Olympic Community of Health

Agenda

Board of Directors Meeting

July 10, 2017

Jefferson Health Care, 2500 W. Sims Way (Remax Building) 3rd Floor, Port Townsend

Web: https://global.gotomeeting.com/join/280841733

Telephone: +1 (786) 535-3211

Access Code: 280-841-733

KEY OBJECTIVES

- Agree on next iteration of the OCH Project Portfolio under the Demonstration Project
- Take action on requirements for Phase II Certification

AGENDA (Action items are in red)

Item		Topic	Lead	Attachment
1	1:00	Welcome	Roy	
2	1:05	Consent Agenda	Roy	1. DRAFT Minutes 6.12.2017 2. Executive Director's Report 3. Opioid Project Director's Report*
3	1:10	Quarter 2 Financials April 2017 – June 2017	Hilary	4. Balance Sheet* 5. Profit & Loss Budget vs. Actual*
4	1:20	Tribal Engagement Policy		6. Tribal Collaboration and Communication Policy
5	1:30	Executive Committee Officers	Elya	7. Executive Committee Election SBAR 8. Executive Committee Charter
6	1:40	Portfolio and Survey Results	Elya Siri	9. Portfolio Recommendation 10. Projects At-A-Glance 11. Portfolio At-A-Glance
7	2:10	Financial and Organizational Framework	Hilary Elya	12. Detailed Budget Plan for Design Funds for Phase II Certification 13. Organizational Framework for Phase II Certification
8	2:50	Governance, Provider Engagement & Consumer Engagement	Elya	14. Visual: Approach to governance for Phase II Certification
9	3:30	Approach to Bi-Directional Integration and Primary Care Transformation Planning	Rochelle	
10	4:00	Adjourn	Roy	

** Distributed at the meeting*

Acronym Glossary

SBAR: Situation. Background. Action. Recommendation.

Olympic Community of Health

Meeting Minutes

Board of Directors

June 12, 2017

Date: 06/12/2017	**Time: 1:00pm-3:00pm**	**Location:** Jefferson Health Care Conference Room, Room #302

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

Voting Members In-Person: Brent Simcosky, *Jamestown S'Klallam Tribe*, Jennifer Kreidler-Moss, *Peninsula Community Health Services*, Anders Edgerton, *Salish Behavioral Health*, Eric Lewis, *Olympic Medical Center,* Chris Frank, *Clallam Public Health,* Hilary Whittington, *Jefferson Health Care*, Joe Roszak, *Kitsap Mental Health Services,* Katie Eilers, *Kitsap Public Health District*, Larry Eyer, *Kitsap Community Resources,* Tom Locke, *Jefferson Public Health,* Caitlin Safford, *Amerigroup*

Alternate Voting Members: Gary Kreidberg, *Harrison Health Partners*

Voting Members Virtual: Tracey Rascon, *Makah Tribe,* David Schultz, *CHI Harrison Medical Center*

Non-Voting Members: Kayla Down*, Coordinated Care,* Allan Fisher, *United Health Care,* Jorge Rivera, *Molina*

Staff: Elya Moore, Lisa Rey Thomas*,* Mia Gregg

Contractors: Rochelle Doan, Siri Kushner

Guests: Jim Jackson, *DSHS,* Dunia Faulx, *Jefferson Health Care,* Wendy Sisk, *Peninsula Behavioral Health,* Pam Brown, *West End Outreach Services,* Mattie Osbourne, *Amerigroup,* Dan Vizzini, *Oregon Center for Health Excellence*

Person Responsible for Topic	Topic	Discussion/Outcome	Action/Results
	June Objectives	1. Agree on next iteration of the OCH Project Portfolio under the Demonstration Project 2. Advise organizational governance and staffing models to inform financial planning and hiring for Phase II Certification	
Roy Walker	**Welcome and Introductions**	Roy called the meeting to order at 1:02 pm.	
Board	**May Minutes**	Approval of minutes	May Board Minutes **APPROVED** unanimously.
Board	**Consent Agenda**	Approval of Consent Agenda	Consent Agenda **APPROVED**.

Elya	**Contract for the first year of the MDP Demonstration**	• Contract between HCA and OCH reviewed by Anders Edgerton, Darryl Wolfe and OCH Accountant Nathanael O'Hara. • It was noted, per the contract that all OCH and subcontractor data produced is owned by the Health Care Authority. • Suggestion to create an internal contract checklist ensuring proper steps as OCH takes on more and more contracts during the five-year demonstration.	MOTION Board authorizes Executive Director to sign contract with HCA. APPROVED Unanimously Jennifer Kreidler-Moss emailing contract checklist template from Peninsula Community Health Services
Hilary	**Quarterly Financials**	• Reviewed balance sheet and profit analysis of the year. • The OCH officially became an organization effective February 1st, 2016, due to this date financial auditing reports will start on 2/1. Unearned grant revenue prior to 2/1 will be reported as deferred revenue. January activity removed to create 11-month budget. Future funds will be recognized as revenue.	MOTION Accept Jan-Apr 2017 financials APPROVED Unanimously
Roy	**Legal Counsel**	• Reviewed legal counsel recommendation, Attorney will work closely with ED, however, she will represent and report to the Board. • Suggestion: set contract parameters ad specific language around legal services that the OCH might need to avoid unnecessary spending.	MOTION Board authorizes Executive Director to engage Heather Erb as OCH's legal counsel. APPROVED Unanimously
Elya	**Executive Committee Term**	• Officer term limits expire in July • Current officers agreed to continue to serve • Open to new interested candidates • Consensus to re-elect current slate if no new nominations come forward	MOTION Board invites interested candidates for officer positions to submit a case statement and brief bio to staff for consideration and election by ballot in July 2017. APPROVED Unanimously
Roy	**Motion to submit a letter to county commissioners regarding Mid-Adopter**	• Executive Committee recommended the Board consider writing a letter to county commissioners to express stance on FIMC mid adopter. • All three county authorities must be in agreement of mid adopter and letter	STRAWPOLL To vote on sending a letter to county authorities to take a position on FIMC.

		must be received by September 15, 2017. • Suggestion: OCH board serve as educators regarding FIMC. • Suggestion: OCH board send an educational letter to county commissioner's outlining pros and cons to Mid-Adopting FIMC. Board ultimately agreed this would not be a good use of OCH staff time. • Noted that our region is sub-capitated, putting us at an advantage for success with VBP contracting. • Noted that DSRIP funding for the state would be ceased if our region decided not to adopt FIMC by 2020. • Noted that if behavioral health providers did not wish to be mid-adopters than it is not the place of this Board to recommend to the contrary. • Noted that there is already so much uncertainty in health care right now, and that going early would add to that uncertainty. • Noted that if King County and Pierce County go mid-adopter, then any opposition against FIMC from Olympic region would not matter • Suggestion: Executive Director serve on interlocal council to promote alignment regardless of mid-adopter stance. • MCO representative voiced conflict of interest, abstained from voting. Stated that there were other conflicts of interest in the room. No other members declared a conflict of interest. The Board decided not to take action on any other potential conflicts of interest.	APPROVED Unanimously MOTION To send a letter to county authorities to take a position on FIMC. REJECTED 13 Nays 1 Yay 1 Abstention MOTION To send educational letter to County Commissioners describing pros and cons of FIMC mid adopter decision. REJECTED Unanimously
Katie Elya	**OCH Medicaid Demonstration Project Portfolio**	• Reviewed revised SBAR and summary of each project proposal within portfolio • Noted lack of clarity regarding metrics and budget, overlaps in workload, not information to properly move forward. • Project portfolio submission deadline recently changed to November 16th	MOTION OCH staff and TA synthesize analysis and new information from the HCA, recommendation from RHAP Committee, revise portfolio and present recommendation to the

		• Strengthen work with tribes, more partnering and collaboration to ensure inclusivity. • Noted that the OCH's main goal is to provide improved services to all 84,000 Medicaid lives in our region, will need to do a deeper dive on number of beneficiaries served by each organization. • More analysis needed to determine which projects are most essential.	board for next steps July 10 APPROVED Unanimously MOTION Form workgroup to review Apple Integrator & Pathways and recommend a path forward the portfolio. APPROVED Unanimously
Elya	**Phase II Certification Readiness**	• Tabled for July board meeting, will send follow up email.	Send Executive Committee packet to Board for review.
Roy	**Adjourn**	The meeting adjourned at 3:27pm	

Olympic Community of Health

Executive Director's Report

Prepared for July 10 Board Meeting

Top 3 Things to Track (T3T) #KeepingMeUpAtNight

1. We are on the hunt for motivated, mission-driven staff to help us kickstart the Demonstration.

2. Phase II certification is due August 14 and we have one board meeting to slog through a litany of requirements to show the HCA we are ready for Demonstration activity.

3. Now that we have seen it, our approach to the Project Plan Template, due November 16, must be strategic, taking into account the focus on Domain 1 activity, planning, and assessment.

Upcoming OCH meetings:

- Care Coordination Workgroup, July 6, 8:00 am to 9:30 am
- Board Meeting, July 10, 1 pm to 4 pm
- Finance Committee Meeting, July 10, 11:30 am to 12:45 pm
- Executive Committee Meeting, July 25, 12:00 pm to 2:00 pm
- Board Meeting, August 14, 1 pm to 3 pm
- Finance Committee Meeting, August 14, 11:30 am to 12:45 pm
- TENTATIVE: Partner Convening, September 21, TBD
- TENTATIVE: Provider Convening, September, TBD

Design I Funds

We received our payment for Phase I Certification on June 30, 2017: $1 million dollars.

Demonstration Project Plan Template

Our ACH has mobilized quickly to develop collaborative and fairly detailed project proposals. Our approach has been open, transparent, and community-driven. In an unanticipated turn, the revised toolkit from the HCA does require ACHs to implement projects or require movement on pay-for-performance measures until June 2019. For some projects, this does not begin until October 2020, allowing only one year to show results on these measures. Essentially, 2018 is a planning year, where the ACHs select target populations, secure formal commitments from providers, and develop an implementation plan.

In another unanticipated turn, the project plan application has a heavy emphasis on ACH leadership and assessment in Domain 1: workforce, systems for population health management, and value-based payment. We have been focusing our energy on Domains 2 and 3.

With this new information, staff has put together a rough plan forward:

- Write the project plans for each of the projects in the portfolio building from the existing project applications submitted by community partners
- Perform detailed assessment in the Domain 1 areas immediately
- Convene key implementers for each project as needed, at least once and likely twice, between now and November to provide input into the elements in the project plan.
- Retain an operational mathematics consultant to perform a preliminary assessment into the data and financial modeling needs of the OCH in the short term and long term. Provide recommendation to the Board. Do not move forward with a large consulting firm until we review the consultant's recommendation.

501c3 Application Status

Given the demands of the Phase II Certification (due August 14), we have put this on the backburner. Our accountant has advised us that we have until the end of the year to complete and file our 1023 with the IRS.

OCH Outreach & Engagement

- WA State Hospital Association, July 11, Seattle (Elya)
- Northwest Portland Indian Health Board, July 18-20, Oregon (Lisa Rey)
- American Indian Health Commission Delegates meeting, August 24, Lummi (Lisa Rey)

Olympic Community of Health (OCH)

Tribal Collaboration and Communication Policy with the Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Port Gamble S'Klallam, Quileute and Suquamish Tribes

I. Purpose

The Olympic Community of Health (OCH) is committed to active engagement with the tribal nations and Indian Health Service (IHS) facilities within our three-county region. All tribes are offered a seat on the Board of Directors. Recognizing that all tribes may not want to be active on the Board, this policy will guide our communications. All tribes/IHS facilities will receive the same level, type, and frequency of communications outlined in this policy.

The purpose of this policy is to establish a clear and concise collaboration policy and communication procedure between the Olympic Community of Health (OCH) and tribal governments in the development of all OCH policies or actions.

II. Governance

The OCH will hold one seat on the Board of Directors for each tribe.

III. Collaboration

The OCH will collaborate and communicate with tribal governments in a manner that respects the tribes' status as sovereign nations and meets the federal trust responsibility and U.S. treaty obligations to American Indians/Alaska Natives (AI/ANs).

- The OCH will not refer to tribes as stakeholders but as partners.
- Because each Tribe has a seat on the Board of Directors, the OCH and Tribes will collaborate from the beginning of and throughout the planning and development process and engage in inclusive decision-making with tribes for all OCH actions, including actions that may have an impact on AI/ANs, tribes (as determined in accordance with Section IV) and not just solicit feedback from tribes.
- The OCH will respect and support the need for Tribal representatives or IHS facility representatives to inform their tribal councils and receive directives from their tribal councils or agency leadership on whether and how the tribe or IHS facility would like to proceed with respect to any OCH action.
- If a tribe declines an invitation to collaborate, the OCH will maintain a standing invitation for the tribe to collaborate with the OCH.

IV. OCH Actions Having Impacts on AI/ANs or Tribes

- **Determining Tribal Impacts.** The OCH will rely on the tribal representatives on the Board of Directors to notify the Board or staff whether an action may have an impact on AI/ANs or Tribes. If authorized by the tribal representatives on the Board, the OCH staff will convene an *ad hoc* Tribal Implications Subcommittee that will include at least one OCH staff member, at least two Tribal OCH Board Members, and one OCH Board member

who is not a representative of a tribe. The committee will meet until it determines whether any OCH actions being contemplated, including the development of policies, programs, or agreements, will have an impact on AI/ANs or Tribes. The OCH lead staff person will ensure that sufficient information about OCH actions is communicated during the meeting, and prior to implementation, to enable the committee to determine whether those actions will have an impact on AI/ANs or Tribes. If no Tribe designates an individual to serve on this committee and until such time when a tribe does designate an individual to serve on this committee, the Board of Directors will make determinations of whether any OCH actions being contemplated will have an impact on AI/ANs or Tribes and inform the tribe(s).

- **Addressing Tribal Impacts.** If the Tribal Implications Subcommittee determines an OCH action has or will have an impact(s) upon a tribe(s) or IHS facility(ies), the Subcommittee will report their findings and any recommendations for addressing those impacts to the Board of Directors. The Board of Directors will determine a plan of action in response to the Subcommittee's findings and recommendations.

V. Communication

A. The OCH will dedicate resources to support the function of tribal liaison when resources permit.

B. The OCH will work with each of the individual tribes to ensure that all contact information is up-to-date and the correct representatives are notified and regularly receive information.

C. The OCH will provide written information to tribes concurrent with, and in the same format and method as, the delivery of written information to board members for board meetings, to committee members for committee meetings, and to other OCH participants for participant or other meetings. Any tribe that wishes to receive mailed hard copies of meeting materials may do so upon request. The tribal liaison will work with each tribe to develop a specific communication strategy as requested.

VI. Sovereignty and Disclaimer

The OCH respects the sovereignty of each tribe located in the State of Washington and that the tribes have the right to request consultation with the State of Washington and/or the United States government in the event the OCH fails to address the impacts on AI/ANs or Tribes. In executing this policy, no party waives any rights, privileges, or immunities, including treaty rights, sovereign immunities and jurisdiction. This policy does not diminish any rights or protections afforded AI/AN persons or tribal governments or entities under state or federal law. The OCH acknowledges the right of each tribe to consult with state and federal agencies, including, where appropriate, the Health Care Authority, the Governor of the State of Washington, the Region X Administrator of the U.S. Department of Health and Human Services, or the President of the United States.

VII. Effective Date

This policy will be effective on _____, and will be reviewed and evaluated annually at the request of any tribe or at the request of a majority of the OCH Board Members.

APPROVED BY:

_____
OCH Board President
Roy Walker

DATE: _____

Olympic Community of Health

Executive Committee Election of Officers July 2017 to June 2016 S.B.A.R.

Presented to the Board of Directors July 10, 2017

Situation

The executive committee officer term limits are up July 2017.
The executive committee charter is up for review in May 2017.

Background

Bylaws

> *The officers of the OCH Board shall be President, Vice President, Secretary, Treasurer, and At-Large. At the end of the President's term, the At-Large office will be replaced by the Past-President. The Board may approve additional officers as it deems necessary for the performance of the business of the OCH. The term of office shall commence on July 1 and each officer shall hold office for one (1) year or until he or she shall have been succeeded or removed in the manner hereinafter provided. Such offices shall not be held for more than three (3) consecutive terms. Such officers shall hold office until their successors are elected and qualified. A vacancy in any office may be filled by the Board for the unexpired portion of the term.*

Executive Committee Membership

Member	Officer Position	Representation
Roy Walker	President	Long-term care
Jennifer Kreidler Moss	Vice President	Primary care
Hilary Whittington	Treasurer	Rural health
Leonard Forsman	Secretary	Suquamish Tribe
Joe Roszak	At-Large	Mental health

Action

All Executive Committee members are willing to continue in their current officer positions for another one-year term. At the last Board meeting, there was a call for nominations for interested Board members to serve as an officer and on the Executive Committee. No Board members were nominated or nominated themselves to serve on the Executive Committee.

Proposed Motion

The Board elects the current slate of officers to serve a second one-year term in their current positions. The Board approves the current Executive Committee charter.

Charter

Approved by the Governance Subcommittee May 19, 2016
Approved by the OCH Board of Directors June 1, 2016
Officers elected July 6, 2016 by the OCH Board of Directors

Executive Committee Charter

Members

	Name	Role	Agency or Affiliation
1	Roy Walker	President	Executive Director, Olympic Area on Aging
2	Jennifer Kreidler-Moss, PharmD	Vice President	CEO, Peninsula Community Health Services
3	Leonard Forsman	Secretary	Tribal Chair, Suquamish Tribe
4	Hilary Whittington	Treasurer	CFO, Jefferson Healthcare
5	Joe Roszak	At-Large	Executive Director, Kitsap Mental Health Services

Executive Committee Purpose

The purpose of the Executive Committee is to discharge the responsibilities of the OCH Board of Directors (Board) relating to the transaction of routine, administrative matters that occur between regularly scheduled meetings of the Board and to tee up policy issues for full Board discussion and decision-making. The Executive Committee will advise the Director regarding emerging issues, problems, and initiatives.

Executive Committee Operating Principles

- Committee membership will comprise of five officer positions: President, Vice-President, Secretary, Treasurer, and At-Large (to be replaced by Past-President after the first term).
- A majority of the Executive Committee shall be necessary and sufficient at all meetings to constitute a quorum for the transaction of business.
- Executive Committee members will be held to term limits outlined in the bylaws.
- The Executive Committee shall be accountable to the OCH Board and shall present all recommendations and actions for review at their next meeting.

Responsibilities

- Work with the President and Director on ongoing issues regarding the business of the organization and to hear and decide on pressing matters of business which may arise between regularly scheduled OCH Board meetings which require a decision before the next meeting.
- Support decision-making by the OCH Board by reviewing material ahead of time to ensure that options are clearly identified and sufficient background information is provided.
- The Executive Committee shall have authority to conduct business on behalf of the OCH between regular Board meetings should authority be expressly given to them by the Board.
- Specific Executive Committee duties include:
  - Preparing for OCH Board meetings
  - Recommending the annual budget to the OCH Board for approval
  - Evaluating the performance and compensation of the director
  - Facilitating development of and implementation of OCH initiatives as needed
  - Monitoring status of internal operations including financial systems, personnel issues, and information systems
  - Appointing authorized subcommittees as needed
  - Assuring that business is conducted in a manner that is consistent with OCH's mission, goals and values

Timeline

The Executive Committee shall meet as needed.

Olympic Community of Health

July 3, 2017

Portfolio Recommendation

Presented to the Board at the July 10, 2017 Board Meeting

Recommendation Summary

Begin compiling the project plan template for seven of eight projects (1. Integration; 2. Opioids; 3. Diversion; 4. Chronic Disease Prevention and Control; 5. Transitions; 6. Oral Health Access; 7. Maternal, Child, and Reproductive Health) The OCH Team will coordinate this effort across organizations, Tribes, and counties.

- Due to their complexity, likelihood to impact the measures, and incentive earning potential, the OCH Team will begin crafting Project Plans immediately for:
  1. 2A. Bi-Directional Integration and Primary Care Transformation
  2. 3A. Addressing the Opioid Crisis
  3. 2D. Diversion: Outward Bound
  4. 3D. Chronic Disease Prevention and Control (includes Chronic Care Model and Breathe Easy)

Flagship Projects These projects meet the minimum criteria: 2 required + 2 optional

- Insert recommendation from Care Coordination Workgroup (meeting July 6) here.
- Consider subcontracting with partner organizations to assist in drafting:
  1. 2C. Transitional Care: Crossroads
  2. 2D. Diversion: LEAD
  3. 3B. Maternal and Child Health: Healthy Beginnings
  4. 3C. Access to Oral Health Services (includes Jefferson and FQHC proposal)
- OCH Team investigates contingencies (see Recommendation) before beginning to draft Project Plans for:
  1. 2C. Transitional Care: Regional Care Transitions
  2. 2D. Diversion: Community Paramedicine

Guiding questions

1. How will this project support **sustainable delivery system transformation** for the target population beyond the demonstration?
2. **Right level of care at the right time:** Does this project identify the most appropriate target population (number, geography, and subgroup), offer the right level and type of services to have a high level of impact (move the measures)?
3. Will this project address our **regional priorities?**
   1. **Access**: a continuum of physical, behavioral, and oral health care services are accessible to people of all ages and care is coordinated across providers
   2. **Aging**: Aging adults and their caregivers are safe and supported
   3. **Behavioral Health**: Individuals with behavioral health conditions receive integrated care in the best setting for recovery
   4. **Chronic Disease**: the burden of chronic diseases is dramatically reduced through prevention and disease management
   5. **Early Childhood**: children get the best start to lifelong health and their families are supported

   Progress on these priorities depends on improving health equity through SOCIAL DETERMINANTS OF HEALTH (housing, education, workforce development, employment, transportation, safety, environmental conditions)

Number of Projects

The number of projects we submit in our portfolio has a direct impact on the amount of DSRIP funds we are eligible to earn in Demonstration Year 1 2017 (DY1). The table on the next page offers a few scenarios for DSRIP funding in DY1, based solely on project plan score and number of projects submitted. The scenarios below are based on what we know about how scoring and valuation will work.

Scenarios for DSRIP funding for Demonstration Year 1 based on Project Plan score and # of Projects							
	A	B	C	D	E	F	G
Scenario	Number of projects submitted	Section I & 2 Score	Eligible to Receive Portion of Unearned Funds	Valuation Based on A&B	Maximum OCH 2018 DSRIP Funds	Earnable OCH 2018 DSRIP Funds	Lost Potential Revenue
1	4	60%	No	60%	$6,220,000	$3,732,000	($2,488,000)
2	6	60%	Yes	70%	$6,220,000	$4,354,000	($1,866,000)
3	8	60%	Yes	80%	$6,220,000	$4,976,000	($1,244,000)
4	4	80%	No	80%	$6,220,000	$4,976,000	($1,244,000)
5	6	80%	Yes	90%	$6,220,000	$5,598,000	($622,000)
6	8	80%	Yes	100%	$6,220,000	$6,220,000	$0
7	4	100%	No	90%	$6,220,000	$5,598,000	($622,000)
8	6	100%	Yes	100%	$6,220,000	$6,220,000	$0
9	8	100%	Yes	100%	$6,220,000	$6,220,000	$0

Project	Evidence-Based Intervention	RHAP Committee Recommendation	Recommendation contingent on:	Staff Proposed Revision to RHAP Committee Recommendation
2A	**Bi-Directional Integration and Primary Care Transformation**	This project must go forward		Agree with RHAP Committee
3 A	**Addressing the Opioid Crisis**	This project must go forward		Agree with RHAP Committee
2D. Diversion from Emergency Department and Jail	**Outward Bound**	This project should go forward	• Inclusion of all four hospitals • Engagement with Tribes	Agree with RHAP Committee and recommend making this a flagship project of the Demonstration, allocating a substantial proportion of DSRIP payments and planning energy to this activity.
	Community Paramedicine	This project should go forward	• Identification of a sustainable funding mechanism beyond the Demonstration • Engagement with Tribes • Whether partners can execute the project with fewer incentive dollars	Agree with RHAP Committee if MCOs agree to negotiate payment for this service beyond the Demonstration.
	LEAD	This project should go forward and be integrated with Crossroads (below).	• Addressing workforce service gaps that exist in Clallam and Jefferson. • Engaging with Tribes • Addressing potential duplication of services • Whether partners can execute the project with fewer incentive dollars	Agree with RHAP Committee

2C. Transitional Care from Hospitals and Jails	**Regional Care Transitions**	This project should not go forward	• A commitment from hospitals and primary care to actively participate in planning and implementation throughout the Demonstration • Engaging with Tribes	Agree with RHAP Committee unless hospital and primary care providers agree to actively partner.
	Crossroads	This project should go forward and integrate with LEAD (above).	• Engaging with Tribes. • Addressing potential duplication of services • Whether partners can execute the project with fewer incentive dollars	Agree with RHAP Committee
3B. Maternal, Child, and Reproductive Health	**Healthy Beginnings**	This project should go forward	• Adding long-active reversible contraceptive • Addressing potential duplication of services • Engaging with Tribes • Whether partners can execute the project with fewer incentive dollars	Agree with RHAP Committee
3C. Access to Oral Health Services	**FQHC Dental** **Jefferson Dental**	These projects should be merged and go forward.	• Whether partners can execute the project with fewer incentive dollars	Agree with RHAP Committee
3D. Chronic Disease Prevention & Control	**Chronic Care Model** **Breathe Easy**	These projects should be merged and go forward.	• Including Jamestown • Expanding into Jefferson • Engaging with Tribes • Whether partners can execute the project with fewer incentive dollars	Agree with RHAP Committee

PROJECT PROPOSALS AT A GLANCE: Chronic Care Model $545,104

GOAL

- System-wide application of Chronic Care Model clinical practice improvements that transform health care system to better prevent and manage chronic diseases, and contribute to a reduction in emergency department utilization and inpatient hospitalization.
- Addresses clinical and community environments that establish solid base of community health workers to provide effective linkages between patient and primary care (PCMH);
- Provides EB self- management programs coordinated with primary care for persons w/ diabetes, cardiovascular disease, and hypertension; focus policies to improve access to nutritious food and physical activity.

CHRONIC CARE MODEL CASE STATEMENT:

Among low income OCH residents: over 40% report ever being told they have HBP, over 30% are obese, about 15% report ever being told they have diabetes, over 10 % ever being diagnosed with CV. About 1 in 4 report no daily leisure time activity, over half report less than 1 hour of daily activity.

TARGET/REACH: 11,880 Adult Medicaid lives annually across region.

Geography	PCMH	Medicaid Lives	Hospital	Medicaid Lives	Other Providers	Medicaid Lives	Other
Clallam	NOHN	2,453 TOTAL 778 diabetes 1,939 HBP 341 asthma 320 SUD	FCH		Olympic AAA		YMCA
			OMC				
Jefferson	JHC	6,200 TOTAL	JHC				
Kitsap	PCHS	17,140 TOTAL 2,274 diabetes 5,637 HBP 1,237 asthma 900 SUD	HMC		PG S'klallam Tribe Suquamish		

Other Collaborators: HHP (10,000 Medicaid covered lives/3 counties), Kitsap AAA, KMHS, Clallam County HHS

STAFFING –Current Budget:

Geography	PCMH		Hospital		Other Providers		Other
Clallam	NOHN	1 Pop Health Nurse Care Mgr 1 CHW	FCH	1 Dec Support RN 1 CareCoor Nurse 1 CHW	Olympic AAA	.5 CDSMP Proj Coor Master Trainer Lay Leaders	YMCA .14 Assoc. Dir .5 ChD Prog Educ
			OMC	1 Diabetes Educ 1 CHW Navigtor			
Jefferson	JHC		JHC	1 NurseCare Coor 1 CHW .25 Data Analyst			
Kitsap	PCHS	.25 CDSM CHW Coordinator *See HMC*	PCHS **&** HMC	4 shared CHW	PG S'klallam Tribe	.2 Director .2 Nurse Mgr	
					Suquamish Tribe	.5 CDSM Data Anlyst	

ROI: Chronic Care Model. ROI when viewed through lens of heart disease:

- **I**n-Person Care Management**:** one study showed average cost savings associated with in-person care management was **$1,541** per person annually.
- Self-Management and Monitoring**:** one study found self-management, monitoring significantly reduced per-month cost each member; ROI ranged between **$1.08 and $1.15 per dollar** spent.
- Decision Support: two studies found savings increased significantly with use of decision support. One study showed median hospital charges were reduced significantly, by 45 percent, **by $2,500.** Another found basic decision support a more cost effective than a more complicated decision support intervention. *https://www.ahrq.gov/professionals/systems/long-term-care/resources/hcbs/medicaidmgmt/*

ROI: Stanford Chronic Disease Self-Management (included in proposal): Significant improvements in exercise, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability, social/role activities limitations. **Fewer days were spent in the hospital, with a trend toward**

fewer outpatient visits and hospitalizations. Data yields a **cost to savings ratio of approximately 1:4. Many results persist as long as 3 years**. *http://patienteducation.stanford.edu/programs/cdsmp.html*

ROI: CDC Diabetes Prevention Program Lifestyle interventions for high risk individuals (modest weight loss and physical activity interventions) could **reduce the risk of developing type 2 diabetes by 58%.**
https://www.niddk.nih.gov/about-niddk/research-areas/diabetes/diabetes-prevention-program-dpp/Documents/DPP_508.pdf

IMPACT:
-increase clinical practices implementing chronic care model
-increase # of people w/visit to PCP
-increase # of persons w/ diabetes receiving eye exams & nephropathy
-increase # of people w/ managed hypertension & cardiovascular disease
-decrease # of persons diagnosed w/diabetes
-decrease ED visits
-decrease inpatient utilization

PROJECT PROPOSALS AT A GLANCE: Breathe Easy $372,167

GOAL: optimize management of childhood and adult respiratory conditions to improve overall health and well-being, resulting in improved daily functioning, reduced utilization of emergency room and decrease hospitalizations for respiratory conditions.

CASE STATEMENT: WA State asthma prevalence rate is 9%, or approximately 7,560 Medicaid covered patients with asthma in the OCH region. PCHS served 1,237 persons with asthma (2016), NOHN served 341. KMHS reports serving 600 children with asthma, and about 500 adults. KCAAA provides services to about 22 patients with asthma on any given day. American Indians, Alaska Natives, Blacks, and people with lower income are more likely to have asthma, and more likely have asthma that is poorly controlled than the rest of WA residents. Studies show low-cost in-home education and reduction of environmental asthma triggers improve outcomes for children with asthma. Public funds pay for about 60% of Washington's asthma hospitalization costs.

TARGET/REACH: 1,799 Child and Adult Medicaid lives across the region.

Geography	PCMH	Medicaid Lives	Health/Housing	Medicaid Lives	SDOH	Medicaid Lives
Clallam	NOHN	341 asthma	Clallam Cty HHS			
Jefferson						
Kitsap	PCHS	1,237 asthma	KCR		Kitsap ALTC	*(22 w/ asthma daily)*

Other Provider Collaborators: CHI-HMC, OMC, HHP, KMHS, PBH, KPHD, Project ACCESS, Bremerton Housing Authority, Olympic AAA, Bremerton Fire Department, Kitsap County Human Services
Insurer Collaborators: Salish BHO, MCOs - Amerigroup, Molina, CHPW, United, Coordinated Care
Workforce Collaborator: Olympic Workforce Development Council

STAFFING- Current Budget

Geography	PCMH		Health/Housing		Other	
Clallam	NOHN	1 CHW	Clallam Cty HHS	.5 EH Spec		
Jefferson						
Kitsap	PCHS	2.5 Proj Mgr .25 CHW Prog Coor 2 CHW	KCR	.33 Hsg Navigator	Kitsap ALTC	.25 Case Mgr

ROI: Several studies show home visits return on investment ranged from $5.30 - $14.00 in costs averted for each $1 spent. EBP 3 visit model shown to reduce ED visits by 79% and hospitalization by 81%. (WA DOH 2014). Asthma home visits among children reduce hospitalizations, emergency department visit and physician office visits, as well as school days missed due to asthma.

IMPACT:
- preventative utilization of medical home
- overall health is improved
- flu and pneumonia vaccine rates higher with fewer flu and/or pneumonia-related deaths
- tobacco rates are lower
- decrease outpatient ED visits
- decrease inpatient utilization

PROJECT AT A GLANCE: Maternal Child Health $545,104

GOAL:

- Through system-level approach, establish an integrated health care and social services referral network and increase community capacity to deliver EBP home-visiting services (NFP and PAT) to Medicaid eligible women ages 0-6 in the OCH region.
- Improve pregnancy outcomes, child health and development, prevents child abuse and neglect, promote protective factors, increase school readiness. Improve parental lifecourse, pregnancy planning, continued education, work opportunities.
- Makes HFP and PAT home visitation programs available throughout region.
- Creates bidirectional referrals between health care and community providers to address SDOH.

CASE STATEMENT: In 2016, 88 families participated in NFP across OCH (31 Jefferson, 57 Kitsap, 0 Clallam. 130 families participated in PAT (130 Clallam, 0 Jefferson, 0 Kitsap), with 1,600 Medicaid eligible births across the region and a population of 9,288 children under 6 in low-income households. Birth outcomes indicate need – only 70% of Medicaid paid births had first trimester prenatal care, 8% had a baby born at low birth weight, 9% had a baby born preterm. Well-child and immunization data show only 59% of members 3-6 years of age receiving one or more well child visits with a PCP, 84% of members 2 – 6 years had a visit with a PCP, only 25% of 2 year olds receiving combo 10 HEDIS vaccine series (14% Clallam, 23% Jefferson, 27% Kitsap (2015).

TARGET POP/REACH: Clallam 25 NFP families. Jefferson 22 PAT families. Kitsap 6 NFP and 66 PAT families. NFP Medi-eligible 1st time pregnant women & children age 0 – 2. PAT Medi-eligible families w/ child age 0 – 6.

Geography	PCMH	Health Providers	Medicaid births 2015	1st time moms 2015
Clallam		1st Step Family Support Center	450	97
Jefferson		JPHD	118	128
Kitsap	PCHS	KPHD	1,092	230

Collaborators: OlyCAP, OlyCAP ECS EHS

STAFFING – Current budget

Geography	PCMH	Health/SDOH	Health Providers		
Clallam			1st Step Family Support Center	.75 Parent Educ .? PAT Supv .?PAT Prog Support	.? PAT Prog Supv .? PAT DataMgr .5 Case Finder
Jefferson			JPHD	1 NFP	.55 CHW/CsFinder
Kitsap	PCHS	.25 CHW Pro Sup 3 CHW	KPHD	.25 Biling. NFP Nurse	.55 CHW/Case Finder

ROI: For every $1 spent on Home Visiting, ROI is $4.40.

ROI NFP - At a total average cost of **$11,646 per family in Washington** by a child's 18th birthday, State and federal cost savings due to NFP will average **$25,182 per family served** or **2.2 times** the cost of the program. Using less tangible savings (potential gains in work, wages and quality of life) along with resource cost savings (out-of-pocket payments including savings on medical care, child welfare, special education, criminal justice) calculate to NFP's total benefits to society equal **$56,535 per family served,** a **4.9 to 1** benefit-cost ratio for every dollar invested in Nurse-Family Partnership. *See Nurse-Family Partnership: Outcomes, Costs and Return on Investment in Washington, NFP 2017*

PAT $4,394 per non special ed student; $8,080 student in special ed. Increases early detection of developmental delays, health issues. Resource referrals for early intervention result in long-term savings.
http://www.pat-mitelternlernen.org/fileadmin/user_upload/Studien_-_Forschung/Fact_Sheet_-_ROI-2-2011.pdf

IMPACT:

-reduction in ED visits
-decrease teen pregnancy and -development
-decrease low birth weight
-interruption intergenerational ACES and poverty
-good pregnancy outcomes
-healthy infant and toddler reduce unintended pregnancy growth
-increase self-sufficient, thriving, healthy, families

PROJECT PROPOSALS AT A GLANCE: FQHC Dental $463,552

GOAL:

- Increase # of oral health visits for Medicaid eligible children, pregnant women, diabetics, seniors;
- increase dental chair availability to reduce emergency room utilization for dental emergencies;
- overall improve individuals' oral health to result in better chronic disease outcomes and including precipitation of opioid use and abuse due to dental pain.

CASE STATEMENT: 2016 data indicates for Medicaid enrollees in NK target dental care access rates are 45.5% of children, 15.4% for adults. In Clallam, of Medicaid enrollees, 22% of adults and 41% of children received dental care in 2015. 2016 PCHS Medicaid population served was 17,140; 2,277 have diabetes, 5,637 have hypertension, 900 substance use disorder. NOHN served 2,453 Medicaid enrollees, 778 with diabetes, 1,939 with hypertension, 320 with substance use disorders.

TARGET POPULATION/REACH:

- 2400 additional Medicaid eligible individuals served by dentist; additional 400 patients served by dental hygienists for a total of 2800 persons to be served in north end of Kitsap County. Services available to persons across OCH region.
- Mobile services dental care provided in 10 skilled nursing facilities in Kitsap for about 840 Medicaid eligible persons case managed by Kitsap ALTC.

STAFFING – Current Budget

PCHS	.25 Prog Mgr	2 Dentist	2 Hygienist	**KITSAP COUNTY ALTC**	1 Case Manager
		7 Dental Asst	1 Case Manager		
		2 Dental Recpt	1 Dental Coor		

Collaborators: NOHN, NK Fishline, CHI HMC, OMC, HHP, KMHS, PBH, KCR, Project Access, Olympic AAA, Kitsap County Human Services, Bremerton Fire Department
Workforce: Olympic Workforce Development Council. Payment: Salish BHO, Amerigroup, Molina, CHPW, United, Coord. Care

IMPACT: Decrease outpatient ED visits, caries. Increase oral health services utilization, fluoride treatments, sealants; higher rate of ongoing periodontal care for chronic periodontitis, HPV vaccination HTN optimally controlled for diabetics and hypertensive patients; preventative utilization of PCMH, overall health is improved.

PROJECT PROPOSALS AT A GLANCE: JHC – Dental $74,693

GOAL:

- increase access to dental health services in Jefferson County through multiple strategies over five years, thus improving patient health and decreasing number of avoidable emergency department visits.
- Supports full integration of oral health into dual-integrated primary care and behavioral health clinics, implements oral care in school-based health clinics in PT and Chimacum,
- May explore value-based purchasing program for oral health services in a critical access hospital network.

CASE STATEMENT: Jefferson County has the lowest utilization of dental care for Medicaid eligible persons in WA State (39 out of 39 counties last 5 years, 38/39 last year). 9,000 county residents are medicaid eligible, 2,700 are children. Of these, only 23.4% received dental care in 2016 and no Jefferson County dentists see adults with Medicaid.

TARGET POPULATION/REACH: Medicaid eligible children and adults in Jefferson County, priority populations include children, pregnant women, and people with diabetes. JHC estimates primary care providers will engage 4,650 Medicaid covered individuals over five years and will provide counseling or refer appropriately.

STAFFING – Current Budget

JHC	.1 Project Manager .05 Clinical Manager	40 hours Dental Hygienist	**JPHD**	.5 Project Manager

Collaborators: intend to engage school districts, private dentists, City of Port Townsend

IMPACT: increase oral health services utilization, caries prevention/intervention at well/ill child visit to PCP, increase number pregnant women receiving oral exam in medical setting, decrease number of outpatient ED visits.

***NOTE re ROI**: No data found. Consider 1) Incorporate savings from reduced avoidable ED or operating room use to treat dental disease, near $1 billion a year nationally 2) Develop new approaches to reporting/ analyzing claims data to capture extent of underlying dental causes for visits to the ED for pain or infection 3) Capture data on lower rates of premature birth for women receiving dental care, earlier use of preventive dental care among children born to women with Medicaid dental coverage. 4) Extend ROI analyses to costs of missed workdays, lost productivity, reduced employability from dental disease 5) Measure ROI of utilizing alternative workforce models* http://www.chcs.org/media/Adult-Dental-Innovations.pdf

NOTE re DENTIST RATIO to POPULATION Clallam 1,102:1 Jefferson 2,015.1 Kitsap 1,374:1

PROJECT PROPOSALS AT A GLANCE: LEAD $859,100

GOAL: Improve public safety and community health with decreased overall cost to communities by reducing

- criminalization of MH and SUD
- unnecessary bookings into judicial system
- unnecessary ED visits, and by increasing engagement in treatment services and social determinants of health.

CASE STATEMENT: Cost for incarceration averages $2100/month per individual based on current interlocal agreements to house inmates, CCF 2008, (does not include other justice system costs, SUD or MH Disorder costs during incarceration. Average ED visit for MH or SUD cost $2000-$3000 depending on labs and treatments provided. A 2015 UW Study found cost of LEAD services averages $899 per person each month including start-up costs, later decreasing to $525 per person.

TARGET POPULATION/REACH: 1-2% or 800 to 1,600 Medicaid eligible persons per year with substance abuse and or mental health needs, likely to be high utilizers involved with the criminal justice and behavioral health systems.
Target 3 counties - Clallam, Jefferson Year 1, Kitsap Year 2 (?).

Geography	CBHC	Medicaid Lives Over 18	Estimated High Utilizer	Arrest Rate per 100,000
Clallam-Forks Port Angeles	WEOS PBH			641.9
Jefferson	DBH			181.4
Kitsap	KMHS (Yr 2)	5,155	103	312.4

STAFFING

WEOS	PBH	DBH	KMHS (Year 2 ?)
1 MS Clinician .5 BA Case Manager	1.5 Project Manager 2 MS Clinicians 2 BA Case Managers	1 MS Clinician	2 MS Clinicians 1 BA Case Manager

Collaborators: OMC, JHC, CHI HMC, NOHN, Police Port Angeles, Sequim, Port Townsend, Suquamish, Clallam Cty Sheriff's Department, Clallam Cty Prosecuting Attorney's Office, Jamestown S'Klallam Tribe, KCHS, Salish BHO, City of Poulsbo

ROI: Each incarceration diverted into LEAD can actualize a cost savings of $1200 - $1600 or more if diversion also prevents an ED visit for clearance prior to arrest. One ED admission diverted a day/year results in estimated savings over $750,000 per community - over $2 million annually region-wide. *No attribution, excerpt from application case statement.*

IMPACT: decrease ED visits, arrests and incarceration, harm to self, recidivism, demand for crisis services
increase completion of Drug & MH Courts, housing stability, use of preventative care, improved physical health
improved relationship with police/participants, decrease BH system & law and justice system costs.
increased community satisfaction with public safety, crisis and emergency services freed up for other uses.

PROJECT PROPOSALS AT A GLANCE: Outward Bound $506,000

GOAL: Community health workers will use a peer-to-peer engagement mode to increase timely and better coordinated follow-up primary or specialty care so that patients have more optimal outcomes. As patients are directed to the most appropriate level of care, the result is reductions in unnecessary readmissions to the Emergency Department.

CASE STATEMENT: About 30% of Kitsap lack a PCP, resulting in unnecessary ED utilization, with 55 patients presenting per day in the HMC ED. Kitsap County as a whole has high ED utilization.

TARGET POPULATION/REACH: 55 Medicaid eligible PCHS patients per day who cycle through HMC ED for a total of 20,075 visits annually, and the estimated 8,320 Medicaid eligible NOHN patients to be served annually at OMC.

Geography	PCMH	Medicaid Lives	Housing	Medicaid Visits at ED	PCMH Staffing	Housing Staffing
Clallam	NOHN	2,453		8,320 visits, duplicate	2 CHW	
Jefferson	JHC	7,500 (new add 6/19/17)				
Kitsap	PCHS	17,140 (19171 assigned)	KCR	20,075 visits, duplicate members	.25 Project Manager .25 CHW Coordinator 5 CHW	.33 Hsg Navigator

Collaborators: CHI HMC, HHP, KPHD, Kitsap AAA, KMHS, Clallam Health, Olympic AAA, PBH, Project Access, KCR, Kitsap County Human Services, Olympic Workforce Development Council, Salish BHO, MCOs- Amerigroup, Molina, CHPW, United, Coordinated Care, Bremerton Housing Authority, Bremerton Fire Department

ROI: *No specific ROI found. Consider impact of patient centered medical homes and care coordination to reduce ED use.*

IMPACT: decrease outpatient ED visits, ED visits, utilization, dental caries. Fewer deaths due to opioid overdose, fewer people homeless. Patients have health insurance and a PCMH, overall health is improved, higher vaccination rates, HTN controlled for diabetics and hypertensive patients.

PROJECT PROPOSALS AT A GLANCE: Community Paramedicine $2,932,843

GOAL:

- decrease inappropriate use of emergency services
- increase access to primary and behavioral health care and social services for high-utilizers
- improve health of persons served while lowering system costs through use of community paramedicine in multiple OCH 3 county jurisdictions.

CASE STATEMENT: In the OCH region, only 72.7% of adults over 18 have a PCP, and access to preventative and ambulatory health services in the OCH was only 77% in 20151, down from 2% and 86% in 2014 and 2013 respectively. The OCH has higher ED utilization per 1000 member coverage months that WA State. In 2013, WA state overall had 100 ED visits per 1000 member coverage months, while the OCH region had 125. In 2014 and 2015, WA State had 80 and 72 visits per 1000 coverage months respectively; OCH continued to remain higher than this at 101 and 93.

TARGET POPULATION/REACH: Estimate of beneficiaries varies, but overall is anticipated to be about 8,000 or 10% of total persons Medicaid eligible over 5 years of project. Medicaid eligible adults and children referred into program across 3 counties who are primarily high utilizers of EMS or who are among the most vulnerable and in need of additional support.

Geograp.	PCMH	Behav. Health	Hospital	Fire, Rescue	EMS	Oly Amb.
Clallam	NOHN .25 Proj Mgr .25 Case Mgr .25 Pt Nav	PBH .5 Med Asst	OMC .5 RN or SW Fork 1 paramedic 1 EMT	PAFD 1 paramedic 1 Med officer .5 Admin Sup Fire Dist 3 1 paramedic 1 EMT .? MPD, QI & Prg Scheduler Neah Bay/Cl. 1 paramedic 1 EMT		.6 paramedic .6 EMT
Jefferson		DBH .25 ? SW	JHC 1 RN or SW .1 ? QA	Fire Dist 2 & 4, Disc By FR, So Jeff EMS 1 paramedic 1 EMT East Jeff .25 paramedic .25 EMT		
Kitsap	PCHS 1 CHW .5 ARNP		HMC 3? RN or SW	BFD 1 EMT CKFR 1 paramedic 1 EMT		

Note: Mason County is outside OCH but is included as partner in application and budget.
Collaborators: KMHS Jefferson County Public Health, Serenity House, Neah Bay Ambulance, Olympic AAA.

ROI being tested in numerous pilots nationally but no ROI found. Model dependent, consider savings on reduced EMS calls and transports, reduced unnecessary ED visits, reduced hospital readmissions.

IMPACT:

- reduce ED utilization via diversion interventions
- provide care transition support for individuals discharged from hospital or justice system
- extends primary and behavioral health services through a home visiting program.
- decrease homelessness, individuals arrested, outpatient ED visits
- increase access to preventative care, improvement in community resiliency

PROJECT PROPOSALS AT A GLANCE: Crossroads - Jail Transitions $390,354

GOAL: provide care coordination to individuals leaving incarceration to support successful transition to housing and primary care for physical, behavioral, oral health needs

CASE STATEMENT: care coordination for persons leaving incarceration to support successful transition into housing and primary care for physical, behavioral, and oral health needs to reduce inappropriate ED utilization and impacting opioid misuse/abuse and recidivism. Meet cultural needs of all members of our communities, including American Indians/Alaska Natives by connecting to tribal health and behavioral health resources as requested and available.

Target Population: 4,051 Medicaid Eligible persons leaving Clallam, Jefferson and Kitsap jails and their families (500).

Geography	Jail/Medicaid #	PCHS/PCMH	KCR/Housing	NOHN/PCMH	OLYCAP/Housing
Clallam	2,555 annually			1 CHW	1 CHW
Jefferson	912 annually				*See above*
Kitsap	3,285 annually	.25 Project Manager	.33 Hsg Navigator		
		.25 CHW Coordinator			
		5 CHW			

Additional Collaborators: OMC, HMC, HHP, KPHD, KMHS, PBH, Olympic AAA, Kitsap AAA, Project Access, Clallam Health TBD, Suquamish Tribe, Port Gamble S'klallam Tribe, Kitsap County Human Services and Workforce Development, Salish BHO, law and justice including corrections, Housing Authorities, MCOs.

ROI: No specific ROI data found. Consider impact of Medicaid enrollment and care coordination to medical home for physical, behavioral (mental/substance use), oral health; impact of connection to housing resources.

IMPACT:

-enroll in health insurance
-preventative use of PCMH & health improvements
-improve mental health
-improve oral health
-reduce ED visits
-reduce inpatient utilization
-fewer deaths due to opioid overdose
-fewer homeless
- fewer recidivate

PROJECT PROPOSALS AT A GLANCE: Regional Care Transitions $396,613

GOAL:

- reduce avoidable hospital utilization, readmissions and ED services
- ensuring individual receives right care, right place, right time through comprehensive discharge planning.
- may also reduce overall length of stay at hospital or nursing home, negate need for higher level of step-down care from hospital stay to nursing facility.

CASE STATEMENT: 21% of the OCH region population is 65+, compared to rest of State (15%). Patients with complex care needs represent high needs with associated costs for health care services. While project targets and serves smaller scale of participants than other OCH projects, it has potential for high impacts in quality improvement and cost reductions.

TARGET POPULATION/REACH: Medicaid patients age 18+ discharging from acute care hospital stay with complex care needs to home or supportive housing, includes persons with 2 or more chronic diseases, persons with routine procedures with extended hospital length of stay due to complications. Est. eligible: JHC 252 OMC 844 FCH 291 CHI HMC 1,997

Geography	# Medicaid acute hospital disch	# Hospital 30/day readmt rate	Eligible	Partners	Staffing
Clallam	FCH 142 OMC 1,077	15.5% 15.2%	291 844	Oly AAA	2 cert. transition coach
Jefferson	JCH 47	15%	252		
Kitsap	CHI HMC 3,175	14.7%	1,997	Kitsap AAA	.5 Project Manager 2 cert. transition coach .5 data analyst

Collaborators: Hospitals - Forks Community Hospital, Jefferson Healthcare, Olympic Medical Center, CHI Harrison Medical Center). Community Behavioral Health - Peninsula Behavioral Health, West End Outreach, Discovery Behavioral Health, Kitsap Mental Health Services. FQHCs – NOHN, PCHS. **NOTE: At Partner Convening 6/19/17 new partners on board.**

ROI: $109.34-$343.06 PMPM thescanfoundation.org/sites/thescanfoundation.org/files/achieving_positive_roi_fact_sheet_3_0.pdf

IMPACT: Decrease inpatient utilization, reduce plan all cause readmission rate, reduce ED visits, increase follow-up after hospitalization for mental illness.

Olympic Community of Health
OCH Project Portfolio At-A-Glance July 3, 2017

Toolkit Category (Domain.Project)	Bi-Directional Integration and Primary Care Transformation (2.A.)	Community-Based Care Coordination (2.B.)	Transitional Care (2.C.)		Diversion (2.D.)			Opioid Response (3.A.)	MCH (3.B.)	Access to Oral Health Services (3.C.)		Chronic Disease Prevention and Control (3.D.)	
Total Max Ave Earnable Incentives for 1 Year w/o Pathways	**$3,138,462**	**N/A**	**$1,275,000**		**$1,275,000**			**$392,308**	**$490,385**	**$294,231**		**$784,615**	
Total Max Ave Earnable Incentives for 1 Year w Pathways	**$2,439,000**	**$1,674,000**	**$999,000**		**$999,000**			**$315,000**	**$387,000**	**$234,000**		**$603,000**	
Total Proposed Allocated Incentive Funds for 1 Year	**$3,138,462**	**$0**	**$350,000**		**$1,425,000**			**$392,308**	**$400,000**	**$300,000**		**$700,000**	
Title	Bi-Directional Integration and Primary Care Transformation	Pathways HUB™	Crossroads (transitions from jail to care)	Regional Care Transitions (transitions from hospital to home)	LEAD (diversions from jail booking)	Community Paramedicine	Outward Bound (community health workers in the ED)	Three-County Coordinated Opioid Response	Healthy Beginnings (Nurse family partnership and parents as teachers)	FQHC Dental (expansion into North Kitsap)	Jefferson County (expansion in Jefferson County)	Breathe Easy (home visits and supports for people with asthma)	Chronic Care Model (Clinical transformation and community linkages)
Medicaid #/year	26,667	4000	4,551	3,384	3000-6000	8,000	28,320	20,000	238	2,800	1162.5	1,799	11,880
Medicaid #/4 yrs	80,000	16000	18204	13536	12,000-24,000	32000	113280	25000	952	11200	4650	7196	47520
Requested Budget	NA	$0	$390,354	$632,093	$859,100	$2,969,590	$506,360	NA	$545,104	$463,552	$39,677	$372,167	$1,161,261
Staff Recommended Allocation for planning purposes only	$3,138,462	$0	$350,000	$0	$450,000	$375,000	$600,000	$392,308	$400,000	$300,000		$700,000	
Cost per person per year (based on recommended allocation)	$39.23	$0.00	$76.91	$0.00	$100.00	$46.88	$21.19	$19.62	$1,680.67	$75.71		$51.17	
Expansion (E) or new (N) program	E	N	N	E	N	N	N	E	E	E	N	N	N/E
VBP adoption will drive long term sustainability *	Very Likely	Likely	Likely	Very likely	Likely	Not likely	Very likely	Likely	Not likely	Likely	Likely	Likely	Very likely
Type of agency *transformed* *		y											
Law Enforcement and Criminal Justice		y	y		y			y					
EMS		y			y	y		y					
Social Services Organizations		y		y	y	y		y	y			y	y
Hospitals and E.D.s	y	y		y		y	y	y			y		y
Behavioral Health Care Organizations	y	y	y		y			y					y
Primary Care Organizations	y	y	y	y			y	y	y	y		y	y
Workforce *													
New workforce (does not currently exist)		y	y				y						
Expansion of existing workforce (recruitment)	y				y			y	y	y	y	y	
Re-trained existing workforce	y			y	y	y		y					y
Community Health Workers (CHW)		y	CHW				CHW					CHW	CHW
Population Health Analytics Workforce	y			y									y
Need for coordinated referral across systems *	**y**	**y**	y	y	y	y	y	y	y	y	y	y	y

** staff assessment*

Recommendation Summary		
Total Max Earnable Incentives for 1 Year	**$7,650,000**	*assumes the region earns 100% of our maximum potential valuation*
Total Proposed Allocation of Incentive Funds for 1 Year	**$6,705,769**	*assumes no regional care transitions program and no Pathways*
		financing for Apple Integrator will need to be taken into account if we decide to move forward

Planning for Design Funds for January 1 to December 31 2017, June 30, 2017

2017		2017		2017	
Approved November 2016		**Approved April 2017**		**Presented July 10, 2017**	
2017 Budget		**AUTHORIZED Increased Spend**		**DESIGN BUDGET PLAN Phase II Application**	
Personnel	**Total**	**Personnel**	**Total**	**Personnel**	**Total**
Personnel and Benefits	251,683	Personnel and Benefits	339,782	Personnel and Benefits	404,837
Non-Personnel	**Total**	**Non-Personnel**	**Total**	**Non-Personnel**	**Total**
Professional Services:		Professional Services:		Professional Services:	
Legal Counsel	5,000	Legal Counsel	7,500	Legal Counsel	10,000
Data and Evaluation	45,872	Data and Evaluation	65,105	Data and Evaluation	95,105
Opioid Contractor	5,194	Opioid Contractor	5,194	Opioid Contractor	5,194
		Project Plan Selection	11,798	Project Plan Selection	25,575
		Project Plan Development	42,900	Project Plan Development	92,800
		HR Consultant	4,000	HR Consultant	4,000
		Financial Advisor/CFO Services	5,000	Financial Advisor/CFO Services	5,000
		Other Consultant	10,000	Other Consultant	10,000
				Provider Engagement	5,000
				Consumer Engagement	5,000
				Project Mngmt in Partner Orgs	15,000
				Data & Analytics in Partner Orgs	15,000
				Operations Math. Modeler	15,000
				Apple Integrator	99,143
Administrative Services		Administrative Services		Administrative Services	
Financial services	20,029	Financial services	25,036	Financial services	25,036
Audit	6,000	Audit	6,000	Audit	6,000
Office Space, IT, Printing	10,000	Occupancy	18,800	Occupancy	37,000
Professional Development	6,250	Professional Development	6,250	Professional Development	6,250
Travel/Mileage	8,424	Travel/Mileage	10,530	Travel/Mileage	11,146
Communications	2,000	Communications	2,000	Communications	3,000
Supplies	4,000	Supplies	7,000	Supplies	8,333
Events	1,500	Events	2,500	Events	2,500
Food and beverage	5,500	Food and beverage	5,500	Food and beverage	5,500
Liability Insurance	2,583	Liability Insurance	2,583	Liability Insurance	2,583
				B&O Tax	90,000
Miscellaneous	1,500	Miscellaneous	1,500	Miscellaneous	1,500
Subtotal Non-Personnel Costs	**123,852**	**Subtotal Non-Personnel Costs**	**239,196**	**Subtotal Non-Personnel Costs**	**600,665**
TOTAL EXPENDITURES	**375,535**	**TOTAL EXPENDITURES**	**578,978**	**TOTAL EXPENDITURES**	**1,005,502**

Initial Planning for Design Funds for 2018, 2019, 2020, & 2021, July 2, 2017

2018		2019		2020		2021	
Work in Progress		**Work in Progress**		**Work in Progress**		**Work in Progress**	
DESIGN BUDGET PLAN Phase II Application		**DESIGN BUDGET PLAN Phase II Application**		**P4:T4**		**DESIGN BUDGET PLAN Phase II Application**	
Personnel	**Total**	**Personnel**	**Total**	**Personnel**	**Total**	**Personnel**	**Total**
Personnel and Benefits	740,670	Personnel and Benefits	975,948	Personnel and Benefits	1,047,115	Personnel and Benefits	1,051,238
Non-Personnel	**Total**	**Non-Personnel**	**Total**	**Non-Personnel**	**Total**	**Non-Personnel**	**Total**
Professional Services:		Professional Services:		Professional Services:		Professional Services:	
Legal Counsel	15,000	Legal Counsel	20,000	Legal Counsel	25,000	Legal Counsel	30,000
Data and Evaluation	95,000	Data and Evaluation	95,000	Data and Evaluation	97,000	Data and Evaluation	98,000
HR Consultant	4,500	HR Consultant	5,000	HR Consultant	4,000	HR Consultant	3,000
Financial Advisor/CFO Services	15,000	Financial Advisor/CFO Services	15,000	Financial Advisor/CFO Services	15,000	Financial Advisor/CFO Services	15,000
Other Consultant	50,000	Other Consultant	50,000	Other Consultant	50,000	Other Consultant	50,000
Provider Engagement	10,000	Provider Engagement	10,000	Provider Engagement	10,000	Provider Engagement	10,000
Consumer Engagement	10,000	Consumer Engagement	10,000	Consumer Engagement	10,000	Consumer Engagement	10,000
Project Mngmt in Partner Orgs	30,000	Project Mngmt in Partner Orgs	45,000	Project Mngmt in Partner Orgs	45,000	Project Mngmt in Partner Orgs	30,000
Data & Analytics in Partner Orgs	15,000	Data & Analytics in Partner Orgs	15,000	Data & Analytics in Partner Orgs	15,000	Data & Analytics in Partner Orgs	15,000
Operations Math. Modeler	20,000	Operations Math. Modeler	10,000	Operations Math. Modeler	5,000	Operations Math. Modeler	5,000
Apple Integrator	0	Apple Integrator	0	Apple Integrator	0	Apple Integrator	
Administrative Services		Administrative Services		Administrative Services		Administrative Services	
Financial services	30,000	Financial services	30,000	Financial services	30,000	Financial services	30,000
Audit	10,000	Audit	13,000	Audit	13,000	Audit	13,000
Occupancy	38,000	Occupancy	40,400	Occupancy	40,400	Occupancy	40,400
Professional Development	7,000	Professional Development	7,800	Professional Development	8,400	Professional Development	8,400
Travel/Mileage	24,846	Travel/Mileage	37,775	Travel/Mileage	40,450	Travel/Mileage	40,450
Communications	4,000	Communications	6,000	Communications	6,000	Communications	6,000
Supplies	16,333	Supplies	26,000	Supplies	28,000	Supplies	28,000
Events	5,500	Events	6,000	Events	6,000	Events	6,000
Food and beverage	10,000	Food and beverage	10,000	Food and beverage	10,000	Food and beverage	10,000
Liability Insurance	5,000	Liability Insurance	6,000	Liability Insurance	6,500	Liability Insurance	6,500
B&O Tax	7,500	B&O Tax	7,500	B&O Tax	7,500	B&O Tax	7,500
Miscellaneous	5,000	Miscellaneous	5,000	Miscellaneous	5,000	Miscellaneous	5,000
Subtotal Non-Personnel Costs	**427,679**	**Subtotal Non-Personnel Costs**	**470,475**	**Subtotal Non-Personnel Costs**	**477,250**	**Subtotal Non-Personnel Costs**	**467,250**
TOTAL EXPENDITURES	**1,168,349**	**TOTAL EXPENDITURES**	**1,446,423**	**TOTAL EXPENDITURES**	**1,524,365**	**TOTAL EXPENDITURES**	**1,518,488**

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

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

Data and Analytics in Partner Organizations: to compensate for data extraction and reporting

Data and Evaluation: Analytics and Reporting Lead (0.6 FTE) & Data and Evaluation Contractor (0.2 FTE) contracted through Kitsap Public Health District

Events: venue rental, audio/visual rental

Financal Services: bookkeeping, accounting, taxes, payroll

Miscellaneous: books, subscriptions, memberships, other

Occupancy: includes rent and IT

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

Project Management in Partner Organizations: assist in drafting projet plans, centralize project management within organizations during implementation

Provider engagement: training, clinical input, design and review of protocols, VBP preparedness

Supplies: Computer, cell phone, software packages (one-time cost), electronics, office supplies

TOTAL OCH EXPENDITURES 2017-2021	
TOTAL Demonstration	$ 6,150,417
TOTAL State Innovation (SIM)	$ 513,710
TOTAL	$ 6,664,126

STATE INNOVATION MODEL REVENUE 2017-2021	
SIM 2017 Revenue	$ 231,000
SIM 2017 Opioid Revenue	$ 30,000
SIM 2018 Revenue	$ 99,000
SIM 2016 Carryover from KPHD	$ 220,000
Total SIM Revenue	$ 580,000

DEMONSTRATION DESIGN FUNDS REVENUE 2017-2021	
Phase I (received)	$1 mil
Phase II (anticipates 1/2018)	$3.5 to 5 mil
Total Design Fund Revenue	$4.5 to 6 mil

OPIOID PROJECT Partner Contributions 2017	
Amerigroup	$ 7,000
Molina	$ 4,000
Community Health Plan of WA	$ 3,000
Total OPIOID Revenue	$ 14,000

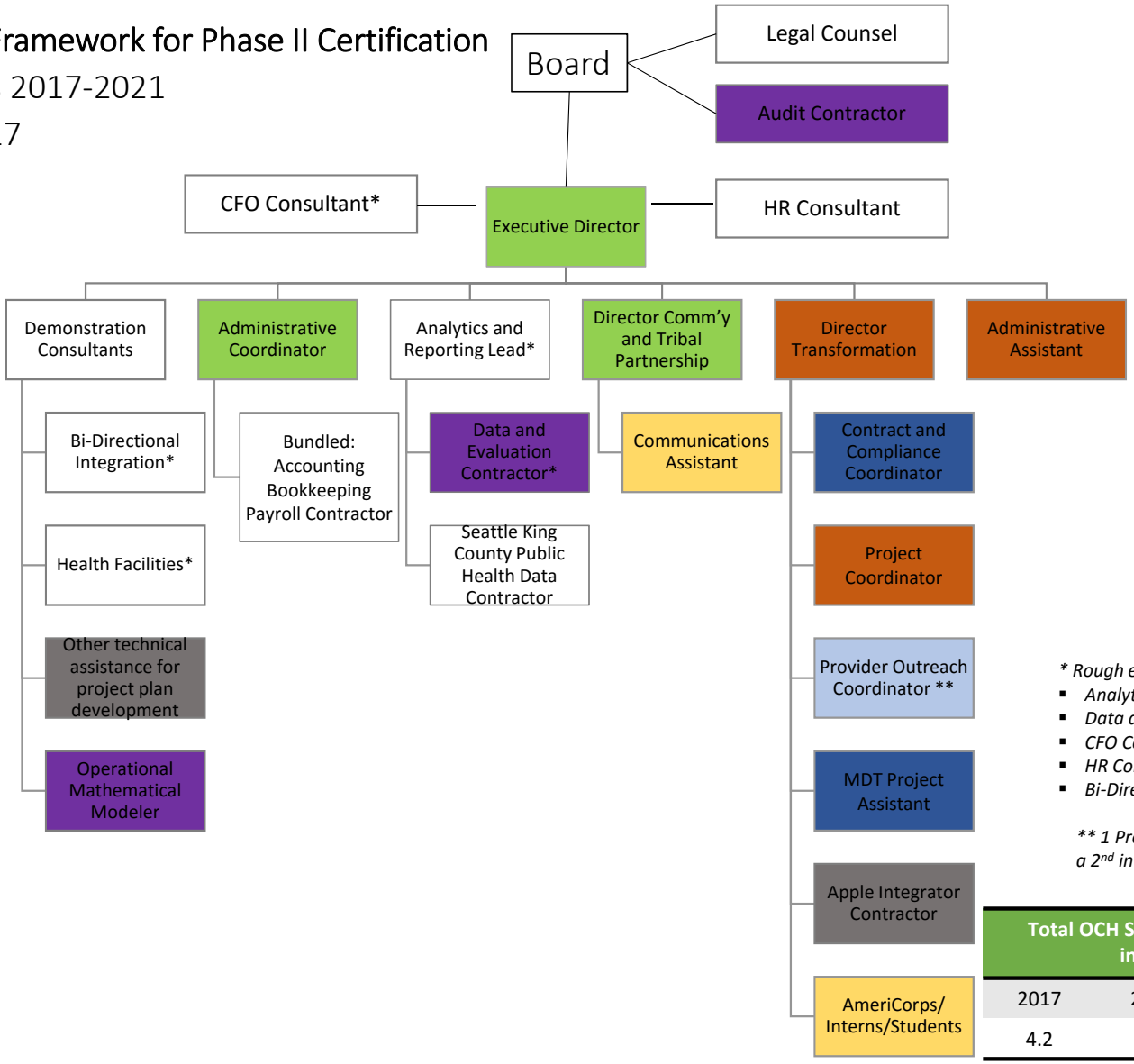
CONVENING Partner Contributions 2017	
Amerigroup	$ 1,500
Coordinated Care	$ 1,500
Total CONVENING Revenue	$ 3,000

OCH Organizational Framework for Phase II Certification

Demonstration Years 2017-2021

Revised June 30, 2017

"Provide a summary of staff positions that have been hired or will be hired, including current recruitment plans and anticipated timelines"



Staffed Services

- **Hired Staff as of 7/1/17**
- **Planned hire by 9/1/2017**
- **Planned hire by 1/1/2018**
- **Planned hire by 5/1/2018**
- **Planned hire by 1/1/2019**

Contracted Services

- **Current Contracted Service as of 7/1/17**
- **Planned Contracted Service by 1/1/2018**
- **Planned Contracted Service Pending Portfolio Selection**

** Rough equivalency estimates of consultants and contractors*

- *Analytics and Reporting Lead equivalent to a 0.6 FTE*
- *Data and Evaluation Contractor equivalent to a 0.2 FTE*
- *CFO Consultant equivalent to a 0.03 FTE*
- *HR Consultant equivalent to a 0.01 FTE*
- *Bi-Directional Integration equivalent to a 0.3 FTE*

*** 1 Project Outreach Coordinator will be hired in 2018 and a 2nd in 2019*

Total OCH Staff FTE by Demonstration Year (includes interns and AmeriCorps in 2019)				
2017	2018	2019	2020	2021
4.2	8.2	13	14	14

OCH Governance Chart: Demonstration Oversight

Demonstration Years 2017-2021

Revised July 3, 2017

Oversees OCH Demonstration activities and reviews committee recommendations on project selection, planning, implementation, and oversight
Develops funds flow allocation plan and monitors performance

Board of Directors

Legal Counsel

Advise Board on key decisions pertaining to the delivery of clinical care and social services under the Demonstration, including supporting the selection and implementation of the region's transformation projects and Domain I activities.

Care Delivery Redesign Committee

Performance Measurement Committee

Executive Committee

Finance Committee

Independent Auditor

Oversees Regional Health Needs Inventory, provides project-specific data support, makes recommendations for improved data sharing and linkage, develops standardized tracking and reporting tools

Provider Associations
Community Coalitions
Government Agencies
Tribal Government

Organization-based teams

Behavioral health agencies
Tribal health clinics
Primary care
Emergency departments
Hospitals
Specialty care
Federally qualified health care clinics
Rural health clinics
Pharmacy

Payers

Community action agencies
Nonprofits and social service organizations
Area agencies on aging

Payers

Local Health Jurisdictions
Jails and prisons
Courts

Law enforcement
Emergency medical providers

Clinical Provider Portfolio

Social Service Provider Portfolio

Social Justice Provider Portfolio

OCH staff partner with Practice Transformation Hub to provide support at an organization-level across all projects in the portfolio. Convening regionally 2-4 times per year. As needed, organization-based teams will combine with other organizations for planning and implementation.