participation in community-based chronic disease self-management programs
Patient Activation	Enhanced collaboration with MCOs to facilitate targeted outreach to covered, un-engaged Medicaid lives; linkages with community based organizations who address social determinants of health will assist in reaching target population
Medicaid benefits do not include coverage of important self-management tools, such as blood pressure monitors	Facilitate budgeting with providers within change plans for blood pressure monitors; explore other potential options for coverage
Sub-populations face cultural and socioeconomic barriers to improved management	Whenever possible, use best and evidence-based practices tailored to sub-populations, including Wisdom Warriors and WHAM
Social determinants of health, particularly housing, compromises patient capacity to self-manage chronic disease	Integrate clinical linkage to housing, homeless service programs, social service programs as standard referral process for all patients in need
Continuous Quality Improvement Processes easily overlooked	Provide technical assistance around lean or QI process
Disjointed efforts resulting in limited improvements to target metrics at OCH level	Facilitate shared learning opportunities within NCCs and across region to identify best practices, leveraging opportunities, barriers to economy of scale, etc.
Practices not truly transforming	Encourage provider organizations to consistently measure progress against transformational

REGIONAL ASSETS, ANTICIPATED CHALLENGES AND PROPOSED SOLUTIONS

Challenge or barrier to improving outcomes and lowering costs for the target populations through this project	OCH strategy for mitigating the identified risks and overcoming barriers
	benchmarks and to innovate or course correct to meet the needs of their population; OCH and Qualis assist in continuous quality improvement
Staff turnover and changes in leadership at the provider and affiliate partner level	Provide support to ensure stable transitions in leadership that promote retainment of staff; encourage succession planning; supports to providers through NCCs and technical assistance will help mitigate the impact of turnover
Variation in prescribing practices for rescue and controller medications for asthma	Work within the OCH to establish clinical practice guidelines consistent across providers to ensure continuity of care for patients
Qualified staff shortage, especially in rural areas	OCH will allow partners to utilize telemedicine and other innovative strategies in the management of chronic diseases, including diabetes

MONITORING AND CONTINUOUS IMPROVEMENT

Monitoring Project Implementation

OCH will ensure timely and effective implementation through detailed planning, formation of Natural Community of Care (NCC) collaborative agreements, NCC steering committees, comprehensive baseline assessments and change plans. Change plans will outline a sequential, stepwise process, co-designed with the provider organization(s), to implement transformational activities.

In 2018, the biggest risk to implementation will be providers failing to meet reporting requirements. OCH will mitigate this risk by precisely noting reporting requirements in provider change plans, which will be developed in early 2018. We will also provide outreach and training on OCH's monitoring system (described below). Trainings will be in person and virtual, with materials specific to each project, and presentation on best practices for specific project measures. To the extent possible, OCH requirements for provider reporting will align with existing reporting requirements (e.g., HEDIS, Alternative Payment 4, and Apple Health Contracts). This will be a joint initiative with MCOs, strategically positioning providers to achieve VBP contract benchmarks.

Funding will flow to providers and affiliate partners upon completion of set milestones, as outlined in change plans. There will be fiscal consequences for lack of progress, as revealed by process and outcome measures. This will all be detailed in provider contracts.

Delays in implementation will be addressed by change managers, either employed by the provider organization or OCH. Change managers will identify cross-cutting implementation barriers among partnering provider organizations. In turn, they will not only make recommendations to address those barriers, but will also revise change plans appropriately.

Monitoring Continuous Improvement

OCH projects share common elements for monitoring and continuous improvement. To track progress, OCH will rely on a host of measures categorized (at its highest level) as follows: process measures, milestones and outcome measures. The latter two categories will include all toolkit required measures for determining project incentive payments. The first category (process measures), although not specified in the toolkit, is critical to ensuring OCH and partner organizations adopt best-practices both for projects and for Domain 1 activities. For the most part, the process measures will serve as real-time indicators.

OCH is planning to build a technology platform that can systematically manage all three categories of measures. The platform will also have enough descriptive context to guide partners and providers in the provision of information to send to OCH. The information coming from providers will primarily fall into our first two categories: process measures and milestones. Outcomes measures will be captured chiefly from existing reporting systems (e.g. Healthier Washington Dashboard, HCA-AIM reports, Washington Health Alliance Reports, DSHS reports, RDA reports, WSHA reports and others). The OCH platform will avoid the inefficiency and inaccuracy inherent in having providers entering data in multiple templates. OCH intends to use the platform for data aggregation and formatting to streamline the population of HCA required templates.

OCH's process measures are the lynchpin to ensuring OCH providers are on track to make the necessary progress expected under the Transformation. Simply put, outcome measures are too lagged and provide no insight into whether foundational operational front-line changes have been undertaken. Milestone

reporting, while providing a real-time sense of overall organizational change, still does not furnish a front-line view of how patient engagement may have changed.

OCH does not anticipate much resistance from partnering providers in providing requested information for tracking purposes. During OCH's letter-of-intent process (March to April 2016), when asked, "*Are you willing to provide project-specific data to OCH for tracking purposes?*", all partnering organizations agreed to send data to OCH for tracking purposes.

Identifying what is not working

OCH will form a steering committee for each NCC. The role of the committee is to oversee the work of the shared change plan, identify barriers, and collaboratively design solutions across sectors and Tribes. OCH staff will share learnings across NCCs, deploying technical assistance where appropriate. OCH will also deploy provider surveys, creating an anonymous vehicle for providers to provide feedback to the OCH.

OCH will hire a Compliance and Contract Coordinator to oversee change plan compliance, conduct site visits, perform annual audits. OCH will form a Compliance Committee to oversee this effort. Partners will receive additional support through a change manager, who will offer regular progress check-ins with participants within each NCC. The OCH Board will approve a mediation plan structure and grievance procedure to provide necessary processes for under-performance and non-compliance.

The Performance Measurement and Evaluation Committee (PMEC) designs and reviews data submissions, interprets trends, and elevates red flags to the Board. The PMEC will swiftly identify issues regarding reporting, data quality, or failure to move metrics and offer counter-measure solutions where appropriate.

Each project implementation plan will include a go/no go decision midway through project implementation. If the work to that point has proven constructive with quantifiable evidence that the program will be both successful and sustainable, then the work will continue through the duration of the Transformation. Evidence that the program or elements of the program are not working will trigger a project plan modification request, specific to the root cause of the issue.

Chronic Disease project risks

Beyond the risk noted above of partners/providers not being set up to meet reporting requirements, we are mindful of the following specific risks with the Bi-Directional Integration project. We intend to devise focused monitoring mechanisms for these risks. This is only a sample of monitoring initiatives.

- Proper identification of and outreach to highest-risk populations, particularly inactivated patients.
- Adequate funding for self-management tools.
- Ability to spread proven models working within the OCH region, e.g. PCHS hypertension management model, KMHS team based integrated programs promoting better self-management.
- Patient adoption of targeted management models, e.g. Whole Health Action Management (WHAM) program or Wisdom Warriors program.
- Ineffective population management and stratification because of low adoption of disease registry tools.

PROJECT METRICS AND REPORTING REQUIREMENTS

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
x	

RELATIONSHIPS WITH OTHER INITIATIVES

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
x	

PROJECT SUSTAINABILITY

The chronic disease prevention and control project supports sustainable health system transformation for people on Medicaid through a newly trained workforce, advancement in population health systems, value-based contracts, and new workflows. These transformations will outlive the MTP and directly translate into the sustainable transformation components described in Section 1: Required Health Systems and Community Capacity (Domain 1) Focus Areas.

<i>Table 7. Driving towards sustainable capacity, infrastructure, workforce, and transformation strategies</i>	
Chronic Disease Prevention and Control→→→→→→→→	Capacity Infrastructure Strategies
Population health platforms integrated within EHRs to allow for sub-group tracking and management	Health information sharing (VBP) (PHS)
Use registries to track patients with diabetes, hypertension, prediabetes, asthma; forms basis for data analytics	Registries (VBP) (PHS)
To identify patients at risk of developing chronic disease	Risk stratification (VBP) (PHS)
To ensure patients receive tailored disease self-management and lifestyle behavior change supports in their community setting	Referral Management (VBP)
An analytic tool to facilitate internal evaluation and rapid-cycle testing of interventions	Analytics - Decision support technology (VBP) (PHS)
Blood pressure cuffs, other self-management tools not covered by Medicaid	Supplies
Chronic Disease Prevention and Control→→→→→→→→	Workforce Strategies
Chronic disease care coordination for patients in rural areas	Telehealth
Training internal staff to perform rapid-cycle testing and evaluation	Population Health Analytics (VBP) (PHS)
Up-training for nurses and other clinicians in population health management and care coordination	Cross training and redefine role
Hire and train CHWs	New workforce
Up-training for nurses and other clinicians in population health management and care coordination	Retraining/Certification/Uptraining
Shared Diabetes Educators, Nurse Managers within NCCs; OCH help identify shared training needs across providers/affiliate partners and arrange for shared workforce development opportunities	Shared workforce
Chronic Disease Prevention and Control→→→→→→→→	Transformation Strategies
Whole person care provides by the patient's medical or behavioral health home; focus on coordinated management of co-morbid conditions	Patient Centered Medical Home (VBP) (PHS)
Whole person care provides by the patient's medical or behavioral health home; focus on coordinated management of co-morbid conditions	Integrated, whole-person care

Standardizing roles and responsibilities within a team-based care approach	Team-Based Care
Strengthening and formalizing care community-clinical care coordination that allow for increased disease self-management	Care Coordination incl. Referral Management (VBP) (PHS)
Linkage to community-based self-management support services that fit the unique profile of each patient; Team-based accountability and supports to patient between visits	Patient-Centered Interactions/Engagement (VBP)
Formal integration of EB decision support structures within practice settings	Organized, Evidence Based Care (VBP)
Enhanced rapid quality improvement processes incorporated within Change Plans	Quality Improvement Strategy/ Workflows (VBP)
All levels of leadership take ownership of transformations based on Chronic Care Model and EP3 Recommendations	Engaged Leadership

VBP: Value-based payment

PHS: Population health systems

The Chronic Care Model's six elements lend themselves to sustained practice transformation because they largely represent fundamental changes to care delivery and enhanced rapid quality improvement processes. The model is systematic in augmenting care delivery redesign, and includes standardizing roles and responsibilities within a team-based care approach, adapting disease-specific guidelines for target conditions, adopting population-health management systems to ensure identification of all target patients, and normalizing measurement tracking. One of the most promising elements of the chronic care model in creating last change for the health of Medicaid recipients in the region is the standardizing of chronic care management visits with target patients. These visits focus solely on the chronic disease of concern and incorporate self-management support at each visit. The purposeful linkage to community-based self-management support services that fit the unique profile of each patient allows for meaningful progress to be made between visits. The care team works with patients together to establish realistic goals, and offers accountability throughout the process to help reach these goals. Patient care teams are primed to maximize any opportunity to engage patients in improving self-management of their chronic condition, including when patients appear for acute visits. Once all of these elements, including community-clinical bi-directional linkages, become standard practice, the project will create long-term impact. Critical to sustainability will be the intentional development of processes for warm hand-offs between clinics, housing service providers, food pantries, and a broad range of other social service providers. Gains in chronic disease self-management will be threatened without ensuring that practice transformation mitigates social determinants of health through partnerships, screening, and referral.

Program impact will be further sustained through implementation of the chronic care model because of its emphasis on community policies that support healthy lifestyles. In the OCH region, providers will collaborate with Healthy Eating/Active Living (HEAL) Coalitions within each county, which focus on policy, systems, and environmental changes necessary to ensure residents have equitable access to healthy living options. HEAL Coalitions are comprised of agencies from multiple-sectors, and their work addresses the community level issues fundamental to the success of patients in managing their chronic diseases. Examples include creating produce gleaning programs in alliance with food banks to ensure low-income residents have access to fresh fruits and vegetables and collaborating with jurisdictional planning departments to promote active transportation infrastructure (e.g., sidewalks and bike paths).

Interested participating provider and affiliate organizations will receive trauma-informed care training and education in the NEAR sciences (neuroscience, epigenetic, adverse childhood experiences, and resiliency sciences). Trauma history and exposure to toxic stress during sensitive developmental periods during infancy, childhood, and adolescence are linked to greater risk for chronic disease, behavioral health issues, and unhealthy lifestyle. Providers and partners will have the opportunity to provide more meaningful and impactful care to patients as they tailor their systems to be more trauma informed.

Throughout the MTP, MCOs will collaborate around the chronic disease management change strategies and assist practices in developing value based care linked to these strategies. Value based contracting reimbursements with MCOs will form the backbone for sustained funding. MCO alignment of benefits to these transformation strategies will assist in sustained impact beyond the demonstration project period. Examples might include coverage of patient participation in WHAM and DPP and coverage of blood pressure monitors. MCOs may play a role in assisting providers to establish shared clinical practice guidelines around asthma prescribing practices and standardized emergency department discharge protocols for follow up with specialty and primary care following acute complications from diabetes, heart disease, and asthma.

ATTACHMENTS

1. *Required* OCH Supplemental Workbook: Tab 3D Partnering Providers
2. *Required* OCH Supplemental Workbook: Tab 3D Implementation Approach

Olympic Community of Health Theory of Action and Alignment

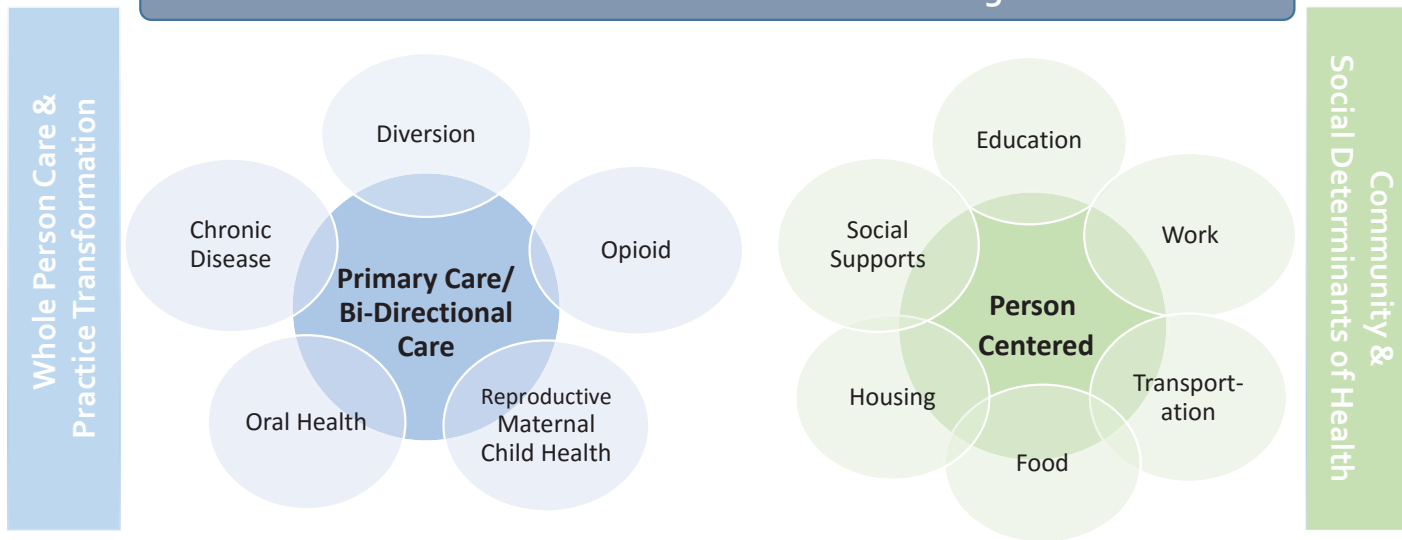
TRANSFORM COMMUNITY AND INDIVIDUAL HEALTH

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 will effectively, efficiently, and compassionately address the well-being and health care needs of every Medicaid client, while advancing the general health and wellness of individuals, communities, and Tribes.

REACH PEOPLE WITHIN THESE POPULATIONS

- ✓ People with mental health and/or substance use including opioid use
- ✓ People leaving the emergency department
- ✓ People transitioning out of jail
- ✓ Parents/caregivers and their young children
- ✓ Women of childbearing age
- ✓ People lacking access to oral health care
- ✓ People needing prevention /early intervention for chronic conditions
- ✓ People with chronic conditions (diabetes, obesity, hypertension, cardiovascular, asthma, behavioral health, including opioids)

Natural Communities of Care – Shared Change Plans



OCH Systems of Care - Transformation Infrastructure

Population Health Management & Interoperability

IT Systems to Support Care Coordination

Work Force Capacity & Training

Value Based Purchasing & Wellness Funding Opportunities

ACROSS ALL PROJECTS

- Outpatient ED Visits

ACROSS MULTIPLE PROJECTS

- Inpatient Hospitalization
- Treatment Penetration: MH, SUD, Opioid
- Child and adolescent access to Primary Care
- Well-Child Visits 3rd, 4th, 5th, 6th Years of Life

PROJECT SPECIFIC

- Follow-up ED discharge for MI, drug dependence
- Follow-up inpatient mental health hospitalization
- Med management for antidepressants
- Patients on high dose opioid therapy, concurrent sedatives
- Percent homeless (narrow definition)
- Percent arrested
- Comprehensive diabetes care measures (5)
- Med management persons with asthma
- Controlling high blood pressure
- Statin therapy patients w/cardiovascular disease
- Childhood immunization status
- Contraceptive Care
- Chlamydia Screening for women 16 – 24
- Prenatal care first trimester
- Utilization of dental services
- Adults with chronic periodontitis
- Dental sealants children, caries intervention well child

OUTCOMES MEASUREMENTS

Olympic Community of Health | Medicaid Transformation Logic Model

PROBLEM STATEMENT. More than 80,000 Medicaid beneficiaries in the Olympic region struggle to receive effective health care due to gaps in services, obstacles to accessing available care, high costs of services, and detrimental social, economic and environmental factors in their communities.

GOALS. Transform the region's health delivery system to provide integrated, consumer-focused, community-supported, value-based, equitable and sustainable services. Achieve measurable improvements in patient and population health and wellness.

ASSUMPTIONS

- Incentives drive system innovations, care integration, and improved outcomes
- Infrastructure and workforce drive capacity for effective care delivery
- Collaborative community partnerships promote effective transformation, address medical, behavioral, and social health determinants
- Consumer-provider partnerships support change and empowerment

RESOURCES

- Human capital provided by implementation partners
- DSRIP funds
- Complementary investments by project partners
- Local public investment
- Wellness and community project investments

ACTIVITIES

- Domain 1 Health systems & community capacity building
- Domain 2 Care Delivery Redesign
 - Bidirectional integration & care transformation
 - Diversions
- Domain 3 Prevention and health promotion
 - Opioid Use Crisis interventions
 - Chronic disease prevention/control
 - Oral Health
 - Maternal and Child Health

OUTPUTS

- DSRIP Transformation progress measures
- Quality Improvement Program (QIP) metrics
- DSRIP Demonstration Project Milestones
 - Planning
 - Implementation
 - Scale & Sustain

OUTCOMES

- Transformed health care delivery:
 - Integrated
 - Consumer-focused
 - Community-supported
 - Value-based
 - Equitable
 - Sustainable
- Increased access to whole person care improves physical, behavioral, and oral health & unnecessary utilization of ED and jail

RESULT

Better health, better care, lower cost, healthier communities

External Factors – Social, economic, and environmental determinants of health

- Geographic disparities in population health care needs, disparities in health care delivery systems and community capacities.
- External forces affecting and/or modifying policies and availability of resources

Partnering Providers Matrix

Partnering Providers are listed if they have participated in OCH meetings or committees, or have expressed an interest in participating, either through commitment forms during OCH's RFA process, or through conversations with OCH staff	2A	2D	3A	3B	3C	3D
	Integration	Diversion	Opioid Crisis Response	Reproductive, Maternal, and Child Health	Access to Oral Health Services	Chronic Disease Prevention and Control
American Indian Health Commission WA						
Amerigroup						
Bogachiel Clinic						
Bremerton Fire Department						
Bremerton Housing Authority						
CHI Franscan Family Residency Program						
CHI Harrison Medical Center						
Cedar Grove Counseling						
City of Poulsbo						
Clallam Bay Clinic						
Clallam County Commissioner						
Clallam County Health and Human Services						
Clallam County Prosecuting Attorney						
Clallam County Sheriff Office						
Clallam County Superior Court						
Community Health Plan of Washington						
Coordinated Care						
Discovery Behavioral Health						
First Step Family Support Center						
Fishline						
Forks Community Hospital						
Harrison Health Partners						
Jamestown S'Klallam Family Health Center						
Jefferson County Commissioner						
Jefferson County Jail						
Jefferson County Public Health						
Jefferson County Sheriff						
Jefferson Healthcare						
Kaiser Permanente						
Kitsap Area Agency on Aging						
Kitsap Children's Clinic						
Kitsap Community Resources						
Kitsap County Commissioner						
Kitsap County Coroner						
Kitsap County Human Services						
Kitsap County Prosecutor's Office						
Kitsap County Sheriff's Office Jail						
Kitsap County Superior Court						
Kitsap County Treatment Court						
Kitsap Housing Authority						

Kitsap Medical Group						
Kitsap Mental Health Services						
Kitsap Public Health District						
Kitsap Recovery Center						
Lower Elwha Tribal Health Center						
Makah Tribe						
Molina						
North Kitsap Family Medicine						
North Olympic Healthcare Network						
Northwest WA Family Residency Program						
OlyCAP						
Olympic Area Agency on Aging						
Olympic Community College						
Olympic Educational School District 114						
Olympic Medical Center						
Olympic Peninsula Healthier Communities Coalition						
Olympic Personal Growth						
Olympic Workforce Development Council						
Peninsula Children's Clinic						
Peninsula Behavioral Health Services						
Peninsula Community Health Services						
Planned Parenthood Bremerton Health Center						
Planned Parenthood Port Angeles Health Center						
Port Angeles Fire Department						
Port Angeles Police Department						
Port Gamble S'Klallam Tribe						
Project Access NW						
Quileute Tribe						
Reflections Counseling Services Group/SUD						
Salish Behavioral Health Organization						
Serenity House						
Silverdale Pediatrics Clinic						
Suquamish Police Department						
Suquamish Tribe						
United Health Care						
Washington Department of Early Learning						
West End Outreach Services						
WestSound Treatment and Recovery Services						
YMCA of Kitsap and Pierce Counties						

Bi-Directional Care and Primary Care Transformation At-a-Glance: Strategies, Projected Outcomes, and Population Served

Strategies	Intermediary Milestone or Metric	Pay for Reporting Metrics	Payment for Performance Metrics	Evidence Base	Natural Community of Care	Target Population	Targeted Subpopulation	Year Est. # Served	Disparities
Support primary care partners adopting Bree Collaborative approach by facilitating practice transformation consultation, improved population health management capacity, shared strategies for sufficient and trained workforce, and furthering payment methodologies for sustainability to develop and maintain: 1. Integrated Care Team 2. Patient Access to BH as Routine Part of Care 3. Accessibility and Sharing of Patient Information 4. Practice Access to Psychiatric Services 5. Operational Systems and Workflows to Support Population-Based Care 6. Evidence-Based Treatments 7. Patient Involvement in Care 8. Data for Quality Improvement	<i>Natural Community of Care Collaborative Agreement in place</i> <i>Natural Community of Care shared change plan</i> <i>Partnering provider organization change plan</i> <i>Contract in place with OCH</i> <i>Monthly reports sent to OCH</i>	# of partnering PCPs who achieve special recognition / certifications / licensure (e.g., MAT) # of practices / providers implementing evidence-based approaches # of practices / providers trained on evidence-based practices: projected vs actual	Antidepressant Medication Management Child and Adolescents' Access to Primary Care Practitioners Comprehensive Diabetes Care: HbA1c Testing Comprehensive Diabetes Care: Medical attention for nephropathy	Bree Collaborative Behavioral Health Integration Report & Recommendations: http://www.breecollaborative.org/topic-areas/behavioral-health/	Clallam Jefferson Kitsap	All Medicaid beneficiaries in primary care	Medicaid beneficiaries with mental health and or substance use diagnosis Medicaid beneficiaries with chronic disease and at least 1 behavioral health comorbidity Medicaid beneficiaries in need of referral to specialty behavioral health care for treatment Medicaid beneficiaries with behavioral health diagnosis and 1) unnecessary use of ED for BH related visits; 2) at discharge from jail; 3) homeless or at imminent risk of homelessness	OCH Region: 17,000 Source: DSHS RDA CY2015, any MH and any SUD treatment need, AAP %positive, age 20-64.	Low income populations have higher incidence of mental illness, substance use and untreated chronic illnesses and including exacerbation of illnesses due to lack of or inadequate housing, transportation nutrition, lack of social support and isolation; and higher incidence of tobacco use and obesity, asthma, hypertension, diabetes, and cardiovascular disease.
Support primary care partners adopting Collaborative Care Model by facilitating practice transformation consultation, improved population health management capacity, shared strategies for sufficient and trained workforce, and furthering payment methodologies for sustainability to develop and maintain: 1. Patient-Centered Team Care / Collaborative Care 2. Population-Based Care 3. Measurement-Based Treatment to Target 4. Evidence-Based Care 5. Accountable Care	<i>Proxy measures under development; will be selected to predict P4P metrics and/or desired outcomes for QIP; will be included in contracts and reported by partners.</i>	% PCP in partnering provider organizations meeting PCMH requirements QIP Metrics Depression screening and follow up for	Medication Management for People with Asthma (5 – 64 Years) Mental Health Treatment Penetration (broad) Outpatient Emergency Department Visits per 1000	Collaborative Care Model: http://aims.uw.edu/collaborative-care	Clallam Jefferson Kitsap	All Medicaid beneficiaries in primary care	Medicaid beneficiaries identified with mental health and or substance use diagnosis Medicaid beneficiaries with chronic disease and at least 1 behavioral health comorbidity Medicaid beneficiaries in need of referral to specialty behavioral health care for treatment Medicaid beneficiaries with behavioral health		Low income populations have higher incidence of mental illness, substance use and untreated chronic illnesses and including exacerbation of illnesses due to lack of or inadequate housing, transportation nutrition, lack of social support and isolation; and higher incidence of tobacco use and obesity, asthma, hypertension, diabetes, and cardiovascular disease.

		adolescents and adults	Member Months				diagnosis and 1) unnecessary use of ED for BH related visits; 2) at discharge from jail; 3) homeless or at imminent risk of homelessness		
Support behavioral health care partners adopting Milbank Report approaches, facilitating practice transformation consultation, improved population health management capacity, shared strategies for sufficient and trained workforce, and furthering payment methodologies for sustainability to develop and maintain: 1. Off-site, Enhanced Collaboration or 2. Co-located, Enhanced Collaboration 3. Co-located, integrated Either option 1, 2 or 3 will be supported by the OCH in applying core principles of the Collaborative Care Model.			Plan All-Cause Readmission Rate (30 Days) Substance Use Disorder (SUD) Treatment Penetration Comprehensive Diabetes Care: Eye Exam (retinal) performed Follow-up After Hospitalization for Mental Illness Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence Inpatient Hospital Utilization	Integrating Primary Care into BH Setting: What Works for Individuals with Serious Mental Illness, http://www.milbank.org/wp-content/files/documents/papers/Integrating-Primary-Care-Report.pdf .	Clallam Jefferson Kitsap	All Medicaid beneficiaries in mental health and/or substance use treatment setting	Medicaid beneficiaries receiving Mental Health and/or SUD specialty care services	OCH Region: 4,000 Source: DSHS RDA CY2015, Clients of State-Funded Alcohol or Drug Services (Age 18+), Risk and Protection Profile for Substance Abuse Prevention. 2,500 Source: Estimated 3.5% penetration of total Medicaid obtained in HCA AIM Cat 1 BH and CC, thru June 2016 CY2015.	Low income populations have higher incidence of mental illness, substance use and untreated chronic illnesses, including exacerbation of illnesses due to lack of or inadequate housing, transportation nutrition, lack of social support and isolation; and higher incidence of tobacco use, obesity, asthma, hypertension, diabetes, and cardiovascular disease.

Diversions Interventions At-a-Glance: Strategies, Projected Outcomes, and Population Served

Strategies	Intermediary Milestone or Metric (toward desired outcome)	Pay for Reporting Metrics and Milestones	Payment for Performance Metrics	Evidence Base	Natural Community of Care	Target Population	Targeted Subpopulation	Estimated # Targeted per Year at Max. Capacity	Disparities
Connect individuals in emergency departments and jails to primary care, behavioral health care, dental care, the coordinated housing intake system, tailored, intensive case management programs	<p>Natural Community of Care Collaborative Agreement in place</p> <p>Natural Community of Care shared change plan</p> <p>Partnering provider organization change plan</p> <p>Contract in place with OCH</p> <p>Monthly reports sent to OCH</p> <p>Proxy measures under development; will be selected to predict P4P metrics and/or desired outcomes from QIP; will be included in contracts and</p>	<p>Report against QIP metrics</p> <p>Number of partners trained by selected approach / strategy: projected vs. actual and cumulative</p> <p>Number of partners participating and number implementing each selected approach / strategy</p> <p>% partnering provider organizations sharing information (via HIE) to better</p>	<p>Outpatient ED Visits</p> <p>Percent Homeless</p> <p>Percent Arrested</p>	<p>ER is for Emergencies</p> <p>Law Enforcement Assisted Diversion</p> <p>Jail Re-Entry Tribal Program</p>	Clallam Jefferson Kitsap	<p>All Medicaid beneficiaries being discharged from the ED and released from jail.</p> <p>[NOTE: Medicaid benefit is suspended while incarcerated and is automatically reinstated within a day of release]</p>	<p>Patients who do not have a patient-centered medical home; in need of housing services; diagnosis of asthma, diabetes, hypertension, behavioral health disorder (emphasis on opioid use disorder diagnosis), dental pain; high recidivism (e.g., ED visits >=5/yr; arrests >=3/yr)</p>	<p>Estimated # served discharging from ED* Clallam: 7,000 Jefferson: 2,000 <u>Kitsap: 20,000</u> TOTAL: 29,000</p> <p>Estimated # served released from jail* Clallam: 900 Jefferson: 540 <u>Kitsap: 2,000</u> TOTAL: 3,440</p> <p>Estimated # served by Tribal Jail Re-Entry Program*: 45 [NOTE: <i>Suquamish and Port Gamble S'Klallam Tribes with option to expand</i>]</p>	<p>Unnecessary ED use is and of itself a marker of poor health equity; indicating underlying issues such as lack of health insurance or transportation, or poor health literacy.</p> <p>Persons incarcerated frequently have chronic medical, mental health and substance use disorders and are often frequent users of the ED. Approx. 60% of people in jail have a behavioral health diagnosis (SOURCE: conversation with Salish Behavioral Health Organization).</p>

Community Paramedicine	reported by partners	<p>coordinate care</p> <p>% of partnering provider organizations with staffing ratios equal or better than recommended</p> <p>VBP arrangement with payments / metrics to support adopted model</p>	Outpatient ED Visits	Community Paramedicine Model	Clallam	Medicaid residents of Port Angeles and Forks.	Patients referred from partnering providers with chronic medical conditions such as chronic heart failure, chronic obstructive pulmonary disease, diabetes; and/or with complex behavioral health conditions	<p>Estimated # served*: 360</p> <p><i>(240 in Port Angeles and 120 in Forks)</i></p> <p>*Estimates arrived at through provider communication about caseload capacity</p>	Medicaid beneficiaries who are referred are more likely to have lack of a support network, lack of transportation, geographic isolation, financial barriers, or poor health literacy.
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Opioid Response Project At-a-Glance: Strategies, Projected Outcomes, and Population Served

Strategies	Intermediary Milestone or Metric	Pay for Reporting Metrics and Milestones	Payment for Performance Metrics	Evidence Base	Target Population	Targeted Subpopulation	Est. # per Year at Max Capacity	Disparities
Improved opioid prescribing practices	Natural Community of Care Collaborative Agreement in place	# and list of community partnerships	Patients on high-dose chronic opioid therapy by varying thresholds Patients with concurrent sedatives prescriptions	Six Building Blocks for Safe Opioid Prescribing	All Medicaid beneficiaries with an opioid use disorder or at risk for developing an opioid use disorder and their families	Beneficiaries with a diagnosis of Opioid Use Disorder (OUD) and their families as well as beneficiaries not yet diagnosed with OUD	2636	The opioid public health crisis touches every single person in our region in some manner. This issue is most prevalent in minority, low-SES communities, and frequently co-exists with other chronic health problems and homelessness. OCH is working closely with the Tribes to support Tribal specific opioid efforts in each of the communities and there is Tribal representation on Steering Committee and each of the 3 workgroups.
	Natural Community of Care shared change plan	# of health care providers, by type, trained on AMDG's Interagency Guideline on Prescribing Opioids for Pain		Washington State Agency Medical Director's (AMDG) prescribing guideline			11488	
	Partnering provider organization change plan			CDC Guideline for Prescribing Opioids for Chronic Pain		Beneficiaries without a cancer diagnosis with an opioid prescription in the last year	2385	
	Contract in place with OCH	# of health care organizations with EHRs that newly provide clinical decision support for opioid guidelines		Bree Collaborative Opioid Prescribing Metrics		Beneficiaries without a cancer diagnosis who are chronic opioid users	2247	
	Monthly reports sent to OCH			Bree Collaborative Dental Guideline on Prescribing Opioids for Acute Pain Management		Beneficiaries without a cancer diagnosis who are on high dose prescriptions	176 (visits, not unique individuals)	
	Proxy measures under development; will be selected to predict P4P metrics and/or desired outcomes from QIP; will be included in contracts and reported by partners. Early	QIP Metrics		2017 WA State Interagency Opioid Response Plan		Beneficiaries who have presented to the ED with an overdose	1009 (children with prescription in previous 12 months; 167 with a high-dose	
				Center for Opioid Safety Education				

Increase in access to and utilization of full spectrum of opioid use disorder treatment	<p>planning from 3CCORP indicate the following QIP measures:</p> <p>Improved treatment for chronic pain, including non-pharmacological interventions</p> <p>Increase in providers accessing and using PMP</p> <p>Increased awareness and education regarding OUD and OUD treatment</p>	<p># and list of community partnerships</p> <p># and location of buprenorphine prescribers</p> <p># and location of MH/SUD providers delivering acute care and recovery services to people with OUD</p> <p># and type of access points for MAT</p> <p>QIP Metrics</p>	Substance Use Disorder (Opioid) Treatment Penetration	<p>Bree Collaborative Opioid Use Disorder Treatment Report and Recommendations</p> <p>2017 WA State Interagency Opioid Response Plan</p> <p>Center for Opioid Safety Education</p>		Beneficiaries under the age of 18 at risk for developing OUD	prescription)	
Prevent or intervene in opioid overdoses to prevent death	<p>Increase in coordination between primary care and behavioral health</p> <p>Increase in people trained to recognize and respond to an overdose</p> <p>Decrease in opioid related ED visits</p> <p>Increase in health care providers' recognizing OUD and linking to appropriate treatment</p> <p>Decrease in fatal and non-fatal opioid related overdoses</p> <p>Increased access to naloxone</p>	<p># and list of community partnerships</p> <p># of EDs with protocols for overdose education and take home naloxone for opioid overdose</p> <p># of local health jurisdictions / CBOs that received TA to organize or expand syringe exchange programs</p> <p>QIP Metrics</p>	<p>Outpatient ED Visits</p> <p>Inpatient Hospital Utilization</p>	<p>2017 WA State Interagency Opioid Response Plan</p> <p>Center for Opioid Safety Education</p> <p>StopOverDose</p>			SOURCE: HCA AIM Team	

Reproductive, Maternal, and Child Health At-a-Glance: Strategies, Projected Outcomes, and Population Served

Strategies	Intermediary Milestone or Metric (toward desired outcome)	Pay for Reporting Metrics and Milestones	Payment for Performance Metrics	Evidence Base	Natural Community of Care	Target Population	Targeted Subpopulation	Estimated # Targeted per Year at Max. Capacity	Disparities
10 preconception health and health care recommendations to improve the health of women, men, and couples, before conception of a first or subsequent pregnancy	<p>Natural Community of Care Collaborative Agreement in place</p> <p>Natural Community of Care shared change plan</p> <p>Partnering provider organization change plan</p> <p>Contract in place with OCH</p> <p>Monthly reports sent to OCH</p> <p>Proxy measures under development; will be selected to predict P4P metrics and/or desired outcomes from QIP; will be included in contracts and reported by partners</p>	<p>Report against QIP metrics</p> <p>Number of partners trained by selected model / approach: projected vs. actual and cumulative</p> <p>Number of partners participating and number implementing each selected model / approach</p>	<p>Mental Health & Substance Use Treatment Penetration</p> <p>Childhood Immunization Status</p> <p>Contraceptive Care – Postpartum</p> <p>Chlamydia Screening in Women Ages 16 to 24</p> <p>Outpatient ED Visits</p> <p>Contraceptive Care – Most & Moderately Effective Methods</p> <p>Prenatal care in the first trimester of pregnancy</p> <p>Well-Child Visits in the First 15 Months of Life</p>	CDC Pre-conception Health and Health Care	Clallam Jefferson Kitsap	<p>Women and men of reproductive age and their partners</p> <p>All sexually active men and women</p> <p>All pregnant women</p> <p>All women following labor and delivery</p> <p>All men and women during assessment visit</p>	Women and men classified as high-risk through provider intake and assessment.	<p>15,000 women*</p> <p>Source: HCA AIM RHNI Phase 3, 4.25.17</p> <p>5,000 men*</p> <p>1,500 pregnant women*</p> <p>Source: DSHS First Steps Database, accessed October 2017</p>	<p>Pregnant women who are Medicaid beneficiaries are more likely to have financial barriers to receiving quality, person-centered care as compared to women on commercial insurance.</p> <p>There is little access to affordable sexual and reproductive health care for low income men and women, particularly in the rural, geographically isolated subareas of the region.</p>

Section 1 - Theory of Action and Alignment-AttG-Reproductive Maternal and Child At a Glance

Olympic Community of Health

Federally qualified health center collaborates with Medicaid Managed Care Organizations to perform targeted outreach and engagement to shared Medicaid clients receive well-child checks.			Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life Well-Child Visits in the First 15 Months of Life	Peninsula Community Health Services well-child visit incentive program		Children ages 0 to 6 years and parents/caregivers	Children attributed to a provider organization who have not come in for a well-child visit.	1,500 babies* Source: DSHS First Steps Database, accessed October 2017 5,000 children* * Values based on proportions on individuals enrolled in Medicaid; some additionally sourced as noted	The rate of well-child visits varies by 27%, between 49%-62%, across race groups. This is an indication of major barriers to access for certain subpopulations. Source: Healthier Washington Data Dashboard, Accessed August 2017
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Oral Health Care Project At-a-Glance: Strategies, Projected Outcomes, and Population Served

Strategies	Intermediary Milestone or Metric	Pay for Reporting Metrics and Milestones	Payment for Performance Metrics	Evidence Base	Natural Community of Care	Target Population	Targeted Subpopulation	Est. # per Year at Max Capacity	Disparities
Mobile Van - Full service van planned including both restorative and preventive dental services	<p>Natural Community of Care Collaborative Agreement in place</p> <p>Natural Community of Care shared change plan</p> <p>Partnering provider organization change plan</p> <p>Contract in place with OCH</p>	<p># of partners / providers implementing the evidence-based approach</p> <p># of partners / providers trained on evidence-based approach: projected vs actual and cumulative</p> <p># of Medicaid beneficiaries served: projected vs actual and cumulative</p> <p>QIP Metrics</p>	<p>Utilization of dental services by Medicaid Beneficiaries</p> <p>Periodontal evaluation in adults with chronic periodontitis</p> <p>Outpatient Emergency Department visits</p> <p>Dental sealants for children at elevated risk</p>	National maternal and child health resource center provides a manual to guide planning and implementation of mobile dental units and portable dental care equipment for school-age children, which could be adapted for adults.	Clallam Jefferson Kitsap	Adults and children on Medicaid without or with limited dental access	Children in school; Elderly in skilled nursing or assisted living facilities; Referrals from primary care providers in the three counties for their patients who do not have access to dental services	1,000	<p>The mobile van will increase access for rural, isolated populations, who are burdened with higher rates of poverty, co-occurring diagnoses, and multiple chronic diseases.</p> <p>The van will also offer services to traditionally vulnerable populations: pregnant women, institutionalized elderly, and children.</p>
Expand use of integration of dental services in medical primary care settings	<p>Monthly reports sent to OCH</p> <p>Purchase and outfit a mobile dental van</p> <p>Proxy measures under development; will be selected to predict P4P metrics and/or desired outcomes from QIP; will be included in</p>		<p>Utilization of dental services by Medicaid Beneficiaries</p> <p>Outpatient Emergency Department visits</p> <p>Dental sealants for children at elevated risk</p> <p>Primary caries prevention intervention as part of well-child visit with PCP</p>	Oral Health in Primary Care: integrating oral health screening, assessment, intervention, and referral, into the primary care setting oral health screening, assessment, intervention, and referral, into the primary care setting.	Clallam Jefferson Kitsap	Adults and children on Medicaid during primary care visit	Patients screened by primary care providers: emphasis on pregnant women, children, and adults on Medicaid	1,000	Integration will focus on populations with highest need and potential benefit from oral health access: pregnant women, adults with diabetes, and children.

Develop new dental FQHC site in North Kitsap (est. operational date: 2019)	contracts and reported by partners		Utilization of dental services by Medicaid Beneficiaries		Kitsap	Adults and children on Medicaid in North Kitsap	Priority populations include patients without dental access	3000 (assumed 2 dentists and 1 RDH)	The two regions identified for capital expansion projects have extremely poor access to dental services, among the lowest in the state. These are rural, isolated settings, with high rates of poverty and poor transportation infrastructure.
Develop new dental RHC site in Jefferson County (est. operational date: 2020)			Periodontal evaluation in adults with chronic periodontitis		Jefferson	Adults and children on Medicaid in Jefferson County	Priority populations include children, pregnant women, and people with diabetes.	1400 (assumed 1 dentists and 1 RDH)	
Support and expand DHAT workforce for tribal clinics			Outpatient Emergency Department visits	Alaska Dental Health Aide Program	Tribes expressing an interest in exploring further:	AI/AN people served by tribal clinics	Same	250	AI/AN born today have a life expectancy that is 4.4 years less than the U.S. all races population (73.7 years to 78.1 years, respectively) and continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases (IHS.gov, April 2017)
			Dental sealants for children at elevated risk						
			Primary caries prevention intervention as part of well-child visit with PCP		Jamestown S'Klallam				
					Lower Elwha Klallam				
					Port Gamble S'Klallam				
Offer preventive dental services to school-based clinics - Begin in Jefferson County (Port Townsend and Chimacum) with potential expansion to Clallam County			Dental sealants for children at elevated risk	SEAL AMERICA: The Prevention Invention, 2016. A manual for provider dental sealants in school-based settings.	Jefferson, possibly scaled to Clallam in later years	Children in school	Same	300 (assumes 1 provider to apply sealants; excludes children served by dental van)	Children living in rural settings are more likely to live in families experiencing lack of transportation, geographic isolation, financial barriers, or poor health literacy.
			Utilization of dental services by Medicaid beneficiaries						

Chronic Care Project At-a-Glance: Strategies, Projected Outcomes, and Population Served

Strategies	Intermediary Milestone or Metric	Pay for Reporting Metrics	Payment for Performance Metrics	Evidence Base / Best Practice	Natural Community of Care	Target Population	Targeted Subpopulation	Year Est. # Served	Disparities
Organization of the Healthcare Delivery System Community Linkages Self-management support Decision support Delivery system re-design Clinic information systems	Securing regional licensing for DPP and CDSM Natural Community of Care Collaborative Agreement in place Partnering provider organization change plan Contract in place with OCH Proxy measures under development; will be selected to predict P&P metrics; will be included in contracts and reported by partners	# of healthcare providers trained in appropriate blood pressure assessment practices # of new / expanded nationally recognized self-management support programs (e.g., CDSMP, NDPP) # of partners participating / implementing each selected model / approach # of partners trained on selected model / approach: projected vs actual and cumulative # of home visits for asthma services, hypertension % of patients provided with automated blood pressure monitoring equipment QIP Metrics	Child and Adolescents' Access to Primary Care Practitioners Comprehensive Diabetes Care: HbA1c Testing Comprehensive Diabetes Care: Medical attention for nephropathy Outpatient Emergency Department Visits per 1000 Member Months Statin Therapy for Patients with Cardiovascular Disease (Prescribed) Comprehensive Diabetes Care: Eye Exam (retinal) performed Inpatient Hospital Utilization	Chronic Care Model, DPP, WHAM, CDSM/ Wisdom Warriors	Clallam, Jefferson, Kitsap	Adult Medicaid beneficiaries	Persons with mild mental health issues; Persons with severe mental illness and/or substance use disorder; persons with CHF; AI/AN	11,880* *Estimate arrived at through provider communication about caseload capacity	AI/AN have highest rate of behavioral health and comorbid mental health and SUD* 70-80% of Medicaid recipients with MH or SUD also have at least one chronic condition* Medicaid recipients in OCH with MH or SUD diagnosis have at least 2-fold increased rate of chronic disease compared to those without MH/SUD* *Source: WA HCA AIM, Cat 1 Behavioral Health and Chronic Conditions, 9/29/2017 Low-income adults report low rates of physical activity Source: BRFSS 2011-2015

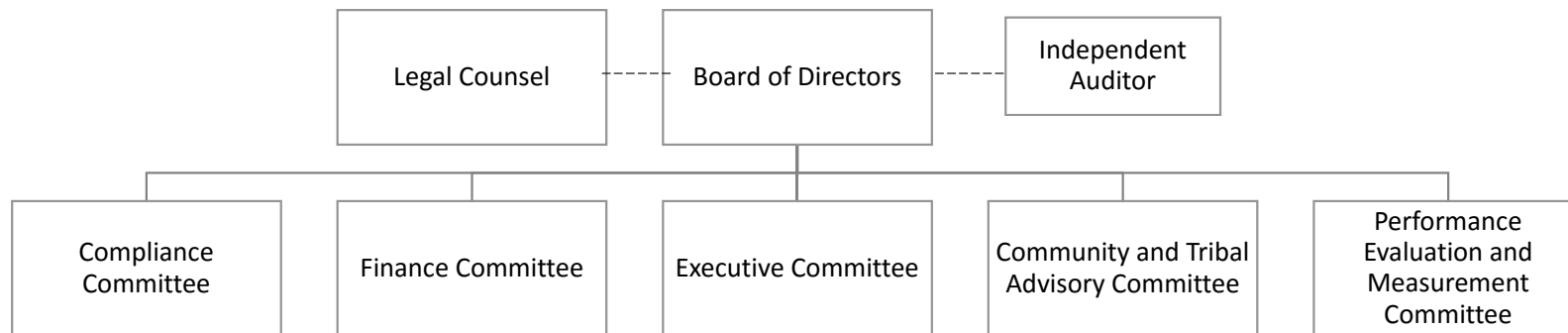
Asthma assessment and monitoring; Education for partnership in asthma care; Control of environmental factors and co-morbid conditions that affect asthma; Managing asthma long-term (including use of EPA Asthma Environmental Checklist)	<p>Natural Community of Care Collaborative Agreement in Place</p> <p>Partnering provider organizations change plan</p> <p>Contract in place with OCH</p> <p>Monthly reports sent to OCH</p> <p>Proxy measures under development; will be selected to predict P4P metrics; will be included in contracts and reported by partners</p>	<p>% of documented, up-to-date Asthma Action Plans</p> <p># of home visits for asthma services, hypertension</p>	Medication Management for People with Asthma (5 – 64 Years)	National Heart, Lung, and Blood Institute Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma	Clallam, Jefferson, Kitsap	Adult and child Medicaid beneficiaries	Persons w/ severe mental illness and/or substance use disorder; AN/AI; Children; Older adults; smokers	<p>2,700*</p> <p>*Estimate based on current number of patients diagnosed with asthma within OCH's two FQHCs and KMHS</p>	<p>Persons with SUD and MH have higher disease burden with asthma</p> <p>6% fewer non-free and reduced lunch OCH students in 8, 10, and 12 grade combined (20%) have been diagnosed with asthma than free and reduced lunch students (26%) (HYS 2016)</p> <p>Adult females in Jefferson and Kitsap have statistically significant higher prevalence of asthma than males (BRFSS, 2011-2016, analysis by KPHD)</p> <p>Low income adults in Jefferson and Kitsap have statistically significant higher prevalence of asthma than non-low income adults (BRFSS 2011-2016, analysis by KPHD)*</p> <p>*Note: Annual household income less than \$35,000. Eligibility for Medicaid is equal or less than 138% of poverty; a family of four earning \$33,948 in 2017.</p>
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Olympic Community of Health

Visual of Governance Structure

Revised October 17, 2017

Section I. Governance



Olympic Community of Health Solicitation for Public Comment

Reminder Newsletter released June 2, 2017, requesting public comment



CLALLAM • JEFFERSON • KITSAP

Still Time for Public Comment

The [OCH](#) received 10 proposals from the community on how to invest Medicaid Demonstration Transformation DSRIP (Delivery System Reform Incentive Payment) over the next 4.5 years.

We want to hear from you.

Please [review the proposals](#) and then fill out this [survey](#) to tell us what you think.

The public comment period will close on June 9. Your input will help the OCH Board of Directors decide which proposals should move forward as full Project Applications to be submitted to the State in October.

In Partnership,
The OCH Team



Join us for the next OCH Partner Convening!
Monday, June 19th,
12:30pm-3:30pm
Red Cedar Hall,
Jamestown Tribal Center,
Sequim, WA

We will discuss the current status of the portfolio of projects under the Demonstration Project. This event is free and open to the public.

PLEASE RSVP to mia@olympicch.org by June 12th.



Survey collecting public comment responses; Open May 26 to June 9



Medicaid Demonstration Project Application Public Comment

Background and Instructions

Background:

Through a collaborative community process, 10 applications have been submitted to the Olympic Community of Health (OCH) for Medicaid Demonstration Projects in 5 categories: Transitional Care, Diversion Interventions, Reproductive and Maternal/Child Health, Oral Health Care Access, and Chronic Disease. The OCH will review those applications and determine the portfolio of projects to develop into formal Project Plans to be submitted to the Health Care Authority in September.

Public Comment Instructions:

Please provide comments related to one or more of the applications submitted to the OCH. Thank you in advance for your constructive comments. If you would like us to post your comments publicly on our website and make them available to reviewers and the OCH leadership, please provide your name in the box below. This public comment survey has 5 pages, one for each category listed in the background paragraph above. There are 1 or more applications within each category, each application is listed by title and has a corresponding text box for you to type in your comments. All comments will be reviewed by staff and shared with the OCH leadership by grouped theme.

Thank you for participating in this process. For more information, please visit the [Olympic Community of Health](#) and WA State Health Care Authority [Medicaid Transformation](#) websites.

The public comment period will close on Friday, June 9th at 3 p.m.

Provide your name below if you would like your comments posted publicly.

A quick update on the Olympic Community of Health!

[View this email in your browser](#)

Reminder Newsletter released June 2, 2017, requesting public comment



CLALLAM • JEFFERSON • KITSAP

May News You Can Use!

The [OCH](#) has received WONDERFUL project ideas from the community on how to invest Medicaid Demonstration Transformation DSRIP (Delivery System Reform Incentive Payment) dollars. Take a look and tell us what YOU think!
Please click -----> [HERE](#) to view all Project Applications, then click -----> [HERE](#) to give us your two cents, or more!

The OCH Regional Health Assessment and Planning Committee (RHAPC) will be reviewing and scoring the applications on June 2. The public comment period will close on June 9 and the OCH Board of Directors will make final determinations about which



SAVE THE DATE!
Monday, June 19th,
12:30pm-3:30pm

The OCH is holding our bi-annual Partner Convening. And we want to see all of you there for snacks, refreshments, important updates and much more!
PLEASE RSVP to mia@olympicch.org no later than Monday, June 12th.



The OCH

Taken November 12, 2017

what is the Transformation?

Through a five-year transformation, this proposal includes three initiatives aimed at improving how we take care of individuals to better address local health priorities, deliver high-quality, cost-effective care that treats the whole person, and create linkages between clinical and community-based services.

Click [here](#) to learn more about the Transformation Project.

[click here to enter feedback
on project plan drafts](#)

[diversion draft UPDATED 20171108](#)

[chronic disease draft UPDATED 20171109](#)

[opioid response draft UPDATED 20171109](#)

[oral health draft UPDATED 20171108](#)

[reproductive, maternal, and child health draft
UPDATED 20171108](#)

[funds flow draft](#)

[bidirectional integration draft](#)

[tribal engagement draft](#)

OCH project plan draft feedback

Which project plan(s) would you like to comment on?

Next

1 of 7

call for feedback

The OCH needs your expertise and perspective! We are requesting feedback of all sorts on each of our project plans, which we will submit to the Health Care Authority by November 16th, 2017. **Please respond before November 9th, 2017.** Please note that these are rough drafts, preliminary in nature, and should not be interpreted as final wording. OCH will continue to improve upon these drafts all the way to the finish line!

Your feedback on these drafts will help us to ensure that the final Project Plans the OCH submits sent to the Health Care Authority are clear, comprehensive, and relevant to regional needs. It doesn't matter if you skim one or read through all of them, we would appreciate hearing what you think about the section(s) that interest you.

Please submit feedback to claudia@olympicch.org or [here](#) by **November 9th, 12:00pm**. We want to know whatever you want to tell us, which might include (but is not limited to):

What do you like

What don't you like?

What is missing?

What is unclear?

Is there another angle or perspective that we haven't explored?

Thank you so much for your attention and contribution to this important work in our region. We appreciate you!

In partnership,

The OCH Team

Olympic Community of Health: 3 County Coordinated Opioid Response Project, Workforce Input

The purpose of this survey is to gather community input related to the opioid crisis in Clallam, Jefferson, and Kitsap Counties. Your responses are anonymous and results will be presented in aggregate. Contact information to learn more about the project is listed at the end of the survey. Thank you for your time!

1. Within which county do you work?

☐ Clallam

☐ Jefferson

☐ Kitsap

☐ Other (please specify)

2. What do you do? Check all that apply.

- ☐ Care coordinator
- ☐ Case manager
- ☐ Community health worker
- ☐ Correctional nurse
- ☐ Counselor
- ☐ Crisis intervention law enforcement officer
- ☐ Crisis intervention/DMHP
- ☐ Discharge nurse
- ☐ Discharge/exit specialist
- ☐ Home visitor
- ☐ Mental Health counselor
- ☐ Navigator
- ☐ Nurse
- ☐ Outreach specialist
- ☐ Patient advocate
- ☐ Peer support
- ☐ Probation officer
- ☐ Psychologist
- ☐ Public health nurse
- ☐ Social worker
- ☐ Substance use disorder counselor
- ☐ Other (please specify)

3. Where do you work? Check all that apply.

- ☐ Courts
- ☐ Hospital
- ☐ Housing Agency/Provider
- ☐ Jail
- ☐ Law Enforcement
- ☐ Managed Care Organization
- ☐ Medical home
- ☐ Behavioral health home
- ☐ Public Health
- ☐ School
- ☐ Social Service Agency
- ☐ Syringe exchange
- ☐ Tribal facility
- ☐ Other (please specify)

4. How long have you been doing this work?

- ☐ Less than 1 year
- ☐ 1-5 years
- ☐ 6-10 years
- ☐ 11-15 years
- ☐ 16-20 years
- ☐ More than 20 years

5. How concerned are you about opioids (e.g. prescription pain medications, heroin, fentanyl, etc.) in the work you do?

- ☐ Not at all concerned
- ☐ A little concerned
- ☐ Somewhat concerned
- ☐ Very concerned
- ☐ Extremely concerned

Olympic Community of Health: 3 County Coordinated Opioid Response Project, Workforce Input

6. Do you have access to and/or carry naloxone (overdose reversal medication, sometimes called “narcen”)?

- ☐ Yes, have access to naloxone
- ☐ Yes, carry naloxone
- ☐ No
- ☐ Unsure

Olympic Community of Health: 3 County Coordinated Opioid Response Project, Workforce Input

7. Please tell us why you do not carry naloxone. Check all that apply.

- ☐ cost
- ☐ training
- ☐ policies
- ☐ access
- ☐ not allowed to
- ☐ not necessary
- ☐ need more information
- ☐ not interested
- ☐ Other (please specify)

8. Have you ever witnessed an opioid related overdose?

- ☐ No
- ☐ Yes, only once
- ☐ Yes, 1-5 times
- ☐ Yes, 6-10 times
- ☐ Yes, more than 10 times
- ☐ Unsure

Olympic Community of Health: 3 County Coordinated Opioid Response Project, Workforce Input

9. Of the opioid related overdose(s) you have witnessed, what percent of the time was:

	0%	25%	50%	75%	100%	I don't know
naloxone administered to reverse the overdose?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
911 called?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
the patient transported by EMS to a hospital?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Have you tried to connect your clients with opioid use disorder treatment?

- ☐ Never
- ☐ Yes

11. In general, how much do the following factors impact your clients ability to participate in opioid use disorder treatment?

	significant barrier	somewhat of a barrier	neither barrier nor facilitator	somewhat of a facilitator	significant facilitator
Access	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appropriate fit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Child care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cost	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Distance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Employment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insurance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other priorities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Readiness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Schedule	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stigma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. Would you support having an outpatient opioid treatment program (OTP) in your community? An OTP offers medically supervised treatment for opioid use disorders such as methadone or buprenorphine (e.g. Suboxone).

- ☐ Yes
- ☐ No
- ☐ Unsure

Please share any comments.

13. Which type(s) of outpatient opioid use disorder treatment would you support?

- ☐ Outpatient facility that offers multiple types of treatment, including medication assisted treatment such as suboxone/buprenorphine and methadone
- ☐ Methadone clinic
- ☐ Withdrawal management center ("detox")
- ☐ Primary care-based medication assisted treatment such as suboxone/buprenorphine
- ☐ Other (please specify)

14. How accessible are the following treatment modalities in your community?

	not at all accessible	a little accessible	somewhat accessible	very accessible	extremely accessible
Conventional abstinence based intensive outpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient substance use disorder treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Withdrawal management services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient substance use disorder treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Assisted Treatment or MAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. In your community, do you know...

	Yes	No	Unsure
where a syringe exchange program is located?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
where to dispose of used syringes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
where to dispose of unused medications?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16. Please describe any successful and/or helpful programs in your community to address the opioid crisis that you are aware of.

17. If we had sufficient funds, what are the top two investment areas you would propose to impact the opioid crisis?

18. What is your gender?

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Prefer not to answer

19. How old are you?

- ☐ Under 18
- ☐ 18-34
- ☐ 35-49
- ☐ 50-64
- ☐ 65 or older
- ☐ Prefer not to answer

20. Is there anything else you'd like to share?

Thank you for completing the Olympic Community of Health survey. Your responses will help shape the coordinated response effort across our region. If you have any questions or would like more information about this work, please visit the OCH website: www.olympicch.org or contact Elya Moore, elya@olympicch.org or Lisa Rey Thomas, lisarey@olympicch.org.

A quick update on the Olympic Community of Health!

[View this email in your browser](#)



CLALLAM • JEFFERSON • KITSAP

Informational Webinar TODAY



Friendly reminder- The OCH is hosting an informational Letter of Intent webinar today March 30th, 3:00pm-4:00pm. Please join us!!!

Please visit our website for more information regarding the Medicaid Demonstration Project.
www.olympicCH.org

Dial in by phone:

United States: +1 (571) 317-3122

Join from computer, Tablet or Smartphone:

<https://global.gotomeeting.com/join/788654893>

Access Code: 788-654-893



In Partnership,

[Elya Moore](#), Director

[Mia Gregg](#), Program Coordinator

[Lisa Rey Thomas](#), Director of Special Programs

[Siri Kushner](#), Epidemiologist, Contracted

through Kitsap Public Health District



Tribal input for OCH project plans

Tribal input for Olympic Community of Health Project Plans

The Olympic Community of Health (OCH) is currently developing project plans as required by the Healthcare Authority for the Medicaid Transformation. The Project Plans are due November 16, 2017. The OCH Board of Directors has approved submitting six out of the eight possible projects. The six projects are:

- 2.A. Bidirectional Integration of physical and behavioral health through care transformation (Required)**
- 3.A. Addressing the opioid use public health crisis (Required)**
- 2.D. Diversion Interventions (Diversion from Emergency Department and Incarceration)**
- 3.B. Reproductive and Maternal/Child Health**
- 3.C. Access to Oral Health Services**
- 3.D Chronic Disease Prevention and Control**

This survey is an opportunity for the seven tribes in our shared region to provide input into the project plans and pose questions to the OCH. There is no individual health information requested. The information you submit will be summarized and shared back with the tribes without identifying information. It will also inform the Healthcare Authority of our work with the tribes. Participation in the survey is completely voluntary and you can skip any questions in the survey. The survey should take about 5-10 minutes to complete. If you have any questions, please contact Lisa Rey Thomas (Director of Community and Tribal Partnership and lead on the 3 County Coordinated Opioid Response Project or 3CCORP) at lisarey@olympicch.org or 360-633-9116. Thank you!

1. Which Tribe do you work for?

- | | |
|--|---|
| <input type="radio"/> Makah | <input type="radio"/> Jamestown S'Klallam |
| <input type="radio"/> Quileute | <input type="radio"/> Port Gamble S'Klallam |
| <input type="radio"/> Hoh | <input type="radio"/> Suquamish |
| <input type="radio"/> Lower Elwha | |
| <input type="radio"/> Other (please specify) | |

2. What is your position with the Tribe?

- ☐ Elected leader
- ☐ Health director
- ☐ Executive director
- ☐ Other (please specify)

3. What are the 3 most important health priorities for the Tribe?

One

Two

Three

4. Please share the top 3 successful programs/approaches that the Tribe has implemented to support health.

One

Two

Three

5. Has the Tribe been involved with the Olympic Community of Health (attending meetings, reading newsletters, communicating with staff, etc.)

- ☐ Yes
- ☐ No
- ☐ Somewhat

Comment

6. Please rank the 6 Medicaid Transformation project areas with 1 being most important and 6 being least important. A link to the Medicaid Transformation Toolkit can be found here:

<https://www.hca.wa.gov/assets/program/project-toolkit-draft.pdf>

2.A. Bi-directional integration of physical and behavioral health through care transformation.

2.D. Diversion interventions (diversion from emergency departments and incarceration).

3.A. Addressing the opioid use public health crisis.

3.B. Reproductive and maternal/child health.

3.C. Access to oral health services.

3.D. Chronic disease prevention and control.

7. Do you have any comments about how you ranked the project areas?

8. Is the participating with the Olympic Community of Health on any of the project areas? Please check all that apply.

- ☐ 2.A. Bi-directional integration of physical and behavioral health through care transformation.
- ☐ 2.D. Diversion interventions (diversion from emergency departments and incarceration).
- ☐ 3.A. Addressing the opioid use public health crisis.
- ☐ 3.B. Reproductive and maternal/child health.
- ☐ 3.C. Access to oral health services.
- ☐ 3.D. Chronic disease prevention and control
- ☐ Unsure
- ☐ Please comment

9. Would the Tribe like to participate with the OCH on the project plans? If not, would you like us to contact you again in January, 2018 when we begin crafting implementation plans that are due at the end of June, 2018?

- ☐ Yes I would like to participate now.
- ☐ No we are not interested in participating at this time.
- ☐ Yes please contact us in January of 2018 to discuss the implementation planning.
- ☐ Unsure

Any comments? If you want to participate and/or be contacted in January of 2018, please leave a name and contact information here.

10. Is the Tribe working with the Healthcare Authority to develop Tribal specific projects and directly access design pool funding in Year One and earn incentive payments in Years Two-Five?

- ☐ Yes
- ☐ No
- ☐ Unsure

Comments

11. Does the Tribe have a current health needs and assets assessment?

- ☐ Yes
- ☐ No
- ☐ Unsure

12. If the Tribe does have a current health needs and assets assessment, would you be willing to share it with the OCH to be included in the Regional Health Needs Assessment?

- ☐ Yes
- ☐ No
- ☐ Unsure

Comments

13. Do you have any questions, comments, thoughts, concerns, suggestions that you would like to share?

Tribal input for OCH project plans

The Olympic Community of Health (OCH) is preparing a project plan portfolio to earn funds for our region under the statewide Medicaid Transformation Project (MTP). For our application to be competitive, we need input and information from you!

The questions below can be answered by email or if you prefer, we would be happy to schedule a brief phone call to collect your responses. We would appreciate receiving your information either as a response to this email or through a phone meeting no later than Monday, October 30th. If you have questions, please contact Claudia Realegeno: claudia@olympicch.org or 360-509-7713

Name of Practice:

Name of Representative Completing Survey:

1. In 2016, how many total Medicaid patients did you serve?

2. In 2016, how many Medicaid patients were assigned to your practice?

3. Of those patients assigned to your practice, how many did you actually see during 2016?

4. What is the current wait time to next appointment for:

a. new Medicaid patients:

b. current Medicaid patients:

5. Do you feel your organization is able to meet the current level of demand for services among the Medicaid population?

6. In 2016, please provide the number of people you served in the following categories:

a. Medicaid

b. Medicare

c. Medicaid/Medicare Dual Eligibles

d. Private/Commercial

e. IHS

f. Self-Pay

g. Uninsured

h. Other

7. Is your website up to date about what services you offer? If not, what is missing?

--

8. What are your perceptions of Medicaid patient barriers to accessing needed care?

--

9. Does your practice do any surveys with your patients to collect input on:

a. need for, access and barriers to health care services?

b. need for, access and barriers to supportive services?

If yes for either, are you willing to share what you learned?

10. Contact information for the person you would like to be your organizations main contact for financial transfers.

Name

Phone Number

11. All partnering providers contracted for work under MTP are required to enter into the financial executor portal. If you would like to enter this information now to expedite the process, please enter the following information (you may provide this information at a later time, but it may delay payment):

a. Employer Identification Number (EIN)

b. Medicaid Provider ID if available

The Olympic Community of Health (OCH) is preparing a project plan portfolio to earn funds for our region under the statewide Medicaid Transformation Project (MTP). For our application to be competitive, we need input and information from you!

The questions below can be answered by email or if you prefer, we would be happy to schedule a brief phone call to collect your responses. We would appreciate receiving your information either as a response to this email or through a phone meeting no later than Monday, October 30th. If you have questions, please contact Claudia Realegeno: claudia@olympicch.org or 360-509-7713

Name of Organization:

Name of Representative Completing Survey:

1. In 2016, how many individuals on Medicaid did your organization serve?

2. Do you feel your organization is able to meet the current level of demand for services among the Medicaid population?

3. Please describe how you currently serve individuals on Medicaid:

4. What are your perceptions of barriers to accessing needed services among individuals on Medicaid?

a. housing/homeless services

b. financial assistance

c. health care

d. nutritional assistance

e. transportation

f. education/workforce training

g. employment services

h. legal services

i. translation services

5. Does your organization do any surveys with your clients to collect input on:

a. need for, access and barriers to health care services?

b. need for, access and barriers to supportive services?

If yes for either, are you able to share what you learned? (yes/no)

6. Please provide the point of contact information for potential contracting purposes:

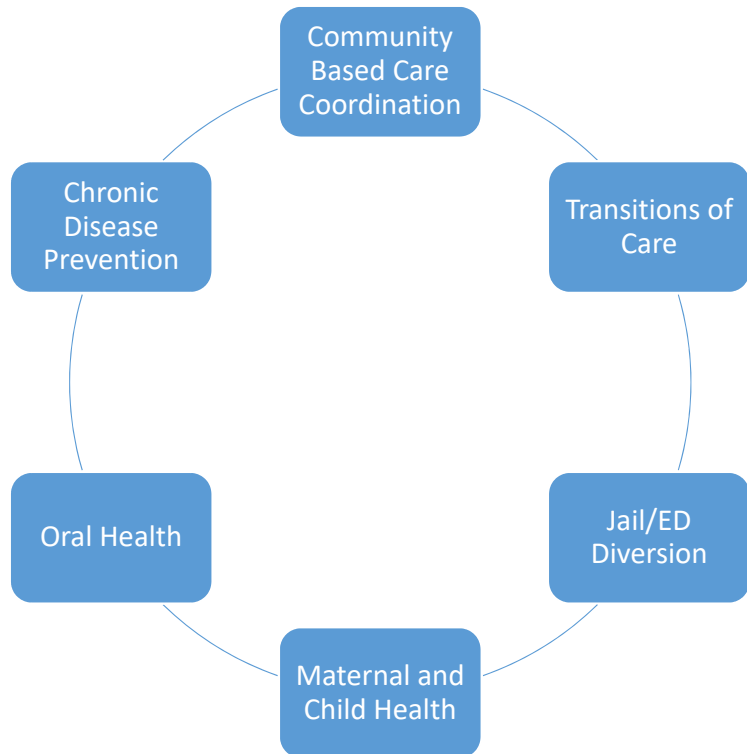
Name

Phone Number

OCH Community Input Survey Results

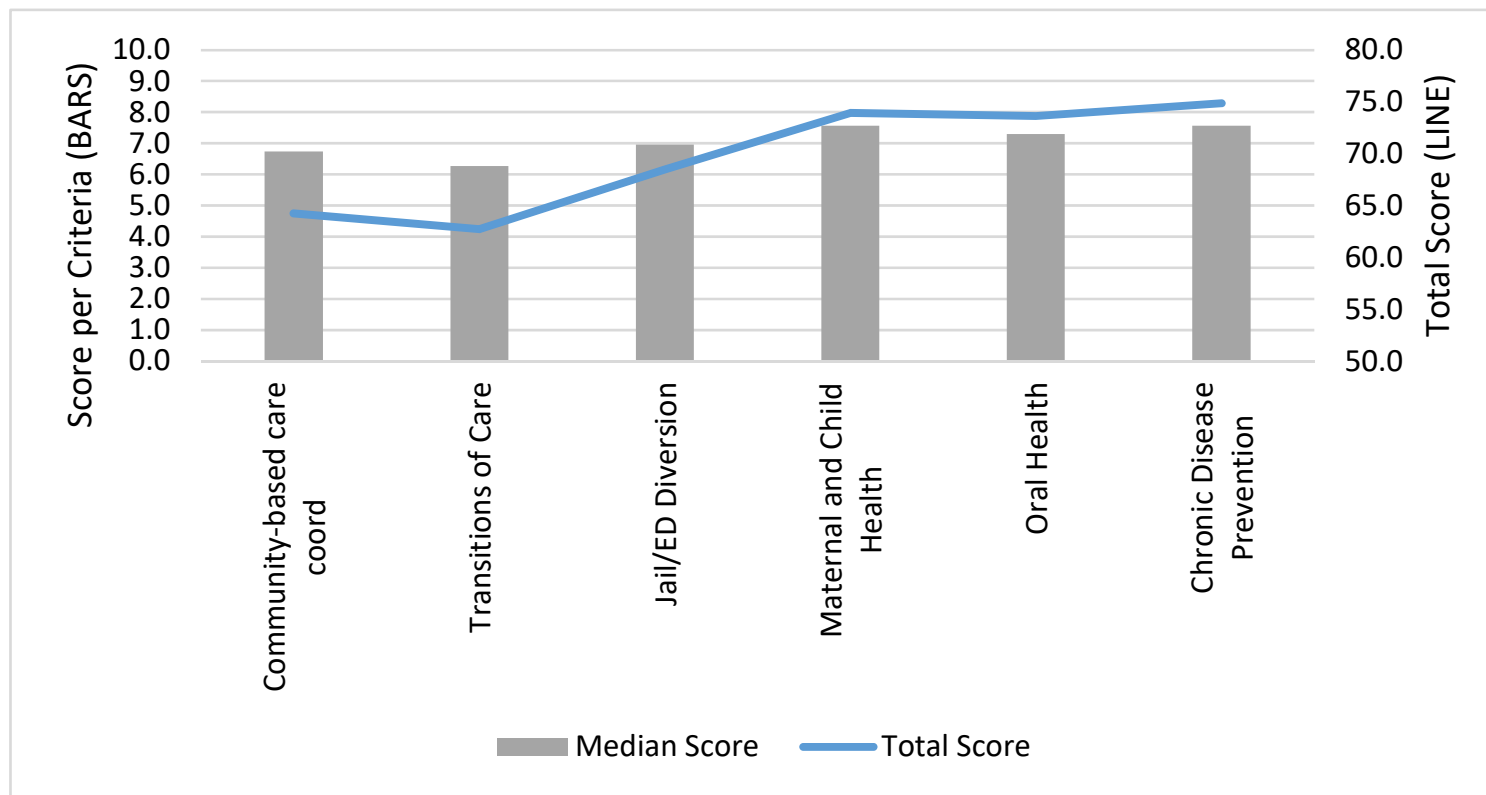
Purpose:	Gather input about the optional projects described in the Medicaid Transformation Project Tool Kit from residents in Kitsap, Clallam, and Jefferson counties.
Distribution Method:	OCH Partner Convening January 2017; OCH Newsletters; OCH website
Period:	January –June 9, 2017
Responses:	64
Instructions:	Score the six optional project areas in the tool kit based on ten different criteria

OCH Community Input Survey Results

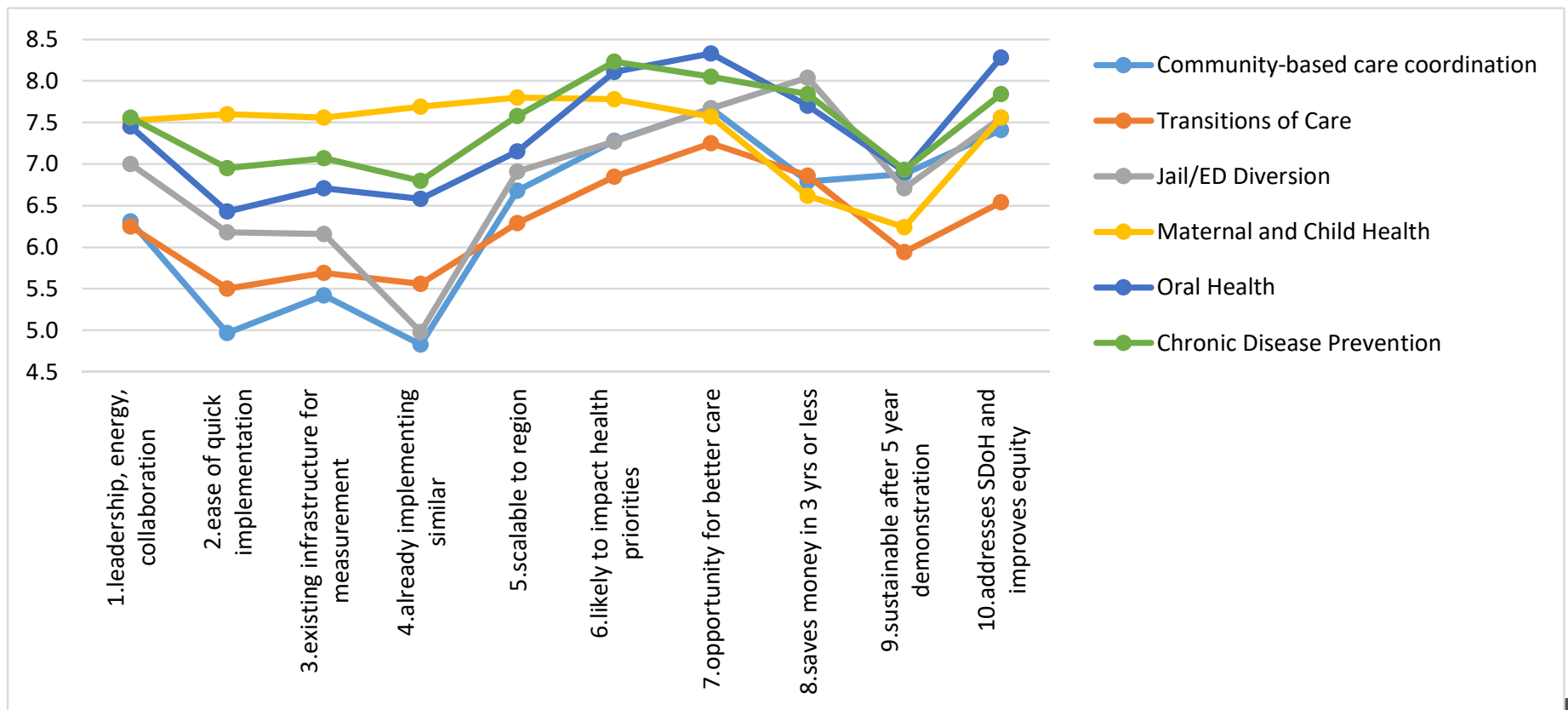


1. Existing local leadership, energy and collaboration around this project
2. Ease of quick implementation
3. Existing infrastructure to measure project process and outcomes
4. Already implementing a *similar* model
5. Scalable to the three-county region
6. Likely to improve health within 1 or more regional health priority area
7. Offers an opportunity for Medicaid providers to provide better care
8. Saves money for Medicaid in 3 years or less
9. Sustainability is possible after 5-year Medicaid Demonstration is over*
10. Degree to which addresses social determinants of health and improves health equity

OCH Community Input Survey Results



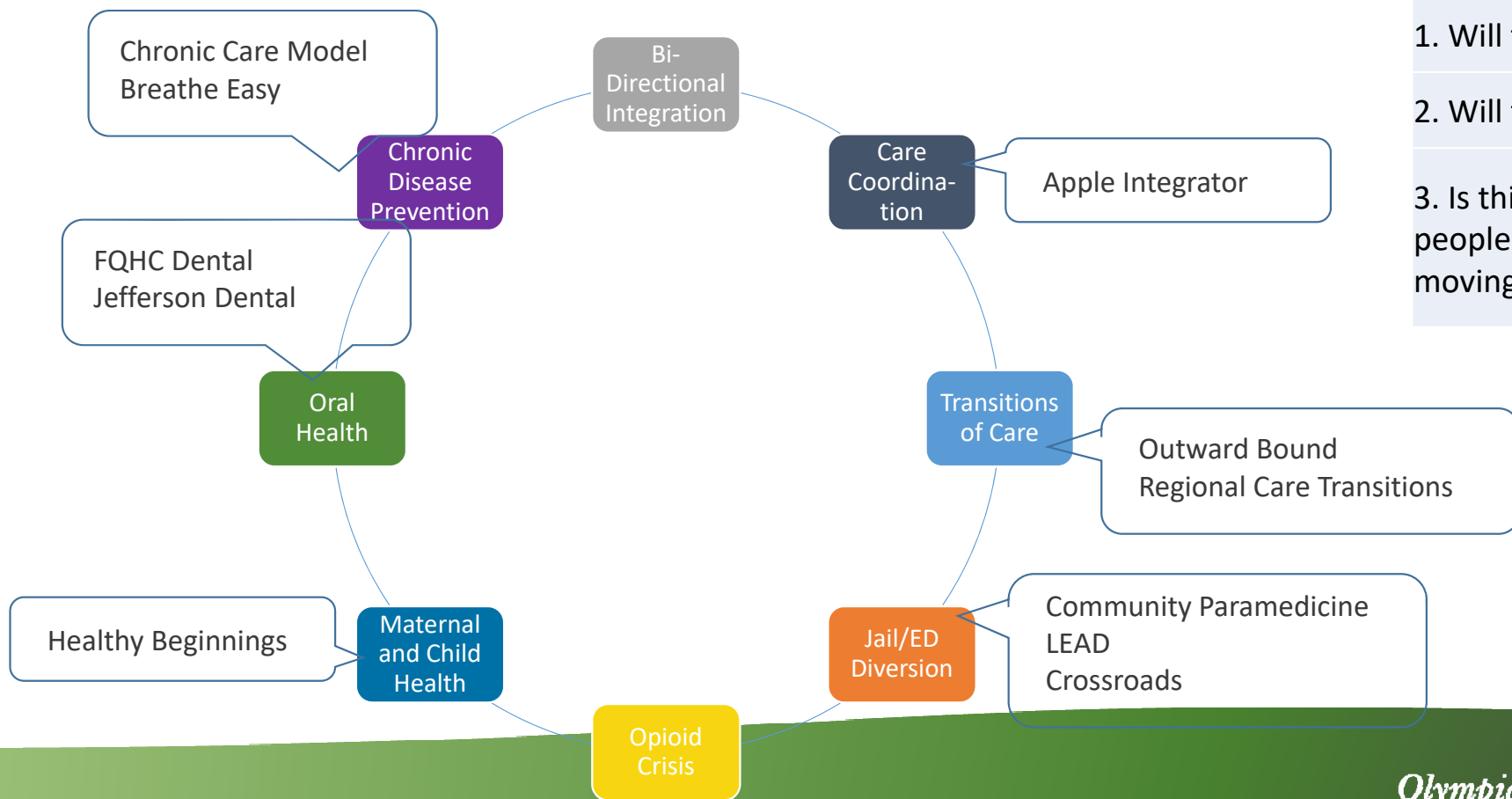
OCH Community Input Survey Results



OCH Potential Project Partner Input Results

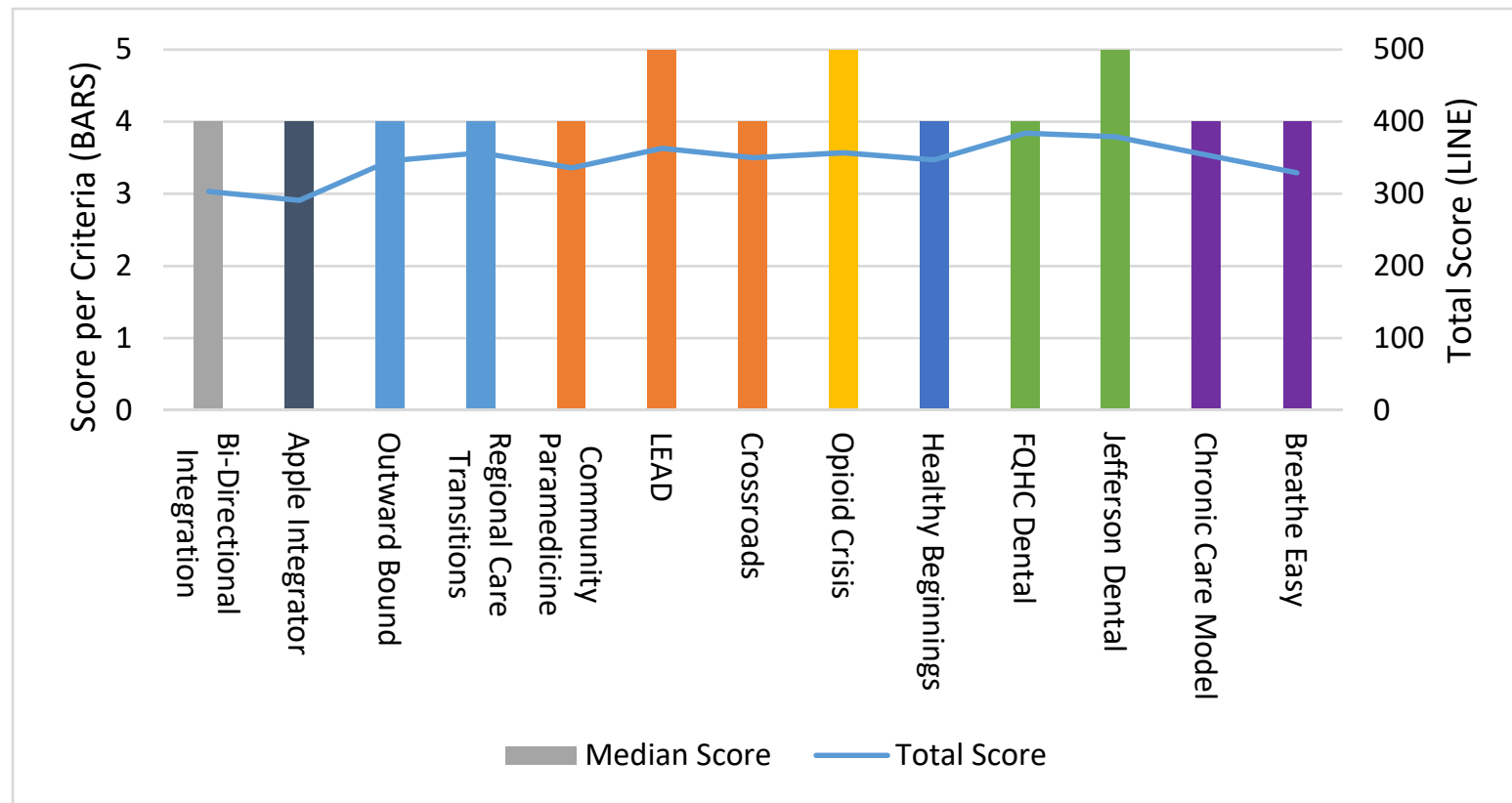
Purpose:	Gather input on the specific projects proposed to the OCH for the Medicaid Demonstration.
Distribution Method:	OCH Partner Convening June 19, 2017 (in person)
Period:	See previous
Responses:	30
Instructions:	After listening to the panel presentations on projects under consideration for the OCH portfolio, provide input for each project.

OCH Potential Project Partner Input Results

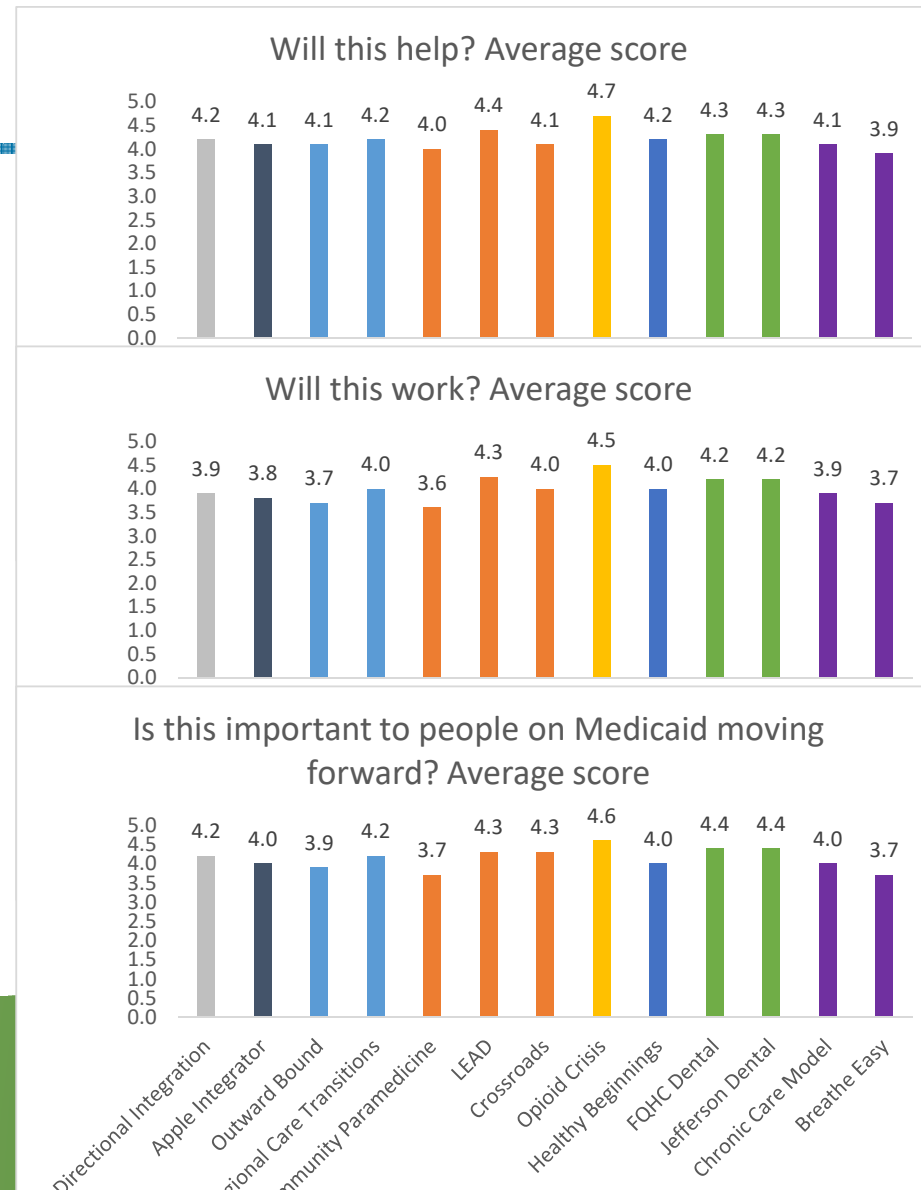


1. Will this help?
2. Will this work?
3. Is this important to people on Medicaid moving forward?

OCH Potential Project Partner Input Results



OCH Potential Project Partner Input Results: Average score by question



OCH Potential Project Partner Input Results: Summary of Comments

2A. Bi-Directional Integration

- Concern about duplication of existing efforts
- If this is required by 2020 how is it innovative
- Have gaps in current system, need to try something else

2B. Apple Integrator

- Concern about development of something brand new
- How much will it cost and who will pay?
- Seems like it can work for many projects

2C. Crossroads

- Much needed
- Concern that there are lots of services already in jail
- Intensive enough?
- CHWs will need a lot of training and support

2C. Regional Care Transitions

- Concern about missing key partners
- Concern about duplication of existing efforts

OCH Potential Project Partner Input Results: Summary of Comments

2D. Community Paramedicine

- Concern about high budget
- Can it be scaled down - target highest need areas?
- Concern about how to target only Medicaid clients
- Has good potential

2D. LEAD

- Important program
- Concern that success depends on housing and other social services which may not be available
- Will save money

2D. Outward Bound

- Concern about duplication of existing efforts
- Looks helpful
- Partnerships critical

3A. Opioid Crisis

- Need public health as a partner

OCH Potential Project Partner Input Results: Summary of Comments

3B. Healthy Beginnings

- Has high return on investment
- Upstream, early intervention/prevention focus
- Concern about long wait for impact
- Concern about small reach (# of people to be served)

3C. FQHC Dental

- Important, needed project
- Combine with Jefferson proposal
- Great to co-locate with physical health
- Concern about cost of care and sustainability

3C. Jefferson Dental

- Concern about small reach (# of people to be served)
- Important project
- Combine with FQHC dental project

3D. Chronic Care Model

- Concern about identifying/enrolling people
- Need additional partners
- Concern about uniform model fidelity across counties and partners
- Much needed
- Concern about cost

3D. Breathe Easy

- Much needed
- Brings care to enrollees
- Concern about client acceptance of model
- Scalable to all three counties?
- Integrate into other project?

A Jail Nurse's Recipe For Championing the Fight against the opioid epidemic

- 1) Data - hard #'s, death's, provider practices, pharmacy reports - will all help w/ the planning process + response level
- 2) Resourcefulness - Get help, guidance, support when you need it, turn to like minded people: Dr. Caleb Banta Green, Monte Levine - Bremerton, Dr. Peter Erickson, Dr. Art Zordini.
- 3) Providers in the community must be open and willing to participate and support creating a new "social norm" of Δ in practice, prescribing.
- 4) Tenacity - even when you are the only one standing up for the cause.
- 5) Using frustration as fuel
- 6) patience, perseverance, resilience, (+) attitude
- 7) Continual & systematic hedging in the needed direction - respectfully
- 8) Not caring who gets the credit
- 9) Teamwork processes, attitude
- 10) Firm, fair, courteous & caring
- 11) Willingness to partake in difficult + confrontational conversations
- 12) Not backing down from naysayers
- 13) There's no such thing as giving up on a person w/ an opioid use disorder.
- 14) It doesn't matter where you start, so long as you start.

My husband's best friend struggled with an opioid dependency. As he struggled obtaining it, he found other ways to get a fix. Combined with his anxiety and an unknown heart condition, his drug use led to his untimely death. He did not overdose, but his heart finally gave out at age 29. There remains a lot of guilt within our friendship circle that we couldn't save our beloved friend.

We have a patient that
came to us addicted and using
heroin + meth. After counseling
and Suboxone the patient is
clean of all illegal need drugs.
He also stopped smoking.
His favorite story is that he
was able for the first time
to have money to take his son
skating with friends for his
BDAY. He is now employed and
has stable housing. We see him

My (former) sister-in-law was one of those people who appeared to "have it all together." The family credited her with helping my brother grow up & learn responsibility.

A surgery/series of surgeries opened the door to opioids. Her addiction has resulted in:

- losing her job as a nurse
- losing her family (including 2 children)
- jail
- and so much more.

Her children continue to suffer.

- Sobriety/recovery should not be a requirement to receive services.
- Housing, counseling and other social services should be ~~first~~ offered regardless of using status.
- There should be robust transition options for individuals transitioning out of jails/prison so they don't return to their old way of life

We are seeing increased #'s of disabled adults due to private use as well as an increase in elders with increased disabilities to private use, entering the long term care system.

I had been addicted to
meth previously and
I had been given heroin
and did not know for
3 months. During this
time I had been
physically abused &
sexually. I had to
detox on my own.
I had never used
on my own.

My first experience with heroin was
in my early 20's with a friend, who
quietly tell us address + N we
and are that ones with it, including
jail due to burglary & theft. His
address left him hopeless and he
hung himself in a county jail before
the day of 21. He had no young friends +
a supportive family of means.



improving health through collaborative action

There is still time to share your perspective!

The OCH team has been hard at work preparing project plans to address regional health needs and goals as part of the Medicaid Transformation Project. We are posting drafts [online](#) for your review. We want to know what you like, what you don't like, what is missing, and what is unclear. This will help us to ensure that the project plans submitted to the Health Care Authority are well-suited to your needs and priorities. Please send your feedback on any or all of the drafts to Claudia@olympicch.org or via [this form](#) by noon on Thursday, November 9th if possible so that we can incorporate your thoughts into the final submission due to the Health Care Authority on November 16th.

Many thanks to those of you who have already submitted feedback! We have been adding and updating, so check back in for more input opportunities.

In partnership,

[Elya Moore](#), Director

[Lisa Rey Thomas](#), Director of Community and Tribal Partnership and Lead on the 3 County Coordinated Opioid Response Project

[Margaret Hilliard](#), Office and Administrative Coordinator

[Claudia Realegeno](#), Executive Assistant

[Siri Kushner](#), Contractor

[Rochelle Doan](#), Contractor

Elya Moore

From: Elya Moore
Sent: Wednesday, November 8, 2017 5:47 PM
To: Elya Moore
Subject: FW: Board Materials

Dear OCH Board of Directors,

Attached is the packet for Monday's Board meeting, November 13th, from 1 pm to 4 pm. Also, if you would like more detail than what is in your packet, you can view our project plans [online](#). Of note, we are revising the plans now and will be posting updated versions on Wednesday if you can wait that long!

Location: Jefferson Health Care, 2500 W. Sims Way (Remax Building) 3rd Floor, Port Townsend

Web: <https://global.gotomeeting.com/join/174726501>

Telephone: 1 (646) 749-3131

Access Code: 174-726-501

Elya Moore, PhD
Executive Director, Olympic Community of Health
Cell: 360.633.9241
Email: elya@olympicCH.org

Olympic Community of Health

Title: Attachment L – Public Comment Process

Community and Stakeholder Engagement

OCH solicited public comment on the Medicaid Transformation Project (MTP) project plans and project plan sections as they were drafted. This was an iterative process as the sections and project plans were revised, refined, and reposted. OCH solicited public comment in the following ways:

- OCH disseminates a monthly newsletter. The October issue was released on October 27, 2017 and provided information about the MTP project plan process, invited public comment and feedback, provided a [link](#) to the draft sections and plans, and email contacts for OCH staff and contractors. OCH sent out a reminder with more information and another [request](#) for public comment on November 7, 2017.
- Once the MTP project plans and sections began being posted OCH staff disseminated the link to OCH networks and listservs. We asked our partners to redistribute to partner networks to increase the outreach and improve opportunities for public comment. OCH driven outreach included:
 - The OCH listserv reaching 386 providers and other partners in the region
 - The 3 County Coordinated Opioid Response Project listservs (4 listservs reaching over 150 community partners in the region)
 - The Tribal partner listserv reaching tribal leaders, health directors, and providers in each of the 7 tribes
 - Promotion of feedback opportunities on social media and the OCH website, including options for submitting anonymous feedback
- OCH staff and contractors targeted invitations to subject matter expert (SME) partners to ensure that specific project plans could be reviewed by partners with relevant expertise
- OCH staff and contractors attend numerous partner meetings in the region. When appropriate, OCH staff announced the posting of project plans and project plan sections and invited public comment
- Social media blasts offer updates from the OCH team and invite social networks to visit the OCH website and attend OCH events.

OCH adhered to the following process to ensure that public comments were appropriately routed to project plan and project section leads for review and incorporation into the next iteration.

- As the public comments were received they were sent to the lead on the project plan and/or project section
- A copy of the public comment was stored in the shared folder, "Community and Partner Feedback" to document public comment
- The lead person on the project plan/project plan section reviewed the comment, feedback, suggested edits and incorporated feedback in the next iteration of the project plan or section. If appropriate OCH responded to the commenter to confirm reception of the feedback and describe how it was incorporated. In all cases, revised project plans were uploaded to the OCH website with the date revised for partner review.

OCH received comments from 10 community partners, Table 1.

Table 1. OCH Public Comment Process

Project/Section	Comment	Resolution
Funds Flow	OCH did not receive public comment on the funds flow section.	
Tribal Engagement and Collaboration	OCH received comment from one tribal partner with appreciation for the tribal work and suggestions to	Lead incorporated suggestions from partner and disseminated revised version for review.

	strengthen the Tribal Engagement section.	
Bi-directional Integration of Physical and Behavioral Health through Care Transformation	OCH received comments on the bi-directional project plan from one partner.	Lead incorporated suggested revisions and disseminated revised version for review. Some language was also incorporated into the opioid project plan.
Diversions Intervention	OCH received comments from three partners on the diversions project plan.	Lead incorporated suggested revisions from three partners and disseminated revised version for review. Some language was also incorporated into the opioid project plan to strengthen it.
Addressing the Opioid Use Public Health Crisis	OCH received comments on the opioid project plan from two partners.	Lead incorporated suggested revisions from both partners and disseminated revised version for review. Some language was also incorporated into the bi-directional project plan to strengthen it.
Reproductive and Maternal and Child Health (RMCH)	OCH received comments on RMCH from one partner.	Lead incorporated suggested revisions and disseminated revised version for review;
Access to Oral Health Services	OCH received comments on the oral health project plan from one partner.	Lead incorporated suggested revisions and disseminated revised version for review.
Chronic Disease Prevention and Control	OCH received comments on the chronic disease project plan from two partners.	Lead incorporated suggested revisions from both partners and disseminated revised version for review.
Other	<p>OCH received public comment expressing concern about lack of substance use disorder provider representation in the project plans.</p> <p>OCH received public comment expressing concern that 1) housing issues were not addressed in project plan drafts, and 2) OCH was not partnering sufficiently with housing agencies/partners.</p>	<p>OCH contacted commenter and determined that they were reviewing documents from an old link. SUD partner reviewed current project plans and expressed no concerns.</p> <p>OCH reviewed the comments and agreed with the concerns. All project plans and project plan sections were revised to incorporate housing concerns and potential solutions. OCH will also ensure that housing agencies are represented in the Natural Communities of Care.</p>

Olympic Community of Health
Community and Tribal Advisory Committee Charter
Approved by the Board of Directors October 9, 2017

Members		
Name	Role	Agency or Affiliation
1	Chair	
2	Co-chair	
3		
4		
5		
6		
7		
8		
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10		
11		
12		
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17		
18		
19		
20		

OCH Team: Director of Community and Tribal Partnership, Executive Director

Purpose

The purpose of the Community and Tribal Advisory Committee (CTAC) is to proactively engage community-based organizations, Tribes, and the beneficiaries of services to ensure that their voice guides and informs the decision making of the Olympic Community of Health. The CTAC will provide recommendations to the Olympic Community of Health (OCH) Board of Directors including but not limited to project selection and implementation, transparent communication strategies, regional whole person health priorities, social justice, and health equity.

Responsibilities

- Work directly with and in communities in the OCH region to solicit guidance on whole person health, social justice, and health equity.
- Identify local forums to serve as natural, local opportunities for community and tribal voice in OCH decision making and dissemination of information of OCH activities.
- Provide data and information to the OCH Board to inform decision making.
- Facilitate partnerships with community providers and community-based organizations.
- Develop recommendations and guidance on investments that support community and tribal voice in OCH decision making.
- Ensure transparency and accountability by developing and monitoring the OCH community and tribal engagement plan.
- Actively recruit and support community and tribal members to serve on OCH's various committees and workgroups.
- Perform other duties as requested by the Board.

Composition

CTAC will consist of at least 12 members representing communities and Tribes in the OCH region. CTAC will have a chair and co-chair.

Eligibility

CTAC members live in the OCH region and provide, receive, and/or coordinate clinical and/or social services; representation from the three counties will be equitable.

Requirements

CTAC members will be expected to:

- Read meeting materials in advance and come prepared to contribute substantively to the work of the Committee.
- Actively engage in discussions and contribute expertise to decision-making processes.
- Provide timely review and feedback on documents when solicited.
- Participate in surveys and information gathering.

Timeline

CTAC will meet as necessary to provide the appropriate level of support to the Board of Directors. All meetings will be held in person; virtual participation will usually be offered. On occasion, the Committee chair may decide that virtual participation will not be conducive for certain discussions. When meetings do not have a virtual participation option, staff will notify members at least 15 days in advance.

Oversight

CTAC is subject to the direction of the OCH Board of Directors. Revisions to this charter must be approved by the Board of Directors.

Reporting

CTAC staff will prepare objectives and materials for each meeting. Agenda and meeting materials will be distributed by email at least 2 business days in advance, and will be available to the public on the OCH website. Decisions will be documented in meeting summaries which will be distributed to CTAC members by email and posted to the OCH website.

Staff list of entities to draw from for Community and Tribal Advisory Committee (CTAC) Membership

Please send additions or suggestions to claudia@olympicCH.org

All nominations will be brought to the Board

Presented to the Board November 9, 2017

Type of Entity	Suggested Organization or Coalition	County
Local health collaborative	Kitsap Strong	Kitsap
Local health collaborative	Community Health Improvement Project Initiative	Jefferson
Local health collaborative	Olympic Peninsula for Healthier Communities Coalition	Clallam
Education	Olympic Educational School District	Regional
Consumer Group	NAMI Consumer Advisory Group	Kitsap
Citizen Group	League of Women's Voters	Kitsap
Workforce	Workforce Development Council	Regional
Consumer Group	Developmental Disability Advisory Boards	Jefferson
Consumer Group	Area Agency on Aging Advisory Council	Jefferson and Clallam
Faith-Based Group	Emmanuel Apostolic	Kitsap
Immigrant Advocacy Group	Kitsap Immigrant Assistance Center	Kitsap
Community-Based Organization	YWCA	Kitsap
Housing Group	Peninsula Housing Authority	Jefferson and Clallam
Parent Group	Head Start Parent Council	Kitsap or Clallam
Early Childhood Development Group	First Step	Clallam
Local Health Collaborative for SUD Recovery	PA CAN	Clallam
Transportation	County Transit Authority	Invite each county
DSHS	Community Service Organization	Clallam/Jefferson
Tribe	As determined by American Indian Health Commission of WA	NA
Business	Chambers of Commerce	Invite each county
First responder	Chief of Police	

Lower Elwha Klallam Tribe, 2851 Lower Elwha Road, Port Angeles, WA 98363

RESOLUTION No. 29 -17**APPOINTMENT OF THE DIRECTOR FOR THE LOWER ELWHA KLALLAM TRIBE
TO THE OLYMPIC COMMUNITY OF HEALTH BOARD OF DIRECTORS**

WHEREAS, the Lower Elwha Tribal Community, also known as the Lower Elwha Klallam Tribe ("the Tribe"), is a federally recognized, self-governing Indian tribe in accordance with the Treaty of Point-No-Point of January 26, 1855, its Constitution and By-laws, approved by the Secretary of the Interior on April 29, 1968, and the Indian Reorganization Act of June 18, 1934; and

WHEREAS, the Lower Elwha Klallam Tribal Business Committee of the Lower Elwha Community Council is the constitutionally and duly elected representative body of the Tribe, and is responsible for ensuring the health, safety, education, welfare, social and economic development, and otherwise promoting the welfare and interests of its tribal citizens; and

WHEREAS, under Article IV, Section 1(a) of the Tribe's Constitution, the Business Community has the authority to consult with other entities, on behalf of the Tribe and to advise and consult with their representatives on activities that may affect the Tribe; and

WHEREAS, the Olympic Community of Health ("OCH") is a regional non-profit corporation formed to improve the overall health and wellbeing of the communities and Tribes across Clallam, Jefferson and Kitsap counties through a collaborative approach focused on sustainable and equitable solutions; and

WHEREAS, the OCH bylaws provide authority for the Tribe to appoint a representative, as well as an alternate, for the Lower Elwha Klallam Tribe to serve as a voting member on the Board of Directors; and

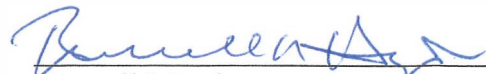
WHEREAS, the Business Committee recognizes the importance of appointing a Director, and an alternate, to represent the Tribe's interests on the OCH Board of Directors.

THEREFORE BE IT NOW RESOLVED THAT, the Business Committee hereby appoints Lance Colby as the Lower Elwha Klallam Tribe's representative Director, and Keri Ellis as the Lower Elwha Klallam Tribe's alternative representative, to serve on the Olympic Community of Health Board of Directors.

CERTIFICATION

The foregoing resolution was presented at a duly called meeting of the Lower Elwha Klallam Business Committee held on the 17 day of April, 2017, at which 3 members were present, constituting a quorum, and the Business Committee voted to adopt by a vote of 2 FOR, 0 AGAINST, and 0 ABSTENTIONS.


Frances G. Charles, Tribal Chair


Council Member

RESOLUTION NO: 17-A-067

THE
PORT GAMBLE
S'KLALLAM
TRIBAL COUNCIL
OF THE
PORT GAMBLE
S'KLALLAM TRIBE

I.

WHEREAS, the Port Gamble S'Klallam Tribe entered into the Treaty of Point No Point with the United States of America on January 26, 1855, reserving sovereign and aboriginal rights in perpetuity; and

II.

WHEREAS, the Port Gamble S'Klallam Reservation was proclaimed on June 16, 1938 to be an Indian reservation, held in trust by the federal government "...for the benefit and use of the Port Gamble Band of Clallam Indians...", under the provisions of Section 5 of the Indian Reorganization Act, the purchase of which was paid in full by Tribe; and;

III.

WHEREAS, the Port Gamble S'Klallam Tribe's General Council delegated the Tribe's primary legislative authority to the Tribal Council under Article IV, Section 3, Letter H of the Constitution of the Port Gamble S'Klallam Tribe, approved by the Secretary of Interior on July 7, 2007, **AMENDED BY CERTIFIED ELECTION JULY 8, 2013**; and

IV.

WHEREAS, the Port Gamble S'Klallam Tribe is a member of the Olympic Communities of Health (OCH), as part of the Accountable Communities of Health within the State of Washington.

V.

WHEREAS, the Port Gamble S'Klallam Tribe wishes to participate fully with OCH and OCH By-Laws state: "To operate exclusively for charitable, scientific, and educational purposes, and to advance the goal of the OCH to improve the overall health and wellbeing of our communities and Tribes across Clallam, Jefferson and Kitsap counties through a collaborative approach focused on sustainable and equitable solutions."


VI.


NOW THEREFORE BE IT RESOLVED, that the Port Gamble S'Klallam Tribal Council hereby appoints Karol Dixon as the Delegate to OCH.

CERTIFICATION

WE HEREBY CERTIFY that on this date there was a regular meeting held of the Port Gamble S'Klallam Tribal Council on the Port Gamble S'Klallam Indian Reservation, at which time a quorum was present;

WE FURTHER CERTIFY, that the above numbered resolution, was at said meeting, introduced, evaluated, and was passed by a vote of 5 FOR, 0 AGAINST, 0 ABSTAIN dated this 12 day of June, 2017


Jeromy Sullivan
Chairperson


Attest:
Council Member

**THE SUQUAMISH TRIBE
PORT MADISON INDIAN RESERVATION
RESOLUTION 2017-089
APPOINTMENT –BOARD OF DIRECTORS AND EXECUTIVE COMMITTEE
OLYMPIC COMMUNITY OF HEALTH**

WHEREAS, the Suquamish Tribal Council is the duly constituted governing body of the Port Madison Indian Reservation by authority of the Constitution and Bylaws for the Suquamish Tribe of the Port Madison Indian Reservation, Washington as approved on July 2, 1965, by the Under-Secretary of the United States Department of the Interior; and

WHEREAS, under the Constitution and Bylaws of the Suquamish Tribe, the Suquamish Tribal Council is charged with the general governance of the Port Madison Reservation and to this end, has the power, right and authority under the Tribe's Constitution to take all actions necessary to carry such duties into effect, including furthering health services and health benefits which serve the needs of the government and its people; and

WHEREAS, the Suquamish Tribe hereby appoints Leonard Forsman as the Suquamish Tribe's member on the Board of Directors for the Olympic Community of Health (OCH) and who will also serve on the OCH Executive Committee; and

WHEREAS, the effective date of this appointment is September 8, 2016 and shall remain in effect until rescinded or modified by a vote of the Suquamish Tribal Council.

NOW, THEREFORE, BE IT RESOLVED that:

The Suquamish Tribal Council appoints Leonard Forsman as the Suquamish Tribe's member on the Board of Directors and Executive Committee for the Olympic Community of Health (OCH).

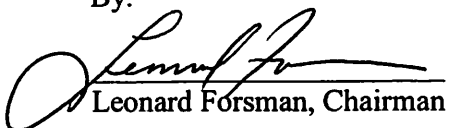
BE IT FURTHER RESOLVED that:

The Chairman and other officers of the Suquamish Tribal Council are hereby authorized and directed to take any further actions necessary to accomplish the purpose and intent of this resolution.

CERTIFICATION

The foregoing resolution was duly adopted on May 22nd 2017, at a regular meeting of the Suquamish Tribal Council at which a quorum was present, by a vote of 5 for and 0 against, with 0 abstention(s), in accordance with and pursuant to the authority vested in it by the Constitution and Bylaws of the Suquamish Indian Tribe.

By:


Leonard Forsman, Chairman

Attests:


Nigel Lawrence, Secretary

Tribal input for OCH project plans

Tribal input for Olympic Community of Health Project Plans

The Olympic Community of Health (OCH) is currently developing project plans as required by the Healthcare Authority for the Medicaid Transformation. The Project Plans are due November 16, 2017. The OCH Board of Directors has approved submitting six out of the eight possible projects. The six projects are:

- 2.A. Bidirectional Integration of physical and behavioral health through care transformation (Required)**
- 3.A. Addressing the opioid use public health crisis (Required)**
- 2.D. Diversion Interventions (Diversion from Emergency Department and Incarceration)**
- 3.B. Reproductive and Maternal/Child Health**
- 3.C. Access to Oral Health Services**
- 3.D Chronic Disease Prevention and Control**

This survey is an opportunity for the seven tribes in our shared region to provide input into the project plans and pose questions to the OCH. There is no individual health information requested. The information you submit will be summarized and shared back with the tribes without identifying information. It will also inform the Healthcare Authority of our work with the tribes. Participation in the survey is completely voluntary and you can skip any questions in the survey. The survey should take about 5-10 minutes to complete. If you have any questions, please contact Lisa Rey Thomas (Director of Community and Tribal Partnership and lead on the 3 County Coordinated Opioid Response Project or 3CCORP) at lisarey@olympicch.org or 360-633-9116. Thank you!

1. Which Tribe do you work for?

- | | |
|--|---|
| <input type="radio"/> Makah | <input type="radio"/> Jamestown S'Klallam |
| <input type="radio"/> Quileute | <input type="radio"/> Port Gamble S'Klallam |
| <input type="radio"/> Hoh | <input type="radio"/> Suquamish |
| <input type="radio"/> Lower Elwha | |
| <input type="radio"/> Other (please specify) | |

2. What is your position with the Tribe?

- ☐ Elected leader
- ☐ Health director
- ☐ Executive director
- ☐ Other (please specify)

3. What are the 3 most important health priorities for the Tribe?

One

Two

Three

4. Please share the top 3 successful programs/approaches that the Tribe has implemented to support health.

One

Two

Three

5. Has the Tribe been involved with the Olympic Community of Health (attending meetings, reading newsletters, communicating with staff, etc.)

- ☐ Yes
- ☐ No
- ☐ Somewhat

Comment

6. Please rank the 6 Medicaid Transformation project areas with 1 being most important and 6 being least important. A link to the Medicaid Transformation Toolkit can be found here:

<https://www.hca.wa.gov/assets/program/project-toolkit-draft.pdf>

2.A. Bi-directional integration of physical and behavioral health through care transformation.

2.D. Diversion interventions (diversion from emergency departments and incarceration).

3.A. Addressing the opioid use public health crisis.

3.B. Reproductive and maternal/child health.

3.C. Access to oral health services.

3.D. Chronic disease prevention and control.

7. Do you have any comments about how you ranked the project areas?

8. Is the participating with the Olympic Community of Health on any of the project areas? Please check all that apply.

- ☐ 2.A. Bi-directional integration of physical and behavioral health through care transformation.
- ☐ 2.D. Diversion interventions (diversion from emergency departments and incarceration).
- ☐ 3.A. Addressing the opioid use public health crisis.
- ☐ 3.B. Reproductive and maternal/child health.
- ☐ 3.C. Access to oral health services.
- ☐ 3.D. Chronic disease prevention and control
- ☐ Unsure
- ☐ Please comment

9. Would the Tribe like to participate with the OCH on the project plans? If not, would you like us to contact you again in January, 2018 when we begin crafting implementation plans that are due at the end of June, 2018?

- ☐ Yes I would like to participate now.
- ☐ No we are not interested in participating at this time.
- ☐ Yes please contact us in January of 2018 to discuss the implementation planning.
- ☐ Unsure

Any comments? If you want to participate and/or be contacted in January of 2018, please leave a name and contact information here.

10. Is the Tribe working with the Healthcare Authority to develop Tribal specific projects and directly access design pool funding in Year One and earn incentive payments in Years Two-Five?

- ☐ Yes
- ☐ No
- ☐ Unsure

Comments

11. Does the Tribe have a current health needs and assets assessment?

- ☐ Yes
- ☐ No
- ☐ Unsure

12. If the Tribe does have a current health needs and assets assessment, would you be willing to share it with the OCH to be included in the Regional Health Needs Assessment?

- ☐ Yes
- ☐ No
- ☐ Unsure

Comments

13. Do you have any questions, comments, thoughts, concerns, suggestions that you would like to share?

Tribal input for OCH project plans

What are the 3 most important health priorities for the Tribe?

	Tribes	Tribes	Tribes
1	Chronic Disease Management	Substance Abuse	BH Integration
2	Population Health and Wellness	Chronic Disease – hypertension and diabetes	Opioid response
3	Patient Engagement	Mental Health	Expand health coverage

Please share the top 3 successful programs/approaches that the Tribe has implemented to support health.

	Tribes	Tribes	Tribes
1	Health insurance for tribal members	Substance Abuse Treatment Program	BH Integration workgroup
2	Wellness program	Mental Health Program	THOR: Tribal Healing Opioid Response
3	Implementation of EPIC electronic health record	Re-entry Program	JBFO: Joint Business Finance Office

Has the Tribe been involved with the Olympic Community of Health (attending meetings, reading newsletters, communicating with staff, etc.)

Yes	2
No	
Somewhat	1

Please rank the 6 Medicaid Transformation project areas with 1 being most important and 6 being least important.

Opioid Project	1
Chronic Disease	2
Diversion	3
Access to Oral Health	3
Bi-directional Integration	3
Reproductive and Maternal Child Health	4

Do you have any comments about how you ranked the project areas?

Co-occurring treatment works very well and this is implemented as the tribe has both mental health and substance abuse treatment available for its members. Substance Abuse is a real crisis among tribes and uses up a lot of the tribes resources
Oral is ranked lower because we have great dental clinic and coverage is very good at the moment. And Tribe is older and have less mothers and children than other tribes.
Not vetted by health advisory committee

Is the Tribe working with the Healthcare Authority to develop Tribal specific projects and directly access design pool funding in Year One and earn incentive payments in Years Two-Five?

Yes	1
No	
Unsure	2

Does the Tribe have a current health needs and assets assessment?

Yes	1
No	
Unsure	2

If the Tribe does have a current health needs and assets assessment, would you be willing to share it with the OCH to be included in the Regional Health Needs Assessment?

Yes	1
No	
Unsure	2

Olympic Community of Health (OCH)
Tribal Collaboration and Communication Policy with the
Hoh, Jamestown S’Klallam, Lower Elwha Klallam, Makah, Port Gamble S’Klallam, Quileute and Suquamish Tribes

I. Purpose

The Olympic Community of Health (OCH) is committed to active engagement with the tribal nations and Indian Health Service (IHS) facilities within our three-county region. All tribes are offered a seat on the Board of Directors. Recognizing that all tribes may not want to be active on the Board, this policy will guide our communications. All tribes/IHS facilities will receive the same level, type, and frequency of communications outlined in this policy.

The purpose of this policy is to establish a clear and concise collaboration policy and communication procedure between the Olympic Community of Health (OCH) and tribal governments in the development of all OCH policies or actions.

II. Governance

The OCH will hold one seat on the Board of Directors for each tribe.

III. Collaboration

The OCH will collaborate and communicate with tribal governments in a manner that respects the tribes’ status as sovereign nations and meets the federal trust responsibility and U.S. treaty obligations to American Indians/Alaska Natives (AI/ANs).

- The OCH will not refer to tribes as stakeholders but as partners.
- Because each Tribe has a seat on the Board of Directors, the OCH and Tribes will collaborate from the beginning of and throughout the planning and development process and engage in inclusive decision-making with tribes for all OCH actions, including actions that may have an impact on AI/Ans or tribes (as determined in accordance with Section IV) and not just solicit feedback from tribes.
- The OCH will respect and support the need for Tribal representatives or IHS facility representatives to inform their tribal councils and receive directives from their tribal councils or agency leadership on whether and how the tribe or IHS facility would like to proceed with respect to any OCH action.
- If a tribe declines an invitation to collaborate, the OCH will maintain a standing invitation for the tribe to collaborate with the OCH.

IV. OCH Actions Having Impacts on AI/ANs or Tribes

- **Determining Tribal Impacts.** The OCH will rely on the tribal representatives on the Board of Directors to notify the Board or staff whether an action may have an impact on AI/ANs or Tribes. If authorized by the tribal representatives on the Board, the OCH staff will convene an *ad hoc* Tribal Implications Subcommittee that will include at least one OCH staff member, at least two Tribal OCH Board Members, and one OCH Board member who is not a representative of a tribe. The committee will meet until it determines whether any OCH actions being contemplated, including the development of policies, programs, or agreements, will have an impact on

AI/ANs or Tribes. The OCH lead staff person will ensure that sufficient information about OCH actions is communicated during the meeting, and prior to implementation, to enable the committee to determine whether those actions will have an impact on AI/ANs or Tribes. If no Tribe designates an individual to serve on this committee and until such time when a tribe does designate an individual to serve on this committee, the Board of Directors will make determinations of whether any OCH actions being contemplated will have an impact on AI/ANs or Tribes and inform the tribe(s).

- **Addressing Tribal Impacts.** If the Tribal Implications Subcommittee determines an OCH action has or will have an impact(s) upon a tribe(s) or IHS facility(ies), the Subcommittee will report their findings and any recommendations for addressing those impacts to the Board of Directors. The Board of Directors will determine a plan of action in response to the Subcommittee's findings and recommendations.

V. Communication

- The OCH will dedicate resources to support the function of tribal liaison when resources permit.
- The OCH will work with each of the individual tribes to ensure that all contact information is up-to-date and the correct representatives are notified and regularly receive information.
- The OCH will provide written information to tribes concurrent with, and in the same format and method as, the delivery of written information to board members for board meetings, to committee members for committee meetings, and to other OCH participants for participant or other meetings. Any tribe that wishes to receive mailed hard copies of meeting materials may do so upon request. The tribal liaison will work with each tribe to develop a specific communication strategy as requested.

VI. Sovereignty and Disclaimer

The OCH respects the sovereignty of each tribe located in the State of Washington and that the tribes have the right to request consultation with the State of Washington and/or the United States government in the event the OCH fails to address the impacts on AI/ANs or Tribes. In executing this policy, no party waives any rights, privileges, or immunities, including treaty rights, sovereign immunities and jurisdiction. This policy does not diminish any rights or protections afforded AI/AN persons or tribal governments or entities under state or federal law. The OCH acknowledges the right of each tribe to consult with state and federal agencies, including, where appropriate, the Health Care Authority, the Governor of the State of Washington, the Region X Administrator of the U.S. Department of Health and Human Services, or the President of the United States.

VII. Effective Date

This policy will be effective on July 10, 2017 and will be reviewed and evaluated annually or at the request of any tribe or a majority of the OCH Board Members.

APPROVED BY:



OCH Board President
Roy Walker

DATE: 9/27/17