Board of Directors
July 6, 2016

Business: 8:30 a.m. to 10:15 a.m.
Work Session: 10:30 a.m. to 11:00 a.m.
Olympic Room – Inn at Port Ludlow
1 Heron Road, Port Ludlow
Web: https://global.gotomeeting.com/join/847611893
Dial-In: +1 (571) 317-3122
Access Code: 847-611-893

Chair: Roy Walker

OBJECTIVES

- Elect an executive committee
- Select a regional health improvement project
- Agree on a direction for next phase of governance and structure

AGENDA (Action items are in red)

Item		Topic	Lead	Attachments
1	8:30	Welcome	Roy	
2	8:35	Consent agenda	Elya	1. Director's Report 2. Minutes Board of Directors Meeting 6/1/2016
3	8:45	Voting on Executive Committee	Eric	3. Bios of nominees 4. Executive Committee Ballot
4	9:00	Selecting a project	Katie Siri	5. Submitted proposals (n=8) 6. Regional Health Assessment and Planning Committee Recommendation
5	9:40	Why and how to move the OCH forward	Elya Roy	7. Pathway toward incorporation and next phase of governance discussion paper
6	10:10	Debrief Early Adopter – Fully Integrated Managed Care panel presentation	Leonard	8. OCH Partner Group Meeting evaluation summary
BREAK – 10:20				
10:30 to 11:00		Value Based Purchasing *Why are we talking about it?*	Elya	9. HCA Value-Based Payment Roadmap, 2017-2021

Olympic Community of Health
Director's Report
Board of Directors
July 6, 2016

A message from your director
The OCH is now full steam ahead! This last month saw the OCH-Tribal Workshop, OCH Partner Group Meeting, and ACH Convening in Chelan. Staff worked diligently to distribute the request for proposals for regional health improvement projects and to set up the process for scoring and vetting of submitted proposals by the Regional Health Assessment and Planning Committee. Selection of a project and your executive committee officers are your main priorities for today's Board meeting.

Stepping back, the ACH whirlwind is upon us. At our current speed, it is easy to lose sight of our aspirational goals. We need to take the time to answer the BIG questions: **Where do we want to go? How will get there?**

Regional Health Needs Assessment | Regional Health Needs Improvement Plan
Siri Kushner, OCH RHNA/RHNI Lead
Since the last Board meeting, we released and closed our Request for Proposals for the first OCH Regional Project. We received 8 proposals that were scored by Regional Health Assessment and Planning Committee members. The Committee recommendation will be discussed for a Board vote on the selected project(s) today. We will begin to develop the format for our RHIP and work with the selected regional project organization(s) to set up monitoring and evaluation.

In addition to submitting our selected project(s) to the HCA, the RHNA/RHIP contract deliverables due to HCA by July 29, 2016 are complete: 1) project proposal template; 2) RHIP one-pager and RHAP Committee Charter.

Plan for Improving Population Health (P4IPH) link
Katie Eilers, appointed OCH Board representative
The purpose of P4IPH is to guide how the state and local communities can best implement population health improvement strategies and ensure the Healthier Washington initiative addresses prevention, health equity and the social determinants of health. P4IPH is creating a website, which will be called *the Washington State Roadmap for Improving Population Health*. Along with key federal deliverables, it will:

- Align with the Prevention Framework
- Promote community-clinical linkages
- Support value-based payment
- Enhance—but not conflict with—other transformation efforts in the state, including Accountable Communities of Health projects.

OCH Outreach & Engagement

- The skeleton of the OCH website and blog have been completed. Any volunteers willing to review prior to launch? In the meantime, please like/follow us on Facebook, Instagram, and Twitter.
- This month we held over 20 meetings with community leaders from our region, including three Tribal Nations. We also began outreach to leadership within the education and first responder sectors.
- Key meetings and presentations:
    - Opiate response plan for Clallam, Jefferson, and Kitsap, May 27th
    - Salish Behavioral Health Organization Board Meeting, May 27th
    - Olympic Medical Center Board of Commissioners, June 15th
    - Olympic Educational School District 114, June 22nd

- Invited speaker *ACH Perspectives from Washington and Minnesota – Tips and Lessons from the Field,* hosted by Public Health Institute for new Vermont ACH program, June 21st
- Forthcoming:
  - Invited panelist, Inland NW State of Reform Health Policy Conference: *A Survey of the Accountable Communities of Health,* September 14th
  - Invited co-presenter, WA State Public Health Association 2016 Annual Conference: *Accountable Communities of Health: The Role of Public Health Leadership - 2016 Update,* October 4th

Medicaid Waiver link
All signs indicate that the Waiver will be "a go", with current weekly negotiations between Health Care Authority (HCA) and Center for Medicare and Medicaid Services (CMS) are focusing around budget neutrality. HCA hopes to be able to announce a principled agreement in the summer. Be prepared for a budgeted amount less than the original $3 billion dollars over the five-year period, probably closer to $2 billion dollars. We do not yet know the breakdown between the three Waiver initiatives (1. Transformation projects, 2. Long-term services and supports, and 3. Supportive housing and supportive employment), but it is likely that Initiative 1 will receive the most significant investment. Also, the CMS has agreed to treat the prescription drug cost growth outside budget neutrality model.

Once approved, the State will head into negotiations around the "special terms and conditions", which will unveil the operational details that we are all so eager to see. In the meantime, I participate on the Waiver workgroup in Olympia. I am also closely following the roll-out of the 2nd year of the Waiver in New York, which has been held up as the gold standard for Waiver implementation by CMS. New York's "midpoint" evaluation materials should be released soon.

Summary: Tribal-OCH Workshop, June 7th, Jamestown S'Klallam Tribal Center in Sequim
Over 30 OCH community leaders joined six of the seven Tribal Nations and the five Medicaid Managed Care Organizations (MCOs) for an afternoon workshop. The session kicked off with a presentation from American Indian Health Commission (AIHC) Executive Director, Vicki Lowe, and HCA Tribal Administrator, Jessie Dean. Together, they gave an extremely informative presentation on Tribal expertise in health care innovation and the Indian health care delivery system. The key take homes for this meeting were: 1) there are tremendous shared learning opportunities and 2) thoughtful, intentional, and meaningful collaboration with the Tribes is essential for shared success in building healthy communities.

Summary: OCH Partner Convening, June 14th, House of Awakened Culture, Suquamish
This OCH Partner Group meeting was well attended, with nearly 60 participants. We heard from 4 panelists on the experience of fully integrated managed care, also called "early adopter" in Southwest Washington. Bottom line: all nine regional service areas in the state of Washington will be under a fully integrated managed care model by 2020. Our partners in the Olympic region will need to continue to digest what this should look like here locally, and respond and prepare accordingly.

After the meeting, we posed this question to the panelists: *Would you provide an overall gestalt of "how it went" for the first 3 months of Early Adopter? We focused a lot today on the "dance floor", but would you be willing to provide a view from the "balcony"?*

Here are excerpts from their responses. Please email Angie for the full response:

- Tabitha Jensen: I think we have worked exceptionally well as a region, taking into consideration the important perspectives of consumers, providers, counties, HCA, and non-health system human services partners who focus on housing and food insecurity. Our focus will now need to pivot from the tactical elements of initial implementation to refinement of processes and true integration of services through

innovation, such as our ongoing ACH projects with care coordination and reverse colocation of primary care in behavioral health settings.

- Julie Lindberg, Molina: Transformation is only just beginning and will take time, but there is considerable enthusiasm to get started with the process because the transformation to more integrated services is the "why" in the equation.
- Dorothy Hardin, CHPW: I think because we put so much effort into aligning processes to make it easy for the providers to transition, we just continue to try to work together with that same focus. We are definitely still learning.

Summary: ACH Convening, Chelan June 28th-June 30th
The OCH was well represented in Chelan for the quarterly ACH Convening. Siri and I were joined by OCH Board Chair, Roy Walker. Since the meeting was held back-to-back with the WSHA Rural Hospital Leadership Conference, Hilary Whittington, Mike Glenn, and Eric Lewis were also able to participate. This meeting had a heavy focus on rural health care transformation and health care financing. Materials will be shared once available.

Financials
We are still tracking under budget as we continue to ramp up our work. We are afforded the opportunity of starting lean as we study the optimal staffing model for the OCH. I will continue to track expenses closely with the new Treasurer.

Kitsap Public Health District (KPHD) has capped our indirect rate at 25%, meaning that any indirect costs they incur above this rate are provided to the OCH as an in-kind donation. Additionally, prior to the arrival of the Director, the KPHD leadership contributed a considerable amount of time to the OCH as an in-kind donation. Between these two modalities, KPHD has donated a total of $26,506.67 in-kind to the OCH since January 2016. In addition, in-kind donations have been contributed by many other partners to get the OCH off of the ground. Our apologies that this is not reflected in these financials. We really appreciate all of your time and effort that are bringing the OCH to life!

KPHD's indirect rate offers a wide array of benefits, including the development of the OCH website (approximately 40 hours to-date), independent financial tracking (approximately 22 hours to-date), an executive coach, and moving expenses for the Director, as well as general IT, HR, payroll, and accounting support.

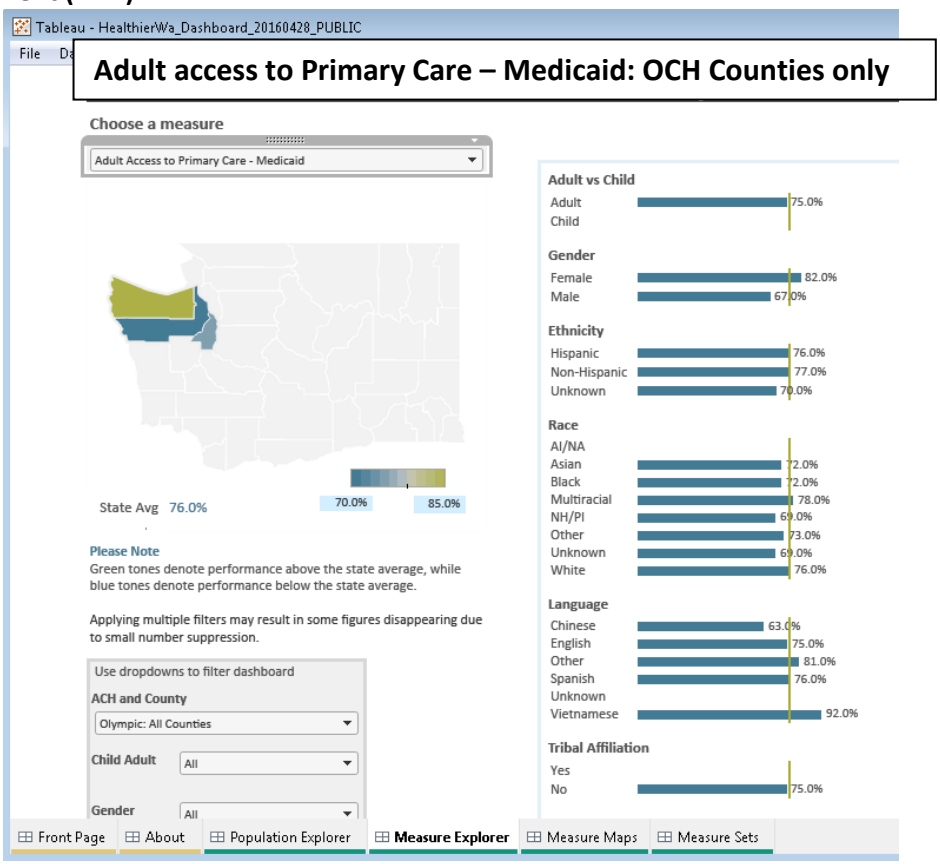
Olympic Community of Health Budget January thru May 2016
Prepared June 23, 2016 for July 6, 2016 OCH Board of Directors Meeting

	2016 BUDGET	BALANCE REMAINING	YEAR TO DATE	% SPENT (Target 42%)
LABOR (SALARY & BENEFIT)				
Epidemiologist	$ 48,463.00	**$ 40,630.15**	7,832.85	16%
Assistant	$ 20,186.00	**$ 16,756.74**	9,095.52	45%
Director	$ 76,249.61	**$ 90,030.80**	26,921.39	35%
Program Coordinator	$ 19,399.00	**$ 19,399.00**	-	0%
			-	
SUBTOTAL	$ 191,219.00	**$ 147,369.24**	43,849.76	23%
Indirect (Billable)	$ 47,804.75	**$ 36,842.31**	10,962.44	23%
LABOR TOTAL	$ 239,023.75	**$ 184,211.55**	54,812.20	23%
NON-LABOR EXPENSES				
Supplies	$ 3,000.00	**$ 2,466.57**	533.43	18%
Professional Services	$ 32,105.00	**$ 12,415.00**	19,690.00	61%
Travel & Mileage	$ 4,000.00	**$ 3,669.84**	330.16	8%
Event/Meeting	$ 5,000.00	**$ 3,001.83**	1,998.17	40%
NON-LABOR EXPENSES	$ 44,105.00	**$ 21,553.24**	22,551.76	51%
TOTAL MONTHLY EXPENSES	$ 283,128.75	**$ 205,764.79**	77,363.96	27%

Analytics, Interoperability, and Measurement (AIM)

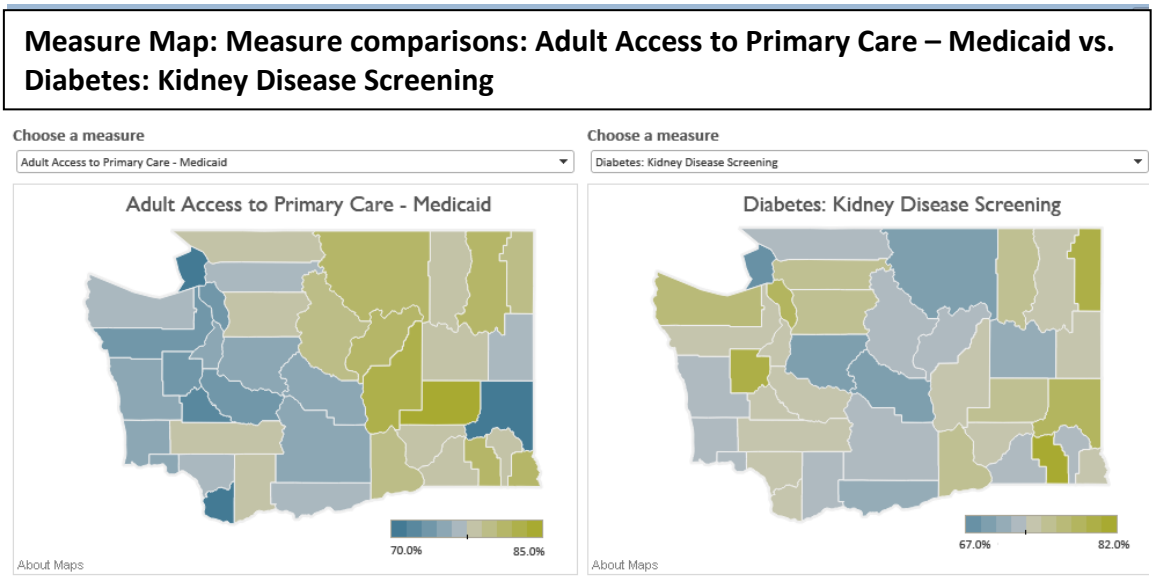
The HCA AIM team together with their contractor, CORE, released the first wave of measures from the WA Common Measure Set's 55 measures in June. HCA is contracting with CORE during the next 12-18 moths to provide data dashboards for the ACHs and other state agencies. These measures came from two data sources:

1. HCA Medicaid Data, Claims-Based (2015): 1. Child and adolescent access to primary care provider, 2. Adult access to preventive/ ambulatory care, 3. Diabetes eye exam, 4. Diabetes blood sugar (HBA1c) test, 5. Diabetes kidney disease screening.
2. DOH Immunization (2015): 1. Childhood immunization status, 2. Immunizations for adolescents, 3. Human papillomavirus vaccine for adolescents, 4. Influenza immunization.



The next wave of measures, to be released in 2-3 months, will include:

1. Well-child visits in the 3rd, 4th, 5th, and 6th years of life;
2. Antidepressant medication management (two time points: 12 weeks & 6 months); and
3. 30-day all cause hospital readmission rate or avoidable ED visits (final selection TBD).



Measures are displayed in an online dashboard using the Tableau platform (see two examples above). If you would like a dashboard walk-through, or need assistance getting into the dashboard, please email Angie and we will set that up. At your request, we also have the option to invite staff from CORE and the HCA AIM team for an in-person work session. **We would love to get your feedback on the new dashboard.**

OCH upcoming meetings and events

- 8/2/2016, **Board of Directors Meeting**, 8:30 a.m. – 11:00 a.m.
- 9/3/2016, **Board of Directors Meeting**, 8:30 a.m. – 11:00 a.m.
- 7/25/2016, **Regional Health Assessment and Planning Committee**, 2:00 p.m. – 4:00 p.m.
- 9/12/2016, **Regional Health Assessment and Planning Committee**, 1:00 p.m. – 3:00 p.m.
- 9/13/2016, **OCH Partner Convening**, 9:00 a.m. – 12:00 p.m.

Healthier Washington upcoming meetings and events

- 07/14/2016, **Healthier Washington Quarterly Webinar**, Register here
- 7/29/2016, **Health Innovation Leadership Network (HILN)**, 9:00 am – 12:00 pm, Cambia Grove, Seattle

DSHS Contact – Jim Jackson, LICSW

At the last board meeting we agreed to circulate the contact details for Jim Jackson, the Accountable Communities of Health Project Specialist at WA Department of Social and Health Services (DSHS). Jim works with the HCA ACH Project Team providing technical assistance and coordination of regional implementation efforts, especially as it intersects with DSHS and its programs. Email: jacksj@dshs.wa.gov, Telephone: 360-725-2283

HCA Value-Based Payment (VBP) Road Map, 2017-2021

Washington State is moving the state's health care market to value to achieve better health, better care, and lower costs. The HCA released a Value-based Road Map that sets an ambitious goal of linking 90 percent of HCA provider payments—through Apple Health (Medicaid) and the Public Employees Benefits Board (PEBB) Program—to quality and value by 2021. This document lays out guiding principles of the role of MCOs, the HCA, providers, and ACHs in value-based payment. This document was created with input from MCOs, the Washington State Hospital Association, and the Washington State Medical Association. It will be supplemented with a F.A.Q. and more detailed information. The HCA intends to align its VBP strategy with the federal framework of alternative payment methodologies, specifically Medicare Access & CHIP Reauthorization Act of 2015 (MACRA).

While reading this document, please ask yourself: *What is the potential role for ACHs in implementing value-based payment?* Note that ACHs will not interfere with provider-payer negotiations. However, there are a multitude of possibilities for the ACH role. Here are some ideas to kick-start your thinking: convening key partners, addressing systematic barriers to implementation, advocating on behalf of the local community, and cross-sector collaboration to help hit quality benchmarks. What else?

Recommended Reading, Viewing, or Participation

1. **Accountable Care Financial Arrangements: Options and Considerations** (June 2016)**:** A new report from the Health Care Transformation Task Force, a consortium of patients, payers, providers and purchasers working to transform the U.S. health care delivery system, explores a range of viable accountable care plan options. HCA's Value-Based Roadmap strategy referenced above dovetails with the national trend as Medicare, the largest health care payer in the U.S., moves to payments based on value.
2. **Alternative Payment Model (APM) Framework** (January 2016)**:** A great resource on health care purchasing, for which VBP is a subcategory, is the Health Care Payment and Learning Action Network. You can register to join the network and participate in webinars and learning collaborative. Their whitepaper, was released in January 2016. Or you can visit them on YouTube.
3. **State levers to advance accountable communities for health** (May 2016): This brief from the National Academy for State Health Policy (NASHP) identifies state levers that advance ACHs by examining the ACH programs in California, Minnesota, Vermont, and Washington State. The HCA was involved in creating this document and it highlights our ACH neighbor to the south – Cascade Pacific Action Alliance.
4. The **Healthier Washington February 1 to April 30, 2016 quarterly report** to the Center for Medicare and Medicaid Innovation (CMMI) is now available.

Olympic Community of Health

Meeting Minutes

Board of Directors

June 1, 2016

Date: 06-01-2016	**Time: 8:30 a.m.-11:00 a.m.**	**Location:** Olympic Room, Port Ludlow Inn, Port Ludlow WA

Chair: Roy Walker, *Olympic Area Agency on Aging.*

Members Attended: Peter Casey, *Mental Health;* Katie Eilers, *Kitsap Public Health District;* Larry Eyer, *Kitsap Community Resources;* Leonard Forsman; *Suquamish Tribe;* Chris Frank, *Public Health;* Kat Latet; *Community Health Plan of Washington;* Eric Lewis, *Olympic Medical Center;* Elya Moore, *Olympic Community of Health*; Joe Roszak, *Kitsap Mental Health;* David Schultz, *CHI/Harrison;* Brent Simcosky, *Jamestown S'Klallam Tribe;* Kelly Sullivan, *Port Gamble S'Klallam Tribe;* Doug Washburn, *Salish Behavioral Health Organization;* Hilary Whittington, *Jefferson Healthcare;* Leslie Wosnig; *Suquamish Tribe*

Other: Scott Daniels, *Kitsap Public Health District;* Rochelle Doan, *Kitsap Mental Health;* Kayla Down, *Health Care Authority;* Allan Fisher, *United Healthcare;* Jolene George, *Port Gamble S'Klallam Tribe;* Jim Jackson, *Department of Social and Health Services*; Vicki Kirkpatrick, *Jefferson County Public Health;* Siri Kushner, *Kitsap Public Health District;* Laurel Lee, *Molina Healthcare;* Angie Larrabee*, Olympic Community of Health;* Chase Napier*, Health Care Authority;* Caitlin Safford, *Amerigroup;* Lisa Rey Thomas*, Suquamish Tribe;* Andrea Tull, *Coordinated Care;*

Person Responsible for Topic	Topic	Discussion/Outcome	Action/Results
	Objectives:	1. Agree on evolving governance structure and supporting policy 2. Agree on plan to select a regional health improvement project 3. Gain a better understanding of the Medicaid Waiver and how it relates to the OCH	
Roy Walker	**Call to order**	Roy called the meeting to order at 8:35 a.m.	
Council	**May 4 Minutes**	Approval of minutes.	May 4 Council minutes **APPROVED** unanimously.
Roy Walker	**Chair Updates**	HCA made decision for one single financial executor. Additionally, the Stakeholder group will now be called the Partner group, as the term "Stakeholder" excludes the tribes in our region which are sovereign nations, not stakeholders.	
Elya Moore	**Directors Report**	Healthier Washington Dashboard will launch tomorrow.	

Roy Walker	**Consent Agenda**	Approval of consent agenda.	Consent agenda **APPROVED** unanimously.
Eric Lewis	**Governance Subcommittee Recommendations**	**Leadership Crosswalk:** Leadership Crosswalk was approved by Governance Subcommittee on May 15, 2016. **Charter:** Eric Lewis was elected chair of Governance Subcommittee at May meeting. It was noted that Allan fisher has been filling in, but Kat Latet is the designee for MCOs on the Governance Subcommittee moving forward. **Name Change to Board of Directors:** The Governance Subcommittee recommends the Leadership Council change its name to the Board of Directors. This change is being made assuming the OCH will become a non-profit organization. OCH would be required to form into a legal entity to make more prominent decisions. **Add New Members:** The Governance Subcommittee agreed that new members are needed from other areas of the social determinants of health (First responders, law and order, EMS, etc…), but would like to wait to add until September to integrate these members onto the Board. It was also noted that Gill Orr, from the Chemical Dependency sector in Clallam has received universal support from his colleagues to join the Board. **Policy to Add New Members and Replace Vacant Seats:** At the May meeting, the Governance Subcommittee approved a policy to add new members and replace vacant seats for members who are retiring or leaving their sector. It was noted that this policy contains the word "stakeholder", which should be removed and replaced with "partners". This should be updated in all documents. OCH needs to establish bylaws, but can momentarily move forward with policies. **Formation of Executive Committee:**	**Charter: APPROVED.** Governance Subcommittee Charter approved unanimously. **Name Change: APPROVED.** Changing the name of the Leadership Council to the Board of Directors was approved unanimously. **Addition of New Members: APPROVED:** Postponing the addition of new members from other areas of the social determinants of health until September was approved unanimously. **Policy to add new members: APPROVED.** Policy to add new members and replace vacant seats approved unanimously.

		The Governance Subcommittee approved a charter for an Executive Committee. Executive committee will be transparent; minutes and packets and packets will be posted on the website. There was a lot of discussion around whether there should be at least one tribal government represented on the Executive Committee. However, it was emphasized that generally the Committee will only be making decisions that the Board has given them authority over. All seven tribes hold a position on the Board and ultimately have a say in the Committee's decisions. A main concern for tribal representation on the Committee was the phrasing within the charter that the Committee would "advise director on emerging issues and initiatives." An alternative suggestion was to have a Tribal Consultant for the Committee. The board encouraged tribal representatives to self-nominate for a position on the Committee. No changes were made to the Charter, however the Board agreed to revise the Charter in a year and add tribal representation if needed. Two people showed interest in submitting nominations for the Committee.	**Formation of Executive Committee: APPROVED** The formation of an executive committee was approved unanimously with the consideration of revisiting in a year.
Katie Eilers	**Regional Health Assessment and Planning (RHAP)**	RHAP is planning to meet quarterly. The responsibility of RHAP is to be reactive to data. Katie reviewed the RHAP Charter (in progress) and the 5 areas of health priorities. **Timeline:** Katie reviewed the OCH Timeline of HCA deliverables. The OCH may be receiving $50k from Health Care Authority for a pilot project.	

		Draft Proposal: Katie reviewed the Draft Project Proposal which was approved by the RHAP committee on May 19. Priority will be given to projects that address the Common Measure Set. There are no specific indications for how projects will be considered an "early win." Elya will work with the HCA team to establish guidelines for this. Short term early win outcomes are addressed in the project proposal outline Funding won't be released for 30-60+ days. It was noted that the project should be an investment in community. It was also mentioned that it should be noted on proposal when funds need to be spent by. **Scoring Template:** Katie reviewed the scoring tool that will be used to evaluate project proposals.	**Draft Proposal: APPROVED** **Scoring Template: APPROVED** The scoring template to evaluate project proposals was approved unanimously.
Roy Walker/ Public	**Public Comment**	Roy opened the floor for public comment. Jim Jackson, from DSHS, introduced himself to the Board as an ach specialist and said he would like to have his contact information distributed to the board. Peter Casey announced that this was his last board meeting, as he is retiring. Joe Roszak will be replacing Peter on the Board representing the Mental Health sector. Roy acknowledged Scott Daniels for his dedication to the OCH, and all his work in the early stages of this ACH. Scott is retiring at the end of June and this was his last OCH meeting.	
Elya Moore		Elya asked the Board for feedback on meeting space. A few members voiced approval of this space. Elya also reminded the Board of two upcoming events: • OCH Tribal Workshop – June 7;	

		12:00 p.m. – 4:00 p.m. • OCH Partner Group – June 14; 9:00 a.m. – 12:00 p.m.	
Roy	**Adjourn**	The meeting was adjourned at 10:10 a.m. A presentation on the Medicaid Transformation Waiver was held immediately following the meeting, Board members were invited to stay for this presentation, but it was not mandatory.	
Marc Provence	**Waiver Presentation**	**Medicaid Transformation Waiver: ACHs and Project Framework** **<u>Waiver Initiatives:</u>** *Initiative 1:* Transformation through accountable communities of health *Initiative 2:* enable older adults to stay at home; delay or avoid the need for more intensive care *Initiative 3:* targeted foundational community supports **<u>Transformation Framework:</u>** *Domain 1*: Health Systems Capacity Building *Domain 2:* Care Delivery Redesign *Domain 3*: Prevention and Health Promotion Roy commented that all framing pertaining to this view is from a medical model out. Metrics: consistency with statewide common measures (n=55) With this model, there is a need for a financial executor. They would have no role in selecting/evaluating projects and would simply be the bookkeeper. Currently, the rough estimate for the waiver is $3billion. Due to time constraints, Marc offered to come back to the Board at a later date to present on the Value Based Payment (VBP) model. For VBP, a question arose regarding how quality and value will be evaluated. The goal is to measure health outcomes of individuals serviced. Potential to move to payment + incentive.	

		Social Determinants of Health projects should have more connection to VBP. HCA, CORE, ACHs will probably all work together to define the value. What if medical providers don't want to participate? Medicaid pays for 25% of services now. Due to time constraints, Marc offered to come back to the Board at a later date to present on the Value Based Payment (VBP) model. The presentation ended at 11:30 a.m.	

Olympic COMMUNITY of HEALTH

EXECUTIVE COMMITTEE

2016 NOMINATIONS

CLALLAM • JEFFERSON • KITSAP

The following self-nominations were received via email for the 2016 Executive Committee. Individuals who self-nominated for multiple positions are listed under each position they expressed an interest in. Those who also noted an interest to serve on the committee in any capacity are noted with a " * ".

Nominee statements and qualifications are attached.

Voting will occur by ballot during the Board meeting on July 6, 2016.

AT LARGE

- Jennifer Kreidler-Moss
- Joe Roszak

TREASURER

- Hilary Whittington*

SECRETARY

- Leonard Forsman
- Kat Latet

VICE PRESIDENT

- Jennifer Kreidler-Moss
- Hillary Whittington*

PRESIDENT

- Roy Walker

Roy Walker
Executive Director: Olympic Area Agency on Aging
Position(s) nominating for: President

Please consider this my self-nomination to serve on the Executive Committee as President.

I feel compelled to continue to serve the OCH as President, in order to provide continuity and consistency in this role as our organization continues to mature. I feel the OCH represents our current best opportunity to move our communities towards better health. I have a strong passion for serving our communities to continue to improve our ability to provide healthcare access and quality within the resources available, as well as to create more successful linkages with services addressing social determinants of health. As the Executive Director for the Olympic Area Agency on Aging, I have a particular focus on the needs of older people and people with disabilities who use long term services and supports.

Hilary Whittington, CPA
Chief Financial Officer: Jefferson Healthcare
Position(s) nominating for: Vice President; Treasurer

I would like to express my passionate interest in serving on the OCH Executive Committee. As the CFO of Jefferson Healthcare, I have been immersed in the community and consistently exposed to the challenges that we, as a community, have not found a solution to prevent high costs of care necessary to make up for insufficient preventative and systematic program investments. I am inspired by challenges and feel that participating in the OCH may be one of the biggest puzzles I have been involved in solving so far in my career, including the implementation of healthcare reform and implementing (and effectively using) an electronic health records system. Jefferson Healthcare has embraced the Accountable Care Organization model and has been a driving contributor of a community health improvement plan; there are many opportunities to share learnings from each of these experiences and I see the opportunity to contribute to the OCH as an inspiring and humbling experience. While Jefferson Healthcare represents the rural health sector of the OCH board, I have a much wider view of the community and the importance of investing in the programs that insulate our community members from socioeconomic challenges. I am most interested in the Vice President or Treasurer roles, but would be honored to serve in any other capacity or role necessary. While my background is in finance, I find the strategy around this concept more in line with my strengths and tendency to look at situations with a wide lens to ensure various perspectives are considered. Thank you for your consideration.

Jennifer Kreidler-Moss, PharmD, CMPE
Chief Executive Officer: Peninsula Community Health Services
Position(s) nominating for: Vice President; At-Large Member

I would like to be considered to serve as the Vice President or At-Large Member of the Olympic Community of Health. I am able to commit to regular attendance at both the Executive and Board meetings across the region or by webinar/call-in when not able to attend in person. I have a significant amount of experience in Board governance. As the CEO of Peninsula Community Health Services (PCHS), I directly report to a community-based Board of Directors mandated to be between 9-25 members, and comprised of at least 51% patient users. Working with such a diverse board has helped me develop a range of skills centered on community and participant engagement, transformational leadership, change management, conflict resolution, and strategic planning. In addition, I have served my local community on the Kitsap County Substance Abuse Advisory Board from 2011-2016 and as the Chair from 2015-16, the Kitsap County Commission on Children and Youth from 2009 – 2015 and as the Chair from 2013-15, and on the Kitsap County Medical Reserve Corps since 2007. As healthcare is a core component of the ACH model, I feel I am especially qualified for the OCH Executive Committee by being board certified as a Medical Practice Executive, Ambulatory Care and Psychiatric Pharmacist. I have certificates in Management and Human Resource Skills, Health IT Foundations, have completed the GWU Capstone Health Public Policy Leadership Training, UW School of Public Health Community Health Leadership training and obtained my doctorate in Pharmacy. I am a regular attendee in both Washington DC and Olympia for Legislative Days related to CHCs. I look forward to this time of Medicaid payment redesign with a focus on providing value, maximizing collective impact and engaging cross-sector participation.

Leonard Forsman
Tribal Chair: Suquamish Tribe
Position(s) nominating for: Secretary

Please accept the following paragraph demonstrating my interest in serving on the OCH Executive Committee:

I believe that my experience as Chairman of the Suquamish Tribe for the past 11 years qualifies me to serve as a member of the Olympic Community of Health Executive Committee. I have been involved in the development of health policy for my Tribal government for the past 30 years as well as on a national level through consultation experiences with the Indian Health Service and the Department of Health and Human Services. I have also been very active with local, state, regional and federal agencies and representatives in developing policy, planning, and project development in my time as a tribal leader. I am interested in serving as Secretary, as this was one of my past roles in my term on Tribal Council from 1987-2002.

Kat Furguson-Mahan Latet
MCO Sector Representative: Community Health Plan of Washington
Position(s) nominating for: Secretary

I, Kat Ferguson-Mahan Latet, am submitting this letter as an expression of interest in serving as the Secretary on the Olympic Community of Health Executive Committee. I serve on the Governing Board as the Managed Care Sector representative and believe the voice of the managed care plans is a critical voice to have on the Executive Committee, especially in the early stages of development of the ACH.
My relevant skills and experience include:

- Extensive experience in health system transformation design and development from multiple vantage points, including safety net provider, state Medicaid agency and managed care organization.
- In-depth understanding and awareness of the Healthier Washington initiative, including the intent and evolution of ACHs, Medicaid Transformation waiver and value based payment.
- The ability to bring forward common themes and lessons learned from other ACHs, as managed care serves on all nine ACHs in a governing board capacity.
- Knowledge of organizational development and good governance principles.
- Strong written and verbal communication skills.

Please don't hesitate to contact me for any additional information regarding my skills and experience. I look forward to serving the Olympic Community of Health in this expanded role.

Joe Roszak, M.A.
CEO: Kitsap Mental Health Services
Position(s) nominating for: At-Large Member

I would like to express my interest in the 'Member at Large' position with the OCH Executive Board. I would be happy to provide additional details of my experience and qualifications if my candidacy is accepted. Thank you.

Additional Information:
Length of time as a Director/CEO: 25+ years in an executive leadership position.
I bring to the OCH over 25 years of leadership experience, skills and knowledge. I have dedicated my career to human services and have had the honor of leading several behavioral health and community action agencies. I am currently providing leadership statewide regarding integrated health care, workforce development, electronic health information exchanges and developing strategic partnerships. Although I have a strong business acumen; my energy and strength is fueled by daily interactions with those who we serve and my commitment to the mission of advancing integrated health services. I firmly believe that such advancements can only be achieved through cooperative partnerships of nonprofit, tribal, governmental and business entities. This perspective, along with a generous sense of humor; I would share with the OCH.

I ask for your vote so I may contribute as a team player with the leadership of the OCH. Each of us brings a different perspective, experience and value to the mission of the OCH; my area of expertise lies mostly in the legislative process, strategic planning and models of integrative care. We continue to face challenging times and I welcome the opportunity to commit my energy, time and resources as your elected board representative. Thank you.

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL

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This form is due via electronic submittal to Angie Larrabee angie.larrabee@kitsappublichealth.org (fax: 360-475-9326) no later than 4pm, Tuesday, June 21, 2016. Please contact Angie if you have questions or have trouble using this form.

PROJECT TITLE: Ready For Kindergarten				
HOST ORGANIZATION: Quillayute School District				
CONTACT NAME AND TITLE: Rob Shadle				
EMAIL: Robert.shadle@qvschools.org		**PHONE: 360-374-6262 x361 (work), 360-991-3082 (cell)**		
CONTRIBUTING ORGANIZATIONS: Quillayute Valley School District				
COUNTIES SERVED BY THIS PROJECT: ■ Clallam ☐ Jefferson ☐ Kitsap ☐ Other:				
TRIBES (please name each): Quillayute, Ho				
THIS PROJECT IS (check one): ■ **New** ☐ **Enhancing an existing project or set of projects**				
SECTORS ENGAGED BY THIS PROJECT (check all that apply)**:**				
☐ Aging	☐ Behavioral Health Org	☐ Chemical Dependency	☐ Chronic Disease	☐ Community Action Pgrm
■ Early Childhood	☐ Economic Development	■ Education	☐ Emergency Medical Services	☐ Employment
☐ FQHC	☐ Housing	☐ Justice	☐ Managed Care Organization	☐ Mental Health
☐ Oral Health	☐ Philanthropy	☐ Primary Care	☐ Private not-for-profit hospital	☐ Public Health
☐ Public Hospital	☐ Rural Health	☐ Social Services	☐ Specialty Care	☐ Workforce development
☐ Other (please list):				

BRIEF PROJECT DESCRIPTION (3-4 sentences):	Ready for Kindergarten is a statistically proven program for improving language skills in incoming kindergartners. *READY's!* targets, trainings, and tools align with current research that effectively impacts family and community programs, which are proven to increase student learning. *READY* has these four features: • Demonstrates an activity for parents, engaging parents in role-playing the parts. • Gives materials to each family, offering advice as they use them. • Helps parents assess children's progress and steer children to next steps. • Lets parents keep materials to use at home with their child. The Quillayute School District, in conjunction with the Ho Tribe, are sending representatives to *READY!* training this July in Kennewick, WA to equip them with the skills and knowledge to implement this program. They will return and train other key personnel and community members how to how to use the Family Kits, conduct family visits to monitor progress, and conduct four community meetings for the year to introduce new family kits and teach families how to effectively use them with their children.
PROJECT GOAL STATEMENT (1-2 sentences):	Our project goal is to improve the Pre-reading scores of children entering Kindergarten, specifically Letter naming fluency, Initial Sound Fluency. In a study performed in the Othello School District it was determined that students who had experienced *READY* performed 16.56% higher in these Pre-reading scores than students who did not participate in *READY.*
PROJECT SCOPE (1-2 sentences):	Initially our program will impact the Quillayute Valley School District, as well as the Ho and Quillayute Tribes in Clallam County. Our hope is that this program will take route and expand to other counties as well. Currently *READY* only exists on the Peninsula (Lower Elwha Head Start in Port Angeles), though *READY* is a national program that has existing programs in Puyallup, Lacey, Tacoma, Kent Spanaway, Renton, Silverdale, Buckley, Enumclaw, Rochester, Gig Harbor, Port Orchard, and Federal Way, to name a few that are relatively local.

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL

PROJECT ACTIVITIES: (Add rows as needed)	CONTRIBUTING PARTNERS: (Include their roles & responsibilities)	ACTIVITY TIMELINE:
Introductory Parent Meeting	Quillayute Valley School District, Ho Tribe: administration and family outreach	September
Fall parent Meeting	Quillayute Valley School District, Ho Tribe: administration and family outreach	October
Winter parent Meeting	Quillayute Valley School District, Ho Tribe: administration and family outreach	January
Spring parent Meeting	Quillayute Valley School District, Ho Tribe: administration and family outreach	March

CATEGORY	DESCRIPTION	RESPONSE
EVIDENCE BASE	Is project an evidence based, promising or innovative practice or model? Include source.	Ready For Kindergarten is an evidence based model that is proven to improve the language skills of students entering kindergarten, specifically letter naming and vocabulary development. Our school district will be using the Independent Reading Levels Assessment (IRLA) for incoming kindergartners to measure the effect of Ready For Kindergarten on letter naming and vocabulary in relation to those students who did not access the program.
ALIGNMENT TO OCH PRIORITY AREAS	Under which one or more of the OCH Priority Areas does this project align?	☐ Access ☐ Aging ☐ Behavioral Health ☐ Chronic Disease ☐ Early Childhood ☐ Social Determinants
VALUE ADD	What difference does OCH involvement make to the project?	OCH can impact this program by helping fund family kits for 20 children for a year ($3600) which will help expand the influence of *READY* to families who couldn't otherwise afford it.
TARGET POPULATION/ SCALABILITY	Who are the project participants? How many are currently served and what is the project's potential reach in terms of individuals and communities? Describe potential for scalability.	____ Annual unduplicated number of participants served, Year: _____ This is a new program that we are working to implement in the 2016-2017 school year. Our hope is to serve the entire community of Forks as well as the Quillayute and Ho tribes. This is a model and program that could be used by any community on the Peninsula.
IMPACT	How does the project impact/address social determinants of health, health disparities, and/or healthy equity?	The study called "The 30 Million Word Gap" definitively shows the disparity between the language skills of three year-old children based upon the education and socio-economic levels of their parents. Children who enter Kindergarten with sub-standard language skills, statistically speaking, are not able to read at grade level in third grade (when instruction in HOW TO READ typically ends). Children who are not reading at grade level coming out of third grade are four times more likely NOT to graduate high school, another statistical reality. *READY* can directly and positively impact the graduation rates of students from low-income families, which will mitigate future social issues and problems.
SUSTAINABILITY	How the project is currently funded? What is the sustainability plan for ongoing/future funding?	The Quillayute Valley School District is a Title I. school district, which means that we receive yearly funding for parent engagement, which is the foundation of *READY.*
ADVANCING THE TRIPLE AIM	Describe how project addresses the Triple Aim of better health, better care, and lower cost?	The long term effects, as implied in the "Impact" section of this application, on lowering a multitude of various health care costs, by developing better educated, and therefore socially functional adults, is hard to calculate, but can't be underestimated.
MEDICAID WAIVER ALIGNMENT	Is this a potential Medicaid Transformation Waiver project (see table on pages 7-14)? If so, name the Waiver project.	No

ALIGNMENT WITH WA COMMON MEASURE SET	List any of the *Common Measures* that this project will track; priority will be given to projects listing at least one.	By positively impacting early learning in Clallam County it will reduce the number of people in need of Mental Health Care for Depression and other related mental health issues. There is a direct correlation between education levels, socio-economic levels, and health care needs. Funding for early learning would not have an immediate impact on the number of people who need access to Mental Health Care, but it is the best means to effect these numbers in the long term, and possibly the best strategy for turning around an at-risk community.

EVALUATION: How is the project evaluated? Describe measures and results if any are available. Add rows as needed.

OUTCOME (Desired result)	**OUTCOME INDICATOR** (How success is measured)	**DATA SOURCE** (Identify partner/s helping with data collection or analysis)	**TIMELINE**	**RESULTS** (Include time frame)
100% of students entering kindergarten will be able to name all 26 letters of the alphabet and make / recognize the correlating sounds of the letters.	The Independent Reading Levels Assessment (IRLA) will be the measurement tool used to assess the attainment of the desired outcome.	The instructional staff of the Quillayute Valley School District will collect and assess the data.	New data will be collected in September of every school year to chart growth over time.	The first data for this program will be collected in September of 2017.

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL

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PROJECT TITLE: Behavioral Health Student Assistance Services				
HOST ORGANIZATION: Olympic Educational Service District				
CONTACT NAME AND TITLE: Kristin Schutte, Executive Director of Student Support Services Center				
EMAIL: schuttek@oesd114.org		**PHONE: 360-405-5833**		
CONTRIBUTING ORGANIZATIONS: Kitsap Public Health District and Bremerton School District.				
COUNTIES SERVED BY THIS PROJECT: ☐ Clallam ☐ Jefferson ☒ Kitsap ☐ Other:				
TRIBES (please name each): N/A				
THIS PROJECT IS (check one): ☐ New ☒ Enhancing an existing project or set of projects				
SECTORS ENGAGED BY THIS PROJECT (check all that apply)**:**				
☐ Aging	☒ Behavioral Health Org	☒ Chemical Dependency	☐ Chronic Disease	☐ Community Action Pgrm
☐ Early Childhood	☐ Economic Development	☐ Education	☐ Emergency Medical Services	☐ Employment
☐ FQHC	☐ Housing	☒ Justice	☐ Managed Care Organization	☒ Mental Health
☐ Oral Health	☐ Philanthropy	☐ Primary Care	☐ Private not-for-profit hospital	☐ Public Health
☐ Public Hospital	☐ Rural Health	☒ Social Services	☐ Specialty Care	☐ Workforce development
☐ Other (please list):				

BRIEF PROJECT DESCRIPTION (3-4 sentences):	The OESD currently operates and provides Behavioral Health Student Assistance Services in seven high schools in Kitsap County, one in Jefferson (Chimacum HS), and three in Clallam (Crescent K-12 and Forks MS & HS). This project would expand the program to Mt. View Middle School, located in Bremerton Kitsap County. Behavioral health student assistance services are designed to provide school-based prevention, early intervention, screening, referral and treatment support. A trained Behavioral Health Student Assistance Professional (BHSAP) is housed in the school and provides screening (using GAINSS) and referral services, facilitation of support groups and individual counseling. The BHSAP also assists in linking students referred to the program to outside behavioral health and physical health resources as needed.
PROJECT GOAL STATEMENT (1-2sentences):	The project has two primary goals: Decrease the number of school-aged youth with unmet behavioral health and physical health needs by providing school-based service and linkages to community resources (i.e. primary care physicians/pediatricians, behavioral health providers, and social support services); and to improve overall behavioral health functioning of the students served by the program.
PROJECT SCOPE (1-2 sentences):	*Please describe what part of your regional community the project will serve (e.g. three counties, patients enrolled with two health plans, four primary care clinics, and approximate number of individuals served by a social service agency in one city).* The targeted community is Mountain View Middle School in Bremerton. The proposed target population are low income students who are impacted by one or more of the following: Evidence of using alcohol, tobacco or other drugs; have experienced three or more Adverse Childhood Experiences (ACEs); evidence of warning signs related to suicide, depression, or other mental health issues; as well as parents of the identified students. A total of 25 students within a school year can be served intensively with up to 12 sessions. An additional 10-15 students may be served through providing screening, referrals and linkages to community resources.

PROJECT ACTIVITIES: (Add rows as needed)	**CONTRIBUTING PARTNERS:** (Include their roles & responsibilities)	**ACTIVITY TIMELINE:**
Post, Hire, and Train staff	OESD Supervisor (budgeted at 5%)	July –August
Introduce staff to school	OESD Supervisor	August/Sept
Train staff on referral process and early warning signs	OESD Community Liaison/Trainer and Supervisor	August/Sept

Announcement of services letter sent out to parents; with information on how to contact BHSAP	OESD Supervisor and School Administrator	September
Community-partner networking – staff meeting with local community resources to gather referral processes and resource information	BHSAP	September & ongoing thereafter
Classroom presentations to introduce services	BHSAP	September-October
BHSAP meets with referred students who are to start screenings and community referrals	BHSAP	October & ongoing thereafter
Identify students for group support and groups needed (e.g. Coping with Substance Abusing Parents, Intervention group, loss and grief, self-regulation techniques etc.)	BHSAP	October & ongoing thereafter
Conduct individual sessions –Teen Intervene for those involved in substance use or abuse	BHSAP	October & ongoing thereafter
Provide crisis intervention and referral (e.g. students that report they are suicidal, harmfully involved with alcohol or other drugs, or child abuse and neglect issues)	BHSAP	October & ongoing thereafter
Host one per quarter parent information night on behavioral health and physical health issues for teens	BHSAP and community resource partners	Fall, Winter and Spring Quarter

CATEGORY	DESCRIPTION	RESPONSE
EVIDENCE BASE	Is project an evidence based, promising or innovative practice or model? Include source.	The project will use multiple evidence based and promising strategies: 1. The Office of Superintendent of Public Instruction has evaluated Student Assistance Prevention-Intervention Services for over twenty years. The program shows a promising approach and evidence of increasing positive pro-social behaviors and dramatically decreasing the use of substances among students. In 2014-15 school year, state data showed participating students had a reduction in substance use by 68% for marijuana, 72% for binge drinking, and 67% for alcohol use. 2. Teen Intervene (*SAMHSA's National Registry of Evidence-Based Programs and Practices)* is an early intervention program which targets adolescents who display early signs of alcohol or drug problems, but are not yet at the stage of daily use or substance dependence. 3. The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program is a school-based, group and individual intervention. It is designed to reduce symptoms of post-traumatic stress disorder (PTSD), depression, and behavioral problems, and to improve functioning, grades and attendance, peer and parent support, and coping skills. CBITS is cited as a recommended practice by several national agencies that assess the quality of mental health interventions, including: CDC Prevention Research Center, SAMHSA's National Registry of Evidence-Based Programs and Practices, U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention. 4. Scientific evidence showing that positive intervention mitigates the impacts of ACEs on individuals and reduces future societal costs as children grow into adulthood (see Foundation for Healthy Generations, www.healthygen.org). In particular, identifying children with behavioral health challenges as early as possible and connecting at risk children with community-based interventions and treatment services will pay huge dividends over time.
ALIGNMENT TO OCH PRIORITY AREAS	Under which one or more of the OCH Priority Areas does this project align?	☒ Access ☐ Aging ☒ Behavioral Health ☐ Chronic Disease ☐ Early Childhood ☒ Social Determinants

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL

CATEGORY	DESCRIPTION	RESPONSE
VALUE ADD	What difference does OCH involvement make to the project?	1. Assisting the OESD to examine the feasibility of setting up a Medicaid billable system. 2. Assisting with tracking outcomes that demonstrate outcomes specific to behavioral health and physical health improvements. 3. Assisting with strategies on how to expand services to other schools within the OCH region. 4. Explore how this project can expand/integrate into a school-based health clinic model.
TARGET POPULATION/ SCALABILITY	Who are the project participants? How many are currently served and what is the project's potential reach in terms of individuals and communities? Describe potential for scalability.	During the 2014-15 school year we served 551 students; and between September 2015-May 30, 2016 we served 590 students. The project has potential to serve every K-12 school within the OCH region where services are currently not in place for a total of 1,950 students (with a .5 FTE per school). The infrastructure is in place to provide the training and foundation for implementation of school-based services. The OESD has a history of school-based services such as this for over 25 years. Scaling up would include: 1. Building the relationships within the local communities to make sure adequate resources are in place to link students to community resources as needed; 2. Assessing school readiness and forming a memorandum of understanding between the OESD and the local schools 3. Implementation of services- barriers to scaling up is revenue and finding qualified staff to deliver the services.
IMPACT	How does the project impact/address social determinants of health, health disparities, and/or healthy equity?	Mental health and chemical dependency issues are closely linked to ACEs. There is a vast body of research detailing the enormous costs associated with individuals who experience ACEs. In several foundational studies conducted by the CDC, the lifetime economic burden for each ACEs impacted individual is $210,012 (in 2010 dollars). The average lifetime cost per death is $1,272,900, including medical costs and productivity losses. Untreated behavioral health issues correlate closely with poor physical health and substantially reduced life expectancy. This places enormous costs on both affected individuals and our society, not to mention, raises serious health equity concerns.
SUSTAINABILITY	How the project is currently funded? What is the sustainability plan for ongoing/future funding?	The services currently in place: funding through Office of Superintendent flow though Federal CSAP Block grant; District match for four sites; and Kitsap County Mental health, Chemical Dependency, and Therapeutic Courts 1/10th of 1% funds. Related to sustainability, the OESD is interested in exploring Medicaid Transformation funding to help sustain program services, district contributions, other grant funding, and fee for service/cooperative agreements.
ADVANCING THE TRIPLE AIM	Describe how project addresses the Triple Aim of better health, better care, and lower cost?	The project is squarely aligned with the Triple Aim goals of improved health and better care at less cost. It combines a cross-sector approach bringing together the clinical, educational, and community-based services sectors.
MEDICAID WAIVER ALIGNMENT	Is this a potential Medicaid Transformation Waiver project (see table on pages 7-14)? If so, name the Waiver project.	Transformation Project Domain(s) involved: • Care Delivery Redesign: Bidirectional Integration of Care; Care Coordination • Prevention and Health Promotion: Chronic Disease Prevention and/or Management
ALIGNMENT WITH WA COMMON MEASURE SET	List any of the *Common Measures* that this project will track; priority will be given to projects listing at least one.	• Mental Health and Depression

EVALUATION: How is the project evaluated? Describe measures and results if any are available. Add rows as needed.

OUTCOME (Desired result)	**OUTCOME INDICATOR** (How success is measured)	**DATA SOURCE** (Identify partner/s helping with data collection or analysis)	**TIMELINE**	**RESULTS** (Include time frame)
75% of students completing 8 or more sessions will have increased overall health and wellbeing by the end of the school year	Protective Factors Index Pre/Post Self Report tool	KPH/OSPI/RMC	September 2014- June 2015 and September 2015- June 2016	Average pre/post change in Protective Factors Index for 196 high school students with 8 or more sessions was +0.10 Data available in August 2016
Students participating in BHSAP program with a substance abuse goal will reduce use by 50% by the end of the school year	Pre/Post self-report tool	KPH/OSPI/RMC	September 2014- June 2015 and September 2015- June 2016	% of high school students with substance use reduction goal who had a reduction: cigarettes=54%; alcohol=69%; binge=79%; marijuana=65% Data available in August 2016
75% of secondary school staff will report improvements in their school's ability to respond effectively to students' behavioral health	Measured by retrospective survey with these data points: 1) Project services have been helpful for students. 2) Improvements in their school's ability to respond effectively to students' behavioral health (prior year comparison). 3) Agreement that services provided have increased student pro-social skills and ability to interact with peers.	KPH	September 2014- June 2015 and September 2015- June 2016	Data Points from survey: 1) 100% 2) 100% 3) 90% Data available in August 2016

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PROJECT TITLE: Olympic Peninsula Coordinated Opioid Response	
HOST ORGANIZATION: OCH/SBHO	
CONTACT NAME AND TITLE: Anders Edgerton	
EMAIL: aedgertn@co.kitsap.wa.us	**PHONE: 360-732-4484**
CONTRIBUTING ORGANIZATIONS: Health Departments	
COUNTIES SERVED BY THIS PROJECT: ☒ Clallam ☒ Jefferson ☒ Kitsap ☐ Other:	
TRIBES (please name each): All seven Tribes within the OCH boundaries will be invited to participate in this project. The project manager will reach out to each Tribe to offer the assistance of the project. Tribes will be invited to any training activities coordinated through this project.	
THIS PROJECT IS (check one): ☒ New ☐ Enhancing an existing project or set of projects	

SECTORS ENGAGED BY THIS PROJECT (check all that apply)**:**

☐ Aging	☒ Behavioral Health Org	☒ Chemical Dependency	☐ Chronic Disease	☐ Community Action Pgrm
☐ Early Childhood	☐ Economic Development	☐ Education	☒ Emergency Medical Services	☐ Employment
☒ FQHC	☐ Housing	☒ Justice	☒ Managed Care Organization	☐ Mental Health
☐ Oral Health	☐ Philanthropy	☒ Primary Care	☐ Private not-for-profit hospital	☒ Public Health
☒ Public Hospital	☐ Rural Health	☐ Social Services	☐ Specialty Care	☐ Workforce development
☐ Other (please list):				

BRIEF PROJECT DESCRIPTION (3-4 sentences):	This project will provide staffing to coordinate and implement a comprehensive Opioid intervention plan across the Olympic and Kitsap peninsulas. Staff will be hired to work under the direction of the OCH, coordinating the efforts of the BHO, County Health Districts, primary care providers, FQHCs, Law enforcement, first responders, and Courts to address the significant Opiate crisis facing the three counties. The project will have multiple tracks, including prevention efforts targeted at primary care physicians, criminal justice diversion, training of primary care and Substance Use Disorder providers to integrate their efforts, and treatment expansion. The Salish Behavioral Health Organization will be a key collaborator in the development and expansion of SUD treatment options, but it is envisioned that the overall Opioid response will go well beyond outpatient treatment expansion and training.
PROJECT GOAL STATEMENT (1-2 sentences):	This project targets decreasing the levels of prescription and illicit opiate abuse across the three counties. Specific goals are to enhance the availability of Suboxone and Naloxone in all three counties and increase the number of opiate-addicted community members who engage in treatment for their addiction. Other goals are to decrease levels of opiate addiction as well as opiate overdoses and deaths, inform prescribing patterns, and create alternatives to criminal justice interventions.
PROJECT SCOPE (1-2 sentences):	*Please describe what part of your regional community the project will serve (e.g. three counties, patients enrolled with two health plans, four primary care clinics, approximate number of individuals served by a social service agency in one city).* This project will serve individuals across the three constituent counties who are currently abusing opioids or at risk of abusing opiates. Also planned are training initiatives targeted at primary care, urgent care and emergency rooms aimed at decreasing the availability of prescribed opioids. Additionally, the reduction in opiate abuse/addiction will have significant ripple effects such as reduced emergency room visits, criminal recidivism, DCFS/CPS involvement, and public health concerns regarding communicable disease.

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL

PROJECT ACTIVITIES: (Add rows as needed)	**CONTRIBUTING PARTNERS:** (Include their roles & responsibilities)	**ACTIVITY TIMELINE:**
Increase availability of Medication Assisted Treatment (MAT) for Opioid Abuse	Salish Behavioral Health Organization Will coordinate expansion of Suboxone ancillary service supports, and coordinate integration of Suboxone prescribers with Substance Use Disorder Outpatient providers Substance Use Disorder Programs Will expand supports available to individuals receiving Suboxone from community physicians Will conduct case coordination activities with Suboxone prescribers, to enhance communication on patient progress in treatment, UA results, etc. Primary Care providers Additional primary care practices will be willing to prescribe Suboxone.	August 1 – contract with part time program coordinator to work with primary care providers August 15 – Coordinate first training for outpatient providers willing to provide MAT supports September 1 – develop structure for client coordination, communication, and flow between primary care and SUD outpatient provider
Expand availability of Naloxone through first responders and potentially community members with family members at risk for opioid overdose	OCH – pursue grants to secure additional Naloxone SBHO– pursue grants to secure additional Naloxone	ongoing
Evaluation	Kitsap Public Health Department Clallam County Health and Human Services Jefferson County Health and Human Services Each will track overdoses reported, and overdose deaths. Data to be compiled by KCPH. SBHO – will track number of individuals being prescribed Suboxone who are enrolled in outpatient treatment.	Quarterly starting with July – September 2016 period
Improve Prescribing Practices for Opioids	Practice Transformation Hub through HCA	

CATEGORY	**DESCRIPTION**	**RESPONSE**					
EVIDENCE BASE	Is project an evidence based, promising or innovative practice or model? Include source.	Medication Assisted Treatment (MAT) through the use of Suboxone is an evidence-based intervention for use with Opiate addiction.					
ALIGNMENT TO OCH PRIORITY AREAS	Under which one or more of the OCH Priority Areas does this project align?	☒ Access	☐ Aging	☒ Behavioral Health	☒ Chronic Disease	☐ Early Childhood	☐ Social Determinants
VALUE ADD	What difference does OCH involvement make to the project?	This is a multi-pronged approach to a very intractable and urgent problem which demands a high level of coordination between behavioral health and primary care, other health-related entities as well as law enforcement and local courts. The OCH is uniquely positioned to provide this level of coordination.					
TARGET POPULATION/ SCALABILITY	Who are the project participants? How many are currently served and what is the project's potential reach in terms of individuals and communities? Describe potential for scalability.	__250__ Annual unduplicated number of participants served, Year: 2016-17_____ The abuse of opioids by residents of the OCH constituent counties is a significant issue, having been referred to as an epidemic by multiple public health officials. The issue cuts across economic and social strata, and demands to be addressed on a variety of levels, from primary care practices to law enforcement. Conservatively, we will directly coordinate access to recovery services for at least 250 individuals initially, with					

CATEGORY	DESCRIPTION	RESPONSE
		additional impacts as prescribing practices are modified and Naloxone is more widely available.
IMPACT	How does the project impact/address social determinants of health, health disparities, and/or healthy equity?	This project addresses a major public health issue facing these counties. Opioid addiction (addiction in general) cuts across all income levels, ethnicities, gender and other demographic variables. The proposed strategy is a whole community approach that works toward ensuring that all in need of help for opioid addiction have the wherewithal to receive it, and that we are able to impact practices that might lead to further addition issues in the future..
SUSTAINABILITY	How the project is currently funded? What is the sustainability plan for ongoing/future funding?	Efforts are not currently focused or coordinated across systems or counties. This proposal will enhance coordination between medical and behavioral healthcare providers to maximize treatment efforts and patient success in recovery. The Naloxone component is directed at first responders in order to prevent opiate fatalities. Care coordination processes developed under this project will endure into the future at no added cost.
ADVANCING THE TRIPLE AIM	Describe how project addresses the Triple Aim of better health, better care, and lower cost?	Well-coordinated treatment for opioid addiction will result in higher success rates for opiate-addicted patients, fewer deaths in the community due to opiate overdose, and decreased health impacts of chronic opiate use. Both community health and safety will be positively affected.
MEDICAID WAIVER ALIGNMENT	Is this a potential Medicaid Transformation Waiver project (see table on pages 7-14)? If so, name the Waiver project.	Yes – Care Delivery re-design – integration of care (the creation of strong ties between primary care prescribers of Suboxone and behavioral healthcare providers, including perhaps grants to primary care clinics for nurse case management/coordination) Chronic Disease Prevention and or management – Opioid addition is a chronic disease and is addressed within this project – both prevention and management.
ALIGNMENT WITH WA COMMON MEASURE SET	List any of the *Common Measures* that this project will track; priority will be given to projects listing at least one.	Adult Access to Primary Care Providers (Suboxone Prescribers) Substance Use Disorder Treatment Penetration Potentially Avoidable ER Use

EVALUATION: How is the project evaluated? Describe measures and results if any are available. Add rows as needed.

OUTCOME (Desired result)	**OUTCOME INDICATOR** (How success is measured)	**DATA SOURCE** (Identify partner/s helping with data collection or analysis)	**TIMELINE**	**RESULTS** (Include time frame)
Number of MAT primary Care prescribers increased	Increase in number of registered physicians	Health Care authority	By March, 2017	Increase number of registered physicians by at least 10 by June of 2017
Decrease in Opiate Overdoses/Deaths	Reduction in Number of Reported Overdoses	Department of Health Reportable Condition	By December 2017	Using 2016 as a baseline, Decrease number of reported Opiate overdoses by 5% in 2017
Number of behavioral health providers (specifically CDPs and CDPTs) trained to support Medication Assisted Treatment increased	Number of outpatient Substance Use Disorder providers trained to support MAT treatment	BHO Data	October 2016	Have at least one provider in each County willing to provide outpatient support to individuals with MAT

SUD Treatment Completion	Increased Substance Use Disorder Treatment Completion for Opiate Addiction	BHO Data	December, 2016	Completion rates for Treatment will increase by at least 5% over 2015 baseline.

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL

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This form is due via electronic submittal to Angie Larrabee angie.larrabee@kitsappublichealth.org (fax: 360-475-9326) no later than 4pm, Tuesday, June 21, 2016. Please contact Angie if you have questions or have trouble using this form.

PROJECT TITLE: Family Fit Camp				
HOST ORGANIZATION: Haselwood Family YMCA (YMCA of Pierce and Kitsap Counties)				
CONTACT NAME AND TITLE: Kim Rose, Senior Director of Health and Wellbeing				
EMAIL: krose@ymcapkc.org		**PHONE:** (360) 307-4006		
CONTRIBUTING ORGANIZATIONS: Kitsap County Medical Society, Kitsap County area physicians/pediatricians, 5210 Kitsap, YMCA of Pierce and Kitsap Counties				
COUNTIES SERVED BY THIS PROJECT: ☐ Clallam ☐ Jefferson ☒ Kitsap ☐ Other:				
TRIBES (please name each): N/A				
THIS PROJECT IS (check one): ☐ New ☒ Enhancing an existing project or set of projects				
SECTORS ENGAGED BY THIS PROJECT (check all that apply)**:**				
☐ Aging	☐ Behavioral Health Org	☐ Chemical Dependency	☒ Chronic Disease	☐ Community Action Pgrm
☐ Early Childhood	☐ Economic Development	☒ Education	☐ Emergency Medical Services	☐ Employment
☐ FQHC	☐ Housing	☐ Justice	☐ Managed Care Organization	☐ Mental Health
☐ Oral Health	☐ Philanthropy	☐ Primary Care	☐ Private not-for-profit hospital	☐ Public Health
☐ Public Hospital	☐ Rural Health	☐ Social Services	☐ Specialty Care	☐ Workforce development
☐ Other (please list):				

BRIEF PROJECT DESCRIPTION (3-4 sentences):	Family Fit Camp is an 8week program offered by the YMCA designed for families who have one or more children in the household between the ages of 8-14 that are currently obese or overweight, are type 2 diabetic, or who are at-risk for becoming obese or diabetic. The YMCA partners with Kitsap County Medical Society for participant referrals to our program. Family Fit Camp provides the family access to the YMCA for 8 weeks to attend specialized classes to gain education for permanent, manageable, and impactful ways to improve diet and nutrition and increase physical activity. Families learn together about meal planning, physical exercise, nutrition, and ways to be healthy together. Classes are lead by fitness experts including personal trainers, YMCA health coaches, and group fitness instructors.
PROJECT GOAL STATEMENT (1-2 sentences):	The overall goal of Family Fit Camp is to educate obese, morbidly obese, and overweight children and families on healthy lifestyle habits to decrease the likelihood of further negative health implications.
PROJECT SCOPE (1-2 sentences):	Family Fit Camp is offered in 8-week sessions year-round at the Haselwood Family YMCA in Silverdale, WA (5 sessions per year).

PROJECT ACTIVITIES: (Add rows as needed)	**CONTRIBUTING PARTNERS:** (Include their roles & responsibilities)	**ACTIVITY TIMELINE:**
Physical Education	Personal Trainers and YMCA Health Coaches will discuss safety and modifications for limitations, education on goal setting, and basic exercise science concepts.	4 sessions/6 hours
Physical Activity	Personal Trainers, YMCA Health Coaches, and Specialized Group Fitness Instructors are responsible to showcase and promote new and exciting ways to exercise in a private setting.	8 sessions/12 hours

Nutrition Education	Using concepts from Actively Changing Together (ACT!), the YMCA's Healthy Eating and Physical Activity (HEPA) and Diabetes Prevention Program (DPP), 5210, among other evidence-based curriculum, trainers will discuss healthy meal planning, food journaling, and balanced diet.	8 Sessions/12 hours

CATEGORY	DESCRIPTION	RESPONSE
EVIDENCE BASE	Is project an evidence based, promising or innovative practice or model? Include source.	Family Fit Camp is built upon evidence based best practices for improving health and wellbeing including ACT!, HEPA, DPP, 5210, Coordinated Approach to Healthy Children (CATCH), among others. This type of program has been found to be successful in improving physical health and managing health care costs. Evidence from previous entrance/exit surveys showed an increase in minutes of exercise per week and decreases in screen time in weekly intake of fast food/takeout.
ALIGNMENT TO OCH PRIORITY AREAS	Under which one or more of the OCH Priority Areas does this project align?	☒ Access ☐ Aging ☒ Behavioral Health ☒ Chronic Disease ☐ Early Childhood ☒ Social Determinants
VALUE ADD	What difference does OCH involvement make to the project?	OCH will play a vital role in the public awareness and expansion of the Family Fit Program. A partnership with OCH will provide credibility to our program and we hope to promote the program to local pediatrician and physician offices, health and welfare offices, WIC locations, etc. Through awareness and promotion, we will increase the number of children and families served through the program. By partnering with OCH, we aim to create a model program that can be replicated throughout the region.
TARGET POPULATION/ SCALABILITY	Who are the project participants? How many are currently served and what is the project's potential reach in terms of individuals and communities? Describe potential for scalability.	75 families per year Annual unduplicated number of participants served, Year: 2016-17 Family Fit Camp is targeting Kitsap County children (ages 8-14) who are overweight, obese, or type 2 diabetic, and their families. In 2015, we offered two sessions serving 14 children per session. With support from OCH, we will increase our target participation to 15 children per 8-week session and offer 5-sessions per year (a total of 75 children and their families).
IMPACT	How does the project impact/address social determinants of health, health disparities, and/or healthy equity?	Family Fit Camp addresses the social determinants of health by removing barriers and improving access to high-quality, evidence based programming aimed to improve overall health and well-being. Family Fit Camp is a free program and provides children and their families' access to a health and fitness professionals, personal trainers, and high-quality programming. The YMCA provides a safe and welcoming environment that embraces people of all backgrounds and fitness abilities and is catered to support health seekers. By eliminating access barriers and providing a high-quality program, we are decreasing the risks for negative health behaviors and lifestyles.
SUSTAINABILITY	How the project is currently funded? What is the sustainability plan for ongoing/future funding?	Family Fit Camp is currently funded through a partnership with Kitsap County Medical Society, and directly by the YMCA. The total cost for a child and their family to participate in the 8-week program is $400. For each eligible child participant, KCMS provides a $130 scholarship. The YMCA contributes the balance, up to $270 per family. Our plan for sustaining this program is continuing our partnership with KCMS, seeking additional grant funding, and including Family Fit Camp as part of our annual fundraising campaign.
ADVANCING THE TRIPLE AIM	Describe how project addresses the Triple Aim of better health, better care, and lower cost?	Family Fit Camp is aligned with the Triple Aim Initiative by providing a high-quality program with experienced health and wellness trainers and the curriculum and training to improve overall health and well-being. By participating in the program and making the necessary lifestyle changes to improve personal health and lifestyles, Family Fit will help reduce the need for additional health care related to chronic disease/illness associated with overweight, obese, type 2 diabetes, etc.
MEDICAID WAIVER ALIGNMENT	Is this a potential Medicaid Transformation Waiver project (see table	N/A

CATEGORY	DESCRIPTION	RESPONSE
	on pages 7-14)? If so, name the Waiver project.	
ALIGNMENT WITH WA COMMON MEASURE SET	List any of the *Common Measures* that this project will track; priority will be given to projects listing at least one.	Family Fit Camp is aligned with the WA Common Measure Set: OBESITY PREVENTION -Counseling for nutrition for children/adolescents -Counseling for physical activity for children/adolescents -Weight assessment for children/adolescents

EVALUATION: How is the project evaluated? Describe measures and results if any are available. Add rows as needed.

OUTCOME (Desired result)	**OUTCOME INDICATOR** (How success is measured)	**DATA SOURCE** (Identify partner/s helping with data collection or analysis)	**TIMELINE**	**RESULTS** (Include time frame)
85% program attendance and participation of children and families	Program attendance, YMCA Membership Scans,	YMCA will record and monitor Program attendance and membership scans	On-going, during grant period	Results to be measured at close of each 8-week session
100% of program participants increase the amount of time exercising per day and week	Participant Entrance/Exit Surveys	Participant Entrance/Exit Surveys	On-going, during grant period	Results to be measured at close of each 8-week session
85% of program participants decrease the amount of recreational screen time to less than two hours per day	Participant Entrance/Exit Survey	Participant Entrance/Exit Surveys	On-going, during grant period	Results to be measured at close of each 8-week session
90% of program participants decrease the amount of fast food or takeout	Participant Entrance/Exit Survey	Participant Entrance/Exit Surveys	On-going during grant period	Results to be measure at close of each 8-week session

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL

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PROJECT TITLE: Kitsap Aging SAIL (Stay Active and Independent Living) Project				
HOST ORGANIZATION: Kitsap County Division of Aging & Long Term Care				
CONTACT NAME AND TITLE: Stacey Smith, Kitsap Aging & Long Term Care Administrator				
EMAIL: sasmith@co.kitsap.wa.us		**PHONE: (360) 337-5624**		
CONTRIBUTING ORGANIZATIONS: subcontract with local non-profit				
COUNTIES SERVED BY THIS PROJECT: ☐ Clallam ☐ Jefferson ☒ Kitsap ☐ Other:				
TRIBES (please name each): **This program will be co-located across Kitsap County and available to the general population, with focus to senior and disabled population.** • **Port Gamble S'Klallam and Suquamish are located within Kitsap County.**				
THIS PROJECT IS (check one): ☒ **New** ☐ **Enhancing an existing project or set of projects**				
SECTORS ENGAGED BY THIS PROJECT (check all that apply)**:**				
☒ Aging	☐ Behavioral Health Org	☐ Chemical Dependency	☐ Chronic Disease	☐ Community Action Pgrm
☐ Early Childhood	☐ Economic Development	☐ Education	☐ Emergency Medical Services	☐ Employment
☐ FQHC	☐ Housing	☐ Justice	☐ Managed Care Organization	☐ Mental Health
☐ Oral Health	☐ Philanthropy	☐ Primary Care	☐ Private not-for-profit hospital	☐ Public Health
☐ Public Hospital	☐ Rural Health	☐ Social Services	☐ Specialty Care	☐ Workforce development
☒ Other (please list): Focused exercise program for seniors, fall prevention and reduced social isolation.				

BRIEF PROJECT DESCRIPTION (3-4 sentences):	Stay Active and Independent for Life (SAIL) is a strength, balance and fitness program for adults 65 and older. Performing exercises that improve strength, balance and fitness are the single most important activity that adults can do to stay active and reduce their chances of falling. The entire curriculum of activities in the SAIL Program can help improve strength and balance if done regularly. This is a very successful evidence-based program available throughout the state through the Aging system. As of January 2014, there were at least 64 known SAIL Programs in Washington State with approximately 1,000 participants. Currently, it is not available in Kitsap County. SAIL classes are conducted by fitness, exercise science and healthcare professional who have completed the SAIL Program Leader training. All program leaders area carefully selected for their ability to deliver effective and efficient training, while adhering to the core components of the SAIL Program. • Adhering to the SAIL Program schedule of one hour classes at least three times a week. See attached "Washington State Older Adult Fall Prevention Strategies for the SAIL Program"
PROJECT GOAL STATEMENT (1-2 sentences):	Kitsap County Division of Aging and Long Term Care plans to subcontract the SAIL pilot project. The planning for the pilot project will be August 1-December 31, 2016. The project will be implemented January 1st and be available through December 31, 2017. • The pilot project will serve approximately 150 disabled adults and older individuals.

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL

PROJECT SCOPE (1-2 sentences):	*Please describe what part of your regional community the project will serve (e.g. three counties, patients enrolled with two health plans, four primary care clinics, approximate number of individuals served by a social service agency in one city).* 20% of all people living in Kitsap County now comprise older adults; by 2020 this number will rapidly increase to 25%. The SAIL pilot project will be co-located to at least 3 sites in Kitsap County- one north, south, and central to the County. The sites may be an interested senior center, community center, faith based or other community organization with a shared mission to serve disabled and older adults. • In at least one site the SAIL program will be paired with a Falls Prevention education component. Falls among older adults in Washington are a leading cause of injury, disability and death. In 2010, falls were the leading cause of injury-related hospitalizations in Washington State, with more than 20,000. According to CDC, one in three older adults fall each year. Falls can cause moderate to severe injuries, such as hip fractures, head injuries and can increase the risk of early death.

PROJECT ACTIVITIES: (Add rows as needed)	**CONTRIBUTING PARTNERS:** (Include their roles & responsibilities)	**ACTIVITY TIMELINE:**
Literature Review	Division of Aging Staff	By August 1st
1st Planning Meeting with Stakeholders/ Partner Non-Profit agency	Division of Aging Staff, interested non-profits agencies, senior centers and community partners	By August 15th
Secure site locations	Division of Aging Staff	September 30th
Purchase equipment (Start up)	Division of Aging Staff	November 29th
Finalize subcontract for CY 2017	Division of Aging Staff	December 15th
Recruit and Train Facilitators	Subcontractor	December 31st
Implement Program	Subcontractor	January 1, 2017
Advertise Events	Division of Aging Staff and Subcontractor	On-going

CATEGORY	**DESCRIPTION**	**RESPONSE**
EVIDENCE BASE	Is project an evidence based, promising or innovative practice or model? Include source.	The SAIL Program meets the highest level criteria for an evidenced-based program and was listed as an approved physical activity program on the website for the Center for Health, Aging National Council of Aging. It is also deemed as an evidenced-based program by the Administration for Community Living (ACL). • Source: Attached document.
ALIGNMENT TO OCH PRIORITY AREAS	Under which one or more of the OCH Priority Areas does this project align?	☐ Access | ☒ Aging | ☐ Behavioral Health | ☐ Chronic Disease | ☐ Early Childhood | ☒ Social Determinants
VALUE ADD	What difference does OCH involvement make to the project?	OCH will track general population health, social determinants, and collective impact to the health of the region. The available funding through the OCH will secure the planning and implementation for the low-cost program; approximately $15,000 for the 18-month pilot.
TARGET POPULATION/ SCALABILITY	Who are the project participants? How many are currently served and what is the project's potential reach in terms of individuals and communities? Describe potential for scalability.	150 Annual unduplicated number of participants served, Year: 2017 This is a new pilot project that will be implemented in at least 3 distinct location across the Kitsap Peninsula. The most desirable sites will be in highly visible and existing senior centers, community centers, faith-based and other organizations with a shared mission and frequented by disabled and older adults. The community-based model has great potential. It creates opportunities for networking and collaboration with existing community partners. This program could potentially be widely available, co-located across the County.
IMPACT	How does the project impact/address social determinants of health, health disparities, and/or healthy equity?	This is a prevention project. As the population ages and the demands for fall prevention interventions increase, there is an infrastructure within the Kitsap Aging and Long Term Care agency to widely disseminate the SIL Program. With funding, the community based program has potential to impact this population and public health need.

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL

CATEGORY	DESCRIPTION	RESPONSE
		In 2010, falls were the third leading cause of injury-related deaths in Washington, with 823 deaths. Older adults had over 2/3 of the hospitalized falls and 83% of the fall-related deaths. • On average, the hospitalization cost for a fall injury among older adults is $17,500.
SUSTAINABILITY	How the project is currently funded? What is the sustainability plan for ongoing/future funding?	This is a low cost project- up to $15,000 for July 1, 2016- December 31, 2017. The SAIL project is currently not funded in Kitsap County. This project may be contingent on funding made available through OCH. Future Funding: The project could potentially blend funds from Aging Title III-D funds (up to $11,000 per year) or seek continued partnership through non-profit grant opportunities.
ADVANCING THE TRIPLE AIM	Describe how project addresses the Triple Aim of better health, better care, and lower cost?	This is a prevention project that could positively impact the general health, overall care and recovery rates of individuals low than the current cost. This project focuses on fall prevention, overall physical strength and balance. In Washington, 1 in 5 older adults report having fallen in the previous three months. In 2010, falls were the third leading cause of injury-related deaths in Washington, with 823 deaths. Older adults had over 2/3 of the hospitalized falls and 83% of the fall-related deaths. • On average, the hospitalization cost for a fall injury among older adults is $17,500. This preventive evidence-based program provides a community-based approach to improved health and decreased use of hospitals/ health care due to decreased falls through community partnerships.
MEDICAID WAIVER ALIGNMENT	Is this a potential Medicaid Transformation Waiver project (see table on pages 7-14)? If so, name the Waiver project.	Domain 2: Care Delivery Redesign through outreach and engagement. For example, outreaching to 1st Responders for chronic Fall referrals and avoiding unnecessary ED visits through Fall Prevention education. Domain 3: Prevention & Health through physical strength and promoting brain health. Potential age-related risk factors for falls include: • Decreased muscle strength and mass • Chronic disease • Impaired gait and balance • Impaired visual acuity and depth perception • Impaired mental status
ALIGNMENT WITH WA COMMON MEASURE SET	List any of the *Common Measures* that this project will track; priority will be given to projects listing at least one.	42. Potentially avoidable ED visits

EVALUATION: How is the project evaluated? Describe measures and results if any are available. Add rows as needed.

OUTCOME (Desired result)	OUTCOME INDICATOR (How success is measured)	DATA SOURCE (Identify partner/s helping with data collection or analysis)	TIMELINE	RESULTS (Include time frame)
Increased quality of life	Use self-report survey: • BRFSS (Behavioral Risk Factor Surveillance Survey) • Create pre- and post survey	Partnering co-located site will provide survey; Aging staff to compile data	• Compile completed surveys, monthly • Review results each quarter	• Review results each quarter • Provide quarterly report to OCH

Decreased use of Emergency Department	Use existing KC4TP (Kitsap Continuum of Care Coalition) – Harrison Qualis data	Harrison Qualis data	Review results each quarter	• Review results each quarter • Provide quarterly report to OCH
Decreased death and hospitalization data	Use existing Kitsap Health District data	Kitsap Health District data	Review results as available	• Review results as available • Provide quarterly report to OCH

Washington State
Older Adult Fall Prevention

Strategies for the SAIL Program

(Stay Active & Independent for Life)
June 2014

Stay Active & Independent for Life

Acknowledgments

Compiled and written by the Injury and Violence Prevention Program
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Visit the Department of Health Older Adult Fall Prevention site

Washington State Department of Health
DOH 346-068 July 2014

Falls among older adults (age 65 and older) in Washington are a leading cause of injury death and disability. According to Centers for Disease Control and Prevention (CDC) one in three adults age 65 and older fall each year. Falls can cause moderate to severe injuries, such as hip fractures and head injuries and can increase the risk of early death.

SAIL Overview

SAIL (Stay Active & Independent for Life) is a strength, balance and physical fitness program for adults 65 and older. Performing exercises that improve and maintain strength, balance and fitness are the single most important activity adults can do to stay active and reduce their risk of falling. If done regularly and in its entirety, the SAIL Program can help improve and maintain strength and balance. SAIL Fitness Classes may be offered at senior centers, community centers, fitness organizations, parks and recreation facilities, churches, retirement communities, independent and assisted living residential facilities, and community colleges. Some sites offer the SAIL Program as one of many benefits of being a member of that community.

In 2003-2005, the Washington State Department of Health led the Senior Falls Prevention Study with funding from the department and CDC. The results of the study are published in the Journal of Gerontology, "Effectiveness of a Community-Based Multifactorial Intervention on Falls and Fall Risk Factors in Community-Living Older Adults: A Randomized Control Trial". [1]

In 2005-2006, the department conducted research in social marketing to determine how to translate the results of the Senior Falls Prevention Study into a community-based fall prevention intervention program. In 2007, primary researchers conducted a translational research evaluation to examine the dissemination and implementation of the SAIL Program in the community. In 2011, the results of the research were published in Health Promotion Practice. This published evaluation firmly established "Stay Active & Independent for Life" as an evidence-based intervention for preventing falls in the elderly population. [2]

SAIL is a public-domain program, which means there are no initial site license fees and no yearly renewal fees for conducting SAIL classes. Current funding for the SAIL Program is provided through our agency and an interagency agreement with Department of Social and Health Service (DSHS), Aging and Long Term Support Administration (ALTSA). The current agreement provides funding to train new SAIL Program Leaders throughout the state. The training sessions are led by a Department of Health contractor. In addition, Pierce College, a public community college located in Lakewood, WA, hosts an on-line version of the SAIL Program Leader training, through their Distance Learning Program. The online training is not funded by our agency or DSHS.

1 Shumway-Cook A, Silver IF, Le Mier M, York S, Cummings P, Koepsell, TD, Effectiveness of a Community-Based Multifactorial Intervention on Falls and Fall Risk Factors in Community-Living Older Adults: A Randomized Control Trial. Journal of Gerontology; MEDICAL SCIENCES 2007, Vol. 62A, No. 12, 1420-1427

2 York S, Shumway-Cook A, Silver IF, Morrison CA, (2010) A Translational Research Evaluation of the Stay Active and Independent for Life (SAIL) Community-Based Fall Prevention Exercise and Education Program Health Promotion Practice.

Currently, a contract is in place with a trainer to offer leader trainings throughout the year. However, there is limited ongoing support for new Program Leaders. Each local Program Leader is responsible for securing funding, a location and support for the class they establish in a local community. Some Program Leaders find opportunities to work for a local senior center, fitness or community organizations that will provide the structure and funding needed to support and sustain the SAIL Program.

The SAIL Program provides two documents for class participants. The blue SAIL Information Guide is the fall prevention education component of the SAIL Program. The green Exercise Guide is for program leaders and class participants.

As of January 2014, there were at least 64 known SAIL Programs in Washington State that provided the fitness class to an estimated 1,000 participants.

As the population ages and the demand for fall prevention interventions increases, DOH does not have the necessary resources to operate, maintain or sustain the infrastructure needed for widespread dissemination of the SAIL Program. The community based model of the SAIL Program has great potential, but needs additional resources to maximize the dissemination and impact. This document is the first attempt to methodically define the needs of the SAIL Program and to achieve the infrastructure needed to continue its growth and sustainability.

Definitions Used in This Plan

Fidelity refers to delivering a program exactly as it was intended according to the original plan. SAIL is effective in improving the strength, balance and fitness of older adults when delivered the same way as developed and planned in the original research study and follow up program evaluation. We strongly encourage you to replicate the original program model by:

- Conducting the SAIL Program in a local community setting;
- Adhering to the SAIL Program schedule of one hour classes;
- Providing the minimum number of three classes per week;
- Using adjustable 10 lb. (20 lbs total/pair) ankle weights. Weights can be used on both ankles and wrist to strengthen arms and legs;
- Having participants perform the mandatory exercises exactly as taught in the SAIL Program Leader training.

Evidence-based programs are based on the best available external evidence from systematic reviews of research literature. They are shown to be effective at helping participants adopt healthy behaviors, improve their health status, and reduce their use of hospital services and emergency room visits. Evidence-based programs can mitigate the impact of chronic diseases and injuries, such as falls. SAIL is one of many evidence-based programs for the prevention of older adult falls.

Evidence-based programs provide an ideal model for giving older adults information and support. Evidence-based programs can add value in many ways. First, they can significantly improve the health and well-being of older adults in the community. Second, they can help attract new participants and funders through innovative programming. Third, they can create powerful partnerships with other organizations, including health care providers.

The SAIL Program was approved by the Administration for Community Living (ACL) as an evidence-based program. ACL is part of the federal Health & Human Services Administration. The SAIL Program has been approved as a Tier III (the highest level) evidence-based program. Title 3D provides grants for education and implementation of activities that support healthy lifestyles and promote healthy behaviors for the population of over 60 years of age. Title 3D funding can be used to implement SAIL Programs at the state and local level.

How This Strategy Plan Was Developed

In June 2013, the Older Adult Fall Prevention Program in the Washington State Department of Health convened a multidisciplinary SAIL task force to develop a plan to coordinate and focus efforts to continue the SAIL Program in Washington State. The goal of the task force was to develop a coordinated and sustainable SAIL Program in Washington State. The task force met three times over a one year period to develop value statements, strategies, and actions for the SAIL Program.

Contents of This Plan

This plan identifies seven components needed for the success of the SAIL Program:

1. Partnerships
2. Data
3. Access to Programs
4. Program Leader Development
5. Marketing & Promotion
6. Program Fidelity
7. Program Sustainability

For each component, a value statement was identified. For each value statements, a list of strategies was developed. Some of the strategies include "ideas for action". While the "ideas for action" are not exhaustive, they are included to help make the strategies more concrete for readers. The priority areas and strategies relate only to the SAIL Program in Washington State. They do not cover all older adult fall prevention interventions. The strategies and ideas serve as a roadmap that can be used to focus, guide and sustain the SAIL Program in Washington State.

For more information and resources, please visit the Department of Health Older Adult Fall Prevention website**.**

For more information contact:
Mary Borges, Older Adult Fall Prevention Program Manager
360-236-2861 or Mary.borges@doh.wa.gov

Visit the Department of Health Older Adult Fall Prevention site

SAIL Strategies

Partnerships: Fall Prevention is everyone's responsibility.

Strategies

- Establish and sustain partnerships around evidenced-based fall prevention programs.
- Create opportunities for networking and collaboration on SAIL.

Data: Use data to develop and support fall prevention strategies.

Strategies

- Identify and review all available data sources (i.e. Behavioral Risk Factor Surveillance Survey – (BRFSS), death & hospitalization data, emergency services utilization data, etc.).
- Make data and reports available to interested parties.
- Institute quality control measures for tracking and reporting data.
- Identify and create opportunities in higher education institutions to assist with data collection and program evaluation.

Access to Programs: All older adults have access to evidence-based strength and balance programs to prevent falls.

Strategies

- Promote availability and access to SAIL classes.
  Ideas for action:
  - ◊ Develop website for SAIL classes, instructors, documents, etc.
- Increase professional awareness of and referrals to strength and balance fall prevention programs
  Ideas for Action:
  - ◊ Promote SAIL through health care provider conferences, newsletters, etc.

Program Leader Development: Program leaders are committed to implement and sustain SAIL Programs in Washington State.

Strategies

- Develop a model of delivery that is effective and sustainable.
  Ideas for Action:
  - ◊ Review & redefine pre qualifications of Program Leaders
  - ◊ Identify attributes of different levels of Program Leaders (i.e. Master Trainer, program lead, assistant).
  - ◊ Investigate and promote options for different types of training – webinar, online, in person, higher education courses, etc.
  - ◊ Provide opportunities and incentives to recruit & retain new Program Leaders.
- Develop user friendly reporting protocols for existing and new SAIL Program Leaders.
- Create Evaluation Plan for the SAIL Program and Program Leaders.

SAIL Strategies (continued)

Ideas for Action:

- ◊ SAIL Program Leaders conduct annual evaluation of classes and submit information to lead agency. Lead agency will use information to publicize classes and use data for research, program evaluation and continuity of program.

- Create opportunities for networking and collaboration for SAIL Program Leaders.
  Ideas for Action:
  - ◊ Investigate structure for master trainings (regional, county, etc.)
  - ◊ Create and maintain a statewide data base of SAIL Program Leaders.
  - ◊ Establish a network of SAIL Program Leaders to provide technical support.
  - ◊ Provide refresher courses, CEUs and resources for other learning opportunities.

Marketing and Promotion: Increase public and professional awareness of the SAIL Program

Strategies

- Develop "How to" guide for implementing the SAIL Program.
- Seek sponsorship for the SAIL Program.
- Review & update 2006 Social Marketing Plan.
- Collaborate with partners to assist in marketing the SAIL Program.
  Ideas for Action:
  - ◊ Conduct a coordinated public education campaign.
- Increase outreach and education to professionals to encourage referrals to classes.

Program Fidelity: SAIL Program and classes are conducted in the original program design and lead by highly qualified and trained Program Leaders.

Strategies

- Provide an effective organizational structure for SAIL Program sustainability and effectiveness.
- Develop a business plan for SAIL.
- Create fidelity, sustainability and evaluation protocols for the SAIL Program.
- Convene a leadership team to oversee the SAIL Program at the state level.
- Designate specialist(s) to consult on SAIL Program clinical issues.

Program Sustainability: The SAIL Program will be sustained as a public health, public domain evidence-based fall prevention intervention.

Strategies

- Provide an effective organizational structure for SAIL Program sustainability and effectiveness.
- Develop a business plan for SAIL.
- Convene a leadership team to oversee the SAIL Program at the state level.
- Expand the SAIL Program oversight beyond DOH.
- Work with partners and sponsors to sustain the SAIL Program.

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL

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This form is due via electronic submittal to Angie Larrabee angie.larrabee@kitsappublichealth.org (fax: 360-475-9326) no later than 4pm, Tuesday, June 21, 2016. Please contact Angie if you have questions or have trouble using this form.

PROJECT TITLE: Improving health through connections: Increasing community health worker capacity				
HOST ORGANIZATION: Kitsap Public Health District				
CONTACT NAME AND TITLE: Yolanda Fong, Public Health Nurse Supervisor, Chronic Disease Prevention				
EMAIL: yolanda.fong@kitsappublichealth.org		**PHONE: 360-337-5275**		
CONTRIBUTING ORGANIZATIONS: N/A				
COUNTIES SERVED BY THIS PROJECT: ☒ Clallam ☒ Jefferson ☒ Kitsap ☐ Other:				
TRIBES (please name each): Lower Elwha, Suquamish Tribe, Makah Tribe, Quileute Tribe, Jamestown S'Klallam Tribe, Port Gamble S'Klallam				
THIS PROJECT IS (check one): ☐ **New** ☒ **Enhancing an existing project or set of projects**				
SECTORS ENGAGED BY THIS PROJECT (check all that apply)**:**				
☐ Aging	☒ Behavioral Health Org	☐ Chemical Dependency	☒ Chronic Disease	☒ Community Action Pgrm
☐ Early Childhood	☐ Economic Development	☐ Education	☐ Emergency Medical Services	☐ Employment
☒ FQHC	☒ Housing	☐ Justice	☐ Managed Care Organization	☒ Mental Health
☐ Oral Health	☐ Philanthropy	☒ Primary Care	☐ Private not-for-profit hospital	☒ Public Health
☐ Public Hospital	☐ Rural Health	☐ Social Services	☐ Specialty Care	☐ Workforce development
☐ Other (please list):				

BRIEF PROJECT DESCRIPTION (3-4 sentences):	Capitalizing on current chronic disease prevention efforts, this project will develop and enhance regional community health worker (CHW) capacity, resources and strategies focusing on high need and vulnerable communities. This will be accomplished through the creation of a regional CHW network and a CHW training/mentoring program in Kitsap that then can be replicated in other counties. The regional CHW network will increase current and future CHW's resources, training opportunities and utilization of evidence based strategies through peer to peer learning across Jefferson, Clallam and Kitsap counties. The Kitsap CHW training/mentoring program will be utilized to identify and document CHW engagement techniques, successful training and mentoring strategies, and exploring partnership models with a local healthcare system and community based non-profits.
PROJECT GOAL STATEMENT (1-2 sentences):	Increase the utilization of community health workers targeting high need communities to prevent and address chronic disease and their impact in our region.
PROJECT SCOPE (1-2 sentences):	*Please describe what part of your regional community the project will serve (e.g. three counties, patients enrolled with two health plans, four primary care clinics, approximate number of individuals served by a social service agency in one city).* This project will serve three counties (Jefferson, Clallam and Kitsap) focusing on high need communities (which may include American Indian, low income, minority, and immigrant populations).

PROJECT ACTIVITIES: (Add rows as needed)	**CONTRIBUTING PARTNERS:** (Include their roles & responsibilities)	**ACTIVITY TIMELINE:**
Develop and maintain a regional community health worker network	**Kitsap Public Health District** - Coordinate a CHW network including regional partners from 1422 and beyond. Network would include meeting opportunities to share resources, trainings and exploration into developing shared measurements for enhanced data collection and sharing. Community organizations	First – eighth quarter

	and Tribes listed in this proposal will be invited to participate in the regional CHW network.	
Identify and recruit at least three potential CHWs from high need communities in Kitsap County. High need communities may include American Indian, low-income, immigrant and minority populations. High need will be defined in partnership with key stakeholders and based on current available data.	**Kitsap Public Health District** – KPHD will lead the coordination of efforts and will support the identification of 3 CHWs in Kitsap County and will be looking to intentionally hire/train CHWs with deep relationships and knowledge in the "high need" communities identified by partners in Kitsap, for example perhaps 1 tribal CHW, 1 Guatemalan CHW, and 1 other CHW with deep connections, knowledge of chemical dependency issues/resources in Bremerton. KPHD will work with public health partners in Jefferson and Clallam counties to replicate our local efforts based on our success with this project. **Kitsap Strong** - Support identification and recruitment efforts. **YMCA of Pierce and Kitsap Counties** - Support identification and recruitment efforts. **Peninsula Community Health Services** - Support identification and recruitment efforts.	First two quarters
Mentor and train recruited CHWs to create linkages with health care systems, connect patients to appropriate community services, and promote evidence based chronic disease prevention strategies including the Diabetes Prevention Program (DPP) and Blood Pressure Self-Monitoring program (BPSM).	**Kitsap Public Health District** - Coordination of efforts and development of training resources. Foster cross collaboration with key stakeholders. **Kitsap Strong** - Train CHWs in NEAR sciences (neuroscience, epigenetics, Adverse Childhood Experiences - ACEs & resiliency) to promote culturally competent trauma-informed interactions. Identify other relevant training opportunities (such as Mental Health First Aid, domestic violence, chemical dependency, etc.) to support CHWs with the identification and development of culturally relevant responses, and the community resources and referral process for individuals with complex needs. **YMCA of Pierce and Kitsap Counties** - Provide training to CHWs to promote, recruit and deliver evidence based YMCA chronic disease prevention programs including DPP and BPSM. **Peninsula Community Health Services** - Connect Health Care Specialist (HCS) with recruited CHWs to enhance linkage to health care services. Health Care Specialists will be trained through the Washington State Department of Health's CHW training and utilize many of the same strategies that neighborhood based CHW will use. Connecting HCS with CHW will improve communication and health care access for high need communities.	Second, third, fourth quarters
Improve blood pressure control in hypertensive residents in Kitsap County utilizing CHWs.	**Peninsula Community Health Services -** Utilizing Health Care Specialists train patients on the proper use of blood pressure cuffs and self-management techniques. **YMCA of Pierce and Kitsap Counties** - Working with KPHD and recruited CHWs identify 2 sites in high need communities to deliver BPSM. Support and train a CHW to promote, recruit and deliver the BPSM program.	Fourth – eighth quarter

CATEGORY	DESCRIPTION	RESPONSE
EVIDENCE BASE	Is project an evidence based, promising or innovative practice or model? Include source.	Evidence continues to support the utilization of CHWs to prevent and control chronic disease: • Integrating CHWs into multidisciplinary health teams has emerged as an effective strategy for improving the control of hypertension among high-risk populations. • The Community Outreach and Cardiovascular Health (COACH) trial, which paired nurse practitioners and CHWs together to manage

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL

CATEGORY	DESCRIPTION	RESPONSE
		cardiovascular disease, demonstrated a $157 reduction per patient in cost for every 1% drop in systolic blood pressure and $190 reduction in cost for every 1% drop in diastolic blood pressure. • A recent review that examined CHWs' effectiveness in providing care for hypertension noted improvements in keeping appointments, compliance with prescribed regimens, risk reduction, blood pressure control, and related mortality. • In reviewing 18 studies of CHWs involved in the care of patients with diabetes, Norris and colleagues found improved knowledge and lifestyle and self-management behaviors among participants, as well as decreases in the use of the emergency department. Centers for Disease Control (2015) *Addressing Chronic Disease through Community Health Workers: A Policy and Systems-Level Approach*
ALIGNMENT TO OCH PRIORITY AREAS	Under which one or more of the OCH Priority Areas does this project align?	☒ Access ☐ Aging ☐ Behavioral Health ☒ Chronic Disease ☐ Early Childhood ☒ Social Determinants
VALUE ADD	What difference does OCH involvement make to the project?	The motto of the OCH "Regional vision, Local action" is in direct alignment with the proposed project and will support the implementation of a project that has a regional thread but needs local action to be successful. The diverse leadership and multi-sector representation in the OCH allows for a broad audience to learn about and participate in the development of this innovative community based intervention.
TARGET POPULATION/ SCALABILITY	Who are the project participants? How many are currently served and what is the project's potential reach in terms of individuals and communities? Describe potential for scalability.	__600__ Annual unduplicated number of participants served, Year: __2yrs____ The above numbers are approximate reach of community health workers based on Blood Pressure Self-Monitoring program targets (PCHS 150, YMCA 150) and potential CHW outreach capacity (3 CHW reaching 100 people each annually). There is potential for greater population impact related to the regional CHW network activities. The Kitsap CHW Training/Mentor program including delivery of evidence based chronic disease prevention programing has potential to be replicated in other counties in our region.
IMPACT	How does the project impact/address social determinants of health, health disparities, and/or healthy equity?	A disproportionate number of people with poorly controlled chronic diseases are low-income, ethnic or racial minorities. CHWs play a key role in reaching the vulnerable and underserved communities. This project will impact/address health disparities and equity by strengthening communication and knowledge of high need communities, thereby increasing an individual's capacity to utilize services and to make informed decisions regarding their health. This project will also address social determinants by diversifying the healthcare workforce and increasing employable skills of other community members.
SUSTAINABILITY	How the project is currently funded? What is the sustainability plan for ongoing/future funding?	Current efforts to assess the utilization of CHWs in our region is funded by a federal grant 1422 Obesity, Diabetes, and Heart Disease and Stroke prevention funding. 1422 funding include 13 funded partners covering Jefferson, Clallam and Kitsap counties. There is potential for two more years of funding and activities include CHW strategies allowing for partners to capitalize on this project proposal's efforts and to strengthen sustainability opportunities.
ADVANCING THE TRIPLE AIM	Describe how project addresses the Triple Aim of better health, better care, and lower cost?	Healthcare systems are complex and in constant change often making it difficult for patients to utilize services. Low income, limited English proficiency, minority and other underserved communities are often high cost patients. CHWs can bridge communication and cultural gaps with health care systems while also addressing social, non-clinical challenges affecting patients' health and care. In a paper by Massachusetts Department of Public Health (2015) *Achieving the Triple Aim: Success with Community Health Workers,* research evidence supports. Reduce costs: CHW interventions targeting patients with high resource utilization result in savings to the medical system often in the form of reduced ER visits and readmissions.

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL

CATEGORY	DESCRIPTION	RESPONSE
		Improve health: CHW help patients engage more fully in their care and adhere to care plans. They also help patients control chronic conditions including increase asthma-free days, lower blood sugar and blood pressure levels. Improve quality of care: CHWs improve retention in care through outreach, and patient satisfaction through better understanding of and help with addressing their social needs.
MEDICAID WAIVER ALIGNMENT	Is this a potential Medicaid Transformation Waiver project (see table on pages 7-14)? If so, name the Waiver project.	Domain 1: Workforce and non-conventional service sites Domain 2: Care Coordination Domain 3: Chronic Disease Prevention and/or Management
ALIGNMENT WITH WA COMMON MEASURE SET	List any of the *Common Measures* that this project will track; priority will be given to projects listing at least one.	Access to care: Adults access to preventive/ambulatory care - ages 20-44, ages 45-64, ages 65+ Cardiovascular Disease: Controlling high blood pressure Obesity Prevention: Weight assessment-ages 18-74

EVALUATION: How is the project evaluated? Describe measures and results if any are available. Add rows as needed.

OUTCOME (Desired result)	**OUTCOME INDICATOR** (How success is measured)	**DATA SOURCE** (Identify partner/s helping with data collection or analysis)	**TIMELINE**	**RESULTS** (Include time frame)
Identify and train three community health workers in Kitsap county.	Number of community health workers trained.	Project report created by KPHD which will include details on number of CHW, trainings, lessons learned and potential for replicability.	First two quarters	Pending implementation of project
High need communities have increased knowledge, skills and/or resources to prevent and address chronic disease.	Number of community member reached, skills and resources shared.	Project report created by KPHD. Partners participating in data collection include: Peninsula Community Health Services and YMCA of Pierce and Kitsap Counties.	Ongoing	Pending implementation of project
Number of Kitsap residents self-monitoring blood pressures for at least 4 months.	Weeks of recorded monitoring	Peninsula Community Health Services YMCA of Pierce and Kitsap Counties BPSM reports	Ongoing	Pending implementation of project
Participation in regional CHW network activities	Number of participants	Sign-in sheets Participant survey	Ongoing	Pending implementation of project

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL

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PROJECT TITLE: Investing in the Health of Future Generations				
HOST ORGANIZATION: Kitsap Public Health District (KPHD)				
CONTACT NAME AND TITLE: Suzanne Plemmons, Community Health Director				
EMAIL: suzanne.plemmons@kitsappublichealth.org		**PHONE:** 360-337-5263		
CONTRIBUTING ORGANIZATIONS: Jefferson County Public Health (JCPH; Jefferson County), First Step Family Support Center (Clallam County); Port Gamble S'Klallam Tribe (PGST; Kitsap County)				
COUNTIES SERVED BY THIS PROJECT: ☒ Clallam ☒ Jefferson ☒ Kitsap ☐ Other:				
TRIBES (please name each): Port Gamble S'Klallam Tribe; potentially Lower Elwha Tribe and Quileute Nation				
THIS PROJECT IS (check one): ☐ **New** ☒ **Enhancing an existing project or set of projects**				
SECTORS ENGAGED BY THIS PROJECT (check all that apply)**:**				
☐ Aging	☐ Behavioral Health Org	☐ Chemical Dependency	☐ Chronic Disease	☐ Community Action Pgrm
☒ Early Childhood	☐ Economic Development	☒ Education	☐ Emergency Medical Services	☐ Employment
☒ FQHC	☐ Housing	☐ Justice	☒ Managed Care Organization	☒ Mental Health
☐ Oral Health	☐ Philanthropy	☒ Primary Care	☒ Private not-for-profit hospital	☒ Public Health
☒ Public Hospital	☒ Rural Health	☒ Social Services	☒ Specialty Care	☐ Workforce development
☐ Other (please list): schools of nursing; alternative high schools				

BRIEF PROJECT DESCRIPTION (3-4 sentences):	Our region has several research-based programs, including Nurse Family Partnership (NFP), Maternity Support Services (MSS), and Parents as Teachers (PAT), which offer the care and support women need to have a healthy pregnancy, provide responsible and competent care for their children, and become economically self-sufficient. This project aims to develop a regional multi-point of entry ("no wrong door") bi-directional referral network for low-income pregnant and parenting women, focused on improving access to existing prenatal and parenting services, including the aforementioned programs. This network will further result in increased support for expansion of needed evidence-based and best practice home visitation programs in low-service areas like Clallam County. The well-being of our community depends on every child having a fair, healthy start at life and this project addresses the ongoing challenge of ensuring families have access to existing evidence-based programs and that programs have the capacity to service all of our highest need families.
PROJECT GOAL STATEMENT (1-2 sentences):	This project focuses on development of a bi-directional referral network across the OCH region to facilitate increased availability and uptake of home visitation services, which will result in healthier babies, children, and adults. This envisioned referral network will include managed care organizations, OB/GYNS, primary care providers (rural and urban), alternative high schools, non-profit social service agencies, public health, and government service providers (DSHS, etc.).
PROJECT SCOPE (1-2 sentences):	*Please describe what part of your regional community the project will serve (e.g. three counties, patients enrolled with two health plans, four primary care clinics, approximate number of individuals served by a social service agency in one city).* Low-income (Medicaid-eligible) pregnant women and mothers in Kitsap, Jefferson and Clallam Counties, including sovereign tribal nations located within these counties – average number of women and children served per year is 1,400

PROJECT ACTIVITIES: (Add rows as needed)	**CONTRIBUTING PARTNERS:** (Include their roles & responsibilities)	**ACTIVITY TIMELINE:**
Developing a gap analysis of referral sources in comparison to existing program capacities	Identify potential referring agencies in each region/tribal nation Identify gaps in home visitation services per target population	First quarter

Using gap analysis, conduct outreach and education on the benefits of prenatal and early childhood home visitation to build bidirectional referral network	Develop outreach plan, outreach materials (including referral forms if needed) and presentation materials, schedule connections with target referring agencies, conduct outreach/education per outreach plan	Second, third, fourth quarter
Ongoing NFP, PAT, MSS implementation	Conduct ongoing services	Ongoing
Develop a plan for service expansion in Clallam and Jefferson County	Identify feasibility of developing NFP program in Clallam and Jefferson Counties, which would also service expansion to Lower Elwha Tribe and Quileute Nation	Last quarter

CATEGORY	DESCRIPTION	RESPONSE
EVIDENCE BASE	Is project an evidence based, promising or innovative practice or model? Include source.	Parents as Teachers is an evidence-based parenting intervention; Nurse Family Partnership is an evidence-based home visitation program for first time low income mothers; Maternity Support Services is a best practice
ALIGNMENT TO OCH PRIORITY AREAS	Under which one or more of the OCH Priority Areas does this project align?	☐ Access ☐ Aging ☐ Behavioral Health ☐ Chronic Disease ☒ Early Childhood ☒ Social Determinants
VALUE ADD	What difference does OCH involvement make to the project?	The OCH strengthens access to health care providers and social services who are an important partners in the envisioned referral network; this project clearly contributes to the Triple Aim by facilitating less costly prevention-focused services, thereby reducing avoidable costly interventions
TARGET POPULATION/ SCALABILITY	Who are the project participants? How many are currently served and what is the project's potential reach in terms of individuals and communities? Describe potential for scalability.	783 Annual unduplicated number of participants served, Year: 2015 This program aims to ensure that existing NFP, MSS, and PAT programs serve at full capacity (regionally 783 clients – 341 KPHD, 382 First Step, 60 JPHD/PGST) by improving the referral networks to these programs (and the number of referrals from these programs to health and social service partners). It further aims to lay a foundation for expansion of NFP services into Clallam County, Lower Elwha Tribe, and Quileute Nation should sufficient funding become available in the future.
IMPACT	How does the project impact/address social determinants of health, health disparities, and/or healthy equity?	This program addresses health disparities and health equity in several ways. • NFP has been proven to improve the economic self-sufficiency of low-income families • All home visitation programs provide skills-building, health education, intensive coordination of resources as a means to ensure every child has equal access to a health start in life • These programs are considered evidence-based and best practices for preventing child abuse and neglect (prevention of ACEs) • Participants in this program have better birth outcomes and childhood well-being indicators than comparable families
SUSTAINABILITY	How the project is currently funded? What is the sustainability plan for ongoing/future funding?	Existing programs are funded through a combination of local flexible public health tax dollars (allocated by public health departments to support this work); funds from the Mental Health, Chemical Dependency, Therapeutic Courts 1/10th of 1% tax; Thrive Washington; designated Health Care Authority Medicaid dollars; and foundation grants
ADVANCING THE TRIPLE AIM	Describe how project addresses the Triple Aim of better health, better care, and lower cost?	These programs have been shown to reduce avoidable use of intensive services such as emergency rooms and improve population health through preventative case management and coordination of care.
MEDICAID WAIVER ALIGNMENT	Is this a potential Medicaid Transformation Waiver project (see table on pages 7-14)? If so, name the Waiver project.	Yes. Maternal and Child Health under Domain 3 – Promoting Improved Birth Outcomes and Childhood Health, as well as Promoting Trauma-Informed Approaches to Care Specifically, similar to – "Creating universal access across the state to evidence-based and –informed home visiting programs…" (P99)
ALIGNMENT WITH WA	List any of the *Common Measures* that this	Child and adolescent access to primary care, ages 12-24 months Unintended pregnancies

CATEGORY	DESCRIPTION	RESPONSE
COMMON MEASURE SET	project will track; priority will be given to projects listing at least one.	Childhood immunizations Adult Mental Health Status Adults Use of Tobacco Use Potentially avoidable ER visits

EVALUATION: How is the project evaluated? Describe measures and results if any are available. Add rows as needed.

OUTCOME (Desired result)	OUTCOME INDICATOR (How success is measured)	DATA SOURCE (Identify partner/s helping with data collection or analysis)	TIMELINE	RESULTS (Include time frame)
Enhanced bidirectional referral network	• Increase in the number of referring agencies	• NFP Outcome Database (ETO) • KPHD, JCPH, First Step, and Tribal health records	One year	Pending funding
Improved maternal health during pregnancy and improved pregnancy outcomes	• reduction in preterm delivery among women who smoke • reduction in first preterm births (<37 weeks)	• NFP Outcome Database (ETO) • KPHD, JCPH, First Step, and Tribal health records	Ongoing	• 79% reduction in preterm delivery among women who smoke* • From 6/1/16 -3/31/16, 33% reduction in smoking for JCPH and PGST NFP clients • From 6/1/16 -3/31/16, a 2% preterm delivery rate among JCPH and PGST NFP clients • From 4/1/15 – 3/31/16 KPHD NFP clients preterm birth rate was 6.4% (Source: NFP ETO data)**
Improved child health and development	• reduction in infant mortality • increase in moms who breastfeed	• NFP Outcome Database (ETO) • KPHD, JCPH, First Step, and Tribal health records	ongoing	• 45% reduction in infant mortality* • 64.5% of KPHD NFP clients were breast feeding at 6 months and 52.2% at 12 months (Source: NFP ETO data)** • From 6/1/16 -3/31/16, 62 % JCPH and PGST combined clients were breastfeeding at 6 months and 44% at 12 months
Decrease in avoidable ED visits	• reduction in emergency department use related to childhood injuries in ages 0-2	• NFP Outcome Database (ETO) • KPHD, JCPH, First Step, and Tribal health records • Hospital ED records	ongoing	• 56% reduction in emergency room visits for accidents and poisoning at age 2*
Improved child immunization rates	• increase in full immunization status (ages 0-2)	• NFP Outcome Database (ETO) • KPHD, JCPH, First Step, and Tribal health records	ongoing	• 94% of KPHD, JCPH, and PGST NFP clients were up to date (Source: NFP ETO data)**
Reduced rate of smoking during pregnancy	• reduction in smoking during pregnancy	• NFP Outcome Database (ETO) • KPHD, JCPH, First Step, and Tribal health records	ongoing	• 40% reduction in smoking for KPHD NFP clients (Source: NFP ETO data)**

Increase in well child care	• more children receive recommended 12 and 24 month well child exams	• NFP Outcome Database (ETO) • KPHD, JCPH, First Step, and Tribal health records	ongoing	• Regional or county results data not available
Increased depression screening during pregnancy and postpartum and referral for evaluation and treatment of those screening positive	• women receive depression screening prenatally and postpartum and 100% of those screening positive are referred for evaluation and treatment	• NFP Outcome Database (ETO) • KPHD, JCPH, First Step, and Tribal health records	ongoing	• In 2014 90% of KPHD NFP clients were screened for depression and 100% of those screening positive were referred (Source: KPHD NN EHR)

*Though we have no regional results the NFP intervention can be expected to achieve this stated result, as evidenced by randomized controlled trials.
**Number based on cumulative data from program initiation through 3/31/16.

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PROJECT TITLE: Child Check	
HOST ORGANIZATION: Lutheran Community Services NW	
CONTACT NAME AND TITLE: Lisa Lyon, Program Manager Crisann Brooks, Family support Director	
EMAIL: llyon@lcsnw.org , cbrooks@lcsnw.org	**PHONE: 360-452-5437 800-300-1247**
CONTRIBUTING ORGANIZATIONS: Prevention Works, Clallam	
COUNTIES SERVED BY THIS PROJECT: ☒ Clallam ☐ Jefferson ☐ Kitsap ☐ Other:	
TRIBES (please name each): Makah, Elwha, Jamestown	
THIS PROJECT IS (check one): ☐ **New** ☒ **Enhancing an existing project or set of projects**	

SECTORS ENGAGED BY THIS PROJECT (check all that apply)**:**

☐ Aging	☐ Behavioral Health Org	☐ Chemical Dependency	☐ Chronic Disease	☐ Community Action Pgrm
☒ Early Childhood	☐ Economic Development	☐ Education	☐ Emergency Medical Services	☐ Employment
☐ FQHC	☐ Housing	☐ Justice	☐ Managed Care Organization	☒ Mental Health
☐ Oral Health	☐ Philanthropy	☐ Primary Care	☐ Private not-for-profit hospital	☐ Public Health
☐ Public Hospital	☐ Rural Health	☒ Social Services	☐ Specialty Care	☐ Workforce development
☐ Other (please list):				

BRIEF PROJECT DESCRIPTION (3-4 sentences):	Child Check will screen children, 18 months to 5 year old living in Clallam County for social, emotional, behavioral and developmental issues. The goal of Child Check is to provide parents and caregivers support in identifying and addressing potential developmental concerns and access to resources for developing parenting skills and preparing their child for school. Child Check includes screening for autism spectrum disorders, developmental delays in motor, speech and cognition, and Adverse Childhood Experiences (ACES). As part of the screening process, all parents will receive parental coaching and a resource packet with information on parenting resources available in the county and specifically highlighting the parenting classes that are "best practices".
PROJECT GOAL STATEMENT (1-2 sentences):	Child Check's overall outcome is for ALL children ages 18 months to kindergarten to have a free opportunity for screening in support of their readiness to learn in all areas of development. Child Checks primary goal is to provide parents and caregivers with support and resources focused on increasing their knowledge as to the social, emotional, and behavioral development of their children and encourage the adoption of effective parenting practices.
PROJECT SCOPE (1-2 sentences):	*Please describe what part of your regional community the project will serve (e.g. three counties, patients enrolled with two health plans, four primary care clinics, and approximate number of individuals served by a social service agency in one city).* Child Check will be available throughout Clallam County within specific screening clinics to in more isolated communities such as Neah Bay, Clallam Bay, Joyce, as well as in Forks, Port Angeles and Sequim including Peninsula Children's clinic, Bogachiel, Lower Elwha and Jamestown clinics and other tribal Head Start and Child Care Centers. We currently serve 209 children annually with our current staffing; with this funding we will expand that number to 325.

PROJECT ACTIVITIES: (Add rows as needed)	**CONTRIBUTING PARTNERS:** (Include their roles & responsibilities)	**ACTIVITY TIMELINE:**
Early child assessment identification of mental health needs/risks, including history of trauma Family mental health history emotional and behavioral concerns Social / relationship skills	Port Angeles School district Medical clinics/Doctor Offices Preschool providers	Ongoing year round

CATEGORY	**DESCRIPTION**	**RESPONSE**
EVIDENCE BASE	Is project an evidence based, promising or innovative practice or model? Include source.	This innovative practice has been developed in collaboration with Prevention Works! Coalition, doctors and mental health professionals for screening, parent engagement, school readiness and has been in use since 2012. Children screened are divided by age into two groups; 18-36 months and 36-66 months. All children are screened with the Denver II, a

CATEGORY	DESCRIPTION	RESPONSE
		nationally recognized general developmental screening tool and the Modified Childhood Assessment for Autism (M-CHAT R). All parents/caregivers are asked to fill out the ACES (Adverse Childhood Experiences) questionnaire for themselves and are also asked what adverse experiences (from the ACES questionnaire) they believed their child may have experienced. Children aged 36-66 months are screened with the Devereux Early Childhood Assessment for Preschool (DECA P2). Children aged 18-36 months are screened with the Brief Infant-Toddler Social and Emotional Assessment (BITSEA) and the Devereux Early Childhood Assessment (DECA I/T). The BITSEA, DECA and MCHAT-R are all based on parent/caregiver/childcare provider report.
ALIGNMENT TO OCH PRIORITY AREAS	Under which one or more of the OCH Priority Areas does this project align?	☐ Access ☐ Aging ☒ Behavioral Health ☐ Chronic Disease ☒ Early Childhood ☒ Social Determinants
VALUE ADD	What difference does OCH involvement make to the project?	Studies show that major child behavior problems in the preschool years are exacerbated by inappropriate parental responses to difficult toddler behavior. Developmental delays often become evident during the toddler years and before a child enter formal education programs. *Multiple studies show that "informal screening" conducted by physicians (for example: asking parents if they have any concerns about their child's behavior) fails to identify approximately 50% of young children with Social, Emotional, Behavioral problems or concerns)(Clallam Prevention Works! Prevention plan, "Early Detection of Developmental and Behavioral Problems", Glascoe, F. P. in Pediatrics in Review, 21, (2000) pp 272-280).* Screening during this critical time period (between the ages of 18 months and five years old) provides the best opportunity to reach struggling parents and caregivers and provide support, information and resources. Connection to these critical resources gives families and children the tools to ensure the child is prepared to the best of their ability to enter and succeed in school. *(Significant numbers of children arrive in Kindergarten without the self-regulatory skills to function productively in the classroom or are expelled from preschool and kindergarten due to behavioral issues.") (Clallam Prevention Works! Prevention plan, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. National Research Council and Institute of Medicine, National Academies Press, Washington, DC, 2009. p. 231).* Screening young children in this age group is important in identifying; early developmental lags, problematic parent/child interactions and confusion about how to parent difficult children. Parents of children in this age group undergo a shift from excusing unwanted child behavior as "behavior the baby will grow out of" to blaming the child for inappropriate behavior and using words such as "stubborn, willful, difficult, manipulating" that label the child. Often parents of children in this age group have misperceptions about what a child of this age should be expected to do, expecting more, or too little, than the child is capable of delivering or and ignoring signs of developmental delays. Many young families on the Peninsula are separated from extended family and are isolated having little to compare their child's behavior to or, even to know that their child has any issues that need to be addressed. *(2011 screening pilot revealed approximately 20% of children who participated in Child Check assessments were identified needing support or interventions)*
TARGET POPULATION/ SCALABILITY	Who are the project participants? How many are currently served and what is the project's potential reach in terms of individuals and communities? Describe potential for scalability.	____ Annual unduplicated number of participants served, Year: _209____ Since its inception the Early Screening & Identification Committee of Prevention Works! has worked collaboratively with the medical community, school districts, ESD staff, Peninsula Behavioral Health staff and a wide variety of individuals from the early learning community to create the Child Check model for early screening. The coalition meets monthly to discuss how the program is developing and to review outcomes, using the evaluations to strengthen the program. Support for this screening model is universal and strong among all the

CATEGORY	DESCRIPTION	RESPONSE
		community. The design of Child Check was built through a collaborative model involving health care providers, child care providers, school district staff, Peninsula Clallam County Health and Human Services WIC, Head Start, Peninsula Behavioral Health Children's division, North Olympic Library System and many other community partners who participated in the planning, development and implementation. Community partners throughout the county are an integral part of outreach to the families and have been an important liaison for hosting the screenings at their locations. As of the end of December 2015, we received a total of 209 referrals from parents and individuals and 80 referrals from preschool teachers for completing the free Child Check screening. The scope for expansion is only limited by funding and with proper funding could reach out geographically to other counties/regions.
IMPACT	How does the project impact/address social determinants of health, health disparities, and/or healthy equity?	One of the significant determinants of health in children is the standard of parental care they receive in the first five years of life. Does the child live in an enriched environment, with developing vocabularies and literate parents who are engaged in the community? Is the child immunized, learning to brush their teeth, eating a healthy diet? Are the parents helping the child to be prepared cognitively, socially and emotionally to participate in kindergarten? **Child Check** utilizes an innovative approach for engaging parents of young children in all of the above areas. The initial focus for the parent is the opportunity to learn about their child's cognitive, social and emotional development. As they watch their child participate in the screening and they complete parent rating forms they enter into a mutual dialogue with the professional screener. As the conversation unfolds over the next 60 to 90 minutes, the screener leads the parent into a better understanding of their child's strengths and areas of weakness. While helping the parent (caregiver) learn more about typical child development, the screener also makes suggestions for ways the parent (caregiver) can become more engaged in the early childhood community of activities. All participants in Child Check learn how they can better prepare their child for entrance into kindergarten through changes in parenting, community, and home based activities. The importance of their child's health is emphasized with an opportunity to discuss oral health, immunizations, exercise and nutrition. Parents (caregivers) are encouraged to complete an ACEs screening form for both themselves and their child. The screener helps the parents understand the meaning of their score and how to use that information to better care for their child. Every child receives a book and parents are encouraged to read to their child every day. By the end of the session, the parent will have learned more about their child, picked up ways to improve parenting approaches to common problems, discovered child-centered resources in their community and, when appropriate, received directed referrals to community professionals both for themselves and their child. Child Check helps parents develop age appropriate parenting skills; learn about early childhood community resources, become more engaged in the wider community of parenting and develop a more holistic, health-based approach to parenting. By offering the simple intervention of a face to face session with a screening professional, Child Check helps to reduce the isolation and frustration experienced by many parents of young children. The impact of Child Check is further enhanced by the follow up availability of parent-coaching after the screening is completed and the encouragement of parents and their child to participate in Play and Learn Groups in their neighborhood.
SUSTAINABILITY	How the project is currently funded? What is the sustainability plan for ongoing/future funding?	Current funding includes local and regional prevention coalitions and United Way initiative funding. Ongoing research and grant development for the Child Check service to be a community model for universal screening for Clallam County is a priority. Program sustainability is of foremost concern. We have preliminary data that suggests the community have *bought-in* to the importance of early screening and the critical role it plays for future academic success of the children of Clallam County. We also have data that suggests that agencies and organizations that are child- focused have also *bought-in* to the importance of Child Check. As with any grant or foundation supported program, the concern for future funding is foremost in our planning and we are focused on community engagement with the program, such as doctors offices and clinics for sponsoring the program financially.

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL

CATEGORY	DESCRIPTION	RESPONSE
ADVANCING THE TRIPLE AIM	Describe how project addresses the Triple Aim of better health, better care, and lower cost?	Child Check offers screening and parent education in a format that is difficult to deliver in a typical physician's office. At a cost of approximately **$125** per child screened, the parent receives not only the information provided by the screener but also a parent resource kit that includes a three ring binder with information about raising a young child in Clallam County. With parental (caregiver) permission the results of the screening can be faxed to the primary care provider. Through follow-up phone calls the screener is able to help the parent complete necessary steps for any specific referrals made during the screening session thus increasing the likelihood that the child and family will receive needed interventions. The cost of replicating this service in a medical office would be significantly higher. Increasing a parent's ability parent their child effectively decreases costs long term of doctor's visits, medication and mental health costs to both the parent/caregiver and child.
MEDICAID WAIVER ALIGNMENT	Is this a potential Medicaid Transformation Waiver project (see table on pages 7-14)? If so, name the Waiver project.	No
ALIGNMENT WITH WA COMMON MEASURE SET	List any of the *Common Measures* that this project will track; priority will be given to projects listing at least one.	Health Screening – Well child checks ages 3-6

EVALUATION: How is the project evaluated? Describe measures and results if any are available. Add rows as needed.

OUTCOME (Desired result)	OUTCOME INDICATOR (How success is measured)	DATA SOURCE (Identify partner/s helping with data collection or analysis)	TIMELINE	RESULTS (Include time frame)
Parents report they have a better understanding of child growth and development	• Results of parent surveys • Phone Surveys to assess success of referrals to other services • Parents report increased participation in parenting programs • Parents report increased participation in services referred such as mental health, support groups, preschool, parent coaching, etc…	• Prevention Works Advisory committee • Port Angeles School District • Medical clinics • Head Start/ECAP	Ongoing throughout the year	• 325 children screened each year • 20% families receive parent coaching • Parents receive relevant information about growth, development, health and school readiness for their child and increase their knowledge and skills in parenting their child(ren). • Children identified needing additional support in social, emotional and behavior issues will be connected to community services for follow up care and support to be kindergarten ready.

Olympic Community of Health

Regional Health Assessment and Planning Committee Recommendation to the Board Regional Health Improvement Project Selection

Situation | **B**ackground | **A**ction | **R**ecommendation

July 6, 2016

Situation

The OCH must select and submit a regional health improvement project by July 29th to be compliant with our contract with the Health Care Authority (HCA) under the State Innovation Model (SIM) grant. In addition, we need to be thinking ahead to a discussion of project funding as we await confirmation from the HCA on $50,000 of SIM project funding and consider $19,400 in the OCH budget reserved for a Coordinator.

Background

The OCH Board tasked the Regional Health Assessment and Planning (RHAP) Committee to do a call for proposals, review proposals, and recommend one or more projects to the Board for selection. When making its recommendation, the RHAP Committee considered four broad criteria:

1. **Coordinated** multi-sector planning and implementation
2. **Strategic alignment** with OCH regional priority areas
3. **Measureable** activities and outcomes that have the potential for impact within the next two-and-a-half years as measured by the Common Measure Set
4. **Advances** the Triple Aim

Process

DEVELOP 5/16-20
- RHAPC creates project proposal template
- RHAPC establishes project scoring criteria

REQUEST 6/1-21
- OCH Board disseminates request for project proposals due 6/21
- 6/1 post Board meeting by email to OCH Partner list
- 6/14 in person at OCH Partner meeting

REVIEW 6/22-27
- OCH staff compile submitted proposals
- RHAPC members score proposals and make recommendation on 6/27

VET 6/28-7/28
- OCH Partners vet RHAPC recommendation (electronic)
- OCH Board reviews recommendation and makes selection on 7/6
- RHAPC assists with final submitted product to the HCA on 7/25

SUBMIT 7/29
- OCH staff submits project(s) to HCA on 7/29

RHAP Committee Project Review Meeting Participants

Attending in Person	**Attending by Web/Phone**
Chair: Katie Eilers, *Kitsap Public Health District* Bobby Beeman, *Olympic Medical Center* Monica Bernhard, *Kitsap Community Resources* Kirsten Jewell, *Kitsap County Human Services* Jennifer Johnson-Joefield, *Peninsula Community Health Services* Siri Kushner, *Kitsap Public Health District/also OCH staff* Gay Neal, *Kitsap County Human Services* John Nowak, *Jefferson Health Care* Caitlin Safford, *Amerigroup* Molly Staudenraus, *Olympic Educational Services District 114*	Allan Fisher, *United Health Care* Vicki Kirkpatrick, *Jefferson Public Health* Gary Kriedberg, *Harrison Health Partners* Kat Latet, *Community Health Plan of WA* Lisa Rey Thomas, *University of Washington*
Consultant through ACH Technical Assistance Contract Lauren Baba, Group Health Cooperative, Center for Community Health and Evaluation **Staff** Elya Moore, Director Angie Larrabee, Assistant	

Synopsis of the Eight Submitted Projects, deadline June 21, 2016

Project Title	**Host Organization**	**Project Goal**
Olympic Peninsula Coordinated Opioid Response	Salish Behavioral Health Organization	Decrease the levels of prescription and illicit opiate abuse across the three counties. Specific goals are to enhance the availability of Suboxone and Naloxone in all three counties and increase the number of opiate-addicted community members who engage in treatment for their addiction. Other goals are to decrease levels of opiate addiction as well as opiate overdoses and deaths, inform prescribing patterns, and create alternatives to criminal justice interventions.
Investing in the Health of Future Generations	Kitsap Public Health District	Development of a bi-directional referral network across the OCH region to facilitate increased availability and uptake of home visitation services, which will result in healthier babies, children, and adults. This envisioned referral network will include managed care organizations, OB/GYNS, primary care providers (rural and urban), alternative high schools, non-profit social service agencies, public health, and government service providers (DSHS, etc.).
Improving Health Through Connections	Kitsap Public Health District	Increase the utilization of community health workers targeting high need communities to prevent and address chronic disease and their impact in our region.
Behavioral Health Student Assistance Services	Olympic Educational Services District	Decrease the number of school-aged youth with unmet behavioral health and physical health needs by providing school-based service and linkages to community resources (i.e. primary care physicians/pediatricians, behavioral health providers, and social support services); and improve overall behavioral health functioning of the students served by the program.

Project Title	Host Organization	Project Goal
Kitsap Aging SAIL Project	Kitsap County Division of Aging & Long Term Care	Kitsap County Division of Aging and Long Term Care plans to subcontract the SAIL pilot project. The planning for the pilot project will be August 1-December 31, 2016. The project will be implemented January 1st and be available through December 31, 2017. The pilot project will serve approximately 150 disabled adults and older individuals.
Child Check	Lutheran Community Services NW	ALL children ages 18 months to kindergarten have a free opportunity for screening in support of their readiness to learn in all areas of development. Child Checks primary goal is to provide parents and caregivers with support and resources focused on increasing their knowledge as to the social, emotional, and behavioral development of their children and encourage the adoption of effective parenting practices.
Family Fit Camp	Haselwood Family YMCA (YMCA of Pierce and Kitsap Counties)	Educate obese, morbidly obese, and overweight children and families on healthy lifestyle habits to decrease the likelihood of further negative health implications.
Ready for Kindergarten	Quillayute School District	Improve the Pre-reading scores of children entering Kindergarten, specifically Letter naming fluency, Initial Sound Fluency. In a study performed in the Othello School District it was determined that students who had experienced *READY* performed 16.56% higher in these Pre-reading scores than students who did not participate in *READY.*

Action

Ranking of proposal submissions, June 27, 2016

#	Proposal Name	Total # Reviewers	Range in Scores	Average Score
1	Olympic Peninsula Coordinated Opioid Response	4	27-30	28.5
2	Investing in the Health of Future Generations	5	23-30	27.8
3	Improving Health Through Connections	4	21-31	27.3
4	Behavioral Health Student Assistance Services	5	24-28	25.8
5	Kitsap Agining SAIL	5	22-28	24.0
6	Child Check	5	18-26	22.4
7	Family Fit Camp	6	14-24	21.3
8	Ready for Kindergarten	5	13-23	17.2

TOTAL POSSIBLE = 31

The RHAP Committee recommended the first two, hereafter referred to as

1. The “Opioid Project”
2. The “Future Generations Project”

Both of these projects clearly met the four broad criteria listed above. The Future Generations Project is likely to be directly funded under the Waiver. The Opioid Project will align provider groups with the OCH to receive Waiver payments. A summary of the RHAP Committee's rationale for each project is below:

Strengths of the Opioid Project	**Concerns of the Opioid Project**
- Strong buy-in: Addresses an immediate health need that is shared by Tribes, multiple sectors, and all three counties. - Will directly impact the Common Measures. - Likely to have measureable impacts on process and outcome measures within a relatively short timeframe. - Aligns the OCH with behavioral health integration and practice transformation, two key components of Healthier Washington. - The OCH has a clear, value-add role.	- Not clear how the funding will be used. - The outcomes may not be realized quickly and may be difficult to measure. - It is important to support and not duplicate work that is already happening in this area.

Strengths of the Future Generation Project	**Concerns of the Future Generation Project**
- Strong theme of social justice and health equity. - Evidence-based. - Long term investment in improving health that also includes some immediate results. - Will directly impact the Common Measures. - Opportunity to align with the CPAA ACH south of us doing similar work.	- Not clear how the funding will be used. - Data sharing with Tribes may pose barriers. - Majority of benefits will be realized many years down the road. - Likely to see mostly process results in the short term, as opposed to outcomes.

Recommendation

The RHAP Committee was unanimous in the following:

1. The RHAP Committee recommends the Opioid Project and Future Generation Projects as the first regional health improvement projects, also called "early wins", under the SIM grant.
2. In the event that the Board only selects one project, the RHAP Committee recommends the Opioid Project.

If this recommendation is approved by the Board, the RHAP Committee advises the following next steps:

1. Staff will request additional information from author(s) of recommended project(s) on budget, implementation and measurement.
2. The RHAP Committee will meet July 25th to provide input into staff's final project submission to the HCA. In the event that the Board approves both projects, only one project needs to be submitted. Note that the HCA is not requiring a project budget in its submission template.
3. Staff will work with the Center for Community Health Evaluation (CCHE), the evaluation technical assistant consultant, to ensure that project measurement and evaluation is compatible under the SIM grant.

Olympic Community of Health

OCH Pathway towards Incorporation and Next Phase of Governance

Presented to the OCH Board of Directors July 6, 2016

Situation

To be a successful ACH, our structure must allow for strategic oversight of regional health assessment and planning and the implementation of one or more regional health improvement projects. Under the Medicaid Transformation Waiver, it also means becoming a legal entity and the single point of authority for transformation project implementation and oversight of projects in the Olympic region. Achieving these elements require a set of actions that need to occur intentionally and sequentially. The purpose of this document is to lay out a potential path. Four motions are proposed on Page 4.

Question to run on for today's Board meeting

What is the optimal structure for achieving our goal and being accountable for this work?

Reminder of our current purpose and rationale (from OCH Readiness Proposal)

To improve the health of our communities in Clallam, Jefferson, and Kitsap Counties through achievement of the Triple Aim:

- Improving patient care, including quality and satisfaction;
- Reducing the per-capita cost of health care; and
- Improving the health of the population.

Major changes are coming to our health care system, and it is critical for our communities to have a strong voice in that process. The OCH is the primary vehicle through which our communities can be heard and can participate in the process of change.

Suggested guiding principles to assist in our path

1. **Accountability.** The OCH will ultimately be held accountable to the mission of improving the health of a community. It must therefore consider and reflect the needs of the community it serves, with a particular emphasis on social determinants of health.
2. **Trust.** Trust is key. The OCH brings together multiple sectors and Tribal Nations to advance a common vision for the future. It is essential that the OCH earn the trust of a broad group so it can guide, serve, and protect our common vision.
3. **Flexibility.** The OCH must be nimble to be able to evolve with changing health care landscape, statewide ACH vision, and local needs of our communities. This argues for staying lean and nimble – flexing up only as deemed necessary by the Board.
4. **Robust and Effective Governance.** An ACH must establish a governance structure that ensures effective decision-making; accountability to the community; representation of partners' interests; proper fiduciary, fiscal, and social responsibilities; appropriate data and information technology policies; and control over funding and staff. To achieve this, an ACH should have a set of rules (bylaws) to hold one another accountable to our obligations, defined fiduciary duties for Directors, established controls over activities and finances, a conflicts of interest policy, and other policies.

Adapted from *Accountable Communities of Health: Legal and Practical Recommendations.* ChangeLab Solutions. December 2014.

Action	Background	Recommendation
Bylaws	Drafting bylaws is an arduous, but essential process. Fortunately for the OCH, we can draw from bylaws currently in place in other ACHs. These bylaws have already undergone legal review and applied testing. The Board may determine that legal consultation is necessary prior to approving the bylaws. Here are three options to seek counsel: ✓ In-kind donation of counsel from organization(s) represented on the Board ✓ Board hires independent counsel ✓ Access $4,950 in Technical Assistance funding to hire legal counsel. This would be considered new revenue for an unbudgeted expense. Be advised that we may not have a choice of vendor with this option. There is a minimum set of OCH policies needed for the Waiver: conflict of interest, financial, and data/IT. Other policies may also be requested.	1. OCH Director develops draft bylaws, drawing from existing ACH bylaws. 2. Executive Committee provides preliminary review and input. 3. Draft bylaws are presented to the Board for review, discussion, and next steps. 4. Policies will be developed in parallel with the creation of bylaws.
Articles of incorporation Chapter 24.03 RCW	Bylaws are not needed to incorporate. Filing articles of incorporation is the first necessary step towards incorporation. It is a low-cost ($50 dollars), quick (5 business days to process), low-energy step (file online). The eight articles are: 1. Name 2. Effective date of incorporation 3. Tenure of incorporation 4. Purpose 5. Distributions upon dissolution 6. Name and address of Directors 7. Address of initial physical location and name of agent 8. Name and address of each incorporator The Board may determine that legal review is prudent. The director will research whether other articles may be desired, such as indemnification or limitations. Draw from Articles of Incorporation submitted by other ACHs. Washington State Nonprofit Articles of Incorporation form: http://www.sos.wa.gov/_assets/corps/forms/NonprofitArticles2014.pdf	1. OCH Director drafts articles of incorporation. 2. Executive Committee provides preliminary review and input. 3. Draft Articles of Incorporation are presented to the Board for review, discussion, and next steps.
Fiscal sponsorship agreement	The Kitsap Public Health District (KDHD) has agreed to provide administrative support, including fiscal sponsorship agreement, for the OCH until a separate legal entity can be	1. OCH Director drafts Fiscal Sponsorship Agreement, borrowing

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<td>created. This means that until this time, the Director is an employee of KPHD. KPHD has been gracious during this transition period by instructing that the Director act as the Executive Director for the OCH Board. However, KPHD Board holds the financial liability for the HCA contract, including the possibility of a State audit.

This issue has been arisen for several other ACHs in the state. To address this issue, ACHs have a “Fiscal Sponsorship Agreement” in place between the ACH governing body and the fiscal agent. This agreement clarifies the OCH’s authority over its budget. It also provides safeguards by clearly stating roles and responsibilities, restrictions, term limits, contingency planning, and fees for fiscal sponsorship service.

Note that even after incorporation, the OCH Board may choose to continue to contract out for fiscal services to stay as lean as possible. It is also possible for the OCH to contract out the various backbone functions such as fiscal sponsorship, physical space, analytic support, communications, I.T., and general administrative support to different agencies.</td>
<td>from Greater Columbia, and in close consultation with the OCH Treasurer and Administrator of KPHD.

2. Executive Committee provides preliminary review and input.

3. Present agreement to the Board for review, discussion, and next steps.</td>
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<td>Legal entity</td>
<td>While there are multiple choices of legal entities, the majority of other ACHs are or are becoming 501(c)3 nonprofit corporations. Under this model, filing federal and state tax exemptions to become a 501(c)3 would be the next step for the OCH.

Becoming a 501(c)3 will take additional time and planning. Fortunately, this step will likely not be necessary to receive the first installment of funding under the Medicaid Waiver. However, it is still a necessary step and the Board may determine that professional consultation is prudent for this stage.
<table>
<tr><th>Strengths of 501(c)3</th><th>Weaknesses of 501(c)3</th></tr>
<tr>
<td>• Makes OCH eligible for government grants, philanthropic grants, and tax-deductible private contributions
• Can conduct joint ventures with other organizations
• Able to issue tax-exempt debt or obtain commercial lines of credit
• Composition of a governing board is not restricted by law, permitting the OCH to uphold its Board structure of 15 sectors + 7 Tribal nations.
• Not constrained by geography or jurisdiction</td>
<td>• Not subject to same transparency requirements as government agencies
• Profit sharing (e.g., shared cost savings program) is not permitted by board members or employees
• Cannot raise capital as easily as a for-profit company
• Obtaining 501(c)3 tax exemption determination can be a slow process</td>
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<td>1. OCH Director researches how this process has worked for other ACHs and suggests a way forward for the OCH.

2. Executive Committee provides preliminary review and input.

3. Present recommendation to the Board for discussion and next steps.</td>
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FOUR PROPOSED MOTIONS

In line with the materials provided in the July 6, 2016 OCH Board meeting, "OCH Pathway towards Incorporation and Next Phase of Governance", I am recommending the following 4 proposed motions:

Proposed Motion 1. The OCH Board authorizes the Executive Director to draft bylaws for presentation and review by the Executive Committee, prior to presenting to the full Board at the August 3, 2016 OCH Board meeting.

Proposed Motion 2. The OCH Board authorizes the Executive Director to draft Articles of Incorporation for presentation and review by the Executive Committee, prior to presenting to the full Board at the August 3, 2016 OCH Board meeting.

Proposed Motion 3. The OCH Board authorizes the Executive Director to draft a Fiscal Sponsorship Agreement for presentation and review by the Executive Committee, prior to presenting to the full Board at the September 7, 2016 OCH Board meeting.

Proposed Motion 4. The OCH Board authorizes the Executive Director to research and present recommendations on a process to become a legal entity to the Executive Committee, prior to presenting to the full Board at the September 7, 2016 OCH Board meeting.

Evaluation RESULTS: Partner Convening, June 14, 2016

Total surveys completed:	Total participants:	Survey participation rate:
30	54	56%

1. Overall, how would you rate this meeting?		☐ Excellent	☐ Very Good	☐ Good	☐ Fair
total respondents:	30	9	16	4	0
percent		30%	53%	13%	0%

2. What did you like about the meeting?

total respondents: 28

content (20)
- *reveals complexity*
- *timely panel discussion*
- *appreciated the presentation although raised many unanswered concerns*
- *presentations and handouts*
- *panelist were well versed and prepared to answer questions*
- *interesting to hear how others are doing what we are moving toward.*
- *learning more about OCH*
- *presentation on the RHAP Committee business*
- *broad participation, openness of questions/answer*
- *panel, background slides*
- *lots of relevant information*
- *hearing from early adopters (2)*
- *broad view of the early adopter process*
- *agenda*
- *very information, good overview and foundational wk., panetlist*
- *good panel on SWWA BH integration*
- *lots of current information*
- *good background info*
- *hearing from experienced ACH*

setting (7):
- *setting*
- *location*
- *space (2)*
- *meeting facility*
- *the environment overall*
- *venue*

format (5):
- *collaborative format*
- *Good to have time for questions*
- *great shared learning,*
- *interaction of participants*
- *the interactivity*

networking (4):
- *networking (3)*
- *appreciate the break for networking*

participants (3):
- *people*
- *great turn out*
- *diverse group*

3. What did you dislike about the meeting?

total respondents: 18

space:	*sound (5)*
	the seating was a bit awkward
	the chairs
content:	*more time for questions/discussion (3)*
	more time to talk to partners in the room
	topic
	hca/mco evasive about financing details (specific loss ratios (risk barriers))
	you cannot have a meeting on tribal land and not include how they can collaborate into presentation
	the information was too vast
	slides in ppt were hard to read, lot of acronyms for newcomers.
speakers:	*a couple of presenters spoke to quickly making it hard to understand what they were saying*

4. The presentations at the meeting gave me a better understanding of the topics presented:

a.Regional Health Assessment and Planning		☐ Excellent	☐ Very Good	☐ Good	☐ Fair
total respondents:	26	7	15	3	1
percent		27%	58%	12%	4%

b.Lessons from SW WA		☐ Excellent	☐ Very Good	☐ Good	☐ Fair
total respondents:	26	5	11	8	2
percent		19%	42%	31%	8%

5. Was the meeting length:		☐ About right	☐ Too long	☐ Too short
total respondents:	29	26	0	3
percent		90%	0%	10%

6. Is there a sector or group not currently represented that you think should be? Which one(s)?

total respondents: 9

total sector/groups: 14

business	food/food banks/orgs (2)
economic development	housing
education/schools (2)	juvenile justice (2)
EMS	law enforcement (2)
doctors	other social det. orgs

7. Other feedback or suggestions on how we can improve these meetings.

would have liked to hear from providers in SW, not just HCA/MCOs

work with partners

I wish tribes had been part of SW presentation

Maybe more protein at the snack table…

Washington State Health Care Authority

HCA VALUE-BASED ROAD MAP, 2017-2021

INTRODUCTION

There is a national imperative led by Medicare, the biggest payer in the U.S., to move away from traditional volume-based health care payments to payments based on value. Over the past year this movement has gained significant traction since Medicare declared its own commitment to value and quality, announced its own purchasing goals (similar to HCA), and made substantial progress in meeting its goals. At the same time, federal legislation—the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, supports Medicare's acceleration of value-based purchasing by rewarding providers through higher Medicare reimbursement rates for participation in advanced value-based payments (VBPs) or Alternative Payment Models (APMs) starting in 2019.

Like Medicare, the Washington State Health Care Authority (HCA) is transforming the way it purchases health care. As directed by the Legislature in statute, and as a key strategy under Healthier Washington, HCA has pledged that 80 percent of HCA provider payments under State-financed health care programs—Apple Health (Medicaid) and the Public Employees Benefits Board (PEBB) program—will be linked to quality and value by 2019. HCA's ultimate goal is that, by 2019, Washington's annual health care cost growth will be 2 percent less than the national health expenditure trend.

To further align with the Centers for Medicare and Medicaid Services (CMS) payment reform efforts and accelerate the transition to value-based payment, HCA is currently in negotiations with CMS for an 1115 Medicaid transformation waiver. If approved, the waiver presents a unique opportunity to accelerate payment and delivery service reforms and reward regionally-based care redesign approaches that promote clinical and community linkages through State-purchased programs. Moreover, if the waiver is approved, HCA commits that 90 percent of its provider payments under state-financed health care will be linked to quality and value by 2021.

PURPOSE AND GOALS

The HCA Value-based Road Map lays out how HCA will fundamentally change how health care is provided by implementing new models of care that drive toward population-based care. This HCA VBP Road Map braids together major components of Healthier Washington (Payment Redesign Model Tests, Statewide Common Measure Set and Accountable Communities of Health (ACHs), for example), the Medicaid transformation waiver, and the Bree Collaborative Accountable Payment Models into one approach. The Road Map is built on the following principles:

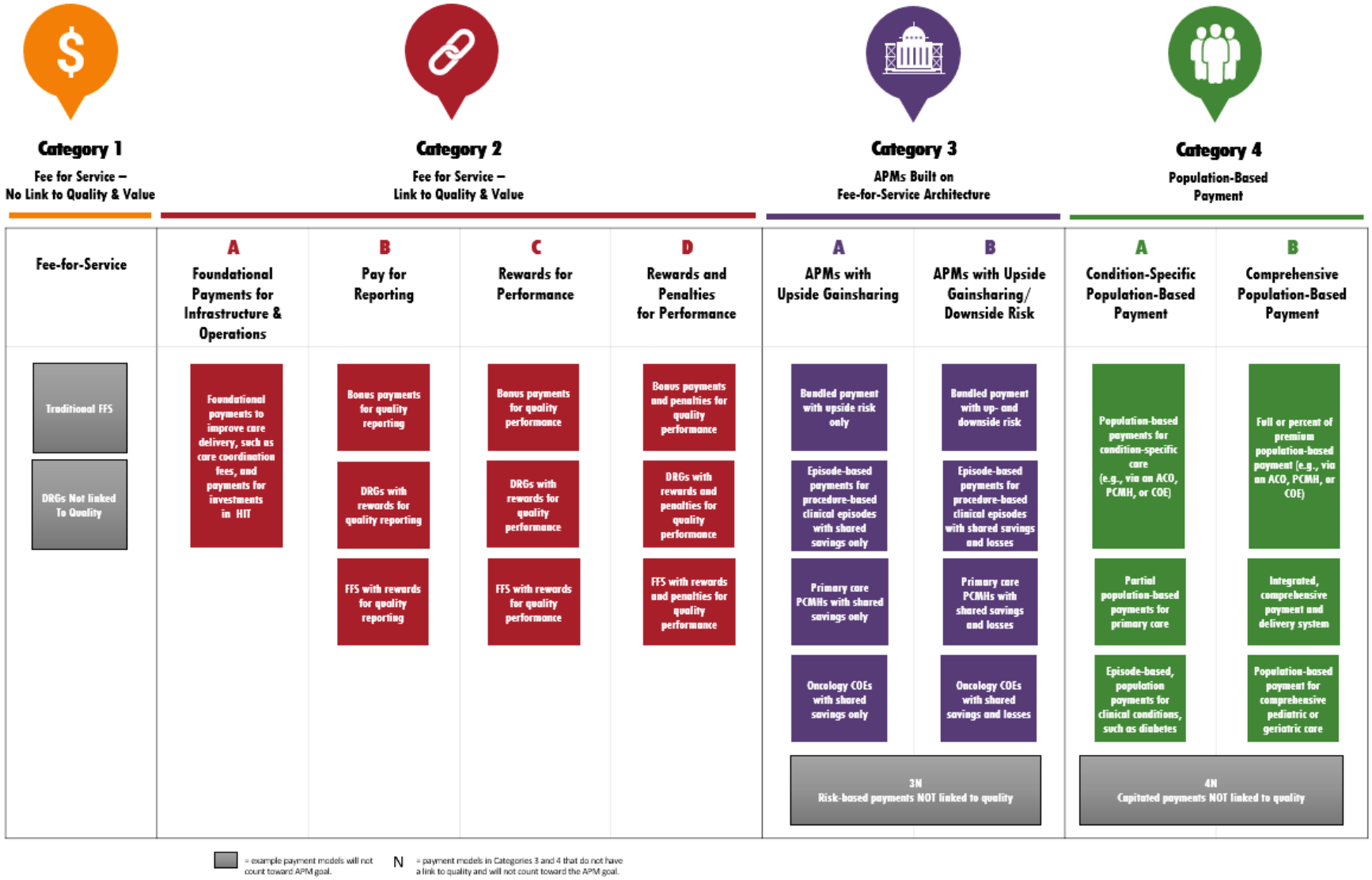
- Reward the delivery of patient-centered, high value care and increased quality improvement;
- Reward performance of Medicaid Managed Care Organizations (MCOs) and provider systems for increased adoption of value-based payments;
- Align payment and delivery reform approaches with CMS for greatest impact and to simplify implementation for providers;
- Improve outcomes for patients and populations;
- Drive standardization based on evidence;
- Increase long-term financial sustainability of state health programs; and
- Continually strive for the Triple Aim of better care, smarter spending and healthier people.

HCA'S FRAMEWORK AND PURCHASING GOALS

As the largest purchaser in Washington State, HCA purchases care for over 2.2 million Washingtonians through Apple Health and PEBB. Annually, HCA spends 10 billion dollars between the two programs. As a purchaser and state agency, HCA has market power to drive transformation using different levers and relationships.

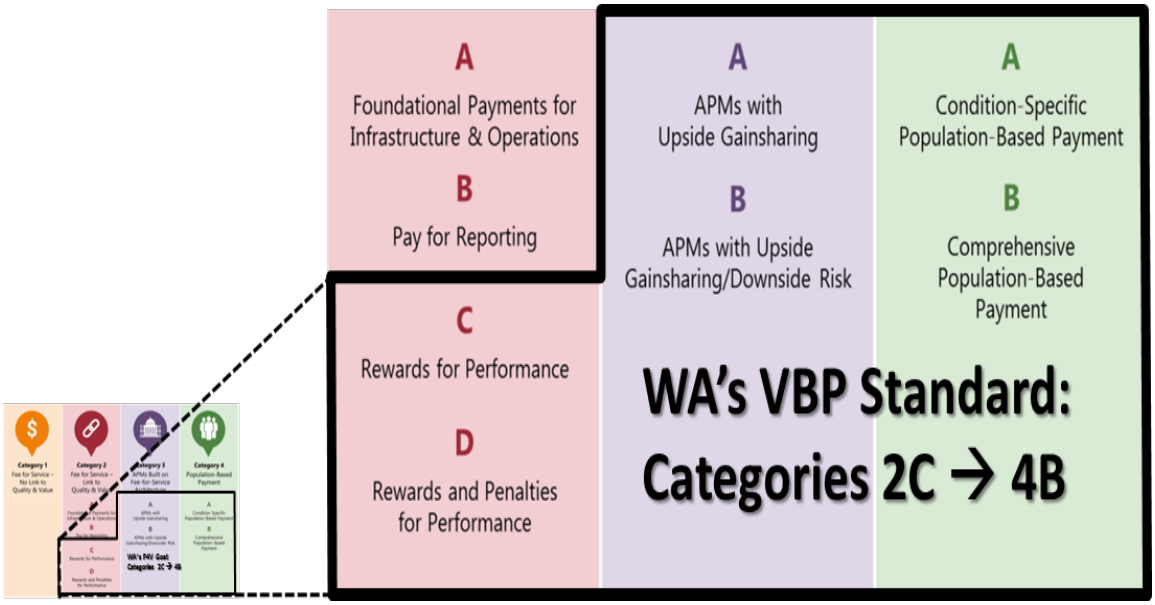
As stated in the HCA Paying for Value survey released in March 2016, HCA has adopted the framework created by CMS to define VBPs, or APMs (see Chart 1, next page).

Chart 1: CMS Framework for Value-based Payments or Alternative Payment Models



HCA's implementation of the CMS framework is shown below in Chart 2.

Chart 2: Washington State's Value-based Payment Framework



To reach its purchasing goal, HCA expects 90 percent of state-financed health care payments to providers will be in CMS' categories 2c-4b by 2021. HCA's ultimate vision for 2021 is:

- HCA programs implement VBPs according to an aligned purchasing philosophy.
- Nearly 100% of HCA's purchasing business is entrusted to accountable delivery system networks and plan partners.
- HCA exercises significant oversight and quality assurance over its contracting partners and implements corrective action as necessary.

HCA's interim purchasing goals and key VBP milestones along the path to 90 percent in 2021 are shown below.

- 2016: 20% in VBP
- 2017: 30%
- 2018: 50%
- 2019: 80%
- 2020: 85%
- 2021: 90%

APPENDIX
CHANGES TO APPLE HEALTH CONTRACTS STARTING IN 2017

This document reflects specific, imminent changes pertaining to the Apple Health program, in alignment with HCA's VBP Roadmap. This document is not all-inclusive of expected long-term changes to the Apple Health program.

Consistent with HCA's VBP targets, there will be significant changes to Apple Health contracts starting in January 2017. MCO contracts will require that a growing portion of premiums be used to fund direct provider incentives tied to attainment of quality. To ensure quality and performance thresholds are being met, HCA will withhold an increasing percentage of plan premiums, to be returned based on achieving a core subset of metrics from the statewide common measure set. HCA will use the same measures in all provider VBP arrangements.

In addition, through use of time-limited funding under the Medicaid transformation waiver, MCOs will be able to earn financial incentives for achieving annual VBP targets (described further in the visual below). In 2018 and each year thereafter, the MCOs' accountability for each of these new contract components will grow progressively.

Finally, the Apple Health program changes include the creation of a "challenge pool" to reward exceptional managed care performance and a "reinvestment pool" to provide similar regional incentives for exceptional performance attributable to the broader participants in an ACH[1].

A description of the approaches as well as the parties to each approach is described in further detail below. A visual summary of funds flow and a table that provides additional detail on how the new incentive structures would work are included at the end of this document.

APPROACHES

TIME-LIMITED INCENTIVES FOR MCOS AND ACHS
HCA-MCO AND HCA-ACH

VBP INCENTIVES

MCOs will earn incentives funded through Initiative 1 of the Medicaid transformation waiver for exceeding VBP target thresholds, starting with 30 percent in 2017. These incentives will be in place for the five years of the waiver, but will not extend beyond the waiver period. Performance will be measured consistent with the approach taken in HCA's Paying for Value RFI, by looking at the

[1] This document refers to the ACH role broadly, recognizing ACH participants include MCOs and providers, for which specific roles are also highlighted.

proportion of payments tied to value-based arrangements (as defined in the HCP-LAN framework). Through the waiver, ACHs will also be able to structure incentive programs regionally to reward providers who are undertaking new VBP arrangements, these will be tied to the same VBP targets.

Provider Incentives under Managed Care

MCO-Provider

MANAGED CARE ORGANIZATION (MCO) INCENTIVES

Value-based payment strategies require risk sharing and other financial arrangements between providers and plans that reward value outside of a fee-for-service model. To ensure that providers are being adequately incentivized in these arrangements, HCA will establish a percentage of premium threshold that each MCO must meet as part of its contractual obligations. Beginning in 2017, MCOs must ensure that at least 0.75 percent of their premium is going to providers in the form of incentives that help ensure that value-based arrangements are adequately rewarding and incentivizing providers to achieve quality and improved patient experience.

Quality Withhold

HCA-MCO

MANAGED CARE ORGANIZATION (MCO) INCENTIVES

HCA will withhold a progressively increasing percentage of premiums paid to MCOs on the basis of quality improvement and patient experience measures. MCOs will need to demonstrate quality improvement against a standard set of metrics to earn back the withheld premium amount. Today, HCA utilizes a 1 percent withhold related to the quality of data submissions from MCOs to HCA. This approach broadens the quality standards being measured and increases the percentage of withhold gradually each year, until it reaches 3 percent in 2021.

Common Measures

HCA-MCO-ACH-Providers

HCA has committed to using standard measures of performance across its purchasing activity, consistent with the statewide common measure set. In addition, these measures will drive the evaluation and incentive payments under the Medicaid transformation waiver. Specifically, HCA anticipates a core subset of common measures to be used in its contracts with MCOs around the quality withhold and also expects to see this same core set of measures used in VBP arrangements between plans and providers. A good example of how the common measure set is already being used in HCA purchasing efforts can be found here.

CHALLENGE POOL

HCA-MCO

Washington State has embraced the value of a competitive managed care model for delivering Medicaid services. HCA's approach to VBP seeks to reward exceptional performance of MCOs through use of a "challenge pool." Unearned VBP incentives from the waiver and uncollected withhold payments from managed care premiums will be made available in a challenge pool that rewards plans that meet an exceptional standard of quality and patient experience, based on a core subset of measures.

REINVESTMENT POOL

HCA-MCO-ACH-PROVIDERS

The value-based payment structure for Medicaid also provides a reinvestment pool, funded similarly to the "challenge pool," which would use unearned ACH VBP incentives and a share of unearned MCO incentives to provide meaningful reinvestment in regional health transformation activities, based on performance against a core subset of measures. This provides a continuing incentive for multi-sector contributions to health transformation and rewards the delivery system and supporting organizations for achieving quality and improved patient experience.

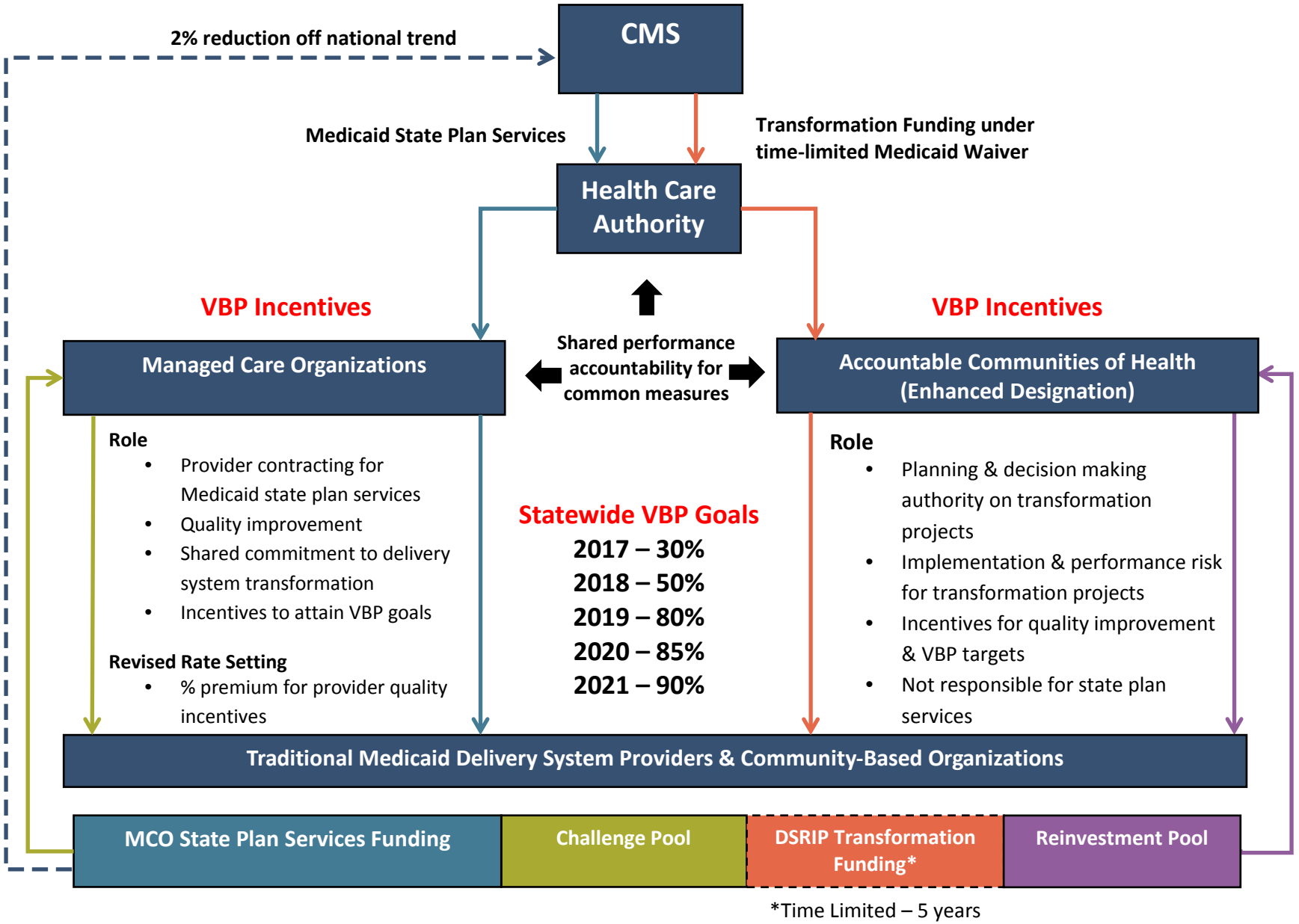
VALIDATING VBP ATTAINMENT IN MANAGED CARE PROVIDER CONTRACTING

To adequately measure the status of payer-provider arrangements under Medicaid that are proprietary in nature, HCA will use a third-party assessment organization to review and validate detailed plan submissions. A similar model is used today through the federally required External Quality Review Organization that provides annual reports on the performance of each MCO.

SUMMARY

Taken together, these components reflect a phased incentive approach that emphasizes more equal weight being placed on ACHs and statewide managed care organizations (payer and provider networks) in achieving the state's roadmap to value-based payment over the next five years. They also show how contractual and financial levers are used to sustain community reinvestment and sustainable incentive structures that can last well beyond the waiver. This approach ensures mutual accountability for the performance of the health system in service of whole-person health outcomes and quality improvement.

Washington State Value-Based Purchasing Framework: Apple Health Program Changes



*Time Limited – 5 years

Apple Health Value Based Payment - Overview and Sample Scenario

CALENDAR YEAR	VBP INCENTIVES			MANAGED CARE ORGANIZATION (MCO) INCENTIVES		CHALLENGE POOL	REINVESTMENT POOL
	Managed Care Organization (MCO specific)	**Accountable Communities of Health** (ACH Specific)		**Managed Care Organization** (MCO specific)	**Managed Care Organization** (MCO specific)	**Managed Care Organization** (MCO specific)	**Accountable Communities of Health** (ACH Specific)
	VBP Target Incentive[1] % of each incremental % point of premium over/under VBP target[2]	**Region Specific VBP Target Incentive**[1] $ tied to each 1% over State VBP Target[3]	**STATE VBP Target**	**Provider Incentives** % premium for provider quality incentives	**Quality Withhold** % premium at Risk for performance[4]	**Unearned VBP Incentives**[5,6] % of unearned MCO Incentives and withhold	**Unearned ACH VBP Incentives**[5,6] % of unearned ACH VBP and a share of unearned MCO incentives
Pre	-	-	20%	-	-	-	-
2017	(+/-) 2%	$200k for each 1%	30%	0.75%	1.0%	(up to) 1%	
2018	(+/-) 1.5%	$300k for each 1%	50%	1.0%	1.5%	(up to) 1%	
2019	(+/-) 1%	$666k for each 1%	75%	1.5%	2.0%	(up to) 1%	
2020	(+/-) 0.75%	$1m for each 1%	85%	2.0%	2.5%	(up to) 1%	

2021	(+/-) 0.5%	$1.2m for each 1%	90%	2.5%	3.0%	(up to) 1%	
Post	Not extended beyond the five year waiver period		90%+	3.0%	2.5%	0.25% + 25% of remaining withhold[7]	0.25% + 75% of remaining withhold[7]

SAMPLE SCENARIO							
2017	MCO "A" with $1B of premiums exceeds VBP target statewide by 20% in year 1 and earns $4M. MCO "B" with $1B of premiums is short in meeting the VBP targets statewide by 10% in year 1 and pays $2M out of its premium withhold.	ACH "A" exceeds VBP regional target by 10% in year 1 and earns $2M of DSRIP incentive. ACH "B" is short in meeting the VBP regional target by 10% in year 1 and does not earn a DSRIP incentive.	30%	MCO "A" is contractually obligated to allocate at least 0.75% of its premium to providers in the form of incentives that help ensure value-based arrangements are adequately rewarding and incentivizing providers to achieve quality and improved patient experience.	MCO "A" demonstrates quality improvement against common measures and earns back 1% withheld premium amount. To earn back the 1% premium withhold, MCO "A" must also achieve the state VBP target and pass at least the required % premium for provider quality incentives.	MCO "A" exceeds quality improvement target by 5 basis points—earns back complete premium withhold and is eligible for challenge pool, not to exceed 1% of premium.	ACH "A" meets quality improvement target and is now eligible for its share of the reinvestment pool.

[1] Challenge and reinvestment pools funded by unearned MCO VBP incentives and ACH VBP incentives (under DSRIP) as well as any unpaid premium withhold for quality

[2] Not to exceed 1% of managed care organization's total premium payment, with a $20m annual aggregate maximum across all MCO VBP Incentives

[3] Not to exceed $7.5M for any region in any year, with a $20M annual aggregate maximum across all ACH VBP incentives

[4] Or 75% of year to year trend increase (averaged across eligibility groups), whichever is lower, but not below 1%

[5] Dollars accrued for reinvestment and challenge pools are split equally between MCO and ACHs.

[6] Total combined value of challenge and reinvestment pools will not exceed $25M on an annualized basis.
[7] Post waiver period, challenge pool is composed of 0.25% of all MCO premiums and 25% of any unearned withhold - the reinvestment pool is funded similarly with 75% of remaining withhold.

Example for MCO "A" 2017

Experience	Calculation	Result
Total premium		1,000,000,000
Quality improvement withhold	1% of premium	(10,000,000)
Achieves 50% VBP vs. 30% target	2% incentive x 20% excess x $1B premium	4,000,000
Amount for provider incentives	0.75% of premium	(7,500,000)
Demonstrates quality improvement	1% of premium	10,000,000
Meets exceptional performance standard	Up to 1% of premium, depending on amount in pool	5,000,000
Total premium plus incentives		1,001,500,000