Olympic Community of Health

Agenda

Board of Directors Meeting

November 13, 2017

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

KEY OBJECTIVE

- Agree on next steps after project plan submission
- Advise or approve OCH 2018 Budget
- Reach a shared understanding on next steps of funds flow modeling
- Approve Whistleblower Policy

AGENDA (Action items are in red)

Item		Topic	Lead	Attachment	Page(s)
1	1:00	Welcome and Approve Agenda	Roy		
2	1:05	Consent Agenda	Roy	1. DRAFT: Minutes 10.9.2017 2. Directors Report 3. Preliminary list or entities for Community and Tribal Advisory Committee members	1-5 6-8 9
3	1:10	Project Plan Application *[NOTE: DRAFT project plans posted on OCH website]*	Elya	4. Public Comment *(not included in packet – handed out at meeting)* 5. Project Plan Summary Tables 6. MEMO to the Board: Project Plan Scoring Update 7. Project Plan Attestations	 10-15 16 17
4	1:35	From planning to implementation: December to July	Elya		
5	1:50	Financial Business	Hilary	8. Quarterly financials 9. MEMO to the Board: Revenue Recognition 10. DRAFT: Investment policy 11. DRAFT: 2018 Budget 12. Budget narrative and personnel summary	18-21 22 23-24 25 26
BREAK					
6	2:45	Funds Flow	Dan Elya Chris	13. Community Needs Index Description 14. STATEMENT OF WORK: 6 Building Blocks for Opioid Prescribing 15. SBAR: 6 Building Blocks for Opioid Prescribing	27-28 29-31 32
7	3:25	Whistleblower Policy	Elya	16. DRAFT: Whistleblower Policy	33-36
8	3:35	Fully Integrated Managed Care	Roy	17. LETTER: Correspondence to HCA 18. LETTER: Correspondence from HCA 19. Number of Managed Care Organizations	37 38-39 40-41
9	4:00	Adjourn	Roy		

Acronym Glossary

FIMC: Fully integrated managed care

SBAR: Situation. Background. Action. Recommendation.

Olympic Community of Health

Meeting Minutes

Board of Directors

October 9, 2017

Date: 10/9/2017	**Time:** 1:00pm - 4:00pm	**Location:** Jefferson Health Care Conference Room, 2500 W. Sims Way (Remax Building) 3rd Floor, Port Townsend

Chair: Roy Walker, *Olympic Area Agency on Aging*
Members Attended In-Person: Anders Edgerton, *Salish BHO*; Brent Simcosky, *Jamestown Family Health*; Chris Frank, *Clallam Public Health*; Eric Lewis, *Olympic Medical Center*; Gill Orr, *Cedar Grove Counseling*; Hilary Whittington, *Jefferson Healthcare*; Jennifer Kreidler-Moss, *Peninsula Community Health Services*; Joe Roszak, *Kitsap Mental Health*; Karol Dixon, *Port Gamble S'Klallam Tribe*; Katie Eilers, *Kitsap Public Health District*; Leonard Forsman, *Suquamish Tribe;* Thomas Locke, *Jefferson Public Health,* Kayla Down, *Coordinated Care*
Members Attended by Phone:
Alternate Members Attended In-Person: Gary Kriedberg, *Harrison Health Partners*; Vicki Kirkpatrick, *Jefferson Public Health*
Non-Voting Members Attended In-Person: Allan Fisher*, United Healthcare*; Cathy Nieman, *CHPW*; Jorge Rivera*, Molina Healthcare;* Kat Latet, *Community Health Plan of WA*
Staff and Contractors: Claudia Realegeno, *Olympic Community of Health*; Dan Vizzini, *OHSU*; Elya Moore, *Olympic Community of Health,* Lisa Rey Thomas*, Olympic Community of Health,* Maria Klemesrud, *Qualis*; Margaret Hilliard, *Olympic Community of Health*; Siri Kushner*, Kitsap Public Health District*; Rochelle Doan, *Kitsap Mental Health Services*; Rob Arnold, *UW*
Guests: Dunia Faulx, *Jefferson Healthcare*; Jeannie Harper, *Reflections Counseling*; Jean Hordyk, *Olympic Medical Center;* Jen Olson, *American Indian Health Commission*; Kayla O'Donnal Cournier, *Amerigroup*; Laura Johnson, *United Healthcare*; Mary Catlin, *Washington State Department of Health*; Mike Sanders, *Port Angeles Fire;* Amy Etzel, *Washington State Department of Health*

Person Responsible for Topic	Topic	Discussion/Outcome	Action/Results
Roy Walker	**Welcome and Introductions**	Roy called the meeting to order at 1:07pm.	
Roy Walker	**Consent Agenda**	Approved agenda	Consent Agenda APPROVED unanimously
Roy Walker	**September Minutes**	Approved September 11, 2017 minutes	September minutes APPROVED unanimously
Elya Moore	**New Demonstration financial projections**	OCH provided updates on a recent $50 million reduction in total available funds, amounting to a 36.5% reduction. For OCH, this means a decline from $6.2 million to $3.97 million. This change is largely due to matching. HCA is working to identify new designated state health programs (DSHPs) to get more funds to ACHs. Intergovernmental transfer (IGT) is not a	

		concern in year 1 but will become significant in the following years. Design funds are secure.	
Eric Lewis	**Finance Update**	OCH is moving forward with DZA. Quarterly financials were presented. Revenue is in line with spending. Quarterly financials will be presented as scheduled at the next board meeting.	
Elya Moore	**Whistleblower Policy**	The updated whistleblower policy was presented. Needs language about how employees can approach the board if they have a grievance with the executive director. Board discusses lack of clarity about who reports and how to report grievances. There was confusion about the Compliance Officer. A concern was voiced regarding privacy in the case of a written report sent to board of directors and if that would make the document public. A preference was voiced to handle reports in executive session. However, this raised concern for protecting both sides, as details may not be found in an official report. Motion to table whistleblower policy. Staff will follow up on concerns, run by legal, and bring back to board	MOTION: Table whistleblower policy until staff and legal have followed up on concerns. Bring back to board for approval. Motion to table whistleblower policy APPROVED unanimously
Elya Moore and Katie Eilers	**Committees**	Feedback from Phase II Certification was largely positive, but identified some deficiencies around community engagement. Proposal made to dissolve RHAPC and form two new committees: • Community and Tribal Advisory Committee (CTAC) • Performance, Measurement, and Evaluation Committee (PEMC) **PEMC:** The PEMC will be a highly technical group to compile information and report back to the Board. Focus will be on identifying data integration gaps and needs, as well as developing and maintaining a reporting system. **CTAC:**	Motion 1: Dissolve RHAPC Motion 1 APPROVED unanimously Motion 2: Form PEMC Motion APPROVED unanimously

		Members of the CTAC will live in Clallam, Jefferson, or Kitsap county and provide and/or receive services in the OCH region. This committee is aimed at improving authentic, bidirectional, and robust engagement. Suggestion made to change language to state option for "up to 21 members." Concern voiced about the time cost of additional meetings. Suggestion to deploy staff to pre-established venues. Suggestions that providers each do patient surveys regularly Concern voiced that communities and Tribes may not belong together in the charter. Response stated that Tribal outreach is specifically targeted through established processes and CTAC is supplementary, with Tribes specified for inclusion purposes. Bylaws need to be updated to accommodate the dissolution of RHAPC and implementation of CTAC and PMEC. This is a convenient time to make additional necessary updates: • OCH is no longer part of the Kitsap Public Health District (KPHD) and ASO language has been removed accordingly • The Executive Committee may act as the Board of Directors in case of emergency	Motion 3: Form CTAC with amendment stating "at least 12 members" Motion 3 APPROVED unanimously. Board asked staff to bring a list of organizations and coalitions to recruit CTAC members from. Motion 4: Update bylaws – ASO language removed as OCH is no longer part of KPHD - Authorize Executive Committee to act as board in case of emergency Motion 4 APPROVED unanimously
Roy Walker	**FIMC Update**	A hard copy of the most recent update was distributed and will be sent out electronically. King County has submitted an MOU and will be going midadopter. Most ACHs have decided to be early- or mid-adopters, though with differing agreements. Our region has planned to wait until 2020. Clallam County is not ready for adoption. This may be a leverage point in negotiations as it takes resources to prepare for managed care. MCO conversations suggest that OCH will be able to advocate for our providers. The decision not to be a midadopter was based on two primary considerations: • Local behavioral health providers were vocally opposed	MOTION Staff will write a letter (with CPAA if possible) to HCA to request midadopter funds to prepare for adoption in 2020. Motion APPROVED with abstention from MCO representative

		• County commissioners were not likely to pass midadopter proposals • Potential opportunity to advocate a change with the legislature Discussion about what action or opportunity may still be open to OCH providers. Cascade Pacific Action Alliance (CPAA) may join OCH in negotiations to release adopter funds. Motion for OCH to draft a negotiation letter (with CPAA if possible) to request funds to prepare for adoption in 2020. MCOs abstained from the vote and will not be included in the negotiation letter.	
	Break	Dr. Chris Frank left and his alternate, Vicki Kirkpatrick, stepped in	
Elya Moore	**Three-legged stool:** **1. Funds Flow** **2. Change Plans** **3. Value-Based Payment**	Presentation of Funds Flow diagram and timeline. Change plans will be completed at provider and natural community of care (NCC) level. A natural community of care is a geographic region where people generally seek care and resources. Change plans are in development and will allow providers to select the actions they would like to implement. Change plans are focused on workflow actions rather than projects. Presented methods for NCC funds flow earning potential and allocation. NCCs will be modeled and organizations will have an account with the financial executor. Board will allocate money across NCCs. The wellness fund will be rolled into the reserves. Allocation of funds will be determined in 2021. The funds flow workgroup will develop a strategy accounting for recent changes to available funds. Apple Integrator has been renamed IT Care Coordination.	

		The Bright Futures model for Maternal and Child Healthcare has been scaled back to CDC preconception guidelines as the reduction in funds means that OCH can no longer financially support the adoption of Bright Futures. Law Enforcement Assisted Diversion (LEAD) will now be nested under diversion. Diversion models became NCC specific as broad interventions haven't gotten full-hearted support and may be best tailored to NCCs. Phased implementation of Value-Based Payments was presented.	
Roy Walker	**Adjourn**	The meeting adjourned at 4:00 pm.	

Olympic Community of Health

Executive Director's Report

Prepared November 13, 2017 Board Meeting

Top 3 Things to Track (T3T) #KeepingMeUpAtNight

1. The OCH team has worked around the clock (literally!) on the project plans, due to HCA November 16th. I literally wake up in the middle of the night thinking - mobile dental van!

2. I can't wait to submit the Project Plan, so we can start convening the Natural Communities of Care, writing change plans and really start to dive into the work.

3. Funds Flow! As we start to model the funds flow, it becomes increasingly clear that we will need to leverage existing assets and matching funds.

OCH meetings:

- IT Care Coordination Workgroup, October 27, virtual
- Funds Flow Workgroup, November 7, Blyn
- Board of Directors Meeting, November 13, Port Townsend
- Finance Committee Meeting, November 27, virtual
- Executive Committee Meeting, November 28, virtual
- 3CCORP Prevention Workgroup Meeting, November 30, Port Townsend
- 3CCORP Treatment Workgroup Meeting, December 1, Port Townsend
- OCH Board of Directors Meeting, December 11, Port Townsend
- 3CCORP Steering Committee Meeting, December 13, Blyn

Other meetings and events:

- Healthier Washington Symposium, October 19, SeaTac
- ACH Peer Learning Session, October 23, Tukwila
- SBHO Advisory Meeting, December 1, Sequim
- SBHO Executive Board Meeting, December 15, Blyn
- Performance Measures Coordinating Committee, December 18, Seattle

Outreach and Engagement

- NAMI Consumer Group, October 30, Poulsbo
- Kitsap Children's Clinic, November 2, Silverdale
- Tribal/Urban/HCA monthly meeting, November 7 (update to follow)

Welcome JooRI! Clinical Transformation Manager

JooRi starts with the OCH November 27th. As a provider, JooRi has always held an all-encompassing perspective of health and is committed to being a focused and compassionate advocate for addressing health on all levels--physical, mental, emotional, spiritual, and social. She received her Doctorate of Naturopathic Medicine from Bastyr University and is a licensed primary care physician in the state of Washington. She brings seven years of senior-level management experience with her to Olympic Community of Health. She grew up internationally before coming to the United States for college and now lives in Port Townsend with her husband, also a naturopathic doctor, and their curious and fearless toddler.

UPDATE: Community and Tribal Advisory Committee (CTAC)
Staff developed a list of organizations, coalitions, consumer groups, and public entities from which to draw membership for CTAC. This list is included in the consent agenda for Board input. Staff will bring nominations back to the Board for discussion.

UPDATE: 501c3 Application
We heard from the IRS! Our application is complete! They will let us know if they need anything else from us.

UPDATE: IT Care Coordination (formerly called "Apple Integrator")
OCH Board approved the Apple Integrator design study project focusing on Opioid care coordination on September 11, 2017. On October 9, Board agreed to target project, leveraging existing IT platforms to support care coordination and interoperability between sectors. Activities since Board approval:

- Negotiated and retained the services of Rob Arnold (RA) to be OCH's digital advisor for this project
- On Oct 9, OCH management and RA met with 3CCORP (Opioid Care Workgroup) to explain project and determine interest of this group to pilot test the system
- At the same meeting, 3CCORP agreed project could be of value and formed an IT Care Coordination Committee led by Kristina Bullington from Olympic Personal Growth Center (SUD)
- From Oct 23rd through 27, OCH management and RA developed a set of interview questions for the committee to learn about their MAT/SUD care. RA completed the committee interview that same week.
- The IT Care Coordination Committee had its first meeting on Friday Oct 27 to discuss:
    - summary results of the interviews
    - must haves/non-negotiables to pilot test concept
    - Develop the project charter
- On Nov 3, the IT Care Coordination committee agreed to a list of early pilot testers, which includes 6 provider organizations in Sequim and Port Angeles
    - Primary Care and Dental-North Olympic Healthcare Network
    - Sequim SUD-Olympic Personal Growth Center
    - PA SUD-Reflections
    - Mental Health and jail coordination-Peninsula Behavioral Health
    - Housing-Serenity House
    - Criminal Justice-Department of Corrections
- Agreement on goal:
    - Digital alternative to paper referrals, paper consents, faxes and un-responded to phone calls
- Early measures of success:
    - Easy look up of longitudinal patient record
    - Digitize referral forms for better care and closed loop tracking
    - Digitize care consents for better management of care
    - Enable "provider to provider" and "provider to patient" secure chat/text for better communication and tracking
- On Nov 6, the IT Care Coordination committee will meet again to plan out use case design
- Elya, Lisa Rey and RA believe we are still on track to present the pilot project and use case design for OCH board "go/no go" in December

UPDATE: 3 County Coordinated Opioid Response Project (3CCORP)

- 3CCORP Steering Committee (SC) and Prevention, Treatment, and Opioid Overdose Prevention Workgroups are meeting monthly
- *3CCORP Steering Committee* voted to recommend to the Board that OCH support the 6 Building Blocks (6BBs) model in 10 clinics in the region. 6BBs:
    1. Leadership and consensus – build organization-wide consensus to prioritize safe prescribing practices; includes an initial clinic-wide self-assessment
    2. Revise policies and standardize work – revise and implement clinic policies and define standard workflows for health care team members
    3. Track patients on chronic opioid therapy (COT) – implement pro-active population management before, during, and between clinic visits for COT patients
    4. Prepared, patient-centered visits – prepare and plan for clinic visits of all patients on COT to support care that is safe, appropriate, and empathic
    5. Caring for complex patients – identify and develop resources and referrals for patients who develop complex opioid dependence
    6. Measuring success – continues monitoring and improvement over baseline assessment and clinic QIP
- *3CCORP Prevention Workgroup* voted to recommend to the SC that they support the 6BBs in the OCH region. There is potential to partner with the DOH to bring the 6BBs to a high prescribing practice in the region in late 2017 or early 2018.
- *3CCORP Treatment Workgroup* has designed a survey for outpatient SUD providers to better understand the services available in our region and to identify barriers and facilitators to coordinating care with primary care providers and Medication Assisted Treatment (MAT) prescribers. They are developing strategies to strengthen alignment across providers and prescribers including developing regional practice recommendations and quarterly county level convenings. They have also formed a sub-workgroup to work with a consultant hired by the OCH to explore IT solutions to coordination of care for OUD clients/patients.
- *3CCORP Overdose Prevention Workgroup* is developing an assessment plan to document points of access for naloxone. They are creating a roster of partners of both clinical and non-clinical agencies to assess capacity to acknowledge and appropriately respond to an overdose as well as how readily available naloxone is in our community. The goal is to increase capacity for both in our region. Additionally, Chief Mike Lasnier (Suquamish Police Department) is working with other first responder agencies and jurisdictions to expand the implementation of ODMAP to the region and state

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	Commuity 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 Commision of WA	NA
Business	Chambers of Commerce	Invite each county
First responder	Chief of Police	

Bi-Directional Integration and Primary Care Transformation: 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**	**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 Pop'n-Based Care 6. Evidence-Based Treatments 7. Patient Involvement in Care 8. Data for Quality Improvement	Natural Community of Care Collaborative Agreement in place Natural Community of Care shared change plan Partnering provider organization change plan Contract in place with OCH Monthly reports sent to OCH 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	# 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 % PCP in partnering provider organizations meeting PCMH requirements QIP Metrics Depression screening and follow up for adolescents and adults	Antidepressant Medication Management Child and Adolescents' Access to Primary Care Practitioners Comprehensive Diabetes Care: HbA1c Testing Comprehensive Diabetes Care: Medical attention for nephropathy Medication Management for People with Asthma (5 – 64 Years) Mental Health Treatment Penetration (broad) Outpatient Emergency Department Visits per 1000	Bree Collaborative Behavioral Health Integration Report & Recommendations	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 diagnosis and 1) unnecessary use of ED for BH related visits; 2) at discharge from jail; 3) homeless or at immanent risk of homelessness	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				Collaborative Care Model		All Medicaid beneficiaries in primary care		
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 Either option 1 or 2 will be supported by the OCH in applying core principles of the Collaborative Care Model.				Integrating Primary Care into BH Setting: What Works for Individuals with Serious Mental Illness		All Medicaid beneficiaries in mental health and/or substance use treatment setting	Medicaid beneficiaries identified with mental health and/or substance use diagnosis receiving BH specialty care services	

Diversion: 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, insurance enrollment services, the coordinated housing intake system, tailored, intensive case management programs	Natural Community of Care Collaborative Agreement in place Natural Community of Care shared change plan Partnering provider organization change plan Contract in place with OCH Monthly reports sent to OCH	Report against QIP metrics Number of partners trained by selected approach / strategy: projected vs. actual and cumulative Number of partners participating and number implementing each selected approach / strategy % partnering provider organizations sharing 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 Emergency Department Visits per 1000 Member Months Percent Homeless (Narrow Definition) Percent Arrested	ER is for Emergencies Law Enforcement Assisted Diversion Jail Re-Entry Tribal Program	Clallam Jefferson Kitsap	All Medicaid beneficiaries being discharged from the ED and jail.	Patients who do not have a primary care 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)	Clallam Emerg. Dept.: 7,000 Jail: 900 Jefferson Emerg. Dept: 2,000 Jail: 540 Kitsap Emerg. Dept: 20,000 Jail: 2,000 Port Gamble and Suquamish nation 45	These subpopulations are often geographically isolated with poor transportation access, home quality, food access, and exhibit unhealthy habits such as smoking and substance use. 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 an behavioral health diagnosis (SBHO).
Community Paramedicine	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		Outpatient Emergency Department Visits per 1000 Member Months	Community Paramedicine Model	Clallam	Medicaid residents of Port Angeles and Forks.	Patients referred from partnering providers with a chronic medical conditions such as CHF, COPD, Diabetes; and/or with complex behavioral medication	Port Angeles: 240 Forks: 120	Medicaid beneficiaries who are referred are more likely to have lack of a support network, lack of transporation, geographic isolation, financial barriers, or poor health literacy.

Opioid Response: 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	Targeted Subpopulation	Disparities
Improved opioid prescribing practices Increase in access to and utilization of full spectrum of opioid use disorder treatment Prevent or intervene in opioid overdoses to prevent death	Natural Community of Care Collaborative Agreement in place Natural Community of Care shared change plan Partnering provider organization change plan Contract in place with OCH Monthly reports sent to OCH 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	# and list of community partnerships # and location of buprenorphine prescribers # and location of MH/SUD providers delivering acute care and recovery services to people with OUD # and type of access points for MAT # of EDs with protocols for overdose education and take home naloxone for opioid overdose # of health care organizations with EHRs that newly provide clinical decision support for opioid guidelines # of health care providers, by type, trained on AMDG's Interagency Guideline on Prescribing Opioids for Pain # of local health jurisdictions / CBOs that received TA to organize or expand syringe exchange programs QIP Metrics	Patients on high-dose chronic opioid therapy by varying thresholds Patients with concurrent sedatives prescriptions Outpatient ED Visits Substance Use Disorder (Opioid) Treatment Penetration Inpatient Hospital Utilization	Six Building Blocks for Safe Opioid Prescribing Washington State Agency Medical Director's (AMDG) prescribing guideline CDC Guideline for Prescribing Opioids for Chronic Pain Bree Collaborative Opioid Prescribing Metrics Bree Collaborative Dental Guideline on Prescribing Opioids for Acute Pain Management Bree Collaborative Opioid Use Disorder Treatment Report and Recommendations 2017 WA State Interagency Opioid Response Plan StopOverDose Center for Opioid Safety Education	Beneficiaries with a diagnosis of Opioid Use Disorder (OUD) and their families as well as beneficiaries not yet diagnosed with OUD (2,636) 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 an rx in last year, 167 high dose rx)	Project willl address the 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. The 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 3 workgroups.

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 is to improve the health of women, men, and couples, before conception of a first or subsequent pregnancy	Natural Community of Care Collaborative Agreement in place Natural Community of Care shared change plan Partnering provider organization change plan Contract in place with OCH Monthly reports sent to OCH 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	Report against QIP metrics Number of partners trained by selected model / approach: projected vs. actual and cumulative Number of partners participating and number implementing each selected model / approach	Mental Health & Substance Use Treatment Penetration Childhood Immunization Status Contraceptive Care – Postpartum Chlamydia Screening in Women Ages 16 to 24 Outpatient ED Visits Contraceptive Care – Most & Moderately Effective Methods Prenatal care in the first trimester of pregnancy Well-Child Visits in the First 15 Months of Life	CDC Preconception Health and Health Care	Clallam Jefferson Kitsap	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	Women and men classified as high-risk through provider intake and assessment.	15,000 women 5,000 men 1,500 pregnant women	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. 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.
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 subpopulatons.

Access to Oral Health Services: 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
Mobile Van - Full service van planned including both restorative and preventive dental services	Natural Community of Care Collaborative Agreement in place Natural Community of Care shared change plan Partnering provider organization change plan Contract in place with OCH	# of partners / providers implementing the evidence-based approach # of partners / providers trained on evidence-based approach: projected vs actual and cumulative # of Medicaid beneficiaries served: projected vs actual and cumulative	Utilization of dental services by Medicaid Beneficiaries Periodontal evaluation in adults with chronic periodontitis Outpatient Emergency Department visits Dental sealants for children at elevated risk	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	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.
Expand use of integration of dental services in medical primary care settings	Monthly reports sent to OCH Purchase and outfit a mobile dental van 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	QIP Metrics	Utilization of dental services by Medicaid Beneficiaries Outpatient Emergency Department visits Dental sealants for children at elevated risk Primary caries prevention intervention as part of well-child visit with PCP	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)			Utilization of dental services by Medicaid Beneficiaries Periodontal evaluation in adults with chronic periodontitis Outpatient Emergency Department visits Dental sealants for children at elevated risk Primary caries prevention intervention as part of well-child visit with PCP		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)					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				Alaska Dental Health Aide Program	Tribes expressing an interest in exploring further: Jamestown S'Klallam Lower Elwha Klallam Port Gamble S'Klallam	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)
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 Utilization of dental services by Medicaid beneficiaries	SEAL AMERICA: The Prevention Invention, 2016. A manual for providers dental sealants in school-based settings.	Jefferson, possibly scaled to Clallam in later years	Children in 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 transporation, geographic isolation, financial barriers, or poor health literacy.

Chronic Disease Prevention and Control: 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	Targeted Subpopulation	Estimated # Targeted per Year at Max. Capacity
Organization of the Healthcare Delivery System Community Linkages Self-management support Decision support Delivery system re-design Clinic information systems	Natural Community of Care Collaborative Agreement in place Natural Community of Care shared change plan Partnering provider organization change plan Contract in place with OCH Monthly reports sent to OCH 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	# 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 ED Visits Statin Therapy for Patients with Cardiovascular Disease (Prescribed) Comprehensive Diabetes Care: Eye Exam (retinal) performed	Chronic Care Model (CCM) Diabetes Prevention Program (DPP) Whole Health Action Management (WHAM) Chronic Disease Self Management Program (CDSM) Wisdom Warriors	West Clallam, East Clallam, Jefferson, Kitsap	Persons w/ mild mental health issues Persons w/ severe mental illness and/or substance use disorder American Indians/Alaska Natives	11,880
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		% 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 Report 3: Guidelines for the Diagnosis and Management of Asthma	West Clallam, East Clallam, Jefferson, Kitsap	Persons w/ severe mental illness and/or substance use disorder American Indian/Alaksa Native Children Older adults	2,700

MEMORANDUM

To: OCH Board of Directors
From: Executive Director
Date: November 6, 2017
Re: Changes to Project Plan Scoring

The purpose of this memo is to update the Board on changes to how ACH Project Plan Applications will be scored and ultimately funded. These changes are final and were shared with ACHs on October 30.

HCA made the following changes to the project plan scoring methodology:

- Eliminate the 90% ceiling on plans that are comprised of a minimum four projects.
- Eliminate rounding and tiers of project plan scores.
- Retain bonus points for plans are comprised of more than four projects.
- Retain the awarding of bonus revenue for plans that include six or more projects. Allocate the bonus revenue based on project valuations and number of projects.

In summary, the modified scoring protocol increases the potential funding for project plan submissions of 4 projects, and thereby reduces the potential amount of bonus pool funds that will be re-allocated to ACHs submitting 6 or more projects. HCA continues to explore options to add funds to the bonus pool to offset this loss. The potential impact to OCH on this new change is presented in the table below.

	Original scoring	Revised scoring	Net
OCH Estimated Project Plan Award*	$5,161,500	$4,686,000	($475,500)

** Note: estimates in the table are averages, based on 1000 random simulations*

The extent of the financial impact to OCH depends on the valuation of its project plan relative to the other ACHs, as well as the number of ACHs that earn project plan scores in excess of 90%. HCA's modifications to the scoring of project plans do not impact the revenue OCH may earn in subsequent years of the transformation project.

In addition to its modification to the scoring protocol, HCA has extended the project plan review process to the end of January 2018. OCH still has a November 16 deadline for filing its project plan. However, HCA's independent assessor will employ iterative cycles of reviews that will afford several opportunities for OCH to refine and strengthen its plan, and make changes to its portfolio of transformation projects. OCH staff does not anticipate making substantive changes to the project portfolio between now and the end of the review process on January 31.

Looking beyond January, OCH will turn its attention to implementation planning, giving priority to developing a series of workflows, action plans, and capacity/infrastructure investments to prepare provider organizations for value-based contracting and practice transformation. OCH and its partners and stakeholders will spend the first half of 2018 developing shared change plans for NCCs, and individual change plans for project partners to achieve its transformation objectives. These plans will feed up into OCH's implementation plans for each project area, for submission to HCA by the end of July 2018. During this planning process, OCH staff will bring any potential issues related to number of projects to the Board for action.

Olympic Community of Health

Attestations for Project Plan Submission

Action taken at the November 13, 2017 OCH Board Meeting

Attestation 1. Staff recommendation: YES
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. DSHS 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.

Attestation 2. Staff recommendation: January 1, 2020
If the ACH attests to not having implemented fully integrated managed care, provide date of projected implementation.

Attestation 3. Staff recommendation: Yes
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.

Olympic Community of Health
Statement of Financial Position
As of September 30, 2017

	Sep 30, 17	
ASSETS		
Current Assets		
Checking/Savings		
First Federal Checking		6,144,140
First Federal Savings		1
Total Checking/Savings		6,144,141
Other Current Assets		
Prepaid Expenses		202
Total Other Current Assets		202
Total Current Assets		6,144,342
TOTAL ASSETS		**6,144,342**
LIABILITIES & EQUITY		
Liabilities		
Current Liabilities		
Accounts Payable		
Accounts Payable		32,912
Total Accounts Payable		32,912
Other Current Liabilities		
Deferred Grant Revenue		
SIM		
KPHD Carryover	132,071	
Opioid SIM Funds	250	
SIM - Other	14,514	
Total SIM	146,836	
Design Funds	5,925,952	
Opioid Contributions	14,000	
Total Deferred Grant Revenue		6,086,788
Wages Payable		19,188
Payroll Taxes Payable		8,249
Total Other Current Liabilities		6,114,226
Total Current Liabilities		6,147,138
Total Liabilities		6,147,138
Equity		
Net Income		-2,796
Total Equity		-2,796
TOTAL LIABILITIES & EQUITY		**6,144,342**

Olympic Community of Health
Profit & Loss Budget vs. Actual
February through September 2017

	Feb - Sep 17	Budget	$ Over Budget
Ordinary Income/Expense			
Income			
Grant Income	345,048	253,791	91,257
Total Income	345,048	253,791	91,257
Expense			
Administrative Services			
CPA services	4,141	9,455	(5,314)
Payroll & Bookkeeping expense	4,726	9,476	(4,750)
Total Administrative Services	8,867	18,930	(10,063)
Computer and Internet Expenses	478		
Continuing Education	150		
Emplolyee Benefits			
Health Insurance	10,854	16,291	(5,436)
SEP Expense	5,173	7,169	(1,995)
Total Emplolyee Benefits	16,028	23,460	(7,432)
Events			
Food	1,946	4,000	(2,054)
Rental (venue, A/V)	998	1,091	(93)
Total Events	2,943	5,091	(2,148)
Insurance Expense	807	1,878	(1,072)
Miscellaneous	1,760	1,091	669
Office Expense			
Supplies	4,282	2,889	1,392
Communcations	2,954	1,413	1,541
Office Space	7,706	816	6,891
Postage	92		
Information Technology	112	5,492	(5,380)
Office Expense - Other	127		
Total Office Expense	15,272	10,610	4,662
Payroll Expenses			
Wages			
Executive Director	83,333	68,973	14,360
Staff Salaries	89,246	60,067	29,179
Total Wages	172,579	129,040	43,539
Payroll Taxes			
FICA	12,834	10,967	1,866
FUTA	173	471	(298)
SUTA	1,502	4,241	(2,740)
L&I	638	535	103
Total Payroll Taxes	15,146	16,214	(1,068)
Total Payroll Expenses	187,725	145,254	42,471
Professional Development	1,351	4,545	(3,194)
Professional Services			
Legal	2,180	3,636	(1,456)
Contract Services	97,251	33,557	63,694
Total Professional Services	99,431	37,193	62,238
Rent Expense	1,390		
Telephone Expense	-		
Travel Expense	11,641	5,739	5,902
Total Expense	347,844	253,791	94,052
Net Ordinary Income	(2,796)	-	(2,796)
Net Income	(2,796)	-	(2,796)

Olympic Community of Health
Profit & Loss by Class
February through September 2017

	1 - Administration & Governance (SIM)	2 - Health Improvement Planning (SIM)	3 - Health & Delivery System (SIM)	3a - Opioid Project (SIM)	1 - Project Plan Development (Design)	2 - Engagement (Design)
Ordinary Income/Expense						
Income						
Grant Income	178,710	35,471	27,069	29,750	18,828	8,626
Total Income	178,710	35,471	27,069	29,750	18,828	8,626
Expense						
Administrative Services						
CPA services	4,141	0	0	0	0	0
Payroll & Bookkeeping expense	4,726	0	0	0	0	0
Total Administrative Services	8,867	0	0	0	0	0
Computer and Internet Expenses	478	0	0	0	0	0
Continuing Education	150	0	0	0	0	0
Emplolyee Benefits						
Health Insurance	10,854	0	0	0	0	0
SEP Expense	3,473	6	15	402	266	156
Total Emplolyee Benefits	14,327	6	15	402	266	156
Events						
Food	0	0	0	0	0	0
Rental (venue, A/V)	35	0	0	0	0	963
Total Events	35	0	0	0	0	963
Insurance Expense	807	0	0	0	0	0
Miscellaneous	846	0	0	0	0	0
Office Expense						
Supplies	3,828	0	0	0	0	37
Communcations	2,338	297	38	77	0	71
Office Space	7,706	0	0	0	0	0
Postage	92	0	0	0	0	0
Information Technology	90	0	0	0	0	0
Office Expense - Other	63	0	0	0	0	0
Total Office Expense	14,117	297	38	77	0	108
Payroll Expenses						
Wages						
Executive Director	44,093	13,418	4,890	1,210	5,365	1,723
Staff Salaries	27,146	4,385	10,515	25,445	4,761	4,164
Total Wages	71,239	17,803	15,405	26,655	10,126	5,887
Payroll Taxes						
FICA	5,308	1,318	1,132	1,980	748	436
FUTA	92	9	24	18	0	5
SUTA	740	199	143	187	42	40
L&I	294	57	45	88	31	19
Total Payroll Taxes	6,434	1,583	1,344	2,273	821	500
Total Payroll Expenses	77,673	19,386	16,749	28,928	10,947	6,387
Professional Development	1,351	0	0	0	0	0
Professional Services						
Legal	0	0	0	0	0	0
Contract Services	50,176	15,676	9,543	0	7,500	0
Total Professional Services	50,176	15,676	9,543	0	7,500	0
Rent Expense	1,390	0	0	0	0	0
Telephone Expense	0	0	0	0	0	0
Travel Expense	8,493	106	724	343	115	1,012
Total Expense	178,710	35,471	27,069	29,750	18,828	8,626
Net Ordinary Income	0	0	0	0	0	0
Net Income	0	0	0	0	0	0

Olympic Community of Health
Profit & Loss by Class
February through September 2017

	3 - Adm/Project Mgmt (Design)	4 - IT (Design)	5 - Health Systems & Community (Design)	5 - DSRIP Funds	TOTAL
Ordinary Income/Expense					
Income					
Grant Income	40,865	5,254	477	0	345,050
Total Income	40,865	5,254	477	0	345,050
Expense					
Administrative Services					
CPA services	0	0	0	0	4,141
Payroll & Bookkeeping expense	0	0	0	0	4,726
Total Administrative Services	0	0	0	0	8,867
Computer and Internet Expenses	0	0	0	0	478
Continuing Education	0	0	0	0	150
Emplolyee Benefits					
Health Insurance	0	0	0	0	10,854
SEP Expense	836	7	13	0	5,174
Total Emplolyee Benefits	836	7	13	0	16,028
Events					
Food	0	0	0	1,946	1,946
Rental (venue, A/V)	0	0	0	0	998
Total Events	0	0	0	1,946	2,944
Insurance Expense	0	0	0	0	807
Miscellaneous	64	0	0	850	1,760
Office Expense					
Supplies	417	0	0	0	4,282
Communcations	120	0	13	0	2,954
Office Space	0	0	0	0	7,706
Postage	0	0	0	0	92
Information Technology	22	0	0	0	112
Office Expense - Other	64	0	0	0	127
Total Office Expense	623	0	13	0	15,273
Payroll Expenses					
Wages					
Executive Director	11,987	229	419	0	83,334
Staff Salaries	12,829	0	0	0	89,245
Total Wages	24,816	229	419	0	172,579
Payroll Taxes					
FICA	1,864	17	31	0	12,834
FUTA	24	0	0	0	172
SUTA	150	0	0	0	1,501
L&I	102	1	1	0	638
Total Payroll Taxes	2,140	18	32	0	15,145
Total Payroll Expenses	26,956	247	451	0	2,180
Professional Development	0	0	0	0	1,351
Professional Services					
Legal	2,180	0	0	0	2,180
Contract Services	9,356	5,000	0	0	97,251
Total Professional Services	11,536	5,000	0	0	99,431
Rent Expense	0	0	0	0	1,390
Telephone Expense	0	0	0	0	0
Travel Expense	850	0	0	0	11,643
Total Expense	40,865	5,254	477	2,796	347,846
Net Ordinary Income	0	0	0	-2,796	-2,796
Net Income	0	0	0	-2,796	-2,796

MEMORANDUM

To: OCH Board of Directors
From: Nathanael O'Hara, CPA
Date: November 6, 2017
Re: Revenue Recognition

Comments:

On October 17, 2017, Nathanael O'Hara, Elya Moore, and Margaret Hilliard had a teleconference with Tom Dingus of DZA to discuss the recognition of revenue in OCH's financial statements. DZA is the audit firm that OCH engaged to complete the organization's annual audit and other financial consulting as necessary. After discussing the nature of the State Innovation Model (SIM) and Medicaid Transformation (DESIGN and DSRIP) funding from the HCA, it was confirmed by Mr. Dingus that these funds are liabilities and will be recorded as deferred grant revenues on the Statement of Financial Position. They will be classified as revenues as the expenses associated with the grants are incurred and reported.

The SIM and DESIGN funds are to be spent according to the requirements of the HCA. If the funds are not spent during the lifetime of the program or if OCH were to cease its operations, they would go back to the HCA, which makes them liabilities instead of net assets. Other sources of funding (grants, DSRIP, etc.) that would not be returned to the granting agency or organization will be classified as net assets in future financial statements.

Olympic Community of Health
Investment Policy

PURPOSE OF INVESTMENT POLICY

The purpose of this Investment Policy is to provide a clear statement of the Olympic Community of Health's (OCH) investment objective, to define the responsibilities of the Board of Directors and Finance Committee involved in managing the OCH's investments, and to identify permissible investments.

INVESTMENT OBJECTIVE

The overall investment objective of the OCH is to minimize risk and expenses.

GENERAL PROVISIONS

- All transactions shall be for the sole benefit of the OCH.
- The Board of Directors (Directors) shall update the OCH's investment policy, and review OCH's risk tolerance and investment horizon on an annual basis.
- The Directors shall conduct an annual review of the OCH's investment assets to verify the existence and marketability of the underlying assets or satisfy themselves that such a review has been conducted in connection with an independent audit (if any) of the OCH's financial statements.
- Any investment that is not expressly permitted under this Policy must be formally reviewed and approved by the Directors.
- The Directors will endeavor to operate the OCH's investment program in compliance with all applicable state, federal and local laws and regulations concerning management of investment assets.
- Investments shall be diversified with a view to minimize risk.

DELEGATION OF RESPONSIBILITY; RELIANCE ON EXPERTS AND ADVISORS

- The Board of Directors has ultimate responsibility for the investment and management of the OCH's investment assets.
- The Board may delegate authority over the OCH's investments to the Finance Committee or other properly formed committee, being a Board Committee comprised only of Directors.
- The Board or Board Committee may hire outside experts as investment consultants or investment managers.

GENERAL INVESTMENT GUIDELINES

- A copy of this Investment Policy shall be provided to all Investment Managers.
- The Organization is a tax-exempt organization as described in section 501(c)(3) of the Internal Revenue Code. This tax-exempt status should be taken into consideration when making OCH investments.
- The OCH is expected to operate in perpetuity; therefore, a 5-year investment horizon shall be employed. Interim fluctuations should be viewed with appropriate perspective.

- A cash account shall be maintained with a zero to very low risk tolerance to keep cash available for budgeted operating expenses.
- Transactions shall be executed at reasonable cost, taking into consideration prevailing market conditions and services and research provided by the executing broker.
- Permitted investments include: Checking, Savings, and CD accounts.
- Investments within the investment portfolio should be readily marketable.
- The investment portfolio should not be a blind pool; each investment must be available for review.

2017		2017		2017		2018	
Approved November 2016		**Approved April 2017**		**Presented July 10, 2017**		**Presented to Board November 13, 2017**	
2017 Budget		**AUTHORIZED Increased Spend**		**DESIGN BUDGET PLAN Phase II Application**		**Draft 2018 Budget**	
Personnel	**Total**	**Personnel**	**Total**	**Personnel**	**Total**	**Personnel**	**Total**
Personnel and Benefits	251,683	Personnel and Benefits	339,782	Personnel	319,125	Personnel	515,917
				Benefits (22%)	70,208	Benefits (15%)	76,938
						Cost of Living Increase (1%)	5,129
						Merit Pool (3%)	15,388
Subtotal Personnel Costs	251,683	**Subtotal Personnel Costs**	339,782	**Subtotal Personnel Costs**	389,333	**Subtotal Personnel Costs**	613,371
Non-Personnel	**Total**	**Non-Personnel**	**Total**	**Non-Personnel**	**Total**	**Non-Personnel**	**Total**
Professional Services:		Professional Services:		Professional Services:		Professional Services:	
Legal Counsel	5,000	Legal Counsel	7,500	Legal Counsel	10,000	Legal Counsel	15,000
Data and Evaluation	45,872	Data and Evaluation	65,105	Data and Evaluation	95,105	Data & Evaluation	140,000
Opioid Contractor	5,194	Opioid Contractor	5,194	Opioid Contractor	5,194	IT Care Coordination	50,000
		Project Plan Selection	11,798	Project Plan Selection	25,575	Information Systems	40,000
		Project Plan Development	42,900	Project Plan Development	92,800	Transformation Project	75,000
		HR Consultant	4,000	HR Consultant	4,000	HR	2,000
		Financial Advisor/CFO Services	5,000	Financial Advisor/CFO Services	5,000	Financial Advisory/CFO Services	5,000
		Other Consultant	10,000	Other Consultant	10,000	Health Facilities	25,000
				Provider Engagement	15,000	Integration	25,000
				Consumer Engagement	10,000	Other	50,000
				Project Mngmt in Partner Orgs	50,000	Consumer Engagement	15,000
				Data & Analytics in Partner Orgs	15,000		
				Operations Math. Modeler	15,000		
				Apple Integrator	170,000		
Administrative Services		Administrative Services		Administrative Services		Administrative Services	
Bundled financial services	20,029	Bundled financial services	25,036	Bundled financial services	25,036	Bundled financial services	15,000
Audit	6,000	Audit	6,000	Audit	6,000	Audit	7,750
Office Space, IT, Printing	10,000	Occupancy (1 site, includes IT)	18,800	Occupancy (1 site, includes IT)	37,000	Occupancy (2 sites, includes IT)	50,000
Professional Development	6,250	Professional Development	6,250	Professional Development	6,250	Professional Development	7,000
Travel/Mileage	8,424	Travel/Mileage	10,530	Travel/Mileage	10,700	Travel/Mileage	32,000
Communications	2,000	Communications	2,000	Communications	3,000	Communications	4,800
						Subscriptions	3,000
Supplies	4,000	Supplies	7,000	Supplies	9,500	Supplies	12,000
Events	1,500	Events	2,500	Events	2,500	Events	5,500
Food and beverage	5,500	Food and beverage	5,500	Food and beverage	5,500	Food and beverage	6,000
Liability Insurance	2,583	Liability Insurance	2,583	Liability Insurance	2,583	Liability Insurance	5,000
				B&O Tax	90,000	B&O Tax	3,750
Miscellaneous	1,500	Miscellaneous	1,500	Miscellaneous	1,500	Miscellaneous	5,000
Subtotal Non-Personnel Costs	**123,852**	**Subtotal Non-Personnel Costs**	**239,196**	**Subtotal Non-Personnel Costs**	**722,243**	**Subtotal Non-Personnel Costs**	**598,800**
TOTAL EXPENDITURES	**375,535**	**TOTAL EXPENDITURES**	**578,978**	**TOTAL EXPENDITURES**	**1,111,576**	**TOTAL EXPENDITURES**	**1,212,171**

Communications: Go-To-Meeting, Survey Monkey, Mail Chimp, website, stock photo, cards, photoshop

Consumer engagement: Focus groups, community surveying, consumer champions, consumer reimbursement

Data and Analytics in Partner Organizations: to compensate for data extraction and reporting
Data and Evaluation: Analytics and Reporting Lead (0.6 FTE) & Data and Evaluation Contractor (0.3 FTE) contracted through Kitsap Public Health District
Events: venue rental, audio/visual rental

Financal Services: bookkeeping, accounting, taxes, payroll (NOTE: bookkeeping will be internalized during 2018)

Miscellaneous: books, subscriptions, memberships, other
Occupancy: includes rent and IT

Operations Math. Modeler: assistance with budgeting, modeling or other quantitative analysis for Project Plan, re-housing and structuring the data for current and future analytical needs, and modeling alternative clinical approaches to improving health sub-population outcomes

Project Management in Partner Organizations: assist in drafting projet plans, centralize project management within organizations during implementation
Provider engagement: training, clinical input, design and review of protocols, VBP preparedness

Supplies: Computer, cell phone, software packages (e.g., Adobe, Microsoft Exchange), electronics, statistical software, customer relationship management software, contract compliance software, office supplies

TOTAL OCH ESTIMATED REVENUE 2018		
DESIGN FUNDS CARRY OVER	$	1,093,421
DSRIP FUNDS ALLOCATION FOR 2018	$	118,750
NEW SIM FUNDS	$	-
TOTAL	$	1,212,171

Olympic Community of Health

2018 budget narrative and personnel summary

Presented at the November 13, 2017 OCH Board Meeting

The draft 2018 budget presented in the Board packet is based on our best estimation of the work that will be needed in 2018. The budget assumes the following:

- The first half of 2018 will be dedicated to securing change plans for each Natural Community of Care and participating partner, and aligning these efforts with implementation plans for each of OCH's six DSRIP projects. Some budget and staffing decisions will need to be revisited once a final set of implementation plans are approved by HCA in the summer of 2018.

- OCH's Phase II Certification feedback included a concern about inadequate staffing level projections. In order to allay these concerns, OCH will require the right balance of contractors (subject matter experts) and internal staff to effectively plan and manage the highly dynamic start-up of the Medicaid Transformation Project (MTP). In particular, OCH will require experienced and competent project managers to successfully support these initiatives throughout the transformation.

- DSRIP funding remains unstable, requiring OCH management to be nimble and adaptive to changing circumstances. It is unlikely that the organization structure and staffing will remain unchanged during the life of the transformation. 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.

Personnel summary built into the 2018 personnel subtotal:

Minimum personnel capacity	**Additional potential personnel capacity**
Executive Director	Contracts and Compliance Coordinator
Director of Partnership/Opioid Project	Communications Coordinator
Director of Finance and Administration	Office and Administrative Coordinator
1st Project Manager	2nd Project Manager
1st Assistant	2nd Assistant

The 2018 budget estimates 7.2 FTE, with 8 "bodies" at full capacity. OCH is exploring office space for the growing staff size.

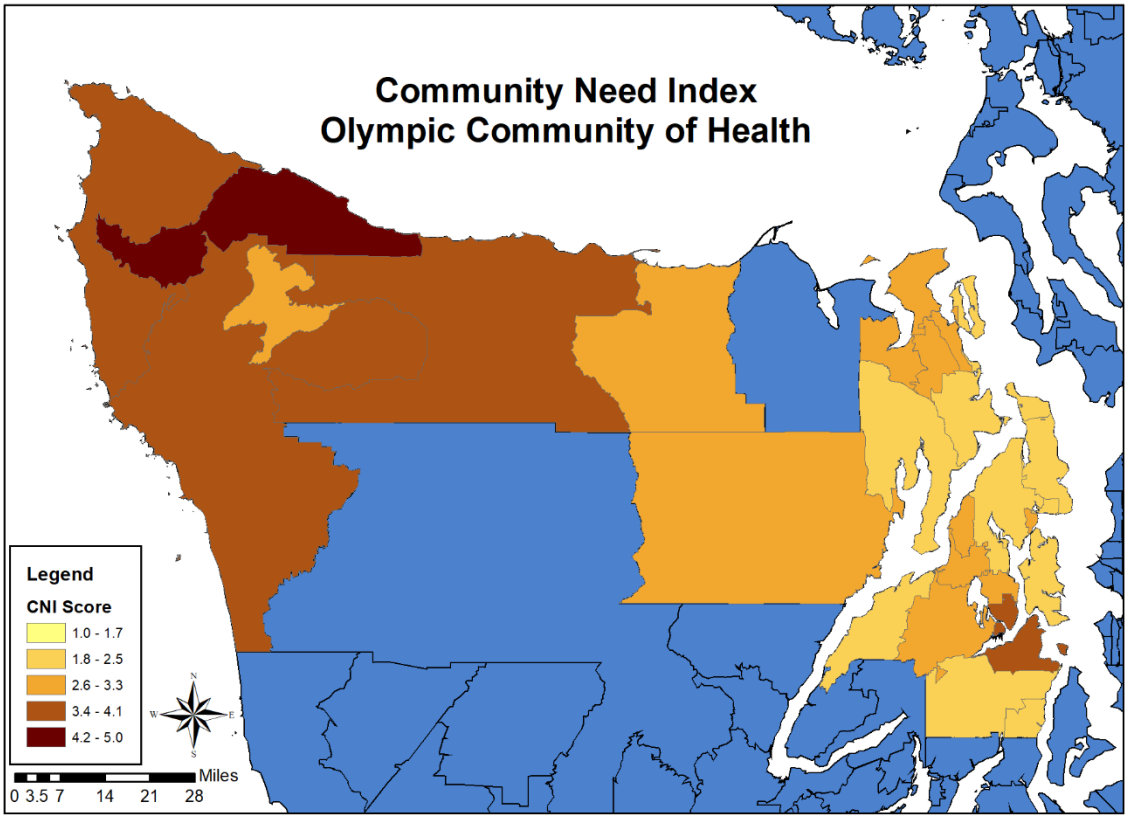
Community Need Index

Background: The Community Need Index (CNI) was jointly created in 2004 by Dignity Health and Truven Health as part of an effort to collect information on socio-economic factors to determine communities with the greatest healthcare needs. The CNI is therefore a strong predictor of a given community's demand for healthcare services.

Scoring: Every populated (non-populated zip codes are not scored) zip code is scored on a need scale of 1.0 to 5.0. Once scored, communities are grouped into one of five need categories: lowest need (1.0 - 1.7), 2nd lowest need (1.8 - 2.5), mid need (2.6 - 3.3), 2nd highest need (3.4 - 4.1), and highest need (4.2 – 5.0).

Methodology: CNI scores represent an equally weighted average of five barrier scores: (1) income, (2) cultural, (3) education, (4) insurance, and (5) housing. These barrier scores are measured for socio-economic indicators of each U.S. zip code. The data is current as of 2015 as reported by the source data.

Clallam Mean	Unweighted: 3.5 Weighted: 3	Jefferson Mean	Unweighted: 2.6 Weighted: 2.7	Kitsap Mean	Unweighted: 2.7 Weighted: 2.8



Source: http://cni.chw-interactive.org/Truven_Health_2014_Source_Notes_Community_Need_Index.pdf

Income Barrier	Cultural Barrier	Education Barrier	Insurance Barrier	Housing Barrier
Percentage of households below poverty line, with head of household age 65 or more Percentage of families with children under 18 below poverty line Percentage of single female-headed families with children under 18 below poverty line	Percentage of population that is minority (including Hispanic ethnicity) Percentage of population over age 5 that speaks English poorly or not at all	Percentage of population over 25 without a high school diploma	Percentage of population in the labor force, aged 16 or more, without employment Percentage of population without health insurance	Percentage of households renting their home

Data Sources:

- 2015 Demographic Data, The Nielsen Company
- 2015 Poverty Data, The Nielsen Company
- 2015 Insurance Coverage Estimates, Truven Health Analytics

Zip Code	CNI Score	Population	City	County	Zip Code	CNI Score	Population	City	County
98305	3.2	347	Beaver	Clallam	98311	2.6	26407	Bremerton	Kitsap
98326	4.6	1343	Clallam Bay	Clallam	98312	3.2	31822	Bremerton	Kitsap
98331	4.0	6311	Forks	Clallam	98315	3.2	6916	Silverdale	Kitsap
98362	3.0	22551	Port Angeles	Clallam	98337	4.0	10203	Bremerton	Kitsap
98363	3.4	13706	Port Angeles	Clallam	98340	2.2	2617	Hansville	Kitsap
98381	4.0	1993	Sekiu	Clallam	98342	2.4	1899	Indianola	Kitsap
98320	3.2	1204	Brinnon	Jefferson	98345	2.0	593	Keyport	Kitsap
98325	2.8	1579	Chimacum	Jefferson	98346	2.2	10406	Kingston	Kitsap
98339	3.2	3751	Port Hadlock	Jefferson	98359	2.4	5181	Olalla	Kitsap
98358	2.0	887	Nordland	Jefferson	98366	3.4	36136	Port Orchard	Kitsap
98365	1.8	4763	Port Ludlow	Jefferson	98367	2.2	29012	Port Orchard	Kitsap
98368	2.8	15434	Port Townsend	Jefferson	98370	2.2	30532	Poulsbo	Kitsap
98376	2.4	2178	Quilcene	Jefferson	98380	1.8	5300	Seabeck	Kitsap
98110	2.0	24013	Bainbridge Island	Kitsap	98383	3.0	20169	Silverdale	Kitsap
98310	3.6	19833	Bremerton	Kitsap	98392	3.0	3447	Suquamish	Kitsap

Source: http://cni.chw-interactive.org/Truven_Health_2014_Source_Notes_Community_Need_Index.pdf

Six Building Blocks for Safe Opioid Prescribing: Proposed Scope of Work, Budget, and Budget Justification for the Olympic Community of Health

University of Washington (UW) Team Based Opioid Management Team:
Team Leaders/6-BBs Content Experts: Laura-Mae Baldwin, MD, MPH; Michael Parchman, MD, MPH; Mark Stephens, BS.
Practice Facilitators/Project Managers: Brooke Ike, MPH and Nicole VonBorkulo, MS
Contact for more information: Laura-Mae Baldwin: lmb@uw.edu, 206-685-4799.

Introduction

In 2014, more than 240 million prescriptions were written for prescription opioids, more than enough to give every American adult their own bottle of opioid medication. Primary care clinic settings are critical to addressing the challenge of prescription opioid overuse within the United States, as the majority of opioids are prescribed by primary care providers. Primary care providers need information and tailored guidance to support team-based, practice improvements in the management of chronic opioid therapy.

Several key evidence-based initiatives have been successfully implemented in multiple care settings within Washington and Oregon to address the opioid use crisis, and can be leveraged to accelerate the response to this crisis. Our team of experts in chronic opioid and pain management from these initiatives is interested in exploring opportunities to integrate best practices from these initiatives into projects addressing the opioid crisis statewide.

The collaborative University of Washington (UW)/MacColl Center for Health Innovation team is able to support primary care-based transformation of chronic pain care in Washington State, aiming to reduce inappropriate and unsafe opioid prescribing.

The UW/MacColl team's work is built on the **Six Building Blocks** (6-BBs) model, which facilitates engagement of primary care teams in providing safer, more effective care to patients with chronic pain. The 6-BBs include:

1. Engaging leadership and securing consensus
2. Revising policies and standard work
3. Tracking patients on chronic opioid therapy
4. Planning for visits and providing patient-centered care
5. Developing resources to care for complex patients (e.g., addiction)
6. Measuring success

Scope of Work

We propose the following scope of work for supporting the Olympic Community of Health clinics, clinical organizations, and health systems as they work to address the opioid crisis using a model that provides direct practice facilitation to clinical organizations:

1. The UW/MacColl Center for Health Innovation team will provide facilitated implementation of the 6-BBs within 10 primary care clinical organizations across the OCH. This will include:
    a. 15 months of support to individual clinical organizations to implement the 6-BBs (staggered start for clinics over 6-12 months), to include:
        i. Orientation of clinic quality improvement teams to the 6-BBs
        ii. Preparation for and conduct of an in-person welcome visit with clinic quality improvement teams and clinic providers and staff – to include 6-BB self-assessment at each site
        iii. Facilitation of the development of an individual clinical organization action plan based on

the self-assessment.

iv. At least quarterly practice facilitation calls and a mid-point in-person visit to review action plan, discuss and problem solve barriers to 6-BB implementation, and self-assess progress on implementing the 6-BBs.
v. Provision of 6-BB resources. Examples of these include: exemplar clinic policies, treatment agreements, workflows, patient education materials, different strategies for monitoring and tracking patients using chronic opioid therapy.
vi. As needed calls to address ad hoc questions and concerns raised by participating clinical organizations.
vii. Monthly shared learning calls at which participating sites learn from each other as they implement the 6-BBs
viii. Connection to weekly University of Washington TelePain sessions. These sessions offer an audio and videoconference-based knowledge network of inter-professional specialists with expertise in the management of challenging chronic pain problems. The goal is to increase the knowledge and skills of community practice providers who treat patients with chronic pain.
UW TelePain includes:
    a. Didactic presentations from the UW Pain Medicine curriculum for community healthcare providers
    b. Case presentations from community clinicians
    c. Interactive consultations for providers with an inter-professional panel of specialists
    d. The use of measurement based clinical instruments to assess treatment effectiveness and outcomes for individuals and larger populations
ix. Facilitation of a closing site visit to review progress made and discuss plans for sustenance of changes made.

Budget (Estimate Only)

	Year 1	Year 2	Year 3
Physician Team Leaders & 6-BBs Content Experts	35,800	36,000	36,150
Practice Facilitators/Project Managers	83,250	86,150	89,150
Consultant (Website management and opioid tracking tool development)	10,000	10,300	10,610
Travel	3,700	3,170	3,925
Supplies and Webinar Technology	1,450	1,500	1,530
Total Direct Costs	134,200	137,120	141,365
Indirect Costs	91,400	79,200	81,610
Total	225,600	216,320	222,975

Budget Justification

Personnel:
Physician Team Leaders and 6-BBs Content Experts 15% FTE (Laura-Mae Baldwin at UW 7.5%, Michael Parchman at MacColl Center for Health Care Innovation 7.5%). Drs. Baldwin and Parchman will provide ongoing communication with practice leaders and physicians, clinical expertise in opioid management, expertise in practice redesign for opioid management, ad hoc academic detailing with clinical providers, supervision of practice facilitators, and attendance at the "Welcome Visits" and “Closing Visits” as well as shared learning calls.

Practice Facilitators (PFs)/Project Managers (PMs) 70% FTE (Brooke Ike 50% PF, Nicole Von Borkulo PF 20%). Ms. Ike and Ms. Von Borkulo will support sites in implementing the 6 Building Blocks for team based opioid management at each site (e.g., conduct regular calls with sites to discuss progress on action plan, run shared learning calls, connect sites with UW Telepain, provide exemplar 6 BBs template resources), organize and attend Welcome Visits, follow up visits, and Closing Visits, and serve as liaisons with DOH team.

TBN Project Manager 2.5% FTE. The Project Manager will manage the subcontract at MacColl Center for Health Care Innovation, Kaiser Permanente Washington Health Research Institute.

Other costs:

Consultant time: $10,000, with 3% increase annually – Mark Stephens will support resource website management, and development of a simple tool for tracking opioid patients, including PMP data.

Supplies and Postage:
$1,450 Year 1, $1,500 Year 2, $1530 Year 3 will cover general project supplies and handouts as needed for site visits, postage as needed to send materials to sites, and a long distance phone line for toll-free shared learning calls and regular check-ins with practice facilitators.

Travel:
$3,700 Year 1, $3,170 Year 2, $3,925 Year 3 – Year 1: Ten “Welcome Visits” each for Drs. Baldwin and Parchman and Ms. Ike – 8 one day and 2 two day trips each. Year 2: Ten follow-up visits for Ms. Ike -- 8 one day and 2 two day trips, and six ad hoc trips if needed for Dr. Parchman or Dr. Baldwin. Year 3: Ten “Closing Visits” each for Drs. Baldwin and Parchman and Ms. Ike – 8 one day and 2 two day trips each.

Indirect costs at UW are 55.5% and at Kaiser Permanente Washington Health Research Institute (MacColl Center) are 61.5%

Olympic Community of Health

S.B.A.R. 6 Building Blocks for Safe Opioid Prescribing

Presented to the Board of Directors November 13, 2017

Situation

The 3 County Coordinated Opioid Response Project (3CCORP) Steering Committee recommends that the OCH Board of Directors commit to allocating Medicaid Transformation Project (MTP) funds to bring the Six Building Blocks for Safe Opioid Prescribing (6BBs) to willing clinics in the region.

Background

3CCORP Prevention Workgroup received a presentation from UW and endorsed 6BBs as part of the coordinated effort to reduce the supply of opioids in circulation in the region. Based on this recommendation, the 6BB team presented the model to the 3CCORP Steering Committee and clinic leadership in the OCH region. The 3CCORP Steering Committee endorsed the Prevention Workgroup recommendation. Participants have begun identifying clinics that might be willing candidates in need of this intervention.

Action

3CCORP is one year ahead of other MTP project areas. There is a lot of momentum among clinic leaders to move from planning to action. Additionally, UW has limited capacity to provide 6BBSs to multiple ACHs at the same time. Therefore, there is a strong interest from 3CCORP participants for the Board to take action on this opportunity.

If the Board chooses to move forward, staff will work with the 3CCORP steering committee and prevention workgroup chairs to ensure alignment between provider organizations' change plans and the clinics identified by 3CCORP for 6BBs.

Proposed Recommendation

1. OCH Board of Directors authorizes the executive director to inform UW of OCH's intent to contract with UW to bring 6BBs to the region, pending contract negotiations and commitment from clinics to participate. Final contract will be brought to the Board for approval.

2. OCH budgets for 6BBs in the Fund Flow modeling process using the 'OCH Programming' category.

Olympic COMMUNITY of HEALTH

OCH WHISTLEBLOWER PROTECTION POLICY

1. **WHO DOES THE POLICY APPLY TO:** This Whistleblower Protection Policy applies to all Olympic Community of Health's (OCH) staff, whether full-time, part-time, or temporary employees, to all volunteers, to all who provide contract services, and to all officers and directors, each of whom shall be entitled to protection.

2. **WHEN A PROTECTED PERSON CAN SUBMIT A REPORT:** A protected person shall be encouraged to report information relating to illegal practices or violations of policies of the OCH (a "Violation") that such person in good faith has reasonable cause to believe is credible. Anyone reporting a Violation must act in good faith, and have reasonable grounds for believing that the information shared in the report indicates that a Violation has occurred.

3. **HOW TO SUBMIT A REPORT:**

    a. Information shall be reported to the Executive Director who serves as the Compliance Officer for the OCH. The protected person may raise concern to the Executive Director through any of the following media:
        i. Formal letter to:
        Olympic Community of Health
        Attn: Elya Moore
        834 Sheridan Street
        Port Townsend, WA 98368
        ii. Dedicated phone number/ communicator chat: (360) 633-9241
        iii. Dedicated email address: elya@olympicch.org

    b. If the report relates to the Executive Director, the report shall be made to an officer of the Board of Directors which shall be responsible to provide an alternative procedure. The contact information found on our website at http://www.olympicch.org/board-of-directors.html.

    c. The report should contain the following information:
        i. Background of the concerns (with relevant dates); and
        ii. Reason(s) why the whistleblower is particularly concerned about the situation.

4. **CONFIDENTIALITY:** The OCH encourages anyone reporting a Violation to identify himself or herself when making a report in order to facilitate the investigation of the Violation. However, Whistleblower Complaint Forms may be submitted anonymously and mailed to the Executive Director or the Chair of the Board. Reports of Violations or suspected Violations will be kept confidential to the extent possible, with the understanding that confidentiality may not be maintained where identification is required by law or in order to enable the OCH or law enforcement to conduct an adequate investigation.

5. **PROTECTION FROM RETALIATION:** No person entitled to protection shall be subjected to retaliation, intimidation, harassment, or other adverse action for reporting information in accordance with this Policy. Any person entitled to protection who believes that he or she is the subject of any form of retaliation for such participation should immediately report the same as a violation of and in accordance with this Policy. Any individual within the OCH who retaliates against another individual

who has reported a Violation in good faith or who, in good faith, has cooperated in the investigation of a Violation is subject to discipline, including termination of employment or volunteer status.

6. **DISSEMINATIONN OF POLICY:** This Policy shall be disseminated in writing to all affected constituencies.

Olympic COMMUNITY of HEALTH

WHISTLEBLOWING RESPONSE PROCEDURE

The whistleblowing procedure involves steps required for the investigation of the reported misconduct. The following procedures shall guide the whistleblowing process:

1. **Actions to be Taken When Report is Submitted to <u>Compliance Officer/Executive Director</u>**

    a. Consult with legal counsel to:

        i. determine whether the complaint pertains to a matter covered by this policy and procedure;

        ii. decide whether the reported violation requires review by the Compliance Officer or should be directed to another person; and

        iii. develop a recommended strategy for the investigation of the complaint including interviewing employees if necessary.

    b. Investigate the complaint reported or designate an investigator.

    c. Document the findings and any action taken.

    d. Submit a copy of the report related to results from the investigation, to the OCH Board or Board Appointed Committee.

2. **Actions to be Taken When Report is Submitted to <u>OCH Board or Board Appointed Committee Member(s)</u>**

    a. Consult with legal counsel to

        i. determine whether the complaint pertains to a matter covered by this policy and procedure;

        ii. decide whether the reported violation requires review by the OCH Board or OCH Board Appointed Committee or should be directed to another person; and

        iii. develop a recommended strategy for the investigation of the complaint including interviewing employees if necessary.

    b. The OCH Chair or Committee Chair shall report to the Submitter, that the complaint is acknowledged, and that appropriate action will be taken. Considering that complaints may be anonymous, it is understood that such acknowledgement may not be possible.

    c. Investigate the complaint reported or designate an investigator.

    d. Document the findings and any action taken.

    e. As deemed appropriate, in the Chair's opinion, and no less than once a quarter, report to the Committee on the status of Submitter reports.

    f. Submit Quarterly reports on the status of all complaints to the Board of Directors.

g. To the extent deemed appropriate, the Chair of the Boar or Committee shall ensure feedback is provided to the person submitting the complaint.

3. Record Keeping and Retention

The Compliance Officer will maintain records of all complaints covered by these Procedures, tracking their receipt, investigation and resolution and shall prepare a periodic report to the OCH Board or the Board appointed committee until the matter has been resolved to the satisfaction of the OCH Board or Board appointed committee. Copies of all complaints and investigation records will be maintained in accordance with the OCH's document retention policy.

4. **Confidentiality**

Confidentiality will be maintained to the fullest extent possible, consistent with the need to conduct adequate review.

Olympic COMMUNITY of HEALTH

CASCADE PACIFIC ACTION ALLIANCE

October 18, 2017

MaryAnne Lindeblad, Medicaid Director
Washington State Health Care Authority
626 8th Ave SE
Olympia, WA 98501

Re: Opportunities to support the transition to integrated managed care in the ten counties of the Olympic Peninsula

Dear MaryAnne,

We are writing to request an opportunity to meet with you to discuss mutually agreeable strategies to support providers in Clallam, Cowlitz, Grey Harbor, Jefferson, Kitsap, Mason, Pacific, Thurston, and Wahkiakum counties to transition to fully integrated managed care (FIMC) by January 1, 2020. Provider organizations, Medicaid Managed Care Organizations, and our two accountable communities of health in the region are eager to carry out the planning process to support successful implementation.

Transitioning to FIMC by 2020 will require extensive and expensive planning efforts and organizational changes. Our Boards of Directors feel there is common interest to provide the same funds to health providers in our regions who will need to go through the same planning process as providers in other regions that received early/mid adopter FIMC funding to make the transition. It is punitive to withhold FIMC funds for those regions that were not ready, or whose county commissioners did not elect to go mid- or early-adopter. The resources available to support this ambitious transition to FIMC will be a major determinate of the quality and effectiveness of the new systems that are created. Ultimately, it is not the providers that suffer, but the consumers if this new system is unable to deliver needed services. This raises deep concerns about health equity and fairness and risks the possibility that consumers in our region will have to live with inferior Integrated Managed Care services as compared to consumers in other parts of the state.

The work on behalf of our two accountable communities of health, Olympic Community of Health and Cascade Pacific Action Alliance, to support the transition will be essential and substantial. Without FIMC funding equal to what other regions are receiving, the level of supportive services provided by our ACHs will be seriously constrained. This threatens the success of the FIMC transition process in our regions.

Successful FIMC is essential to implementing the key mandated Medicaid Transformation Project area of bi-directional integration. With a significant reduction of MTP incentive funds, it is essential that our providers receive FIMC funds to avoid having to scale back on their commitment to bi-directional integration, which would result in a proportionate reduction in overall project scope and impact. By handicapping our ability to prepare for FIMC, HCA risks undermining the entire Medicaid Transformation Project (MTP). Our regions and the state cannot afford to have this important effort fail.

We would like to convene a meeting between the executive directors of OCH and CPAA and one or two members of our leadership with the leadership at the HCA and the integration team as soon as possible. The output of this meeting is a list of mutually agreeable options to support FIMC in our regions.

In Partnership,

Elya Moore, Executive Director
Olympic Community of Health

Winfried Danke, Executive Director
Cascade Pacific Action Alliance

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

October 27, 2017

Elya Moore
Executive Director
Olympic Community of Health
2500 West Sims Way
Port Townsend, WA 98368

Winfried Danke
Executive Director
Cascade Pacific Action Alliance
1217 Fourth Avenue East
Olympia, WA 98506

Dear Elya and Winfried:

SUBJECT: Fully Integrated Managed Care

Thank you for your letter regarding opportunities to support integrated managed care in your Regional Service Areas (RSA). The Health Care Authority (HCA) appreciates your leadership and willingness to partner as we continue to move toward whole person care, including integrated financing and administration.

First, I want to acknowledge our willingness to engage in discussions regarding strategies to support providers in the transition to Integrated Managed Care. As you suggested, a successful transition will ultimately result in improved experiences and better outcomes for the recipients of care. We appreciate and share your desire to explore opportunities to further support providers ahead of 2020.

The Funding and Mechanics Protocol (approved by CMS on June 26, 2017) stipulates the timeline for qualification (implementation prior to 2020) and the two phases of incentive (binding letter of intent and actual implementation), so unfortunately, the Integrated Manage Care incentive funding is only available to regions moving to adoption in 2019 or earlier. That being said, below are several strategies we believe are worth exploring:

- Engaging in discussion with partners in your region early on in the process, including HCA staff support to provide guidance, discuss lessons learned, etc.
- Providing opportunities to inform future procurement efforts and engage in the design process to the extent possible.
- While we do not have other financing mechanisms identified to support adoption in 2020, we can explore the use of existing Practice Transformation resources under SIM, promising practices from early and mid-adopters, and strategies to support providers with Integrated Manage Care planning as part of a broader bi-directional integration project (2a).

We look forward to connecting with you to discuss these options. We will reach out to provide a few options to meet, per your suggestion. If you have any questions, please contact me at 360-725-1863 or via email at MaryAnne.Lindeblad@hca.wa.gov.

Sincerely,

MaryAnne Lindeblad, BSN, MPH
Medicaid Director

By email, mail

cc: Rick Weaver, Senior Policy Advisor, BHI, GOV
Laura Zaichkin, Acting Chief Policy Officer, PPP, HCA
Chase Napier, Acting Deputy Chief Policy Officer, PPP, HCA
Marc Provence, Director, OMT, PPP, HCA
Alice Lind, Grants and Program Development Manager, MPOI, HCA
Isabel Jones, Integration Policy Manger, PPP, HCA

STATE OF WASHINGTON

HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

November 3, 2017

Dear Managed Care Organizations, Behavioral Health Organizations, Accountable Communities of Heath, and Other Interested Parties:

SUBJECT: INTEGREATED MANAGED CARE – NUMBER OF MANANAGED CARE ORGANIZATIONS - REQUEST FOR REGIONAL INPUT BY 12/1/17

The Health Care Authority (HCA) is preparing to release a final Request for Proposals (RFP) to secure Managed Care Organizations (MCOs) that will implement Integrated Managed Care in the remaining regions across the state of Washington. As part of this RFP, HCA will include the number of MCOs it intends to contract with, within each Regional Service Area (RSA).

Though the final number of MCOs selected will depend on the results of the procurement, HCA proposes using the following methodology to determine the number of proposed MCOs per region:

1. Up to 150,000 Medicaid lives: 3 MCOs
2. 150,000-250,000 Medicaid lives: 4 MCOs
3. 250,000 or more Medicaid lives: 5 MCOs

This approach would result in the following number of MCOs by region:

Region	Number of Medicaid Enrollees	Number of MCOs
Greater Columbia	264,379	5
King	426,683	5
North Sound	282,394	5
Salish	85,743	3
Pierce	232,427	4
Spokane	217,158	4
Thurston-Mason	87,986	3
Great Rivers	103,017	3

These numbers serve as a guideline, not an absolute requirement. As previously stated, HCA welcomes input from regions on their preference for the number of MCOs contracted.

Please provide any recommendations to this approach **by December 1, 2017**. Recommendations can be sent to Alice Lind via email at alice.lind@hca.wa.gov. Thank you.

Please forward information to any interested party.

Sincerely,

MaryAnne Lindeblad, BSN, MPH
Medicaid Director

By email

cc: Rick Weaver, Senior Policy Advisor, BHI, GOV
Alice Lind, Grants and Program Development Manager, MPOI, HCA
Isabel Jones, Integration Policy Manger, PPP, HCA