Olympic Community of Health

Agenda

**Board of Directors Meeting**

**April 10, 2017**

1:00 pm to 3:00 pm

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

**Web**: https://global.gotomeeting.com/join/749484341

**Phone**: 1 (571) 317-3122

**Access Code**: 749-484-341

KEY OBJECTIVES

1. Approve draft tools to select optional projects for Medicaid Demonstration Project
2. Approve proposed recommendation for Clinical Engagement Capacity
3. Approve proposed recommendation for Organizational Readiness

AGENDA (Action items are in red)

| Item | | Topic | Lead | Attachment |
|---|---|---|---|---|
| 1 | 1:00 | Welcome | Roy | |
| 2 | 1:05 | Consent Agenda | Roy | 1. DRAFT: Minutes from 3.13.2017<br>2. Director's Report<br>3. DRAFT: ACH Certification Process<br>4. Incentives for Mid-Adopters of Integrated Managed Care |
| 3 | 1:10 | Tribal Collaboration and Communication Policy | TBD | 5. DRAFT: Tribal Collaboration and Communication Policy |
| 4 | 1:20 | Selecting Medicaid Demonstration Transformation Optional Projects | Katie | 6. DRAFT: Request for Applications |
| 5 | 1:50 | Clinical Engagement Strategy | Jennifer | 7. SBAR: Clinical Engagement Strategy |
| 6 | 2:10 | Organizational Readiness | Caitlin<br>Hilary | 8. SBAR: Organizational Readiness |
| 7 | 2:50 | The Future of Oral Health. What's the North Star? | TBD | |
| 8 | 3:00 | Adjourn – All are welcome to stay | Roy | |
| 3:00 to 4:30 pm | | ORAL HEALTH STRATEGIC PLANNING SESSION | Kristen West, Washington Dental Service Foundation | 9. DRAFT: Oral Health Strategic Planning Guide |

** *TENTATIVE*: BHO ORIENTATION May 8 from 3:00 pm to 4:00 pm, right after Board Meeting **

**Acronym Glossary**

ACH: Accountable Community of Health

BHO: Behavioral Health Organization

SBAR: Situation. Background. Action. Recommendation.

MDTP: Medicaid Demonstration Project (previously called "the Waiver")

Olympic Community of Health

Meeting Minutes

Board of Directors

March 13, 2017

| **Date:** 3/13/2017 | **Time: 1:00pm-3:00pm** | **Location:** Jefferson Health Care Conference Room, Room #302 |
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**Chair:** Jennifer Kreidler-Moss, *Peninsula Community Health Services*

**Members Attended:**, Hilary Whittington, *Jefferson Health Care,* Leonard Forsman, *Suquamish Tribe,* Chris Frank, *Clallam Public Health,* Thomas Locke, *Jefferson County Public Health*, Katie Eilers, *Kitsap Public Health District,* Lance Colby, *Lower Elwha Klallam,* Brent Simcoscky, *Jamestown S'Klallam Tribe*, Joe Roszak, *Kitsap Mental Health Services,* Anders Edgerton, *Salish Behavioral Health Organization* (voted in as a Board Member today)

**Alternate Members Attended:** Daryl Wolfe *(for Eric Lewis)*

**Phone Members**: Larry Eyers, *Kitsap Community Resources,* Tracey Rascon, *Makah Tribe,* Doug Washburn, *Kitsap Human Services,* David Schultz, *CHI Harrison Medical Center,* Karol Dixon, *Port Gamble S'Klallam Tribe,* Andrew Shogren, *Quileute Tribe,* Caitlin Safford, *Amerigroup*

**Staff:** Elya Moore, *Olympic Community of Health*

**Guests:** Maria Klemesrud, *Qualis Health*

| Person Responsible for Topic | Topic | Discussion/Outcome | Action/Results |
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| | **March Objectives** | 1. Agree on process to select from optional project from Toolkit<br>2. Agree of structures to put in place for certification | |
| Jennifer Kreidler Moss | **Welcome and Introductions** | Jennifer called the meeting to order at 1:06 pm. | |
| Jennifer Kreidler Moss | **Consent Agenda** | - Approval of minutes<br>- Discussion of fund development decision – move carefully and rely on staff | Feb 2017 Board Minutes and consent agenda **APPROVED** unanimously. |
| Jennifer Kreidler Moss | **BHO Sector Representation** | | **MOTION**: Anders Edgerton replaces Doug Washburn on the OCH Board of Directors representing BHO |

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| | | | **APPROVED**<br>unanimously |
| Elya Moore | **Medicaid Demonstration Update** | - Update on Medicaid Demonstration Project:<br>o Design funding timeline<br>o Project weights<br>o Fully-integrated managed care (FIMC)<br>- Discussion about FIMC, pros and cons.<br>- Explanation of FIMC versus bi-directional integration of care | Staff will organize a BHO Orientation with Anders Edgerton |
| Jennifer Kreidler Moss | **Preparing the OCH for MDP certification and readiness** | - How do we make these decisions without knowing the payer mix/fully integrated managed care in 5 years?<br>- Pending legislation may help clear up<br>- Want to make system work for all payers, not just Medicaid<br>- PROPOSED PROCESS for ORGANIZATIONAL READINESS<br>1. Convene a small group of representatives from provider organizations and tribal health clinics to review options and recommend a solution for Clinical Capacity and Engagement readiness.<br>2. Convene a small workgroup of the Board of Directors to provide input into organizational readiness and supporting use of Design Funds<br>3. Engage with the tribes to seek input on optimal strategies for Tribal Consultation and Engagement for our region.<br>- Volunteers for each group above noted by the number in the parentheses<br>o Jennifer Kreidler Moss (1)<br>o Lance Colby (1)<br>o Joe Roszak (1)<br>o Eric/Darryl (1)<br>o Caitlin Safford (2)<br>o Hilary Whittington (2)<br>o Anders Edgerton (2)<br>o Brent Simcosky (2)<br>o Tracey Rascon/John Miller (3) | **MOTION**<br>To move forward with organizational readiness as proposed.<br><br>**APPROVED**<br>Unanimously |
| Katie Eilers<br>Elya Moore | **Proposed process to select from the** | - Review of RHAP Committee membership | **MOTION** |

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| | **optional Demonstration Projects** | - RHAP Committee will have a conflict of interest policy<br>- Review Letter of Intent<br>- LOIs might get declined - How do we incorporate input from the<br>- Tribes will be invited to apply individually<br>- Discussion about current administration<br>- Think about regional projects cooperatively and inclusive of Tribes<br>PROPOSED PROCESS TO SELECT OPTIONAL PROJECTS:<br>- Open the Request for LOI to the public as soon as the final toolkit is released by the WA State Health Care Authority.<br>- RHAP Committee select and invite full applications based on review of LoIs; review full applications, and make a recommendation to the Board<br>- Executive Director to contract for technical assistance to assist in the development of high-quality, full applications<br>REVISION:<br>- Staff will inform Board of RHAPC LOI decision ahead of May 8 Board Meeting<br>- Cover page – add required projects | The Board approves the process to select projects as recommended by the RHAP Committee and as revised by the Board. Request to receive<br><br>**APPROVED** unanimously |
| Elya Moore | **A look ahead for the OCH Board** | - Review six-month plan | |
| Jennifer Kreidler Moss | **Adjourn** | The meeting adjourned at 2:55 pm. | |

## Olympic Community of Health

**Director's Report**

Prepared for April 10 Board of Directors Meeting

Top 3 Things to Track (T3T) #KeepingMeUpAtNight

Preparing the organization for the Medicaid Demonstration Project poses some challenges:

1. We are on a rapid pace to get the high-quality, competitive project plans submitted by September.
2. We are trying to build an organization fast and furious, without really knowing what the "job" is, and at risk of cutting corners that may leave us with unwanted legacies.
3. The Pathways Community-Based Care Coordination Hub is the buzzword these days. It seems that many ACHs are leaning towards selecting this project. I have concerns about missing the proverbial "bandwagon" while also sharing some of the reservations that are shared by several partners.

**Upcoming OCH meetings**:

- RHAP Committee Meeting, April 14, 9 am to 1 pm, Bremerton
- Executive Committee Meeting, April 25, 12 pm to 2 pm
- Board of Directors Meeting, May 8, 1 pm to 3 pm, Port Townsend
- BHO Orientation, May 8, 3 pm to 4 pm, Port Townsend
- *Tentative* Pathways HUB Meeting with Dr. Sarah Redding, April 26th, likely in Bremerton

**Upcoming ACH Quarterly Convenings:**

- June 28-29, Chelan (right after the WSHA Rural Health Conference)

**Pathways Community-Based Care Coordination Meeting**

- Cascade Pacific Action Alliance (CPAA) held a webinar about Pathways on March 27th. If you would like the handouts, please email Mia Gregg and we will get those to you.
- We have scheduled meeting with Alison Carl White, executive director of Better Health Together for April 6th from 4:30 pm to 6:00 pm at Peninsula Community Health Services. Alison operates the first Pathways pilot in the state, a jail transitions project in Ferry county. A call-in number is available.
- If there is interest, we also have the option of scheduling an in-person meeting with Pathways Co-Founder, Dr. Sarah Redding: Wednesday April 26th, time and location TBD

**Behavioral Health Orientation (BHO) led by Anders Edgerton**

In response to the Board's interest in a better understanding of Behavioral Health Organizations, Anders has offered to host a one-hour orientation. The preferred option is May 8th immediately after the Board meeting from 3:15 pm to 4:15 pm. A second option is May 1st from 1 pm to 2 pm. Please email Mia if you are interested and have a preference. A call-in number will be available for both dates.

**Fully Integrated Managed Care**

The HCA released incentive amounts for Mid-Adopters of Fully Integrated Managed Care (FIMC) on Wednesday April 5th. This document is included in your packet. For our three-county region, the total incentive for FIMC is $4,945,000. This assumes that a non-binding letter of intent from the counties is received by the Medicaid Director by September 1, 2017 and that implementation begins November 1, 2018 or January 1, 2019. The incentive payments earned for integrated managed care milestones are intended to be used to assist providers and the region with the process of transitioning to integrated managed care. This could include using funds to assist with the uptake of new billing systems or technical assistance for behavioral health providers who are not accustomed to conducting traditional medical billing or working with managed care plan business processes. Additionally, the incentive payments can further support and build upon the region's work to implement integrated clinical models.

HCA continues to underscore its strong preference for ACH regions to move forward with FIMC prior to 2020. There is an amendment to a bill in the legislature that may delay or alter this course.

**Tribal Collaboration and Communication**
We are talking with each Tribe in our region to assess how engagement has been going between the Tribe and the OCH. We have spoken with 4 of the 7 Tribes thus far. In your packet today is a draft Tribal Collaboration and Communication Policy. This policy recognizes that all Tribes have a voting seat on the Board of Directors; however, all may not wish to be active on the Board. This policy establishes a clear and concise collaboration policy and communication procedure between the OCH and tribal governments in the development of all OCH policies or actions.

**Value-Based Payment (VBP) Action Team**
We were asked to provide the HCA with nominations for the Medicaid Value-Based Payment Action Team. Four members from provider organizations volunteered (below). The HCA will select at least one nomination from each of the nine ACHs. This group will begin meeting as early as May.

1. Hilary Whittington, CFO Jefferson Health Care
2. Jennifer Kreidler Moss, CEO, Peninsula Community Health Services
3. Joe Roszak, CEO, Kitsap Mental Health Services
4. Karol Dixon, Health Director, Port Gamble S'Klallam Health Clinic

**Transition of Funds from Kitsap Public Health District**
We received and deposited our check from Kitsap Public Health Department for $221,073.78.

**Regional Health Needs Inventory**
We have received the second phase of data to populate our regional health needs inventory. This data has been visualized by King County Seattle Public Health and can be found here.

**Medicaid Demonstration Transformation Project (MDTP)** (formerly called the Waiver)

- Included in your packet is the DRAFT ACH Certification Process for ACHs. Several changes to bring to your attention:
  - The Phase I documentation is considered final
  - The Phase II documentation is considered draft
- The State selected a technical assistance contractor: Manatt Health. Manatt brings experience from several other states in operationalizing Delivery System Reform Programs (DSRIP). One of their specialties is in funds flow and provider engagement. Each ACH will be able to draw from this resource throughout the demonstration.
- The Funding Mechanics Protocol draft will be released soon, and will go through several iterations of changes before it is finalized.
- Several key documents are now posted online:
  - DSRIP Planning Protocol (includes the new toolkit)
  - Financial Executor Scope of Work

**OCH Outreach & Engagement**

- Washington Dental Service Foundation, March 20, Kingston
- CHI Harrison, March 29, Bremerton
- Department of Early Learning, March 31, Virtual
- ACH/MCO Care Coordination Conversation, April 4, Seattle
- Washington State Hospital Association, April 5, Seattle
- National Behavioral Health Council Conference, April 3-5, Seattle
- Healthier Washington Quarterly Webinar, April 5, Seattle

- Federal Grant Administration Training, April 11-12, Seattle
- Rural and Public Hospital Retreat, April 13, Leavenworth
- Olympic Educational School District, April 17, Bremerton
- North Olympic Health Network, April 19, Port Angeles
- Performance Measurement Coordinating Council, April 24, Seattle
- Project Access NW, Edmonds, April 27

**Three-County Coordinated Opioid Response Update**

- We received the payment from Amerigroup for $7,000
- We signed the contract with the HCA for $30,000.
- Received a pledge from CHPW for $3,000 and Molina for $4,000
- Steering Committee and Workgroup meetings are scheduled and work is underway.

# Accountable Community of Health Certification Process
# Medicaid Transformation Project demonstration

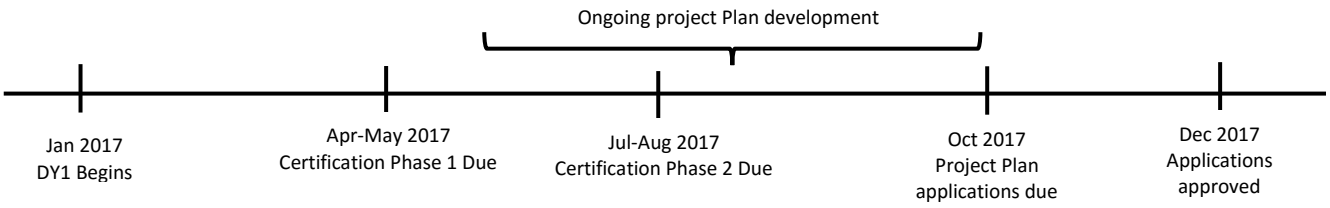
The certification process will ensure each Accountable Community of Health (ACH) is capable of serving as the regional lead entity and single point of performance accountability to the state for transformation projects under the Medicaid Transformation Project demonstration (demonstration). The certification process requires ACHs to provide information to demonstrate compliance with expectations set forth by the state and the Centers for Medicare and Medicaid Services (CMS). Through this process, the state will assess whether each ACH is qualified to fulfill the role as the regional lead and therefore eligible to receive project design funds. Specifically, certification will determine that each ACH meets expectations contained within the Special Terms and Conditions (STCs) including alignment with SIM contractual requirements, composition requirements, and organizational capacity expectations and development.

Certification criteria are established by the state in alignment with the demonstration STCs. Each ACH will submit both phases of certification information to the state within the required time frames. The state will review and approve certification prior to distribution of Project Design funds. Each ACH must complete both phases of certification and receive approval from the state before the state will consider its Project Plan application. Given the level of effort necessary to develop thorough project plan applications, ACHs will begin project plan development prior to completion of both certification phases.

The certification process, scoring criteria and subsequent awarded funding amount is at the sole discretion of the Washington State Health Care Authority (HCA). Certification will be scored according to the table below. ACHs must receive overall scores of 3 or higher in every category to pass the certification process. Additional information regarding the scoring process will be forthcoming.

| Score | Description | Discussion |
|---|---|---|
| 0 | No value | The response does not address any component of the requirement, or no information was provided. |
| 1 | Poor | The response unsatisfactorily addresses the requirement and the bidder's ability to comply with the requirement, or has simply restated the requirement. |
| 3 | Average | The response shows an acceptable understanding or experience with the requirement. Sufficient detail to be considered "as meeting minimum requirements." |
| 5 | Excellent | The response has provided an innovative, detailed, and thorough response to the requirement, and clearly demonstrates a superior experience with or understanding of the requirement. |

Certification Process Timeline




The certification materials submitted by the ACH will be posted on the HCA website for public review. Upon successful completion of the Phase 1 and Phase 2 certification, ACHs will earn Project Design funds. These funds go directly to ACHs as opposed to incentive payments, which will flow through the financial executer. Project Design funds are intended for ACH use on development, submission and oversight of a successful Project Plan application and execution.

To craft responses, ACHs should refer to the following key documents for important information outlining various obligations and requirements of ACHs and the state in implementing the Medicaid Transformation Project:

1. The Medicaid Transformation Project demonstration Special Terms and Conditions (STCs), which set forth in detail the nature, character, and extent of federal involvement in the demonstration, the state's implementation of the expenditure authorities, and the state's obligations to CMS during the demonstration period. The STCs were approved on January 9, 2017.
2. The Medicaid Transformation Toolkit, and any finalized protocols that support the demonstration STCs.
3. Other key documents and resources as listed in each section.

**Certification Submission Instructions**:

1. Please submit documents electronically according to the following specifications. Electronic copies must be submitted by 3pm on May 15, 2017 for phase 1 and by 3pm on August 14, 2017 for phase 2.
    a. Must be emailed to Medicaidtransformation@hca.wa.gov
    b. Narrative documents and supporting materials including governance charters must be submitted in Word or similar format.
    c. Must include contact information for the point of contact for any follow-up questions.
2. Certification phase 1 must be submitted between: April 17, 2017 and May 15, 2017.
3. Certification phase 2 must be submitted between: July 17, 2017 and August 14, 2017.

**Questions regarding the certification process must be directed to medicaidtransformation@hca.wa.gov.**

## ***Certification Phase 1***

ACHs must respond to a series of questions listed below to demonstrate achievement of expectations in the following areas:

- Theory of Action and Alignment Strategy
- Governance and Organizational Structure
- Tribal Engagement and Collaboration
- Community and Stakeholder Engagement
- Budget and Funds Flow
- Clinical Capacity and Engagement

**Amount:** Each ACH is eligible to receive up to $1 million for successful demonstration of Phase 1 expectations. Funding[1] will be distributed if certification criteria are fully met (score of three or higher) and the ACH and HCA have executed a contract for receipt of demonstration funds.

**Submission**: Between 04/17/2017-05/15/2017

| **Theory of Action and Alignment Strategy** |
|---|
| Each ACH is expected to adopt an alignment strategy for health systems transformation that is shared by ACH partners and staff. The goal is to ensure the work occurring within the region (e.g., clinical services, social services and community-based supports) is aligned and complementary, as opposed to the potential of perpetuating silos, creating disparate programs, or investing resources unwisely.<br><br>Provide a narrative and/or visual describing the ACH's regional priorities and how the ACH plans to respond to regional and community priorities, both for the Medicaid population and beyond. Please describe how the ACH will consider health disparities across all populations (including tribal populations), including how the ACH plans to leverage the opportunity of Medicaid Transformation within the context of regional priorities and existing efforts. |
| *References: ACH 2016 Survey Results (Individual and Compilation), SIM Contract, Medicaid Transformation STC Section II, STC 30* |
| *Narrative word-count range: 400-800*<br><br>*ACH Strategic Vision:*<br>1. *What are the region's priorities and what strategies are in place to address these priorities across the region?*<br>2. *Describe how the ACH will consider health disparities to inform regional priorities.*<br>3. *Describe strategies for aligning existing resources and efforts within the region. How is the work oriented towards an agreed upon mission and vision that reflects community needs, wants and assets?*<br>4. *Describe any in-kind contributions and non-Medicaid resources that have been identified for supporting the ACHs work over the near-term and long-term.*<br><br>*Alignment with Delivery System Reform:* |

[1] Timing and amount of Project Design funding is contingent on CMS approval of all related protocols.

5. *Describe how the ACH will leverage the unique role of DSRIP and consider the needs of Medicaid partners and beneficiaries to further the priorities identified above.*
6. *Describe how the ACH will leverage the Demonstration to demonstrate a business case for bringing clinical and community sectors and efforts to increase the health of populations.*

*Required Attachment(s): Not Applicable*

**Governance and Organizational Structure**

The ACH is a balanced, community-based table where health care, social, educational, and community entities influence health outcomes and align priorities and actions. To support this, the ACH must clarify roles and responsibilities, adopt bylaws that describe where and how decisions will be made, and describe how the ACH will develop and/or leverage the necessary capacity to carry out this large body of work.

*References: ACH Decision-Making Expectations, Medicaid Transformation STC 22 and STC 23, Midpoint Check-Ins for Accountable Communities of Health, DSRIP Planning Protocol*

*Narrative word-count range: 800-1,500*

*ACH Structure:*

1. *What governance structure is the ACH using (e.g.., Board of Directors/Board of Trustees, Leadership Council, Steering Committee, workgroups, committees, etc.)?*
2. *Describe the process for how the ACH organized its legal structure.*

*Decision-making:*

3. *What decisions require the oversight of the decision-making body? How are those decisions made? (E.g. simple majority, consensus, etc.)*
4. *How and when was the decision-making body selected? Was this a transparent and inclusive process? Include term limits, nominating committees, and make-up, etc. If a board seat is vacant, how will the ACH fill the vacancy?*
5. *How is decision-making informed? What are the documented roles and communication expectations between committees and workgroups to inform decision-making?*
6. *What strategies are in place to provide transparency to the community?*
7. *If the decision-making body makes a decision that is different from recommendations presented by committees and/or workgroups, how does the ACH communicate how and why that decision was made?*
8. *Describe how flexibility and communication strategies are built into the ACH's decision-making process to accommodate nimble decision-making, course corrections, etc.*
9. *Describe any defined scope, financial accountability or other limits placed on staff or the Executive Director decision making outside of board approval.*

*Staffing and capacities:*

10. *Provide contact information for the ACH's Executive Director. How long as the Executive Director been in that position for the ACH?*
11. *What gaps has the ACH identified related to its capacity for data-driven decision making and formative adjustments? How will these gaps be addressed?*

12. *Has the ACH signed a data sharing agreement (DSA) with the HCA? Provide contact information for the ACH point person for data related topics.*

*Required Attachment(s):*

A. *Visual/chart of the governance structure.*
B. *Copy of the ACHs By-laws and Articles of Incorporation.*
C. *Other documents that reflect decision-making roles, including level of authority, and communication expectations for the Board, committees and workgroups.*
D. *Decision-making flowchart.*
E. *Roster of the ACH decision-making body and brief bios for the ACH's executive director, board chair, and executive committee members.*
F. *Organizational chart that outlines current and anticipated staff roles to support the ACH.*

**Tribal Engagement and Collaboration**

ACHs are required to adopt either the State's Model ACH Tribal Collaboration and Communication policy or a policy agreed upon in writing by the ACH and every ITU in the ACH's region. In addition, ACH governing boards must make reasonable efforts to receive ongoing training on the Indian health care delivery system with a focus on their local ITUs and on the needs of both tribal and urban Indian populations.

Provide a narrative of how ITUs in the ACH region have been engaged to-date as an integral and essential partner in the work of improving population health. Describe and demonstrate how the ACH complies or will come into compliance with the Tribal Engagement expectations, including adoption of the Model ACH Tribal Collaboration and Communication Policy or other unanimously agreed-upon written policy.

*References: Medicaid Transformation STC 24, Model ACH Tribal Engagement and Collaboration Policy, workshops with American Indian Health Commission*

*Narrative word-count range: 700-1,300*

1. *Describe the process that the ACH used to fill the seat on the ACH governing board for the ITUs in the ACH region to designate a representative.*
2. *Describe whether and how the ACH has reached out to regional ITUs to invite their participation in the ACH.*
3. *Describe, with examples, any accomplishments the ACH has realized in collaborating and communicating with ITUs, including when in the planning and development process the ACH first included or attempted to include ITUs.*
4. *Describe the process the ACH used to adopt the Model ACH Tribal Collaboration and Communication Policy. If the ACH has not yet adopted the Model ACH Tribal Collaboration and Communication Policy, what are the next steps, including anticipated dates, to implement the requirements?*
5. *Describe key lessons the ACH has learned in its attempts to engage with ITUs and the next steps the ACH will take to support meaningful ITU engagement and collaboration.*
6. *Describe how the ACH governing board will receive ongoing training on the Indian health care delivery system with a focus on their local ITUs and on the needs of both tribal and urban Indian populations.*

*Required Attachment(s):*

A. *Demonstration of adoption of Model ACH Tribal Collaboration and Communication Policy, either through bylaws, meeting minutes, correspondence or other written documentation.*

*Recommended Attachment(s):*

A. *Statements of support for ACH certification from every ITU in the ACH region.*

**Community and Stakeholder Engagement**

ACHs are regional and align directly with the Medicaid purchasing boundaries. This intentional approach recognizes that health is local and involves aspects of life and community beyond health care services. The input of community members, including Medicaid beneficiaries, is essential to ensure that ACHs consider the perspectives of those who are the ultimate recipients of services and health improvement efforts.

Provide a narrative that outlines how the ACH will be responsive and accountable to the community.

*References: Medicaid Transformation STC 22 and 23, Midpoint Check-Ins for Accountable Communities of Health, NoHLA's*
*"Washington State's Accountable Communities of Health: Promising Practices for Consumer Engagement in the New Regional Health Collaboratives," DSRIP Planning Protocol*

*Narrative word-count range: 800-1,500*

*Meaningful consumer engagement:*

1. *Describe the ACH vision for fostering an authentic relationship with the community members.*
2. *What barriers/challenges has the ACH experienced or anticipate experiencing toward meaningful community and consumer engagement?*

*Partner engagement:*

3. *What strategies does the ACH employ, or plan to employ, to provide opportunities for engagement beyond the decision-making body to ensure that community partners are addressing local health needs and priorities?*
4. *What opportunities are available for bi-directional communication, so that the community and stakeholders can give input into planning and decisions? How is that input then incorporated into decision making and reflected back to the community?*

*Transparency and communications:*

5. *Describe how the ACH does or will fulfill the requirement for open and transparent decision-making body meetings. Please include how transparency will be handled if a decision is needed between public meetings.*
6. *What communication tools does the ACH use? Describe the intended audience for any communication tools.*

*Required Attachment(s):*

A. *Provide links to webpages where partners can access meeting schedules and other engagement opportunities, meeting materials, and contact information.*

| **Budget and Funds Flow** |
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| ACHs will oversee decisions on the disbursement of Demonstration incentive funds to partnering providers within the region. This requires a transparent and thoughtful budgeting process. Demonstration funds will be earned based on the objectives and outcomes that the state and CMS have agreed upon. Demonstration funds and funds from other federal sources (e.g., State Innovation Model sub-awards) should be aligned but ACHs cannot duplicate or supplant funding streams.<br><br>Provide a description of how Project Design funding will support Project Plan development. |
| *References: Medicaid Transformation STC 31 and STC 35, DSRIP Planning Protocol* |
| *Narrative word-count range: 800-1,500*<br><br>1. *Describe how the ACH plans to use the Project Design funds to support Project Plan development and other capacities or infrastructure.*<br>2. *Provide a description of budget and accounting support, including any related committees or workgroups.*<br>3. *Define the levels of expenditure authority held by the Executive Director, specific committees (e.g., Executive Committee), and the decision-making body.*<br>4. *Provide a description of the tracking mechanisms to account for various funding streams (e.g., SIM and Demonstration).*<br>5. *Describe how capacities for data, clinical, financial, community and program management, and strategic development will be met through staffing, vendors or in-kind support from board/community members.* |
| *Required Attachment(s):*<br>A. *High-level budget plan (e.g. chart or excel document) for Project Design funds to accompany narrative required above.* |

| **Clinical Capacity and Engagement** |
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| The demonstration is based on a Delivery System Reform Incentive Payment (DSRIP) program. As such, there needs to be engagement and input from clinical providers, including but not limited to MDs, RNs, ARNPs, CHWs, SUD providers, and mental health providers such as therapists and counselors. |
| *References: Medicaid Transformation STC 36, DSRIP Planning Protocol* |
| *Narrative word-count range: 500-1,000* |

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|---|
| 1. *Provide a summary of current work or plans the ACH is developing to engage clinical providers. Include a summary of input the ACH has already received from clinical providers or subject matter experts regarding the mechanisms and strategies to engage providers.*<br>2. *Describe how the ACH is approaching provider engagement, as well as identification of provider champions within the ACH. Include any targeted committees, panels or workgroups.*<br>3. *Demonstrate how the ACH is partnering with local and state clinical provider organizations (e.g., local medical societies, statewide associations, and prospective partnering providers).* |
| *Required Attachment(s):*<br>A. *Bios or resumes for identified clinical subject matter experts or provider champions* |

## ***Certification Phase 2***

Certification Phase 2 is intended to ensure that each ACH has met state expectations regarding progress and accomplishments. Each ACH will demonstrate that it is well positioned to submit a transformation Project Plan application to the state. The strength and quality of the Project Plan application, including addressing considerations or concerns the state has emphasized in Certification Phase 1 and 2, will in part determine the maximum incentive payments that regions will be eligible to earn over the course of the demonstration. In addition to recent developments and capacities, if significant changes in direction or structure have occurred since Phase 1, those need to be clearly explained and documented as part of Certification Phase 2.

Please ensure narrative is supported by documentation and evidence of accomplishments, including but not limited to the required attachments listed within each section. The ACH must respond to questions in the following areas:

- Theory of Action and Alignment Strategy
- Governance and Organizational Structure
- Tribal Engagement and Collaboration
- Community and Stakeholder Engagement
- Budget and Funds Flow
- Clinical Capacity and Engagement
- Data
- Transformation Project Planning

**Amount:** Each ACH is eligible to receive up to $5 million for successful demonstration of Phase 2 expectations. Funding[2] will be distributed if certification criteria are met and the ACH and HCA have executed a contract for receipt of demonstration funds.

**Submission**: Between 7/17/17-8/14/17

| **Theory of Action and Alignment Strategy** |
|---|
| Each ACH is expected to adopt an alignment strategy for health systems transformation that is shared by ACH partners and staff. The goal is to ensure the work occurring within the region (e.g., clinical services, social services and community-based supports) is aligned and complementary, as opposed to the potential of perpetuating silos, creating disparate programs, or investing resources unwisely.<br><br>Provide a narrative and visual describing the ACH's regional priorities and how the ACH plans to respond to regional and community priorities, both for the Medicaid population and beyond. Please describe how the ACH will consider health disparities across all populations (including tribal populations), including how the ACH plans to leverage the opportunity of Medicaid Transformation within the context of regional priorities and existing efforts. |
| *References: ACH 2016 Survey Results (Individual and Compilation), SIM Contract, Medicaid Transformation STC Section II, STC 30* |

[2] Timing and amount of funding is contingent on CMS approval of all related protocols.

*Narrative word-count range: 400-800*

*ACH Strategic Vision:*

1. *Has the ACH modified its regional priorities since phase 1? If so, please describe those modifications.*
2. *Summarize the health care needs and disparities that affect the health of your local community.*
3. *What progress has been made to align existing resources and efforts within the region?*
4. *Describe any in-kind contributions and non-Medicaid resources that have been identified for supporting the ACHs work over the near-term and long-term.*

*Required Attachment(s):*

A. *Logic model[3] describing how the ACH will address regional priorities. The logic model must include regional activities and effects, in addition to Demonstration activities and effects on the Medicaid population specifically.*

| **Governance and Organizational Structure** |
|---|
| Provide a description on the evolution of the governance and organizational structure of the ACH since Phase 1 certification. |

*Narrative word-count range: 500-1,000*

*ACH Structure:*

1. *Describe the ACH sector representation approach.*
2. *Provide a summary of any significant changes that have occurred within the governance structure (e.g., composition, committee structures, decision-making approach), including rationale for those changes.*
3. *Demonstrate how personal and organization conflict of interest concerns are addressed within the ACH, including considerations regarding the balanced and accountable nature of the ACH decision-making body to directly address identified conflicts*

*Staffing and Capacities:*

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

*Required Attachment(s):*

A. *Copies of charters for committees and workgroups that outline purpose, members, responsibilities and scope.*
B. *Conflict of interest policy.*
C. *Draft or final job descriptions for all identified positions.*

[3] At a minimum, the logic model must include: a purpose or mission statement, key resources and constraints, activities, outputs, and effects or results. http://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/logic-model-development/main

D. *Short bios for all staff hired.*
E. *Sector representation policy.*

| **Tribal Engagement and Collaboration** |
|---|
| Provide a narrative describing specific activities and events that further the relationship between the ACH and ITUs, including progress on implementing the requirements of the previously adopted Model ACH Tribal Collaboration and Communication Policy. |
| *Narrative word-count range: 500-1,000*<br><br>1. *Provide an update on the ACH efforts described for Phase 1 Certification, particularly for any next steps identified.*<br>2. *Describe any opportunities for improvement that have been identified regarding the Model ACH Tribal Collaboration and Communication Policy and how the ACH intends to address these opportunities.*<br>3. *Describe what training the ACH governing board has received on the Indian health care delivery system with a focus on the local ITUs and on the needs of both tribal and urban Indian populations. Describe how the ACH governing board will ensure that it receives ongoing training going forward.*<br>4. *Demonstrate how ITUs have helped inform the ACH's regional priorities and project selection process to-date.* |
| *Required Attachment(s):*<br>A. *Demonstration of adoption of the Model ACH Tribal Collaboration and Communication Policy, either through bylaws, meeting minutes or other evidence. Please highlight any modifications that were agreed to by all required parties.*<br>B. *Provide a bio(s) for the representative(s) of ITUs seated on the ACH governing board.*<br><br>*Required Attachment(s):*<br>A. *Statements of support for ACH certification from every ITU in the ACH region.* |

| **Community and Stakeholder Engagement** |
|---|
| Provide a narrative that describes current and future efforts regarding community and stakeholder engagement and how these actions demonstrate inclusion of and responsiveness to the community. |
| *Narrative word-count range: 500-1,000*<br><br>*<u>Meaningful consumer engagement:</u>*<br><br>1. *What strategies or processes have been implemented to address the barriers and challenges for community/consumer engagement identified in phase 1? What are the next steps the ACH will undertake to continue to address remaining barriers and challenges?*<br>2. *How has community member/consumer input informed the project selection process to-date?* |

3. *How is the ACH satisfying requirements for holding at least two public meetings to solicit community input in the Project Plan development? How will/did the ACH advertise these meetings?*
4. *What specific strategies have been implemented to provide adequate opportunities for people from diverse life experiences, who have different understandings of this work and different schedules, to participate in the ACH?*

*Partner Engagement:*

5. *What opportunities were provided to partners and stakeholders to inform project selection, beyond those included directly in the ACH governance structure?*
6. *How is the ACH fulfilling the requirement for open and transparent discussion-making body meetings? Please include how transparency has been handled if a decision was needed between public meetings.*
7. *How is the ACH ensuring that partnering providers (for transformation projects) serve a significant portion of Medicaid covered lives in the region and represent a broad spectrum of care and related social services that are critical to improving how care is delivered and paid for?*

*Transparency and Communications:*

8. *What communication tools does the ACH use? Provide a summary of what the ACH has developed regarding its web presence, including but not limited to: website, social media and any mobile application development.*
9. *Provide a link to the ACH's public-facing website.*
10. *Provide a list of all public ACH related engagements or forums for the last 3 months.*
11. *Provide a list of all public ACH related engagements or forums scheduled for the next 3 months.*

*Required Attachment(s):*

A. *A list of communication tools/resources and corresponding target audiences.*
B. *Meeting minutes or meeting summaries for the last 3 decision-making body meetings.*
C. *Attestation of meaningful participation by at least one Medicaid consumer reflecting meaningful participation in the process described in the narrative.*
D. *Attestation from a partner not participating directly on the decision-making body of meaningful participation in the process as described in the narrative.*

**Budget and Funds Flow**

Design funding should be sufficient to ensure ACHs have the resources necessary for serving as regional lead for Medicaid Transformation.

Provide a description of how design funding has been used to date to ensure successful Project Plan development. Summarize discussions relating to funds flow and incentive payments and distribution.

*Narrative word-count range: 500-1,000*

1. *Demonstrate how the ACH has and plans to use Design funds to support successful Project Plan development.*

2. *Demonstrate how capacities for data, clinical, financial, community and program management, and strategic development have been met through staffing, vendors or in-kind support from board/community members?)*
3. *Provide a projection of budget categories (e.g. ACH program administration, partnering provider incentives, and other) and allocations over the course of the Demonstration.*
4. *Provide an update on funds flow and incentive structures, including a summary of discussions to date with partnering providers to inform agreements as part of the project plan application.*
5. *Describe any state or federal funding provided to the ACH and how this does or does not align with the Demonstration activities and funding.*
6. *What is the status on the use of tracking mechanisms to account for various funding streams (e.g., SIM and Demonstration)?*

*Required Attachments:*

A. *Bio or resume for the treasurer and/or CFO or equivalent*
B. *Audited Financial Statements for the previous 2-4 quarters, as applicable*
C. *Actual expenditures for Phase 1. Provide amounts and description.*
D. *Demonstration budget projection for years 1-5. Provide budget categories and percentages, if applicable (e.g., administrative costs, participating providers and community based organizations).*
E. *Provide documentation of in-kind support or resources being provided.*

**Clinical Capacity and Engagement**

The Medicaid Transformation demonstration is based on a Delivery System Reform Incentive Payment (DSRIP) program. As such, there needs to be engagement and input from clinical providers, including but not limited to MDs, RNs, ARNPs, CHWs, SUD providers, and mental health providers such as therapists and counselors.

Provide a summary of current work the ACH is undertaking to engage clinical providers.

*References: Medicaid Transformation STC 36, DSRIP Planning Protocol*

*Narrative word-count range: 500-1,000*

1. *Demonstrate clinical expertise and leadership to inform project planning and decision-making.*
2. *Demonstrate that input was received from clinical providers and that prospective clinical partnering providers are participating in project planning.*
3. *Demonstrate how clinical input on workforce needs has been incorporated into project planning.*
4. *Demonstrate how the ACH is partnering with local and state clinical provider organizations (e.g., local medical societies, statewide associations, and prospective partnering providers).*

*Required Attachment(s):*

A. *Additional and/or current bios or resumes for identified clinical subject matter experts or provider champions not provided in phase 1.*

| **Data** |
|---|
| Data will be an underlying, foundational piece of the Medicaid Transformation demonstration. With the need to quantify improvement in health outcomes, ACHs will need to interpret and use data to drive key decisions including: project selections, tracking outcomes and making adjustments. |
| *References: Medicaid Transformation STC 36, DSRIP Planning Protocol* |
| *Narrative word-count range: 500-1,000*<br><br>1. *Describe how the ACH is collaborating, or plans to collaborate, with other ACHs for data-related activities such as interpreting data sets provided by the state.*<br>2. *Describe how the ACH has utilized health information provided by the state, leveraged existing community health needs assessments, as well as other sources of data, to direct the project planning process.*<br>3. *Describe ACH-led efforts to collect information at the regional level pertaining to health care and community-based service systems and capacity.*<br>4. *Describe asset mapping efforts conducted by the ACH to inform project selection and planning.* |
| *Required Attachment(s):*<br>A. *Provide meeting minutes or materials that highlight data-driven decision making for the demonstration (i.e. project selection, target populations, partnering providers).* |

| **Transformation Project Planning** |
|---|
| Provide a summary of current transformation project selection efforts including the projects the ACH anticipates selecting. |
| *References: Medicaid Transformation STC 36, DSRIP Planning Protocol* |
| *Narrative word-count range: 500-1,000*<br><br>1. *Provide a summary of the anticipated projects, including rationale for selection and how the ACH is approaching alignment or intersections across anticipated projects in support of a portfolio approach.*<br>2. *Demonstrate any efforts to support cross-ACH project development and alignment. Include reasoning for why the ACH has, or has not, decided to undertake projects in partnership with other ACHs.*<br>3. *What risks and mitigation strategies have been identified regarding successful project application submission?*<br>4. *What strategies are being considered to obtain commitments from interested partnering providers? What is the timeline for obtaining these commitments?* |
| *Required Attachment(s):*<br>A. *Provide an initial list of partnering providers or categories of partnering organizations interested in or committed to implementing projects.* |

# INCENTIVES FOR MID-ADOPTERS OF INTEGRATED MANAGED CARE

Counties that commit to implementing integrated managed care before 2020 will be eligible for significant incentive funds to deliver improved coordinated health care for people in their region.

## How does Medicaid Demonstration incentive funding work?

*This information is dependent on the approval of the Funding and Mechanics Protocol currently under review by CMS, and pending Washington legislative appropriation for the Medicaid Demonstration:*

As currently proposed, here's how the math works: The incentive payments eligible to each region is calculated using a base rate of up to $2 million and a per member rate based on total attributed Medicaid beneficiaries.

**Proposed integration incentive methodology** = [$2 million] + [$36 x Total Attributed Medicaid Beneficiaries] x [Phase Weight]

The incentives for integrated managed care will be distributed in two phases: delivery of binding letter(s) of intent and implementation. These phases represent two key activities towards integration. ACHs and partnering providers are eligible for an incentive payment for completion of each phase.

Based on the proposed methodology, estimates for incentives available to each region are as follows:

| Accountable Community of Health* | Regional Client Count | Eligible Incentives for Binding Letter of Intent | Eligible Incentives for Implementation | Total Incentives for Integrated Managed Care |
|---|---|---|---|---|
| **Better Health Together** | 188,757 | $3,518,000 | $5,277,000 | $8,795,000 |
| **Cascade Pacific Action Alliance** | 179,382 | $3,382,000 | $5,074,000 | $8,457,000 |
| **Greater Columbia ACH** | 243,934 | $4,312,000 | $6,468,000 | $10,781,000 |
| **King County ACH** | 407,352 | $6,665,000 | $9,998,000 | $16,664,000 |
| **Olympic Community of Health** | 81,819 | $1,978,000 | $2,967,000 | $4,945,000 |
| **Pierce County ACH** | 221,396 | $3,988,000 | $5,982,000 | $9,970,000 |
| **North Sound ACH** | 267,923 | $4,658,000 | $6,987,000 | $11,645,000 |

**Southwest ACH and North Central ACH have already committed to or implemented integrated managed care and are not reflected in this table as a result.*

# A FEW BASIC FACTS

## 1. Integration of physical and behavioral health care for Apple Health (Medicaid) clients is on a firm path.

The state Health Care Authority (HCA) is moving forward to meet the legislative direction under E2SSB 6312 to integrate behavioral health benefits into the Apple Health managed care program so that clients have access to the full complement of medical and behavioral health services through a single managed care plan. Regions statewide are required to integrate no later than 2020.

## 2. Evidence supports integrated health care is better for patients.

A strong body of evidence for integrated care has emerged over the past 20 years, particularly for depression but increasingly for other conditions, including anxiety disorders, PTSD and co-morbid medical conditions such as heart disease, diabetes and cancer. While mental health and primary care historically have been siloed, evolving payment models are spurring more integrated models of care. This wave of innovation is particularly important in safety net health systems, which serve a high proportion of uninsured and Medicaid patients — and where poverty, language barriers, and other social determinants of health may contribute to the complex physical and behavioral health needs of patients.

## 3. Regions that move to integrated care before 2020 can earn additional incentive funds.

Senate Bill 6312 allows the county authority or authorities within a region to elect to move forward with integrated managed care on an earlier timeline if desired. Under the Medicaid Demonstration, regions that implement integrated managed care before 2020 will be eligible for additional incentive payments through their Accountable Community of Health. These “mid-adopter” regions can earn these particular incentive dollars. The incentive would be in addition to funds ACHs and regional partners can receive for implementing a set of projects selected from the Demonstration Project Toolkit, pending legislative appropriation of these incentives.

## 4. By design, counties and BHOs play important roles in the transition so that local needs are addressed.

The transition to integrated managed care starts by building from the strong foundation set by behavioral health organizations (BHOs), which have taken the first step in integrating behavioral health services (E2SSB 6312 directed the integration of mental health and chemical dependency purchasing as a first step to full integration by 2020). The MCO contracts require that the MCO coordinate with county-managed programs, criminal justice, long-term supports and services, tribal entities, etc. via an Allied System Coordination Plan.

## 5. Two key steps will signal a region’s eligibility for incentive payments.

The incentives for integrated managed care will be distributed in two phases:

1. The county submits binding letter(s) of intent to the state Medicaid director no later than September 1, 2017.
2. Implementation of new integrated MCOs in the region begins on November 1, 2018, OR January 1, 2019. Regions are eligible for an incentive payment for completion of each phase, pending legislative appropriation of these incentives.

## Next steps

### 1. How can the Accountable Community of Health in my region earn the Demonstration incentives?

Regions are eligible to earn the Demonstration incentives if they elect to move forward with integrated managed care on an earlier timeline than is required in Senate Bill 6312.

The incentives will be provided, pending legislative appropriation, through ACHs in two installments based on the achievement of:

1. Submission of a binding letter of intent signed by the County Authority or authorities in the region to the Washington State Health Care Authority **by September 1, 2017**;
2. Implementation of integrated managed care effective November 1, 2018, or January 1, 2019.

### 2. Who has the authority to sign the binding letter of intent?

In statute, the county authority is defined as "the board of county commissioners, county council, or county executive having authority to establish a community mental health program, or two or more of the county authorities specified in this subsection which have entered into an agreement to provide a community mental health program." (RCW 71.24.025). In a multi-county regional service area, the county authorities for *all counties in the region* must sign the binding letter of intent. The Health Care Authority will send a formal letter to all counties informing them of the date and process to submit a binding letter of intent.

### 3. Do the incentive dollars have to be used for the transformation projects that are selected by the ACH?

No. These incentives are for partnering providers in regions that implement integrated managed care before January 1, 2020. They are complementary to but separate from funds for specific transformation projects.

### 4. If the incentives are not going to be used to fund the projects, what are they for?

The incentive payments earned for integrated managed care milestones are intended to be used to assist providers and the region with the process of transitioning to integrated managed care. This could include using funds to assist with the uptake of new billing systems or technical assistance for behavioral health providers who are not accustomed to conducting traditional medical billing or working with managed care plan business processes. Additionally the incentive payments can further support and build upon the region's work to implement integrated clinical models.

Before funds are disbursed to providers, they must be reflected in project plans. These plans are reviewed by an independent assessor, and ultimately approved by the Health Care Authority.

### 5. Why would a region choose to implement in November 2018 versus January 2019? Are there additional incentives for choosing November 2018?

The transition to integrated managed care requires significant focus, resources and dedication from the Health Care Authority, DSHS, providers, the transitioning BHO, and managed care plans. The HCA strongly recommends regions consider a November 2018 start date so that mid-adopter implementation can be staged. This will allow resources for each region to be more focused during the critical transition days. Incentive funds for November and January start dates are the same, pending legislative appropriation.

## 6. If the region does not want to move forward early, when will the region transition to integrated managed care? If the region does not move forward early, will there still be incentive dollars available?

Senate Bill 6312 directs the state to fully integrate the purchasing of medical and behavioral health services through a managed care health system no later than January 1, 2020. An integrated managed care model will be in place in all regions by January 1, 2020. Only "mid-adopter" regions can receive the proposed incentive dollars tied to integrated managed care.

## 7. My region needs more information. Who do we contact?

For questions about integrated managed care, please contact Isabel Jones: Isabel.Jones@hca.wa.gov or 360-725-0862.

For questions about the Medicaid Demonstration funds, please contact Kali Klein: Kali.Klein@hca.wa.gov or 360-725-1240.

## 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 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 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 to inform their tribal councils and receive directives from their tribal councils on whether and how the tribe 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 facility to collaborate with the OCH.

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

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 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.

## V. Communication

A. 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.

B. 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.

## 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:

_____

# Request for Applications

Release date: April 19, 2017

## Purpose of this document

The Olympic Community of Health seeks applications from invited partners in Clallam, Jefferson, and Kitsap counties for projects under the Medicaid Demonstration Transformation Project in the following areas:

1. Community-Based Care Coordination
2. Transitional Care
3. Diversion Intervention
4. Maternal and Child Health
5. Access to Oral Health
6. Chronic Disease Prevention and Control

*(By clicking on the links above, you will be directed to a one-page summary of the project area.)*

## 1. Background

The Olympic Community of Health (OCH) serves Clallam, Jefferson, and Kitsap counties and is one of nine accountable communities of health (ACH) in the state. Through the Medicaid Demonstration Project (MDP), the OCH will serve as the administrative lead for its region to coordinate and oversee regional projects selected from the toolkit. Both clinical providers, such as primary care providers, and non-clinical providers, such as social service providers, will collaborate on the implementation of projects and be responsible for committing to and carrying out the project objectives. Participating providers will be eligible for incentive payments for their role in meeting Medicaid transformation milestones and benchmarks.

**This is not a grant.** It is a five-year demonstration project, beginning with "pay for reporting" in 2018, and moving in a stepwise fashion each consecutive year to "pay for performance". By 2021, 20% of all payments will be based on performance. Additionally, there may be some capacity building funding available to provide support for projects 2017. Payment may not supplant existing funding sources. Services may not supplant existing services. Projects are intended to create new or build on existing capacity and infrastructure.

## 2. Purpose

The purpose of this Request for Applications to seek potential applications from the community within the six optional Medicaid Demonstration Project categories in the toolkit. The optional project categories are:

1. Community-Based Care Coordination
2. Transitional Care
3. Diversion Intervention
4. Maternal and Child Health
5. Access to Oral Health
6. Chronic Disease Prevention and Control

This application submission will be reviewed by the public, the OCH Board of Directors, and the OCH Regional Health Assessment and Planning (RHAP) Committee. By June 2017, through a transparent, community process, our goal is to have general agreement on the subset of projects we wish to submit to the Health Care Authority. The OCH must submit final Project Plans to the Health Care Authority for at least two of the optional projects. The submitted projects will likely represent our Medicaid Demonstration Project portfolio from 2018 to 2021.

**This application nonbinding.** The purpose of this application is to provide an adequate level of information about potential projects to inform which ones should be submitted as Project Plans in September 2017. The final Project Plans will include detailed information about funds flow, data, partner participation, target population, and other key factors.

**This is a community process.** The OCH feels that for projects to be successful in the long term, they must arise from the community they will serve. We recognize that all information about MDP is not yet available and that our timeline is ambitious. New information will be shared as soon as it is available.

We encourage applicants to do their best to answer the questions in this application based on current information. Incomplete answers are acceptable and technical assistance will be provided.

3. **Instructions: Applications are due electronically May 26th at 12:00 p.m. to mia@olympicCH.org.**

Applications must represent regional collaboration. For reference, here is an inventory of projects already underway in the three-county region within each project category. Here is a list of people and organizations who expressed an interest in being contacted to assist in the development of a project in a specific category area.

No more than three project applications are invited to present to the OCH Board of Directors from each of the six optional project categories.

Technical Assistance on the Application is available to all applicants by contacting Mia Gregg, mia@olympicCH.org.

A mandatory informational webinar will be held April 27, 2017, from 10-11:30 am. At least one participant for each application must attend.

The Application has six sections:

A. BACKGROUND
B. PARTNER COMMITMENT FORM
C. LOGIC MODEL
D. POPULATION, APPROACH, AND RESULTS*
E. IMPLEMENTATION ACTIVITIES AND TIMELINE*
F. BUDGET

**Sections D & E will be prepopulated for each of the six project areas, be sure to use the version for your project area.*

Prior to filling out the Application, applicants should read the specific information for their project area in the toolkit as the Application closely follows the format and content of that document.

**Criteria**: Applications will be scored against a set of criteria using a scoring tool. Please consider the following areas in developing your Application:

1. **Footprint**: The Project will impact many people on Medicaid and involve wide-scale Medicaid provider involvement.
2. **Scale**: The Project will be operational throughout three counties in the region.
3. **Impact**: The Project will move system-wide and project-specific measures within the 4-year demonstration window.
4. **Capacity**: The organization(s) listed to do the Project have the capacity, workforce, infrastructure, and experience to achieve the desired goals within the timeline of the Medicaid Demonstration Project.
5. **Transformational**: The Project fundamentally improves the way we serve people on Medicaid. It improves the Medicaid provider workforce. It impacts whole-person health.
6. **Budget**: The budget is reasonable. The cost is worth the return. There are other funding sources contributing to the cost of the Project.

**Eligibility:** Applicants must submit projects that will impact the Medicaid population in at least one, and preferably all, of the three counties: Kitsap, Clallam, or Jefferson. Any entity (nonprofit, governmental, tribal, coalition, etc…) may apply.

**Timeline:**

| | | |
|---|---|---|
| ➢ | April 19 | Successful LOI applicants invited to submit full application; technical assistance available |
| ➢ | April 27 | Mandatory information webinar, 10:00 am to 11:30 am; at least one person from the Application team must participate |
| ➢ | May 26 | Applications due 12:00pm via email; all submissions posted online for public comment |
| ➢ | June 9 | Public comment closes |
| ➢ | June 12 | Board of Directors invites successful applicants to present project idea |
| ➢ | July 10 | Board of Directors hears presentations and selects projects to move forward |
| ➢ | July –Sept | Olympic Community of Health, with technical assistance, will assist project teams in developing full Project Plans |
| ➢ | September 12 | Olympic Community of Health submits final Project Plans to the Health Care Authority for Medicaid Demonstration Transformation Projects in our three-county region |

**Contingency Process:** If no Applications are received for a project category, or if the Application submissions are not satisfactory, the OCH Board of Directors, either independently or through recommendation from the RHAP Committee, may direct the OCH staff to convene community partners and determine next steps.

Applications are due electronically May 26th at 12:00pm to mia@olympicCH.org.
All Application submissions will be posted: http://www.olympicch.org/medicaid-demonstration-project.html
Please sign up to receive updates as new information becomes available.

**Acronym Glossary**
ACH: Accountable Community of Health
BHO: Behavioral Health Organization
CMS: Center for Medicare and Medicaid Services
FQHC: Federally Qualified Healthcare Clinic
MDP: Medicaid Demonstration Project (previously called "the Waiver")

Application

Please do your best to limit responses to the space provided

Due May 26th by 12 pm to mia@olympicCH.org

Submitted Applications will be posted here: http://www.olympicch.org/medicaid-demonstration-project.html

| SECTION A. BACKGROUND | | | | | | | |
|---|---|---|---|---|---|---|---|
| **PROJECT TITLE** | | | | | | | |
| **APPLICATION CONTACT NAME, TITLE, AND ORGANIZATION** *This person will be the single point of contact for the submission.* | | | | | | | |
| **EMAIL** | | | **PHONE** | | | | |
| **COUNTIES SERVED BY THIS PROJECT** ☐ Clallam ☐ Jefferson ☐ Kitsap ☐ Other: | | | | | | | |
| **TRIBES SERVED BY OR COLLABORATING ON THIS PROJECT** (please name each) | | | | | | | |
| **THIS PROJECT IS**: ☐ **New** ☐ **Enhancing an existing project or set of projects** | | | | | | | |
| **PROJECT CATEGORY** *Please indicate which optional category area(s) from the toolkit your project will meet:* | | | | | | | |
| ☐ Community-Based Care Coordination<br>☐ Transitional Care | | ☐ Diversion Intervention<br>☐ Maternal and Child Health | | ☐ Access to Oral Health<br>☐ Chronic Disease Prevention and Control | | | |
| **SECTORS ENGAGED BY THIS PROJECT** (check all that apply)**:** | | | | | | | |
| ☐ Aging | ☐ Behavioral Health Org | ☐ Chemical Dependency | ☐ Chronic Disease | ☐ Community Action Pgrm | ☐ Other (please list): | | |
| ☐ Early Childhood | ☐ Economic Development | ☐ Education | ☐ Emergency Medical Services | ☐ Employment | | | |
| ☐ FQHC | ☐ Housing | ☐ Criminal Justice | ☐ Managed Care Organization | ☐ Mental Health | | | |
| ☐ Oral Health | ☐ Philanthropy | ☐ Primary Care | ☐ Maternal/Child Health | ☐ Public Health | | | |
| ☐ Hospital | ☐ Rural Health | ☐ Social Services | ☐ Specialty Care | ☐ Workforce development | | | |
| | | | | | | | |
| **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 |
| **BRIEF PROJECT DESCRIPTION** (3-4 sentences) | *Provide a brief description of the project.* | | | | | | |

Application

Please do your best to limit responses to the space provided

Due May 26th by 12 pm to mia@olympicCH.org

Submitted Applications will be posted here: http://www.olympicch.org/medicaid-demonstration-project.html

| | |
|---|---|
| **PROJECT GOAL STATEMENT** (2-3 sentences) | *What do you hope to achieve with this project? What issue are you addressing?* |
| **CASE STATEMENT** *(2-3 sentences)* | *Briefly describe the community need for this project including baseline data that are available. Bullets of data points are acceptable, include the source and year of the data. Here are some useful links to regional-level data:*<br>***Overall population***<br>• *Visualized Regional Health Needs Inventory (RHNI) data on the overall population (produced by Public Health Seattle King County (PHSKC))*<br>• *Raw Tables: Regional Health Needs Inventory (RHNI) data on overall population (produced by Health Care Authority, Department of Health, and Department of Social and Health Services*<br>***Medicaid population***<br>• Healthier Washington Data Dashboard *(produced by Providence CORE)*<br>• Cross-system performance measures (5732-1519) for Medicaid population *(produced by PHSKC)*<br>***Joint DSHS/HCA clients***<br>• Demographic/health profile of joint DSHS/HCA clients *(produced by PHSKC)* |

SECTION B. PARTNER COMMITMENT FORM – Please include all partners contributing to this project on the form.

SECTION C. LOGIC MODEL – Please fill out the logic model template.

Application

Please do your best to limit responses to the space provided

Due May 26th by 12 pm to mia@olympicCH.org

Submitted Applications will be posted here: http://www.olympicch.org/medicaid-demonstration-project.html

| SECTION D. POPULATION, APPROACH, AND RESULTS - Use the prepopulated Section D table for the specific project area of your application. The prepopulated information comes directly from the first pages for each project area as written in the Toolkit. | | | | | |
|---|---|---|---|---|---|
| **ELEMENT** | **DESCRIPTION** | **RESPONSE** | | | |
| **TARGET POPULATION** | Who is the target population for your project? How many unique individual do you expect to serve? How many Medicaid providers? | **TARGET POPULATION** *Broad definition (e.g., pregnant women living in…)* | **ESTIMATED # and % MEDICAID BENEFICARIES** *Estimated unique # of Medicaid lives; proportion of Medicaid population that will be served. Where appropriate, breakdown by county and/or Tribe.* | **ESTIMATED # FTE and TYPE of CLINICAL MEDICAID PROVIDERS** *Estimated # full-time equivalents and type of licensure (e.g., nurse, MD, DO, LMHP…) by each partner organization.* | **ESTIMATED # FTE and TYPE of NON-CLINICAL MEDICAID PROVIDERS** *Estimated # full-time equivalents and type (e.g., educator, community health worker…) by each partner org.* |
| | | | | **Organization 1:**<br>**Organization 2:**<br>**Organization 3:** | **Organization 1:**<br>**Organization 2:**<br>**Organization 3:** |
| **SYSTEM-WIDE METRICS** Will be provided by the State at the ACH level at least annually, | The metrics, as written in the toolkit, are pre-populated in the next column.<br>**Metric definitions can be found in** | **METRIC** *Pre-populated from the toolkit* | **IS THIS METRIC SOMETHING YOUR PROJECT PARTNERS CAN COLLECT AND REPORT?** *If yes or "sort of", please tell us about it. If no, please explain how you will be willing to use this metric or how you might collect it in the future. How will your project impact this metric?* ***Please reference these metrics in Section C. Logic Model.*** | | |
| | | Rate of Teen Pregnancy (15 – 19) | | | |

Application

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| SECTION D. POPULATION, APPROACH, AND RESULTS - Use the prepopulated Section D table for the specific project area of your application. The prepopulated information comes directly from the first pages for each project area as written in the Toolkit. | | | | | |
|---|---|---|---|---|---|
| **ELEMENT** | **DESCRIPTION** | **RESPONSE** | | | |
| or if possible at the same frequency as the project-level measures. | **the toolkit appendix.** | Unintended Pregnancies | | | |
| | | Low Birth Weight Rate | | | |
| **PROJECT-LEVEL METRICS** Intended to track performance at a level more directly tied to project deliverables. The project-specific metrics should be reported at the ACH level and, if possible and applicable, at the practice or organization | The metrics, as written in the toolkit, are pre-populated in the next column. Several of these metrics may not be relevant to your specific project area. Please delete those rows or leave blank.<br><br>**Metric definitions can be found in the toolkit appendix** | **METRIC** *Pre-populated from the toolkit* | **ABLE TO REPORT THIS METRIC? IF SO, HOW OFTEN?** *Weekly, Monthly, Quarterly…* | **LEVEL** *Unit of analysis (clinic, hospital, etc..)* | **DATA OWNER** *Organization(s) responsible for providing data* |
| | | Prenatal care in the first trimester of pregnancy | | | |
| | | Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life | | | |
| | | Well-Child Visits in the First 15 Months of Life | | | |
| | | Chlamydia Screening in Women Ages 16 to 24 | | | |
| | | Contraceptive Care – Most & Moderately Effective Methods | | | |
| | | Contraceptive Care – Access to Long Acting Reversible Contraceptive (LARC) | | | |
| | | Contraceptive Care – Postpartum | | | |

| SECTION D. POPULATION, APPROACH, AND RESULTS - Use the prepopulated Section D table for the specific project area of your application. The prepopulated information comes directly from the first pages for each project area as written in the Toolkit. | | | | | |
|---|---|---|---|---|---|
| **ELEMENT** | **DESCRIPTION** | **RESPONSE** | | | |
| level. They should be reported as frequently as feasible and relevant; frequency may vary by measure. | Use the rows below to write in metrics that are not in the toolkit that would help gauge the success of the project. | Childhood Immunization Status | | | |
| **ADDITIONAL PROJECT-LEVEL METRICS (NOT IN THE TOOLKIT)** Metrics to be collected, tracked, and reported for the same purpose and at the same frequency as metrics in the toolkit (see above). | We recognize that the toolkit may not include a complete list of metrics that should be considered to track Project success.<br><br>Please write in metrics that are not in the toolkit that would help gauge the success of the project. | **ADDITIONAL RECOMMENDED METRICS NOT IN THE TOOLKIT** *List and define the metric include source for definition* | **ABLE TO REPORT THIS METRIC? IF SO, HOW OFTEN?** *Weekly, Monthly, Quarterly…* | **LEVEL** *Unit of analysis (clinic, hospital, etc..)* | **DATA OWNER** *Organization(s) responsible for providing data* |
| | | | | | |
| | | | | | |
| | | | | | |

Application

Please do your best to limit responses to the space provided

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Submitted Applications will be posted here: http://www.olympicch.org/medicaid-demonstration-project.html

| | | |
|---|---|---|
| **EVIDENCE BASED APPROACH** | List which approach(es) your project will use of those written in the toolkit. Justify your selection. | *Refer to pages 45-46 of toolkit.* |

Application

Please do your best to limit responses to the space provided

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Submitted Applications will be posted here: http://www.olympicch.org/medicaid-demonstration-project.html

| PROJECT IMPLEMENTATION | | | | |
|---|---|---|---|---|
| **STAGE 1. PLANNING PROGRESS MEASURES** are like milestones to gauge readiness for implementation. | The measures (milestones), as written in the toolkit, are pre-populated in the next column. | **MILESTONE** | **ORGANIZATION LEAD** | **ESTIMATED DATE OF COMPLETION** |
| | | Complete Project Implementation Plan | | |
| | | List implementation partners with formal written commitment to participate in the project | | |
| **STAGE 2. IMPLEMENTATION PROGRESS MEASURES** milestones to gauge progress of implementation. | The measures (milestones), as written in the toolkit, are pre-populated in the next column. | **MILESTONE** | **ORGANIZATION LEAD** | **ESTIMATED DATE OF COMPLETION** |
| | | Adopt guidelines, policies, protocols, and/or procedures, specific to the selected approach | | |
| | | Identify number of partners and providers implementing evidence-based approach(es). | | |
| | | Identify number of partners and providers trained on the evidence-based approach: projected vs. actual and cumulative. | | |
| **STAGE 3. SCALE AND SUSTAIN PROGRESS MEASURES** | The measures (milestones), as written in the toolkit, are pre-populated in the next column. | **MILESTONE** | **ORGANIZATION LEAD** | **ESTIMATED DATE OF COMPLETION** |
| | | Identify number of partners participating in the project strategies. | | |
| | | Identify number of partners trained on the approach: projected vs. actual and cumulative. | | |

**SECTION E. IMPLEMENTATION TIMELINE.** Please follow the instructions and fill out the Implementation and Activities Timeline template (attached).

**SECTION F. BUDGET AND BUDGET NARRATIVE.** Please complete the budget template and provide a budget narrative in the space provided at the bottom of Attachment F.

lympic Community of Health

**ATTACHMENT B. PARTNER COMMITMENT FORM**
**REQUEST FOR APPLICATIONS – APRIL 19, 2017**
PROJECT TITLE: _____

*Please have all anticipated implementation partners and/or clinical provider partners fill out and sign this form. If unable to engage with potential partners due to time constraints, please still note each one and their anticipated types of participation in the table below, and check the box in the last column. Please fill out the questions on the back of this form to describe how the partnership will work together, how partners planned/worked together to prepare the application, and previous experience in project management.*

| **PARTNER NAME** | **AGENCY/ ORGANIZATION NAME** | **TYPE OF PARTICIPATION CHECK ALL THAT APPLY** | | | | | | | | **GEOGRAPHIC SERVICE AREA** (County/City/Tribal Reservation) | **COMMITMENT LEVEL** | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Provide data | Manage data | House interve-ntion | Provide staff | Provide equipt-ment | Serve on commit-ee | Provide clinical champi-on | Other Please specify | | **ENGAGED PROVIDE SIGNATURE ELECTRONIC OK** | **INTEND TO ENGAGE** |
| | | | | | | | | | | | | ☐ |
| | | | | | | | | | | | | ☐ |
| | | | | | | | | | | | | ☐ |
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| | | | | | | | | | | | | ☐ |
| | | | | | | | | | | | | ☐ |

**Partner Commitment Narrative**

a. **How do you anticipate that partners will work together over the demonstration period (quarterly meetings, steering committee, learning collaborative, etc..)?**

| |
|---|
| *3-5 sentences* |

b. **Describe how partners planned/worked together to prepare this application.**

| |
|---|
| *3-5 sentences* |

c. **Describe the capacity to implement this project amongst your coalition of partners.** Provide evidence and examples of similar projects implemented and managed which demonstrates the ability of the coalition of organizations to successfully implement and manage publicly funded projects in a timely manner, within budget, and consistent with funding requirements. Please include experience working with federal contracts and note any history of default.

| |
|---|
| *3-5 sentences* |

Olympic Community of Health

**SECTION C: LOGIC MODEL**

**REQUEST FOR APPLICATIONS – APRIL 19, 2017**

"A logic model is a systematic and visual way to present and share your understanding of the relationships among the resources you have to operate your program, the activities you plan, and the changes or results you hope to achieve." (W.K. Kellogg Foundation 2004)

| **PROJECT TITLE:** | |
|---|---|
| **ASSUMPTIONS:**<br>*These relate to the root causes of the problem and/or to external community and social factors that might influence the program.* | |

| **RESOURCES/INPUTS** | **ACTIVITIES** | **OUTPUTS** | **OUTCOMES** | | | **IMPACT** |
|---|---|---|---|---|---|---|
| ***PLANNED WORK*** | | ***INTENDED RESULTS*** | | | | |
| *These are the assets you need to implement your program – e.g. staff, participants, materials, supplies, funding.* | *The actions you will implement to achieve program results.* | *Direct result of each program activity, e.g. number of participants, number of trainings, hours of classes.* | *How will you know how your project is going? Include outcomes for all time periods to measure change in status, behavior, knowledge, skills, or functioning as a result of program activity.*<br>**short**<br>**< 1 year** | **medium**<br>**1-5 years** | **long term**<br>**5 years +** | *The very long-term community, organizational, and/or systemic change that will occur as a result of program activities. Be sure to cover system-wide metrics from the toolkit.* |
| | | | | | | |

**SECTION E. IMPLEMENTATION ACTIVITIES AND TIMELINE**

**REQUEST FOR APPLICATIONS – APRIL 19, 2017**

PROJECT 3B: REPRODUCTIVE AND MATERNAL/CHILD HEALTH PROJECT TITLE: _____

**Instructions: For each activity (pasted below as written in the toolkit), describe how you will implement the activity and fill in the quarters on the timeline during which you anticipate the work will be done.**

| ACTIVITY | DESCRIPTION OF IMPLEMENTATION OF THE ACTIVITY | Year 1 | | | | Year 2 | | | | Year 3 | | | | Year 4 | | | | Year 5 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| **STAGE 1:PLANNING** | | | | | | | | | | | | | | | | | | | | | |
| Utilize the Regional Health Needs Inventory data to guide selection of evidence-based approach(es) and specific target population(s). | | | | | | | | | | | | | | | | | | | | | |
| Identify, recruit, and secure formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach. | | | | | | | | | | | | | | | | | | | | | |
| Develop a project implementation plan that includes, at minimum the elements below * (see list below). | | | | | | | | | | | | | | | | | | | | | |
| **STAGE 2: IMPLEMENTATION** | | | | | | | | | | | | | | | | | | | | | |
| Implementation of evidence-based practice or emerging strategies or promising practice. | | | | | | | | | | | | | | | | | | | | | |
| For all approaches, implementation must include the following core components: | | | | | | | | | | | | | | | | | | | | | |
| Establish guidelines, policies, protocols, and/or procedures as necessary to support consistent implementation of the model | | | | | | | | | | | | | | | | | | | | | |
| Ensure each participating provider and/or organization is provided with, | | | | | | | | | | | | | | | | | | | | | |

| ACTIVITY | DESCRIPTION OF IMPLEMENTATION OF THE ACTIVITY | Year 1 | | | | Year 2 | | | | Year 3 | | | | Year 4 | | | | Year 5 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner | | | | | | | | | | | | | | | | | | | | | |
| Implement robust bi-directional communication strategies, ensure care team members, including client and family/caregivers, have access to the care plan | | | | | | | | | | | | | | | | | | | | | |
| Establish mechanisms for coordinating care management and transitional care plans with related community-based services and supports such as those provided through supported housing programs | | | | | | | | | | | | | | | | | | | | | |
| Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes | | | | | | | | | | | | | | | | | | | | | |
| Establish a performance-based payment model to incentivize progress and improvement | | | | | | | | | | | | | | | | | | | | | |
| **STAGE 3: SCALE AND SUSTAIN** | | | | | | | | | | | | | | | | | | | | | |
| Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities. | | | | | | | | | | | | | | | | | | | | | |
| Employ continuous quality improvement methods to refine the model. | | | | | | | | | | | | | | | | | | | | | |

| ACTIVITY | DESCRIPTION OF IMPLEMENTATION OF THE ACTIVITY | Year 1 | | | | Year 2 | | | | Year 3 | | | | Year 4 | | | | Year 5 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion | | | | | | | | | | | | | | | | | | | | | |
| Develop payment models to support care transitions approaches. | | | | | | | | | | | | | | | | | | | | | |
| Incorporate value-based payment (VBP) strategies to support the program. | | | | | | | | | | | | | | | | | | | | | |

* **Implementation Plan must include each of the following core components**:

- The selected evidence-based approach(es) and description of the target population, including justification for how the approach is responsive to the specific needs in the region.
- List of committed implementation partners and potential future partners that demonstrates sufficient initial engagement to implement the approach in a timely manner.
- Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts. Project plans must consider current implementation of all Home Visiting Models and how they might be strengthened or expanded.
- Implementation timeline.
- Description of the mode of service delivery, which may include home-based and/or telehealth options.
- Roles and responsibilities of partners

## ATTACHMENT F. BUDGET AND BUDGET NARRATIVE

**Olympic Community of Health Request for Applications - April 19, 2017** **Project Title:** _____

*Instructions: Please provide an approximate budget for one year of project implemetation at full capacity. Grey-shaded cells will autocalculate.*

| | Organization 1 <Insert name of organization here> | | | Organization 2 <Insert name of organization here> | | |
|---|---|---|---|---|---|---|
| **Enter the estimated costs associated with your project by Organization** | **Total Cost** | **Requested from Medicaid Demonstration Project** | **Percent of Total Requested from MDTP** | **Total Funds Budget** | **Requested from Medicaid Demonstration Project** | **Percent of Total Requested from MDTP** |
| **Personnel (FTE)** | | | | | | |
| <Employee title/description (FTE)> | $ - | $ - | #DIV/0! | $ - | $ - | #DIV/0! |
| <Employee title/description (FTE)> | $ - | $ - | #DIV/0! | $ - | $ - | #DIV/0! |
| <Employee title/description (FTE)> | $ - | $ - | #DIV/0! | $ - | $ - | #DIV/0! |
| Total Benefits | $ - | $ - | #DIV/0! | $ - | $ - | #DIV/0! |
| **SUBTOTAL** | **$ 0.00** | **$ 0.00** | #DIV/0! | **$ 0.00** | **$ 0.00** | #DIV/0! |
| **Operating Costs** | | | | | | |
| Supplies/Materials | $ - | $ - | #DIV/0! | $ - | $ - | #DIV/0! |
| Travel | $ - | $ - | #DIV/0! | $ - | $ - | #DIV/0! |
| Other (Describe): | $ - | $ - | #DIV/0! | $ - | $ - | #DIV/0! |
| **SUBTOTAL** | **$ 0.00** | **$ 0.00** | #DIV/0! | **$ 0.00** | **$ 0.00** | #DIV/0! |
| % Indirect (Limited to 10%) | $ - | $ - | | $ - | $ - | |
| **Total Project Budget** | **$ 0.00** | **$ 0.00** | #DIV/0! | **$ 0.00** | **$ 0.00** | #DIV/0! |

**Budget Narrative:** *Use the space below to provide a brief narrative justifying the items included in your proposed budget and a description of existing resources or other support you expect to have for the proposed project. Please remember that MDTP incentives cannot supplant current funding. [NOTE: At the time this template was created the exact amount of earnable funds for each project area was unknown. We ask that applicants present actual costs to the best of their knowledge to implement the project. Once selected, we will work closely with partners July through September to specify fund flow details]*



*** For Technical Assistance, contact Mia Gregg, mia@olympicCH.org ***

STAFF WILL REVIEW AND COMPILE SCORES FOR SECTIONS I AND II.

I. **Footprint**. *The Project will impact many people and involve wide-scale provider involvement.* ***20% of TOTAL***
   a. **Medicaid Beneficiaries**. How many Medicaid Beneficiaries will this project impact by 2021. [**15%**]
      i. > 5,000
      ii. 3,000-4,999
      iii. 1,500-2,999
      iv. 500-1,499
      v. 1-499
   b. **Medicaid Providers** (clinical): *How many clinical Medicaid providers (# FTE, not agencies/organizations) will collaborate or participate?* [**5%**]
      i. >50
      ii. 30-49
      iii. 20-29
      iv. 10-19
      v. 1-9

II. **Scale.** *The Project will be operational throughout three counties in the region.* ***20% of TOTAL***
   a. **Organizations.** *How many organizations are on the commitment form?* [**4%**]
      i. 8-10
      ii. 5-7
      iii. 2-4
      iv. 1
   b. **Counties**. *How many counties are working on this project?* [**10%**]
      i. 3
      ii. 2
   c. **Tribes**. *How many Tribes are working on this project?* [**6%**]
      i. 5-7
      ii. 3-4
      iii. 1-2

III. **Impact.** *The Project will move the system-wide and project-specific metrics within the 4-year demonstration window.* ***20% of TOTAL***
      i. **Measurable.** *On a scale of 1 to 5, please rate the ability and/or willingness to collect, monitor and report metrics. Will the data be reported at the right level? Will it allow us to track project progress and make timely performance-based payments? Emphasize ability to measure and report on the project-level metrics.* [**5%**]
      ii. **Movable.** *On a scale of 1 to 15, please rate how well the project will "move the dial" on the metrics? How soon do you expect these measures to move in the right direction? Will many project and system-level metrics be impacted by this project? Refer to content provided in Section E Implementation Timeline* [**15%**]

IV. **Capacity.** *On a scale of 1-10, please rate how likely it is that the organizations listed to do the Project have the capacity, workforce, infrastructure, and experience to achieve the desired goals within the four-*

*year time-period? Gather information for this from throughout the application, especially in Section B partner commitment form and Section D system and project level metrics.* ***10% of TOTAL***

V. **Transformational.** *On a scale of 1-10, please rate how transformational the project is. Will the Project fundamentally change the way we serve Medicaid? Will it change the workforce of Medicaid providers? Will it have a major impact on population health?* ***10% of TOTAL***

VI. **Budget.** *On a scale of 1-10, please rate whether the budget is reasonable, at a high-level. Is the cost worth the return? Is the cost per "widget" (e.g., cost per person served or cost per intervention) worth it? Are there other funding sources, planned or confirmed, contributing to the cost of the Project, either in-kind or cash?* ***10% of TOTAL***

VII. **Need.** *On a scale of 1-10, please rate how well this project addresses a community health need. Based on the available baseline data, is there a clear community health need that this Project can address within a four-year window?* ***10% of TOTAL***

**TOTAL:**
**TOTAL POSSIBLE: 100**

**REVIEWER COMMENTS.** *Include reflections on the overall application as well as positive elements not captured in scoring and/or concerns that did not come through in the scoring.*

_____

_____

_____

_____

_____

_____

Olympic Community of Health

**Clinical Engagement Strategy S.B.A.R.**

Presented to the Board of Directors April 10, 2017

## Situation

The Medicaid Demonstration is based on a Delivery System Reform Incentive Payment (DSRIP) program. We must have significant engagement and input from clinical providers who work within the current delivery systems and will benefit from and influence a new delivery system.

## Background

The table below represents the major providers that serve Medicaid in our three-county region.

| Hospitals and Outpatient Services | Federally Qualified Healthcare Clinics | Large Provider Groups | Tribal Clinics | Behavioral Health Clinics |
|---|---|---|---|---|
| CHI Harrison | North Olympic Health Network | Bogachiel Medical Clinic | Port Gamble S'Klallam Health Clinic and Wellness Center | Discovery/Jefferson Behavioral Health |
| Forks Community Hospital | Peninsula Community Health Services | Harrison Health Partners/Doctor's Clinic | Suquamish Wellness Center | Kitsap Mental Health Services |
| Jefferson Healthcare | | Jamestown Family Health Center | Lower Elwha Health Clinic | Peninsula Behavioral Health |
| Olympic Medical Center | | Jefferson Healthcare Adult and Pediatric Clinics | Quileute Health Center | Safe Harbor Recovery |
| | | Olympic Medical Physicians | Jamestown Family Health Center | West Sound Treatment Center |
| | | | Makah Health Center | West End Outreach Services |

## Action – Timeline for Provider Engagement

### May-June 2017

**Activity**: Evaluate proposed evidence-based programs

**Questions to Run On**: Are these projects a good fit for us? Can we implement these well and in the allotted time? Can we really move the dial? Do these move us towards our strategic goal(s)? Are these sustainable?

**Organizational Representatives**: Executive Leadership and/or Operations

### June-July 2017

**Activity**: Agree on ACH-level and organization-level performance measures and targets

**Questions to Run On**: Which measures align with our payer contracts? What is our baseline performance? What is our footprint/scalability? How much can we move these measures, as organizations and as a region?

**Organizational Representatives**: Quality Improvement, Data/Analytics, Population Health Management, Frontline Providers, Contracting, MCOs; technical assistance from Manatt Health

**July-September 2017**

**Activity**: Agree on and set organization-level incentive payments based on targets
**Questions to Run On**: How much do we need to do the work? What incentive payment plan will work (timing, amount, etc…)? What are our contingencies?
**Organizational Representatives**: Executive Leadership in Finance and/or Business/Operations; technical assistance from Manatt Health

Proposed **Recommendation**
The Board approves a Phase I Clinical Engagement Strategy:

- ✓ Identify and hire TA contractor in May to begin work on the Project Plan for Bi-Directional Integration of Care/Primary Care Transformation
- ✓ Executive director will assess willingness to participate from major Medicaid providers for short term goals (May-September) and begin to schedule key meetings in May, June, and July.
- ✓ Form a distribution list of Medicaid providers to streamline communication. Use Survey Monkey for short surveys as needed.
- ✓ Table discussion of ongoing provider-level committees/provider champion until after September.

Olympic Community of Health

**Organizational Readiness S.B.A.R.**

Presented to the Board of Directors April 10, 2017

**Frame:** The recommendations proposed in this document are designed to take us to September 2017, at which point we may reassess based on new information. This new information includes the portfolio of projects we select and the details of the Project Plans we submit in September. Additional information will come from the HCA, detailing earnable revenue for each Project Plan.

**Purpose:** The purpose of this SBAR is to propose a series of preliminary steps to prepare us to submit high-quality, competitive Project Plans that will successfully address community health needs and yield the highest amount of incentive payments to providers as possible.

## Situation

Under the Medicaid Demonstration Transformation Project (MDTP), the OCH will authorize millions of dollars of incentive payments to subcontractors through several dozen contracts for between 4 and 8 projects.

## Background

OCH will receive up to $1,000,000 and $5,000,000 in Project Design Funds in Phase I (May) and II (September) respectively.

**Questions to run on:** MDTP is a single, time-limited project under the OCH. Key questions to guide our thinking:

- What do we want to buy (employ)?
- What do we want to rent (contract)?
- What do we want to share (with other ACHs or Partner Organizations)?

**Guiding Principles** to guide our thinking: The OCH should be…

- responsive, able to flex up or flex down, in response to the community's needs,
- efficient and results-oriented: as big as we need to be to get the job done, and
- a value-add organization.

**Preliminary Steps for Board Consideration:** The OCH will serve as the regional lead entity and single point of performance accountability for transformation projects under MDP. To prepare for this, the Board is asked to consider the following preliminary actions:

1. Data and Analytic Capacity
2. Financial Capacity
3. Staffing Capacity
4. Project Plan Development
5. Vendors and Contracts
6. Other Adjustments
7. Long term, strategic fiscal planning - Three broad categories to consider:
    a. Distribute funds strategically allocate to community partners to support MDT Project efforts in a way that it open and transparent; decided proactively based on data and need
    b. Reserves to run OCH operations for 2018-2021
    c. Invest to support future innovations

## Actions [For all actions below, reassess in September/October 2017]

1. **Data and Analytic Capacity** – [Increase of $19,233]

a. Continue current contract with **Kitsap Public Health District** (KPHD) for $45,872, covering 2017. Authorize Executive Director (ED) to increase up to 25% to $57,340 if additional assistance from KPHD is required.
b. Explore contract with **Seattle King County Public Health** for additional support to assist KPHD with Regional Health Needs Inventory and data visualization tool, estimating $7,765, covering May – September 2017
c. Explore opportunities to **collaborate with ACHs** for evaluation of same programs

2. **Financial Capacity -** [Increase of $10,007]
    a. Continue current contract with **accounting firm**. Current budget allows for $9,900 for bookkeeping, $3,129 for payroll services, and up to $7,000 for accounting services. Authorize the Executive Director to increase these, as needed, up to 25% to $25,036 in total.
    b. Under advisement of the Finance Committee…
        i. authorize the ED to **rent CFO-level services** ($100/hour with nonprofit discount) from the accounting firm above, not to exceed $5,000.
        ii. the ED solicits bids from ≥ three firms to perform an **independent audit** in early 2018.
        iii. seek **in-kind donation of financial services** from Board Member organizations.
        iv. **monitor internal financial capacity needs** and make recommendations to the Board as needs evolve.
    c. Explore **sharing financial services** with other ACHs.

3. **Staffing Capacity** - [Increase of $88,099]
    a. Authorize the ED to **hire a full time Administrative Assistant** as soon as possible. The current budget only authorizes up to 0.5 FTE for 8 months.
    b. **Increase the FTE for the Director of Special Projects** from 0.6 FTE to 1.0 FTE. Broaden this job description to include community engagement, tribal engagement and, most importantly, assistance with project plan development.

4. **Project Plans** - [Increase of $54,698]
    a. **Project Selection**: Authorize up to $11,798 in a professional service contract to assist application teams to develop stellar applications in April and May.
    b. **Project Plan Development**: Authorize up to $42,900 in one or more professional service contracts to assist in the development of project plans between May and September.

5. **Vendors and Contracts** - [Increase of $25,300]
    a. **Legal Consult**: Authorize the ED to increase the approved budgeted amount by up to 50% from $5,000 to $7,500, as needed.
    b. **HR Consult**: Contract with an HR consultant to rapidly set up a performance evaluation system, assist with job description development, internal HR policies and procedures, and help set organizational culture. We have identified someone willing to do this pro-bono or at a greatly reduced rate. Authorize the ED up to expend up to $4,000 for this service.
    c. **Space**: Authorize the ED to lease space and IT support from Jefferson Health Care to support 4 employees. Current contract supports $10,000/year. The amended contract will likely be $18,800/year. Allow flexibility in forming a new arrangement if needed.
    d. **Other Consultants**: Board authorizes the Executive Committee to advise the ED on ad hoc consultant/TA opportunities that may benefit the organization, up to $10,000, as needed.
    e. **Contract Monitoring and Compliance**: Table this for now and reassess in September 2017

6. **Other Adjustments** - [Increase of $6,106]

a. **Supplies**: Increase from $4,000 to $7,000 (Office furniture, equipment, cell phones)
b. **Travel/Mileage**: Increase up to 25% from $8,424 to $10,530
c. **Venue Rental**: Increase from $1,500 to $2,500

7. **Long Term Strategic Fiscal Planning**
    a. Under advisement of the Finance Committee, begin a draft **2018-2021 OCH Budget** in June. Bring to Board in August/September, for approval at the annual meeting in November. Offer a comparison of the approved budget versus forecasted spend.
    b. As soon as we select Projects and have general consensus on annual operating budget:
        i. Under advisement of the Executive Committee, and with ongoing input from the provider community and Manatt Health, begin a draft of a **Design Fund Allocation Plan** and/or **Provider Capacity- Building Allocation Plan.** Bring a draft to the Board as soon as possible, no later than October. Target approval at the annual meeting November 2017 depending on information availability regarding total earnable payments for Projects.
    c. Charge staff to develop an **investment policy** and bring to Finance Committee for a proposed recommendation to the Board.

**Table 1. Forecasted Spend.** Approved budget versus forecasted spend associated with all combined proposed actions – Increase of $203,442 (54%)

| Item | Approved 2017 Budget | Forecasted 2017 Budget |
|---|---|---|
| Personnel Costs + Benefits | $251,683 | $339,782 |
| Professional Services/Contractors | $56,066 | $151,497 |
| Administrative Services (finance, space, IT) | $36,029 | $49,836 |
| Other | $31,757 | $37,863 |
| **APPROVED VS FORECASTED** | **$375,535** | **$578,977** |

**Table 2. Estimated Draw on Reserves.** Project Design Funds will not be banked until May, at the earliest. The proposed recommendation is to authorize the ED to draw down our reserves for April and May:

| Item | Estimated draw from reserves |
|---|---|
| Administrative Assistant | $8,500 |
| Director of Special Projects | $18,500 |
| Data Support | $2,500 |
| Technical Assistance for Project Selection | $12,000 |
| Technical Assistance for Project Plan Development | $3,000 |
| Financial Support | $5,000 |
| HR Consultant | $4,000 |
| **TOTAL MAXIMUM DRAW** | **$53,500** |

Proposed **Recommendation**
The Board authorizes the proposed actions defined above to

- enhance Data and Analytic Capacity; Financial Capacity; and Staffing Capacity
- develop competitive Project Plans
- broaden the scope or number of contracts with vendors to support our work
- make minor adjustments to absorb the increased number of FTE and meetings
- begin long term fiscal planning for the organization and strategic planning for our investments in Medicaid Transformation in the region

## Olympic Community of Health

### Oral Health Access Strategic Planning Guide

Prepared for April 10th planning session
3:00 pm to 4:30 pm
2500 SIMS Way, Jefferson Health Care, 3rd Floor

#### PURPOSE

The purpose of this document is to start the conversation about how to move towards improved oral health access in our three-county region. The goals and strategies listed herein are designed to stimulate discussion and move us towards a recommendation for the Board.

#### KEY OBJECTIVE

Agree on a recommendation for the Board on a strategic plan, including key partners, to increase access to oral health services for the three-county region over the next five years

#### GOALS

1. Over the next five years, increase access to oral health services for:
    a. Kids on Medicaid by 25%
    b. Seniors by 50%
    c. Pregnant Women on Medicaid by 25%
    d. Diabetic Adults on Medicaid by 25%

#### ANCHOR STRATEGIES

1. **Oral Health Coordinated Referral Pathway**
   Embed the Access to Baby and Child Dental (ABCD) Program and leverage the enhanced reimbursement for oral health services for pregnant women and diabetics on Medicaid, to create a centralized referral pathway from primary care to dentists. Incorporate and scale existing referral pathways from emergency departments to dentists. Engage with MCO partners on a managed dental care pilot.
   **Key Partners**: dentists, primary care, pediatricians, family practice, tribal health clinics, emergency departments

2. **Fully integrated behavioral health, primary care, and oral health**
   Support rural health clinics, tribal clinics, FQHCs, and behavioral health clinics as they integrate services to provide whole-person care.
   **Key Partners**: rural health clinics, FQHCs, behavioral health clinics, tribal clinics

3. **School-based programs**
   Support the development of school-based interventions such as sealants in schools and mobile vans. Consider leveraging the mobile vans to also provide integrated services, such as well-child checks or behavioral health screens. We can also explore school-based clinics.
   **Key Partners:** FQHCs, rural health systems, Tribes

4. **Oral Health Disease Management**
   Integrate oral health standards of care and oral population health management into the clinical setting. Consider new technology infrastructure, such as mobile apps and integrated EHRs.
   **Key Partners:** EPIC, tribal health clinics, FQHCs, rural health clinics, independent primary care clinics

5. **Increase the Number of Dental Chairs**
   Support the development of new dental chairs, such as a nonprofit dental clinic, expansion of FQHC-offered dental services, development of a rural clinic dental clinic, or co-location of dental services into alternative clinical settings.
   **Key Partners:** rural health clinics, FQHCs, behavioral health clinics, tribal clinics

6. **Workforce Development**
   Train a cadre of the Dental Health Aid Therapist (DHAT) to expand access to oral health services, emphasizing native and rural populations. Explore the viability of a dental residency program. Offer basic oral health training to primary care physicians through the WA Dental Service Foundation. Offer technical assistance in dentist recruitment.
   **Key Partners:** Tribes, hospitals, WA Dental Service Foundation, primary care

7. **Oral Health Services in Long-Term Care and In-Home Settings**
   Explore the viability of dental hygienists serving seniors in skilled nursing and assisted living settings. Engage with the area agencies on aging to offer in-home services for COPES or dual-eligible clients.
   **Key Partners:** skilled nursing facilities, assisted livings, area agencies on aging, long-term care businesses, independent dental hygienists

8. **Value-Based Oral Health Purchasing Pilot**
   Investigate value-based purchasing (VBP) arrangements in the oral health setting.
   **Key Partners:** tribal clinics, rural health clinics, dental providers