Olympic Community of Health
Agenda

**Board of Directors Meeting**
**June 10, 1 pm to 3 pm**
**Location:** Red Cedar Hall, Jamestown Tribal Center, 1033 Old Blyn Hwy, Sequim, WA 98382
**Web:** https://global.gotomeeting.com/join/937538149
**Phone:** +1 (872) 240-3311
**Access Code:** 937-538-149

**Key Objective:** To collaboratively advance the work of Olympic Community of Health

**Agenda (Action items are in red)**

| # | Time | Topic | Purpose | Lead | Attachment | Pg # |
|---|---|---|---|---|---|---|
| 1 | 1:00 | Board and guest introductions<br>Housekeeping | | Roy Walker | | |
| 2 | 1:10 | Approve agenda | Action | Roy Walker | 1. Board Agenda | 1 |
| 3 | 1:15 | Consent agenda | Action | Roy Walker | 2. DRAFT: Board Minutes: May 13, 2019<br>3. Executive Director report | 2-6 |
| 4 | 1:20 | 2019 legislative and budget update | Information | Celeste Schoenthaler | | |
| 5 | 1:35 | 2019 winter site visit report | Discussion | JooRi Jun & Miranda Burger | 4. Site Visit Report | 7-51 |
| 6 | 2:05 | Integrated Managed Care | Discussion | Stephanie Lewis & Celeste Schoenthaler | | |
| 7 | 2:25 | Olympic Medical Center (OMC) 2018 payment correction | Action | Celeste Schoenthaler | 5. SBAR: OMC 2018 Payment Correction | 52-53 |
| 8 | 2:45 | Officer elections | Action | Roy Walker | 6. SBAR: 2019 Officer Elections | 54-55 |
| 9 | 3:00 | Adjourn | Action | Roy Walker | | |

Acronyms
BOD: Board of Directors
OCH: Olympic Community of Health
MTP: Medicaid Transformation Project
SBAR: Situation. Background. Action. Recommendation.

**Olympic Community of Health**
**Board Meeting Minutes**

| **Date:** 05-13-2019 | **Time: 1:20-2:28 PM** | **Location:** Red Cedar Hall, Jamestown S'Klallam |
|---|---|---|

**Acting Chair:** Jennifer Kreidler-Moss, Peninsula Community Health Services

**Members Attended:** Bobby Beeman, *Olympic Medical Center*; Brent Simcosky, *Jamestown S'Klallam Tribe,* Gary Kreidberg*, Harrison Health Partner;* Gill Orr*, Cedar Grove Counseling;* Hilary Whittington, *Jefferson Healthcare*; Laura Johnson, *United Healthcare*; Scott Kennedy, *Olympic Medical Center*; Stephanie Lewis, *Salish Behavioral Health*; Vicki Kirkpatrick, *Clallam County Public Health*; Wendy Sisk*, Peninsula Behavioral Health*

**Non-Voting Members Attending:** Mike Maxwell*, North Olympic Healthcare Network;* Marissa Ingalls, *Coordinated Care*; Susan Turner, *Kitsap Public Health District*; Joe Roszak, *Kitsap Mental Health Services;* Mattie Osborne, *Amerigroup*; Denise Wong (via phone), *Molina;*

**Guests and Consultants Attended by Phone:** Amy Etzel, *Department of Health;* Dan Vizzini, *Oregon Health Sciences University;*

**Staff Attending:** Celeste Schoenthaler, Daniel Schafer, Debra Swanson, Margaret Moore

| Person Responsible for Topic | Topic | Discussion/Outcome | Action/Results |
|---|---|---|---|
| Jennifer Kreidler-Moss | Board and guest introductions Housekeeping | | |
| Jennifer Kreidler-Moss | Approve agenda -Action | Approval of Minutes | **APPROVED** unanimously |
| Jennifer Kreidler-Moss | Consent agenda - Action | Approval of Consent Agenda, with Removal of Last Line Item, CTAC Update | Consent Agenda **APPROVED** unanimously |
| Jennifer Kreidler-Moss | Meeting frequency and mode (follow-up from April) | • Concern of dwindling engagement, so Executive Committee recommends keeping the regular board meeting schedule the same for now.<br>• (Questions regarding ACH update, dental managed care, Celeste will learn more and provide update after tomorrow's ACH meeting.)<br>• Hilary says if we reduce the number of meetings, some will | |

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| | | be less informed, and we need the voice of all sectors. | |
| Jennifer Kreidler-Moss<br>Celeste Schoenthaler | Elections (follow-up from April):<br>Officer elections in June<br>Board member elections in September | • Elections coming up, officers in June, BOD members in September<br>• Executive Committee is two members short, so it is best to keep that order of elections and vote officers in June.<br>• Self-nomination process for officers proposed<br>• Hilary could serve one more term as Treasurer. Treasurer must have competency in reading financial statements. With Nathanael's support (OCH CFO), it is manageable.<br>• Wendy willing to self-nominate for President seat.<br>• Celeste will send an email follow-up asking other BOD members if they want to self-nominate.<br>• Andrew Shogren Recommended for Secretary seat.<br>• Officer elections will occur at June meeting. | |
| Celeste Schoenthaler | 2019 Retreat | • Move the BOD retreat from Fall to Summer<br>• Proposing that we send a doodle poll, pick the best date, and later discuss the focus of the retreat.<br>• Celeste would like a group of individuals help her with the board retreat agenda. Allocating bonus pools of money will be worth discussing. Sustainability of OCH, etc.<br>• Bobby, Mike, and Brent volunteer to help Celeste with retreat plan.<br>• If MTP well dries up, what do we see for the vision of this work.<br>• Maybe we communicate to HCA what we think sustainability should look like for ACHs.<br>• Statewide HIT and sustainability are the topics for consultant | |

| | | | |
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| | | Artemis that has been hired by the nine ACHs.<br>• August or September suggested for Retreat doodle poll. | |
| Hilary Whittington<br>Margaret Moore | 2019 Quarter 1 Financial Statement | • The budget will change with the revenue recognition.<br>• Unless there is a change in methodology, Hilary recommends we use the same budget with the revenue recognition only.<br>• OCH looks great financially. | |
| Celeste Schoenthaler | Performance, Measurement and Evaluation Committee (PMEC) membership | • PMEC in need of new members.<br>• Celeste passed around a nomination seat for PMEC.<br>• In EPIC, you can set up what you want to measure in advance, and cannot as easily backtrack. | |
| ~~Jody Moss, John Nowak, Amy Etzel~~ | ~~Community & Tribal Advisory Committee (CTAC) update~~ | ~~Discussion~~ | |
| Jennifer Kreidler-Moss | Adjourn | The meeting adjourned at 2:28 pm. | |

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Olympic Community of Health
Executive Director Report – June 2019 BOD Meeting Packet

- Hot Topics
    - Audit & Revenue Recognition: OCH is ahead of other ACHs in completing its 2018 finance audit. One of the most significant issues of the 2018 audit is whether to recognize the revenue and distributions from the Financial Executor (FE) portal. DZA, the OCH audit firm, has been discussing this issue with OCH staff, Board Treasurer Hilary Whittington, the OCH CFO, contractors, and other auditing firms. Due to OCH's desire to mitigate risk, we have decided to hold our determination about the appropriate timing of revenue recognition in anticipation of the decision of other ACH auditing firms to ensure that our process is in alignment and provides a fair picture of OCH's financial position. Staff anticipate bringing this matter, as well as the full auditor's report, to the Board in July.
    - Medicaid Transformation Program (MTP) Payments: The first round of 2019 MTP payments for Implementation Partners (except hospitals) will be disbursed through the Financial Executor portal in late June. Partners can expect to receive payments during the first week of July. Hospital payments will be made at the end of 2019 per the approved payment model.
    - OCH contract with Qualis/Comagine: Maria Klemesrud, Practice Coach with Qualis/Comagine, was reassigned to the King County ACH region. OCH terminated the contract with Qualis/Comagine and is reevaluating options for providing support and assistance to partners in alignment with change plan goals.
- Subcommittee reports/updates
    - Community & Tribal Advisory Committee (CTAC): The May CTAC meeting was cancelled in order to provide OCH leadership time to review the current CTAC charter and provide guidance for next steps.
    - Contract Monitoring & Compliance Committee (CMAC): Did not meet in May.
    - Finance Committee: Did not meet in May.
    - 3-County Coordinated Opioid Response Program (3CCORP): OCH was not awarded funding for the HRSA Rural Communities Opioid Response Project – Planning. However, we are excited for the Jefferson County Community Health Improvement Plan (CHIP) project, which was successful. The 3CCORP Steering Committee will meet June 6, Treatment Workgroup June 19, and Prevention Workgroup June 24. We have begun planning for the third regional opioid summit to happen in September.
    - Olympic Oral Health Steering Committee: The first meeting of this new group is scheduled for mid-June.
    - Performance, Measurement & Evaluation Committee (PMEC): PMEC will meet in July to discuss revisions to the committee charter and partner input on intermediary metrics. PMEC will submit a revised charter and a recommendation

on intermediary metrics to the Board for review at the September Board meeting. Please contact Siri Kushner with any questions or feedback.

- Upcoming meetings and events
  - June 6, 3CCORP Steering Committee, Poulsbo
  - June 11, SBHO Providers meeting, Sequim
  - June 11, All ACH Executive Director meeting with MCOs and HCA, SeaTac
  - June 18, Olympic Oral Health Steering Committee, TBD
  - June 18, CTAC, Blyn
  - June 19, 3CCORP Treatment Workgroup, Blyn
  - June 24, 3CCORP Prevention Workgroup, Poulsbo
  - June 25, Regional Natural Communities of Care Convening, Blyn
- Staffing updates
  - Communications and Development Coordinator Daniel Schafer accepted a faculty position in the Department of English at McDaniel College in Maryland. His last day at OCH will be July 1.
  - A revised Communications & Special Projects Coordinator position was posted on May 31.
  - Dr. Lisa Rey Thomas began work under a new job title: Opioid Response Project Director. The change will allow her to focus primarily on opioid response work in the Olympic region. OCH staff will share community engagement and Tribal partnership duties.
- Administrative updates
  - OCH Communications: In order to streamline and consolidate communications, staff created a weekly Community Briefing that will be sent via email every Tuesday. This communication includes upcoming meetings and events, training and resource announcements, and Implementation Partner updates.
  - Progress to Date reporting: Reporting for the January-June 2019 period will be open in ORCA on July 1st. All Implementation Partners are required to submit this report by July 31st.

Olympic COMMUNITY of HEALTH

January–March 2019 Site Visit Report

## Purpose of Report:

- Inform the Olympic Community of Health (OCH) staff, Board of Directors, and Natural Community of Care (NCC) partners of progress on Medicaid Transformation Project (MTP) work.
- Synthesize and share common challenges and successful transformation approaches across the region.
- Summarize requests and feedback from sites and provide recommendations for path forward.

# I. Background:

## A. Purpose of site visits

The site visit is a reporting requirement for Implementation Partners as outlined in the OCH 2019 MTP Payment Model. It is also a component of OCH's Quality Improvement Strategy, a deliverable required by the Health Care Authority (HCA).

Site visits allow OCH to better understand successes and barriers Implementation Partners experience and assesses the progress of MTP work in the region. It is also an opportunity for staff to solicit feedback and recommendations from Implementation Partners to inform OCH processes and procedures moving forward.

Currently, under the 2019 MTP Payment Model Implementation Partners will complete two site visits per calendar year. Moving forward, site visits will occur in the spring (March–April) and fall (September–October). OCH evaluates and adjusts site visit procedures on a rolling basis.

## B. Components of January–March 2019 Site Visits

OCH staff completed 32 site visits from January to March 2019. Site visits were primarily attended by organization leadership. Some Implementation Partners included clinical staff in the meetings. Site visits lasted 1.5 to 2 hours; the length of visits was largely determined by the scope of each Implementation Partner's Change Plan. The site visit agenda included:

- Review of baseline Progress to Date report: submitted December 2018
- Identification of Change Plan focus areas for January–June 2019 reporting period
- Discussion of MTP successes and challenges

- Verification of quality improvement (QI) process and incorporation of MTP work into QI process
- Review Community-Clinical Linkage Assessment tool and solicit partner feedback
- Review MTP Calendar of Deliverables and upcoming due dates
- Preview list of process measures/Standard Operating Procedures (SOPs) to be collected at next site visit
- Receive requests for training/technical assistance
- Solicit feedback for OCH staff on processes, practices, and procedures

# II. Summary of Findings

## A. Change Plan Activities

The following is a high-level summary of successes, challenges, and opportunities identified during site visits organized by Change Plan Domains (Care Coordination, Care Integration, Care Transformation, Care Infrastructure).

See Appendix 1 for a grid detailing each Implementation Partner's focus area for the January–June 2019 reporting period at the Change Plan Tactic level. This matrix was used to help identify high-level areas of focus as well as potential gaps in Change Plan activities.

For more comprehensive information on specific projects Implementation Partners identified as a focus, as well as information on the sub-tactic level (Populations of Focus and Partners), please see Appendix 2.

*Notes:*
*-A limited site visit was completed with Discovery Behavioral Health due to key personnel changes.*
*-One Implementation Partner terminated their contract following the site visit; data from this organization is not included in this report.*

## Care Coordination

### Successes

- **Coordination of EHRs:**
  - Four MH agencies (DBH, KMHS, PBH, WEOS) transitioned to the same EHR (Care Logic). This transition will support increased in-sector and cross-sector care coordination.
  - Four Community Connect Epic users (OMC, JFHC, JH, and now NOHN) collaborate to streamline care coordination and reporting practices.
  - Four SUD providers use the same EHR (ReliaTrax).

### Challenges

- **EHR capabilities:**
  - Limited resources result in use of EHRs that lack ability to improve care coordination, shared information exchange, and population health management.
  - Community Connect Epic lacks functionality to build registries and seamlessly pull relevant data for population health management.

### Opportunities

- **SDOH screening and implementation:**
  - There is a strong commitment across Implementation Partners to screen for SDOH needs with high potential to collaborate and share screening templates, resources, and workflows.
- **Care coordination for MAT patients:**
  - SUD providers note a decrease in MAT referrals. 3CCORP workgroups and other meetings can provide opportunities to improve care coordination efforts.
- **CDSM programs:**
  - There is imited knowledge of existing programs, particularly in Clallam NCC. O3A and OlyCAP have begun problem solving strategies to increase referrals.

## Care Integration

### Successes

- **Bi-directional integration:**
  - There is significant movement toward integrating physical and behavioral health across all Implementation Partners (e.g. hiring new staff, contracting cross-sector, expansion of services).

### Challenges

- **Preparing for IMC:**
  - Behavioral health providers must prioritize IMC transition over clinical integration.

### Opportunities

- **Collaboration between OCH and SBHO:**
  - There is an opportunity to coordinate financial and clinical integration for a transition that will result in more effective transformation.

## Care Transformation

### Successes

- Opioid work:
  - Three Implementation Partners have begun 6 Building Blocks (JFHC, NWFMR, FCH).
  - 3CCORP remains active and partners are invested in opioid work.

### Challenges

- Gaps
  - Limited participation and energy in focus areas beyond opioids (Reproductive Maternal Child Health, Chronic Disease).

### Opportunities

- Sharing resources:
  - Sharing SOPs, workflows, and resources can support transformation activities.
- New services:
  - New maternity support services will be avaliable in Kitsap NCC
- Integration:
  - Better integrate 3CCORP activities into MTP work.

## Care Infrastructure

### Successes

- **Expansion**
  - Increase in services and access across NCCs: new programs, new service lines, expansion of existing services, new staff hires, and capitol expansion programs.

### Challenges

- **Limited access**
  - Access to some services remain limited in rural communities: adult dental, behavioral health, pediatric, and specialty care.

### Opportunities

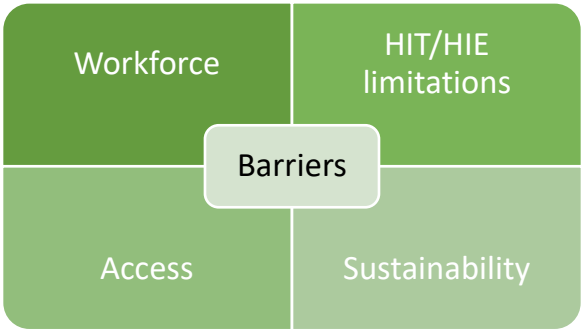
- **Partnerships:**
  - There are many pre-existing partnerships as well as new opportunities to enhance community-clinical linkages and formalize referral pathways.

*Acronyms used in tables:*

*3CCORP – Three County Coordinated Opioid Response Project, CDSM – Chronic Disease Self-Management, DBH – Discovery Behavioral Health, EHR – Electronic Health Record, FCH – Forks Community Hospital, IMC – Integrated Managed Care, JFHC – Jamestown Family Health Clinic, JH – Jefferson Healthcare, KMHS – Kitsap Mental Health Services, MAT – Medication Assisted Treatment, MH – Mental Health, NCC – Natural Community of Care, MTP – Medicaid Transformation Project, NOHN – North Olympic Healthcare Network, NWFMR – Northwest Washington Family Medical Residency, O3A – Olympic Area Agency on Aging, OCH – Olympic Community of Health, OlyCAP – Olympic Community Action Programs, OMC – Olympic Medical Center, PBH – Peninsula Behavioral Health, SBHO – Salish Behavioral Health Organization, SDOH – Social Determinants of Health, SOP – Standard Operating Procedure, SUD – Substance Use Disorder, WEOS – West End Outreach Services*

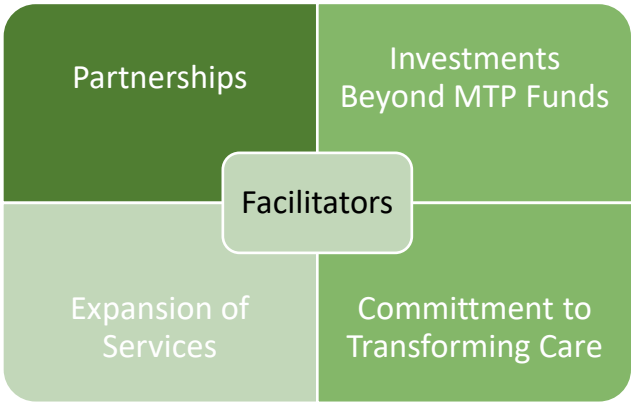
## B. Overarching Barriers and Facilitators

### Barriers




1. Workforce: Frequent staff turnover and hiring difficulties delay work. There is a lack of qualified applicants in rural communities, particularly for: data analysts, nurse care managers, and chemical dependency providers.
2. EHR/HIT/HIE limitations: Significant Electronic Health Record (EHR) limitations exist across all sectors, especially with clinical tools for building registries and tracking patients. Providers across all sectors use off-line tracking systems (i.e. Excel files). Additionally, transitioning to a new EHR and restructuring systems present time and staffing challenges. Community-based organizations and social service partners remain largely without access to any comprehensive technology platform. In addition, varying interpretations of 42 CFR Part 2 limit coordinated care across physical and behavioral health providers.
3. Access: Access to specific services remain limited, particularly in rural communities, resulting in long wait times and loss of clients/patients without adequate transportation.
4. MCO/Sustainability/IMC: Behavioral health providers intently focused on successful transition to Integrated Managed Care (IMC) possess minimal bandwidth to focus on other activities. Few physical health providers in Clallam NCC have contracts with Managed Care Organizations (MCO) and community-based organizations and social service partners have limited knowledge of what changes MCO contracting will bring. Some integrated clinics are unable to bill for certain behavioral health services until they secure an agency license.

## Facilitators

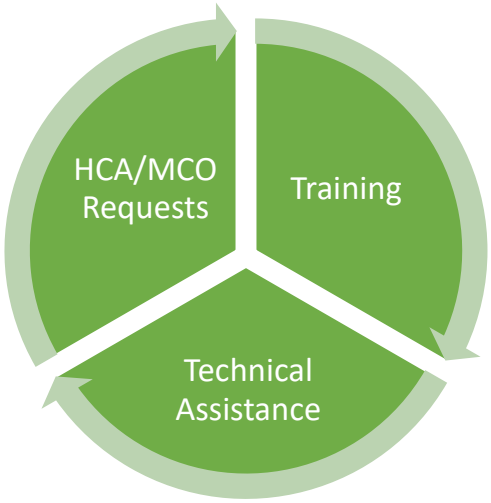



1. Partnerships: There is increased collaboration amongst partners including coordination of EHR and reporting systems. Convening partners allows for opportunities to connect. Partners report, "Care has never been so coordinated."
2. Investments Beyond MTP Funds: Many Implementation Partners are using multiple funding sources to fully implement all transformation activities. Some Implementation Partners have sought external funding or invested significant organizational funds to carry out many Change Plan activities.
3. Expansion of Services: Several Implementation Partners have expanded service lines including: three new dental clinics across all NCCs, increased crisis and residential services for mental health (MH) and substance use disorder (SUD), and investment in care coordination staff.
4. Commitment to Transforming Care: Overall, Implementation Partners understand Change Plan activities and the necessity of transforming care. While various barriers to accomplishing transformation activities have been identified, all Implementation Partners are highly invested in improving care and finding sustainable solutions.

### C. Requests from Implementation Partners

OCH staff use Implementation Partner requests to help assess regional needs as well as inform recommendations for future investments. Overall, behavioral health and community-based organizations and social service partners made more requests for training than hospital or primary care partners. A full summary of Implementation Partner requests can be found in Appendix 3.

Request categories include:




1. Training: Requests prioritized Change Plan activities, including selected sub-populations. Social Determinants of Health (SDOH) training was the most requested across provider types.
2. Technical Assistance: Requests prioritized systems transformation (EHR capability, data collection, reporting, etc.), Change Plan activities, and overarching supports (convenings, staff orientation, information sharing, etc.).
3. HCA/MCO Requests: Several requests for HCA and MCOs emerged during the site visits. Overall, Implementation Partners seek more alignment between MCOs and opportunities to reduce provider burden. Additionally, Implementation Partners requested clear guidance on surrounding sustainability issues (value-based care billing, 42 CFR Part 2 and information sharing, collaborative care codes for billing, etc.).

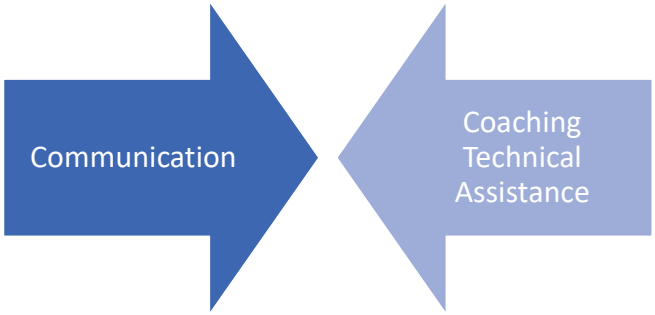
## D. Feedback from Implementation Partners

As a part of OCH's Quality Improvement Strategy, staff solicited feedback from Implementation Partners. Feedback centered around two themes:

1. Communication:

Most Implementation Partners identified OCH staff as very responsive and available for problem solving and fulfilling partner requests.

Many Implementation Partners expressed concern about the excessive amount of email communication from OCH. Partners also reported that emails from OCH are too long and time consuming to read.




2. Coaching Technical Assistance: Feedback was solicited from all Implementation Partners regarding coaching technical assistance provided by the regional Practice Coach via OCH's contract with Comagine Health (formerly Qualis Health). OCH used this opportunity to promote the coaching resource as well as assess value.

Most Implementation Partners already engaged with coaching see it as a valuable resource that has supported improvements to internal QI processes and contributed to successes in selected QI projects.

Overall, smaller organizations found this resource more helpful than larger organizations with already established QI teams and processes.

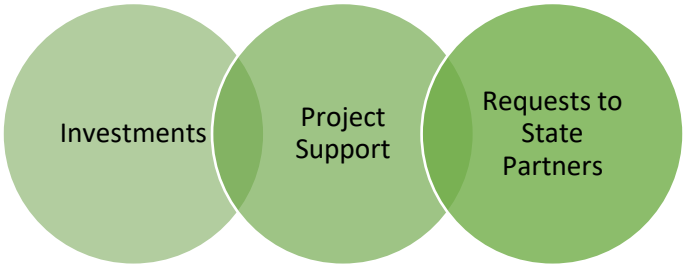
Several Implementation Partners reported disinterest in coaching. These partners reported that the process was too time intensive and did not offer an added value to their already-established QI processes.

Three partners who had not yet participated in coaching indicated interest in pursuing it. OCH staff have since connected these partners with the Practice Coach Connector**.**

Note: While it is helpful to know that some Implementation Partners were comfortable offering feedback about OCH to OCH staff, it is likely there is additional feedback that was not shared during the site visit.

## III. Recommended Action Plan:

Based on information learned during the site visits and the summaries provided above, OCH staff proposes the following three-part action plan to the OCH Board of Directors:




### A. Recommended Investments:

Trainings: Based on the number of direct requests from Implementation Partners and identified high-level areas of focus in Change Plan activities across the region OCH staff recommends investing in the following trainings:

- SDOH: best practices for capturing and using data collected around SDOH. Recommended timeline: 2019
- Co-occurring MH and SUD: best practices for managing and treating this population. Recommended timeline: 2020
- Chronic disease management for behavioral health providers. Recommended timeline: 2020

Note: Primary care and hospital Implementation Partners offered limited specific training requests during site visits. Recommendations may be revised pending more provider feedback.

### B. Project Support

1. Technical Assistance: Based on the number of direct requests from Implementation Partners and identified high-level areas of focus in Change Plan activities across the region OCH staff recommends prioritizing the following technical assistance/resources. All recommendations for technical assistance to be completed by OCH staff.
    - **Support IMC:** Continue partnership efforts with SBHO for successful transition to IMC. Behavioral health providers continue to need support. OCH staff recommends prioritizing

information technology assistance needs for behavioral health agencies. Other early/mid-adopter regions have highly recommended investment in Xpio Health.

- **Mitigate EHR challenges:**
  - Epic view-only access for partners: Facilitate Implementation Partners gaining view-only subscriptions to Epic to access shared patient/client records to improve workflow and enhance information exchange and referral capabilities.
  - Exploration of Pre-Manage implementation: Pre-Manage, offered by Collective Medical Technologies, can provide real-time information on high-risk, high-utilizing clients and assist providers with care coordination and management of care resources. Other Accountable Communities of Health regions have made implementing Pre-Manage a priority, and OCH plans to participate in a statewide workgroup for lessons learned in other regions to inform future implementation in this region after IMC.
- **Naloxone availability:** The 3CCORP (Three County Coordinated Opioid Response Project) Overdose Prevention workgroup prioritized surveying the region on availability and distribution of naloxone. OCH will strategize opportunities for making naloxone available across the region.
- **Facilitation of same sector convenings:** In addition to NCC convenings, Implementation Partners expressed interest in coordinating and collaborating with same sector partners on similar Change Plan outcomes. OCH will include same sector collaborative partners in the Regional NCC scheduled for June 25, 2019 and will continue to convene same sector partners as requested.
- **Resource sharing:** Create standard of practice (utilizing ORCA (Olympic Reporting and Community Activities) and NCC convenings) to share relevant resources (i.e. policies, procedure manuals) and promote a shared learning environment.

2. Staff Adjustments: Based on the constructive feedback received OCH staff have already made several adjustments and are planning additional improvements to OCH's communication strategy.

| Completed Adjustments | Planned Adjustments |
|---|---|
| Attach all deadlines to calendar invitations. | Create OCH email address for streamlined communication to all partners. |
| Condense length and highlight action items in emails. | Restrict email frequency to a weekly community briefing. |
| Condense frequency of MTP-related emails. | Create guidelines for Implementation Partner responses to action items. |
| Utilize more personalized communication approach with partners in preferred method. | Establish predictable cadence to action items. |
| Identify additional/appropriate partner organization staff for distribution lists. | |

## C. Requests to State Partners

In response to requests from Implementation Partners, OCH staff plan to prioritize the following requests to state partners:

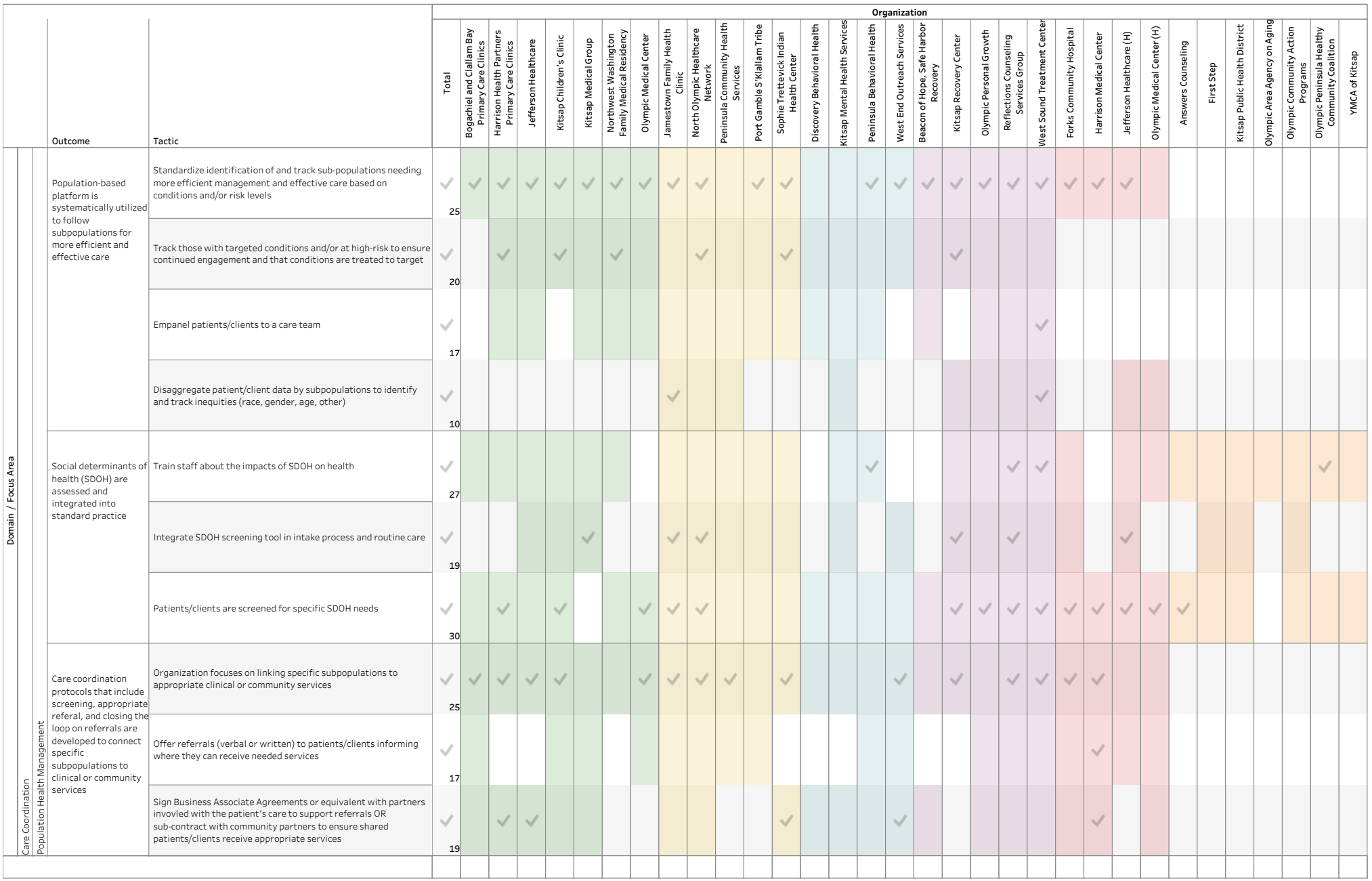
1. HCA requests: Guidance on information sharing pertaining to 42CFR Part 2. Without clear guidance from HCA, it is unlikely care coordination in the form of information sharing will be drastically improved.
2. MCO requests: Streamlined communication process, responsiveness, and engagement as providers enter contracts with MCOs. Through IMC coordination efforts, OCH has already engaged with MCOs and will continue to advocate for practices that reduce the burden to partners.

## D. Conclusion:

Site visits provided opportunities to further evaluate the region's progress toward MTP activities. OCH staff recognizes and appreciates Implementation Partners' time and energy in completing this reporting requirement. Implementation Partners face multiple challenges as they move forward. OCH staff strives to be strategic in addressing these, as well as being responsive to feedback. Despite great challenges, Implementation Partners exhibit a creative problem-solving spirit and commitment to improving and transforming care in the Olympic Region.

*Acronyms used in report:*

*3CCORP – Three County Coordinated Opioid Response Project, EHR – Electronic Health Record, HCA – Health Care Authority, IMC – Integrated Managed Care, MCO – Managed Care Organization, MH – Mental Health, MTP – Medicaid Transformation Project, NCC – Natural Community of Care, OCH – Olympic Community of Health, ORCA – Olympic Reporting and Community Activities, QI – Quality Improvement, SDOH – Social Determinants of Health, SOP – Standard Operating Procedure, SUD – Substance Use Disorder, SUD – Substance Use Disorder*




Focus
- Selected in Change Plan but not Focus Period
- ✔ Selected in Change Plan and Focus Period

OrgType
- Community-Based Organization / Social Service
- Hospital
- Mental Health and Substance Use Disorder
- Physical Health
- Physical Health and Behavioral Health
- Substance Use Disorder
- *

| Domain / Focus Area | | Outcome | Tactic | Total | Bogachiel and Clallam Bay Primary Care Clinics | Harrison Health Partners Primary Care Clinics | Jefferson Healthcare | Kitsap Children's Clinic | Kitsap Medical Group | Northwest Washington Family Medical Residency | Olympic Medical Center | Jamestown Family Health Clinic | North Olympic Healthcare Network | Peninsula Community Health Services | Port Gamble S'Klallam Tribe | Sophie Trettevick Indian Health Center | Discovery Behavioral Health | Kitsap Mental Health Services | Peninsula Behavioral Health | West End Outreach Services | Beacon of Hope, Safe Harbor Recovery | Kitsap Recovery Center | Olympic Personal Growth | Reflections Counseling Services Group | West Sound Treatment Center | Forks Community Hospital | Harrison Medical Center | Jefferson Healthcare (H) | Olympic Medical Center (H) | Answers Counseling | First Step | Kitsap Public Health District | Olympic Area Agency on Aging | Olympic Community Action Programs | Olympic Peninsula Healthy Community Coalition | YMCA of Kitsap |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Organization | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Population Health Management | Care Coordination | Care coordination protocols that include screening, appropriate referal, and closing the loop on referrals are developed to connect specific subpopulations to clinical or community services | Create and implement protocol to follow-up with referral partner after referral is made | ✓ 22 | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | | | | | |
| | | | Organization refers specific subpopulations to appropriate clinical or community services | ✓ 7 | | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | ✓ | | | | |
| | | | Sign Business Associate Agreements or equivalent with clinical partners involved with the client's care to support referrals OR contract with clinical partners to ensure shared patients/clients receive appropriate clinical services | ✓ 6 | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | ✓ | | | | | |
| | | | Create and implement protocol to facilitate ongoing sharing of information to referring provider(s) about shared client(s) | ✓ 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | | | | | |
| | | Organization participates in an NCC bi-directional referral network for at-risk subpopulations | Receive referrals from NCC partners for the following subpopulations | ✓ 7 | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ |
| | | | Utilize screening tools and protocols to identify client physical, behavioral, and/or oral health needs and inform appropriate referrals | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Review data by subpopulations to identify inequities by category such as race, gender, age, zip code, other(s) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | | | | |
| | | Organization provides care coordination services, social services and consumer education services for referred clients | Provide effective chronic care services such as Diabetes Prevention Program (DPP), Chronic Disease Self-Management (CDSM), Whole Health Action Management (WHAM), exercise programs, and/or other | ✓ 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | ✓ | | |
| | | | Assist those with reccurent ED utilization to identify barriers to accessing primary care, identify solutions and resolve issues | ✓ 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | | | |
| | | | Partner with public health and clinical partners to develop social marketing campaigns to promote healthy pre-conception care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Focus
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OrgType
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- Hospital
- Mental Health and Substance Use Disorder
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| | | | | Organization | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Population Health Management | Care Coordination | Organization provides care coordination services, social services and consumer education services for referred clients | Provide evidence-based prenatal or early childhood interventions to promote optimal health outcomes (Early Head Start, Head Start, Early Childhood Education and Assistance Program, Parents as Teachers, Parent Child Assistance Program, Nurse Family Partnership, Maternity Support Services) | ✓ 5 | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | | ✓ | | | | |
| | | | Provide information or education to clients about appropriate clinical care settings | ✓ 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | | | | |
| | | | Ensure clients and their caregivers have access to instructions on how to get clinical advice after hours | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Educate clients/school/ children/ organizations/ community on healthy eating and active living | ✓ 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | | | | ✓ |
| | | | Raise public awareness about obesity through programs such as 5-2-1-0 | ✓ 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | | ✓ | | ✓ |
| | | | Educate clients on safe medication return and disposal programs (also called "drug take back") | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Raise public awareness programs about opioid misuse and abuse prevention through data and programs such as It Starts with One | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Needle exchange program or syringe exchange program | ✓ 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | | | | |
| | | | Educate clients on safe storage of opioids | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Offer chronic pain groups | ✓ 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ |

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| | | | | Organization | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Care Coordination | Shared Care Management | Streamlined process is in place for information to be shared in a timely manner for shared patients/clients | Implement protocol to obtain shared patient/client records | ✓ 16 | | | | | | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | |
| | | | Sign inter-organizational agreements for access to records of referred and/or shared patients/clients | ✓ 23 | | | | | | | | | | | | | | | | | | ✓ | | | | | ✓ | | | | | | | | | |
| | | | Participate in a technology platform that allows necessary patient/client information to be exchanged between the referee and referral organization | ✓ 14 | | | | | ✓ | | | | | | ✓ | | | | | | | | | ✓ | | | | | | | | | | | | |
| | | | Maintain collaborative care plan in both physical and behavioral health records or in the same shared record | ✓ 11 | | | | | | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | |
| | | | Establish and document a protocol for convening cross-sector care meetings | ✓ 14 | | | | | | | | | | | ✓ | | | | | | | | ✓ | | | | | ✓ | | | | | | | | | |
| | ED Diversion | At ED visit, patients are linked to a patient-centered medical home (PCMH) and appropriate services to treat mental health, substance use disorders and/or co-occurring disorders | Implement process to link patients to their patient-centered medical home or primary care provider. If they do not have one, establish a new patient referral to a primary care provider | ✓ 11 | | | | | | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | |
| | | | Implement process to link patients needing behavioral health services to a behavioral health provider | ✓ 12 | | | | | | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | |
| | | | Kitsap NCC: Embed community health workers in the ED to link patients to a patient-centered medical home or primary care provider | ✓ 2 | | | | | | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | |
| | | | Implement process to review the PRC (patient review and coordination) list and EDIE feeds, assess patient needs, and link patients to community providers | ✓ 9 | | | | | | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | |
| | | Organization develops or enhances services to help keep | Jefferson and Clallam NCC: Community paramedics or EMTs perform home visits through a sub contractual relationship with your organization | ✓ 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | | | Organization | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Care Coordination | ED Diversion | Organization develops or enhances services to help keep patients/clients out of ED | Jefferson and Clallam NCC: Community paramedics or EMTs perform alternative transports through a sub contractual relationship with your organization | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Create new open access/same-day/walk-in capacity | ✓ 11 | | | ✓ | | ✓ | | ✓ | ✓ | ✓ | | | | | | ✓ | | | | ✓ | | | | | | | | | | | | | |
| | | Patients/clients are assisted to understand appropriate settings for receiving health care services including ED utilization | Provide information or education to patients/clients about appropriate care settings | ✓ 14 | | | ✓ | ✓ | | | ✓ | ✓ | | ✓ | | ✓ | | ✓ | ✓ | | | | ✓ | | ✓ | ✓ | | ✓ | | | | | | | |
| | | | Ensure patients and their caregivers have access to instructions on how to get advice after hours | ✓ 14 | | | ✓ | ✓ | | | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ | ✓ | | | | ✓ | ✓ | ✓ | | | ✓ | | | | | | | |
| | | | Assign care managers to assist those with recurrent ED overuse to identify barriers to accessing primary care, identify solutions, and resolve issues | ✓ 9 | | | | ✓ | | | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | | | | ✓ | | | ✓ | | | | | | | | | |
| | | | Provide on-call staff with resources including crisis intervention lines | ✓ 13 | | | ✓ | ✓ | | | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | | | | | | | | | | | | |
| | | | Follow-up with patients following ED visit and guide toward more appropriate setting in future as needed | ✓ 14 | | | ✓ | ✓ | ✓ | | ✓ | ✓ | | ✓ | | ✓ | | ✓ | ✓ | | | | ✓ | ✓ | | | | | | | | | | | |
| | | Providers are notified of patient/client ED visits | Establish notification system between hospital and patient's medical/behavioral health home within NCC when a patient/client visits the ED | ✓ 23 | | | ✓ | ✓ | | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | | ✓ | | | | | | | |
| | | | Implement workflows to review and triage Emergency Department Information Exchange (EDIE) feeds | ✓ 14 | | | | | ✓ | ✓ | | ✓ | | ✓ | | | ✓ | ✓ | ✓ | | | | ✓ | | | | | | | | | | | | |
| | | | Implement Pre-Manage | ✓ 9 | | | ✓ | ✓ | ✓ | | | | | | | | ✓ | | | | | | ✓ | ✓ | ✓ | | | | | | | | | | |

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| | | | | | Organization | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Care Integration | Primary Care Integrating Behavioral Health | Patients are screened for behavioral health conditions and patient tracking is initiated (BC 6, ColCa 1) | Implement a protocol to refer patients who screen positive to behavioral health services | ✓ 10 | | | | | | ✓ | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Organization performs other screen for specific behavioral health conditions as part of routine care | ✓ 8 | | | ✓ | | | | ✓ | ✓ | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Organization screens for anxiety (GAD-7) as part of routine care | ✓ 8 | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Organization performs Screening, Brief Intervention, and Referral to Treatment (SBIRT) for alcohol and illicit drug use as part of routine care | ✓ 9 | | | ✓ | | | | | ✓ | | | | ✓ | | | | | | | | | | | | | | | | | | | | |
| | | | Organization screens for depression (PHQ-9) as part of routine care | ✓ 12 | | | ✓ | | | ✓ | | ✓ | | | | ✓ | | | | | | | | | | | | | | | | | | | | |
| | | Organization chooses and implements an evidence-based program for care integration | Train providers in and implement elements of Collaborative Care Model/AIMs Center | ✓ 9 | | | | | | ✓ | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Train providers in and implement elements of Bree Collaborative Behavioral Health Integration | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Care Coordination | Jail Diversion | Services are provided to individuals to keep them out of jail | Implement protocol with community partners to coordinate care for patients/clients/individuals/tribal members who have been recently incarcerated in order to reduce recidivism to the jail and reduce 9-1-1 calls | ✓ 10 | | | | | | | | ✓ | | | | | | | | | | ✓ | | | ✓ | | | | | | | | | | | |
| | | Individuals utilizing the criminal justice system are linked to a patient-centered medical home and appropriate services to treat mental health, substance use disorders and/or co-o.. | Kitsap NCC: Embed community health workers in the criminal justice setting to link individuals to primary care, behavioral health, and/or other community services | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | unspecified | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | | | Organization | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Care Integration | Primary Care Integrating Behavioral Health | Patients are screened for behavioral health conditions and patient tracking is initiated (BC 6, ColCa 1) | Track referrals between physical and behavioral health including closing the loop with confirmation that clients/patients attended or did not attend an appointment | ✓ 12 | | | ✓ | | | ✓ | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Staff work together regularly across physical and behavioral health to coordinate care | Incorporate recommendations of psychiatrists and other behavioral specialists into the overall plan of care | ✓ 10 | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Co-manage patients with positive behavioral health screens until they achieve their treatment outcomes or are connected with appropriate services | ✓ 11 | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Design integrated care teams to function as a collaborative practice to support patients/clients to achieve treatment goals | ✓ 11 | | ✓ | | | ✓ | | | | | | ✓ | ✓ | | | | | | | | | | | | | | | | | | | | |
| | | | Develop shared care plans for patients/clients for integrated treatment | ✓ 8 | | | | | | | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | |
| | | | Track patient/client status over time with standardized workflows to ensure they are treated to target for both physical and behavioral health treatment goals | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Survey shared patients/clients regularly regarding access, outcomes and experience | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Access to behavioral health services is convenient and timely | Create an agreement with at least one behavioral health care provider to provide care for patients in need of behavioral health services | ✓ 11 | | | | | ✓ | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Make "same day" behavioral health services available through face-to-face and/or virtual interactions | ✓ 9 | | | | | | ✓ | | | | | ✓ | | | | | | | | | | | | | | | | | | | | |
| | | | Co-locate a behavioral health specialist on site | ✓ 11 | ✓ | | | | ✓ | ✓ | ✓ | | ✓ | | ✓ | | | | | | | | | | | | | | | | | | | | | |

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| | | | | Organization | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Behavioral Health Integrating Primary Care | Care Integration | Access to behavioral health services is convenient and timely | Make behavioral health pre-consultation available to assist with urgent needs | ✓ 7 | | | | | | ✓ | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | |
| | | | Ensure psychiatric services for patients are available on an as needed basis | ✓ 9 | | | | | ✓ | ✓ | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Offer tele-psychiatry for patients as needed | ✓ 3 | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Ensure psychiatric services are available to assist the care team to develop a treatment plan or adjust treatments | ✓ 8 | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Organization chooses and implements an evidence-based program for care integration (BH) | Train providers in Chronic Disease Management in a behavioral health setting | ✓ 8 | | | | | | | | ✓ | | | | | | | ✓ | | | | | | | | | | | | | | | | | |
| | | | Assess clinicians and care teams understanding of Chronic Disease Management in a behavioral health setting and provide training where needed | ✓ 10 | | | | | | | | ✓ | | | | | | | ✓ | | | | | | | | | | | | | | | | | |
| | | | Establish protocol for tracking Chronic Disease Management in the electronic health record | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Patients are screened for physical health conditions and patient tracking is initiated | Screen all clients for engagement with a primary care provider | ✓ 13 | | | | | | | | | | | | | | | | ✓ | | ✓ | | | | | | | | | | | | | | |
| | | | Screen high-risk clients for ongoing engagement in medical care | ✓ 12 | | | | | | | | | | | | | | | | ✓ | | ✓ | | | | | | | | | | | | | | |
| | | | Screen for history of chronic disease (physical) | ✓ 13 | | | | | | | | | | | | | | | | ✓ | | ✓ | | | | | | | | | | | | | | |

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| | | | | Organization | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Care Integration | Behavioral Health Integrating Primary Care | Patients are screened for physical health conditions and patient tracking is initiated | Create a process to link clients to a primary care provider as needed | ✓ 13 | | | | | | | | | | | | | | | | ✓ | | ✓ | | | ✓ | | | | | | | | | | | |
| | | | Track referrals between behavioral and physical health including closing the loop with confirmation that clients/patients attended or did not attend an appointment | ✓ 12 | | | | | | | | | | | | | | | | ✓ | | ✓ | | | ✓ | | | | | | | | | | | |
| | | Staff work together regularly across behavioral and physical health to coordinate care | Design integrated care teams to function as a collaborative practice to support patients/clients to achieve treatment goals | ✓ 10 | | | | | | | | | | | ✓ | ✓ | | | | | | ✓ | | | | | | | | | | | | | | |
| | | | Develop shared care plans for patients/clients for integrated treatment | ✓ 9 | | | | | | | | | | | | ✓ | | | | | | ✓ | | | | | | | | | | | | | | |
| | | | Incorporate recommendations of primary care providers into the overall plan of care | ✓ 13 | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | | | |
| | | | Track patient/client status over time with standardized workflows to ensure they are treated to target for both physical and behavioral health treatment goals | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Co-manage patients with positive physical health screens until they achieve their treatment outcomes or are connected with appropriate services | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Survey shared patients/clients regularly regarding access, outcomes and experience | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Access to physical health services is convenient and timely | Create an agreement with at least one physical health care provider to provide care for patients in need of physical health services | ✓ 13 | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | | | |
| | | | Make "same day" physical health services available through face-to-face and/or virtual interactions | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | | | Organization | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Integrating Oral Health | Care Integration | Access to physical health services is convenient and timely | Co-locate a physical health provider on site | ✓ 9 | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | | | |
| | | | Make physical health pre-consultation available to assist with urgent needs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Behavioral Health Integrating Pri | Oral health education, screening and/or preventive procedures are integrated into care | Train providers on screening for oral health needs and engagement with oral health provider | ✓ 10 | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Train providers on fluoride varnish application procedure | ✓ 6 | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Provide oral health counseling and education to patients as part of care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Perform oral health screening when appropriate | ✓ 10 | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Apply fluoride varnish to pediatric patient population | ✓ 6 | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Oral health education and screening are integrated into care | Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Screen clients for oral health needs and engagement with oral health provider | ✓ 9 | | | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | | |
| | | | Refer clients in need to oral health provider and close the loop on referral | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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OrgType
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| Care Integration | Integrating Oral | Oral health education and screening are integrated into care | Provide oral health counseling and education to patients | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Opioid Misuse and Abuse Prevention | Care Transformation | Best practices for opioid prescribing are promoted and used | Referrals for patients with chronic pain | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Train providers on the Agency Medical Directors' Group's (AMDG) interagency or CDC guidelines on prescribing opioids for pain | ✓ 12 | | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | ✓ | ✓ | | ✓ | | | | | | | |
| | | | Update all opioid prescribing protocols, policies, and patient agreements, train staff on them, and review them annually | ✓ 13 | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | ✓ | | ✓ | ✓ | | | | | | | |
| | | | Create standardized chronic opioid prescribing policies and care pathways | ✓ 13 | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | ✓ | | ✓ | | | | | | | |
| | | | Standardize workflows for chronic opioid therapy (COT) refills | ✓ 11 | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | ✓ | | | | | | | | | |
| | | | Create a COT registry and assign staff member to ensure information is routinely updated | ✓ 11 | ✓ | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | ✓ | | | | | | | | | |
| | | | Create a standardized approach for dealing with complex patients including an outline for patient-centered discussions | ✓ 8 | | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | | | | | | | | | ✓ | | | | | | | | | |
| | | | Reconcile medications routinely to avoid unsafe combinations | ✓ 12 | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | ✓ | | ✓ | | | | | | | |
| | | | Incorporate the use of the Prescription Drug Monitoring Program (PDMP) into workflow | ✓ 12 | ✓ | | ✓ | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | ✓ | | ✓ | ✓ | | | | | | |

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**OrgType**

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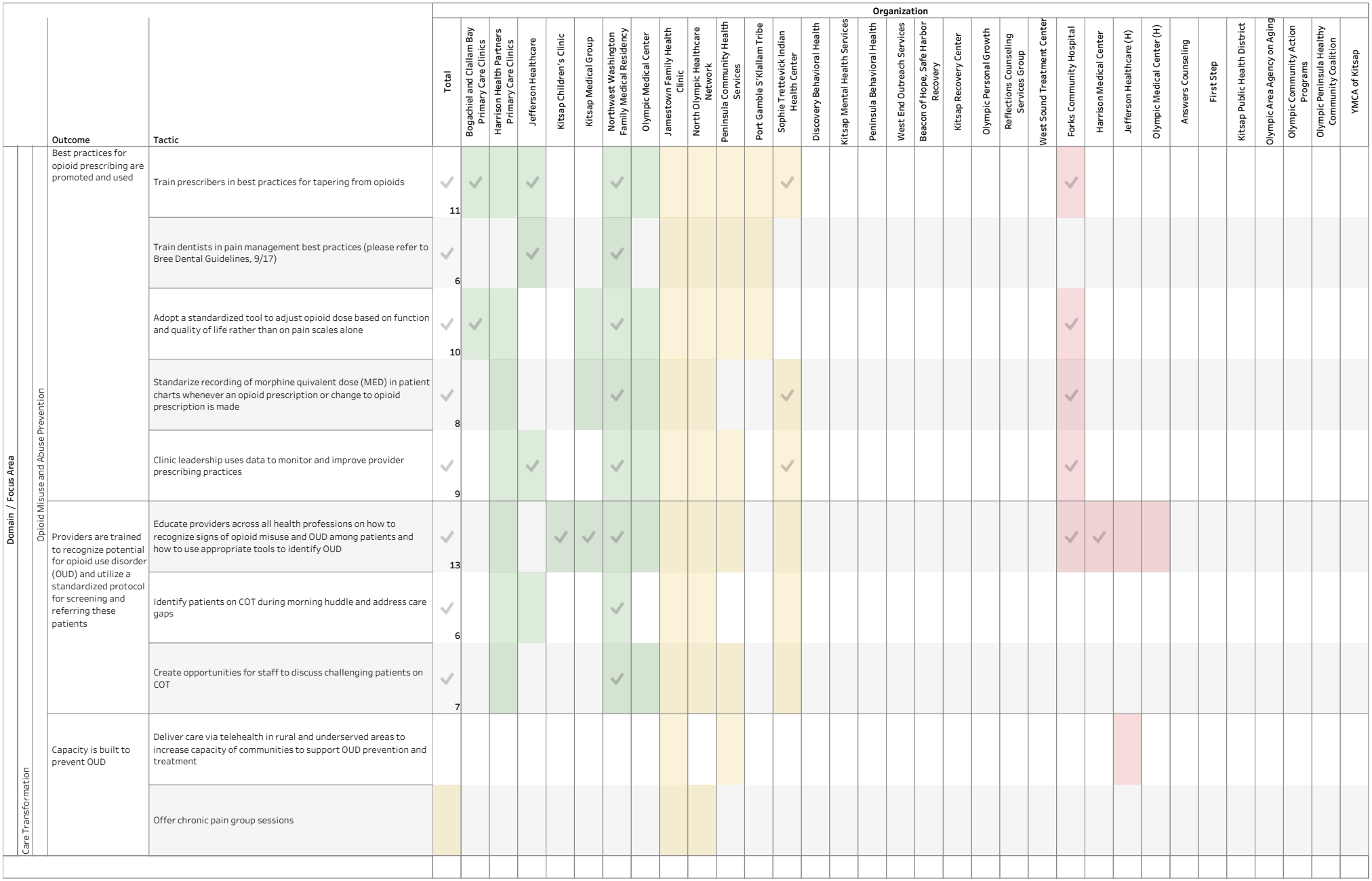


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| | | | Organization | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Care Transformation / Opioid Misuse and Abuse Prevention | Capacity is built to prevent OUD | Offer or arrange for alternatives to opioids to relieve pain | ✓ 7 | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Patients are engaged around prevention of OUD | Create patient agreements for COT that aligns with clinic policies and review with patients annually | ✓ 8 | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Inform patients of the rationale for patient agreements and periodic drug screening for those receiving COT | ✓ 7 | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Reach out to patients who exceed safe opioid dosages or have dangerous polypharmacy and ensure plan to transition to safe prescribing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Review safe storage of opioids with patients | ✓ 10 | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Refer all patients with narcotic prescriptions to safe medication return and disposal programs (also called "drug take back") | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Public is offered education and awareness around opioid epidemic | Link to public awareness programs such as It Starts with One | ✓ 6 | | | | | | | | | ✓ | | | | | | | | | | | | ✓ | | | | | | | | | | | |
| | | Use local data to raise awareness of regional impact of opioid epidemic | ✓ 10 | | | | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | |
| Care Transformation / Opioid Overdose Prevention | Naloxone is accessible | Co-prescribe naloxone for patients on opioid medication as best practice per AMDG guidelines | ✓ 10 | | | | | | | | | | | | | | | | | | | | | | | ✓ | | | ✓ | | | | | | |
| | | Provide overdose education, peer support and take-home naloxone to individuals seen in the ED for opioid overdose | ✓ 9 | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Care Transformation | Opioid Overdose Prevention | Naloxone is accessible | Train staff to recognize and appropriately respond to an overdose | ✓ 20 | | | | | | | | | | | | | | | | | | ✓ | ✓ | | ✓ | | | | | | | | | | | |
| | | | Add prompts to EHR to encourage providers to prescribe naloxone to patients on high doses of opioids | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Encourage patients on COT to involve caregivers to learn how to administer naloxone | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Co-prescribe naloxone with medication-assisted treatment (MAT) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Increase Naloxone access and distribution points | ✓ 8 | | | | | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | |
| | | | Develop policy to taper opioids safely after an overdose | ✓ 9 | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Opioid Use Disorder Treatment | Full spectrum of evidence-based care for OUD is available | Build skills of health care providers to have supportive patient conversations about problematic opioid use and treatment options | ✓ 15 | | | | | | ✓ | | | | | | | | | | | | | ✓ | ✓ | | | ✓ | | | | | | | | | |
| | | | Incorporate SBIRT into workflow | ✓ 10 | | | | | | | | | | | | | | | | | | | ✓ | ✓ | | | | | | | | | | | | |
| | | | Increase the number of providers waivered to provide MAT | ✓ 12 | | | ✓ | | | ✓ | | | | | | | | | | | | | ✓ | | | | | | | | | | | | | |
| | | | Offer patients MAT | ✓ 16 | | | ✓ | | | ✓ | | | | | | | | | | | | | ✓ | | | | | | | | | | | | | |

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| Care Transformation / Opioid Use Disorder Treatment | Full spectrum of evidence-based care for OUD is available | Offer patients psychosocial support services | ✓ 17 | | | ✓ | | | ✓ | | | ✓ | | | | | | | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | | | | |
| | | Train outpatient SUD providers in best practices for treatment of OUD | ✓ 17 | | | | | | ✓ | | | | | | | | | | | | ✓ | ✓ | | | | | | | | | | | | | |
| | | Build linkages/communication/referral pathways between those providers providing medication and those providing psychosocial therapies | ✓ 17 | | | | | | ✓ | | | | | | | | | | | ✓ | ✓ | ✓ | | | | | | | | | | | | | |
| | | Support staff to attend quarterly convenings between prescribers and providers | ✓ 13 | | | | | | ✓ | | | | | | | | | ✓ | | | | ✓ | ✓ | | | | | | | | | | | | |
| | | Develop regional standards of practice (adopt Bree OUD report and treatment recommendations) | ✓ 10 | | | | | | | | | | | | | | | | | | | ✓ | ✓ | | ✓ | | | | | | | | | | |
| | | Build structural supports (e.g. case management capacity, nurse care managers, integration with substance use disorder providers) to support medical providers and staff to implement and sustain medication assisted treatment, such as methadone and buprenorphine; examples of evidence-based models include t.. | ✓ 14 | | | | | | | | | | | | | | | | | | | ✓ | ✓ | | | | | | | | | | | | |
| | | Give pharmacists tools on where to refer patients who may be misusing prescription pain medication | ✓ 8 | | | | | | | | | | | | | | | | | | | ✓ | ✓ | | | ✓ | | | | | | | | | |
| | | Enhance referrals to syringe exchange program | ✓ 10 | | | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | |
| | | Develop/support linkages between syringe exchange programs and physical health providers to treat any medical needs that require referral | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Develop/support linkages between syringe exchange programs and behavioral health providers to treat any behavioral health needs that require referral | ✓ 6 | | | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | |

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| Care Transformation / Opioid Use Disorder Treatment | Full spectrum of evidence-based care for OUD is available | Enhance/develop or support the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery | ✓ 12 | | | | | | | | | | | | | | | | | | ✓ | ✓ | ✓ | | ✓ | | | | | | | | | | |
| | Manage OUD among pregnant and parenting women (PPW) and Neonatal Abstinence Syndrome (NAS) among newborns | Implement the guideline Substance Abuse during Pregnancy: Guidelines for Screening and Management | ✓ 8 | | | | | | | | | | ✓ | | | | | | | | | | | | ✓ | | | | | | | | | | |
| | | Implement the Washington State Hospital Association Safe Deliveries Roadmap standards to health care providers | ✓ 7 | | | | | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | |
| | | Educate pediatric and family medicine providers to recognize and appropriately manage newborns with neonatal abstinence syndrome (NAS) | ✓ 8 | | | | | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | |
| | | Increase the number of obstetric and maternal health care providers permitted to dispense and prescribe MAT through the application and receipt of DEA approved waivers | ✓ 6 | | | | | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | |
| | Treatment is expanded to those with OUD in the criminal justice system | Train and provide technical assistance to criminal justice professionals to endorse and implement best practices for the treatment of OUD for people under criminal sanctions | ✓ 3 | | | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | |
| | | Optimize access to OUD treatment services for offenders who have been released from correctional facilities into the community and for offenders living in the community under correctional supervision, through effective care coordination and engagement in transitional services | ✓ 6 | | | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | |
| | | Ensure continuity of treatment for persons with an identified OUD need upon exiting correctional facilities by providing direct linkage to community providers for ongoing care | ✓ 7 | | | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | |
| | | Provide access to treatment and recovery support services/MAT services at jail | ✓ 6 | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | | | |
| | Hospitals and primary care clinics partner with mental health | Formalize referral relationship through inter-organizational agreement with providers who offer these services | ✓ 14 | | | | | | | | | ✓ | | | | | | | | | | | | | ✓ | | | | | | | | | | |

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| Care Transformation | Hospitals and primary care clinics partner with mental health and substance use disorder providers to deliver acute care and recovery services to patients with OUD | Employ or contract with providers who offer these services | ✓ 7 | | | | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | |
| Opioid Use Disorder Treatment | | Create informal referral relationships with providers who offer these services | ✓ 14 | | | | | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | |
| Chronic Disease Prevention and Control | Culture shift across organization to prioritize chronic disease prevention and management is created | All levels of staff participate in Chronic Care Model training | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Support chronic care improvement at all levels of the organization, beginning with the senior leader | ✓ 21 | ✓ | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | | | | | | |
| | | Encourage transparent and systematic handling of errors and quality problems to improve chronic care | ✓ 14 | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Health information technology is used efficiently to facilitate effective care | Identify relevant sub-populations by creating disease-specific registry/module/report in EHR/or appropriate electronic tracking tool | ✓ 21 | ✓ | ✓ | | ✓ | | ✓ | | | ✓ | | | ✓ | | | | ✓ | | ✓ | ✓ | ✓ | | | | | | | | | | | | |
| | | Close the loop for referrals | ✓ 19 | ✓ | ✓ | | ✓ | | ✓ | | | ✓ | | | ✓ | | | | | | ✓ | | | | | | | | | | | | | | |
| | | Systematically integrate information from referrals into care plan | ✓ 13 | | | | | | | | | ✓ | | | ✓ | | | | | | ✓ | | ✓ | | | | | | | | | | | | |
| | | Provide timely reminders to patients and staff of case management activities (follow-up calls and appointments, bi-directional coordination with community providers) | | | ✓ | | ✓ | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Monitor performance of practice team and care system within agency's quality improvement (QI) processes; course correct as needed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Care Transformation / Chronic Disease Prevention and Control | Community-clinical linkages are enhanced to ensure patients are supported and active participants in their disease management | Form bi-directional referral system within the Natural Community of Care between clinical and community partner for effective chronic care services such as Diabetes Prevention Program (DPP), Chronic Disease Self-Management (CDSM), Whole Health Action Management (WHAM), exercise programs, and/or other; refer to .. | ✓ 23 | | | | | | | ✓ | ✓ | ✓ | ✓ | | | | | ✓ | | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ | | | | | | | |
| | | Maintain internal community resource list to provide ongoing self-management support to patients | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Engage local health coalitions, to advocate for policies to improve patient care and to develop programs to address social determinants within community | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Patients are empowered and prepared to manage their own health care | Facilitate patient care planning, including coordinated care plan with community partners that provide evidence-based programs in disease self-management and identification of patient role/responsibility in self-management | ✓ 8 | | | | | | | | | | | | | | | ✓ | | | | ✓ | | | | | | | | | | | | | |
| | | Use and refer to effective, culturally-relevant self-management support strategies that include assessment, goal setting, action planning, problem-solving and follow-up | ✓ 7 | | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | | | | | | |
| | | Provide team-based (including specialists) clinical case management services for complex patients, including regular follow-up by the care team and planned interactions to support evidence-based care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Embed evidence-based guidelines into daily clinical practices, including provider education methods and evidence-based guidelines for patients | ✓ 12 | | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | | | | | | |
| Reproductive Maternal Child Health | Patient reproductive health planning and management is promoted and offered across the life course | Screen women of childbearing age for desire for future pregnancy | ✓ 6 | | | | | | ✓ | | | | ✓ | | | | | | | | | | | | | | | | | | | | | |
| | | Integrate risk assessment, educational/health promotion counseling to women of childbearing age to reduce reproductive risk and improve pregnancy outcomes | ✓ 5 | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Use interconception period to provide additional intensive intervention to women who have had a previous pregnancy that ended in an adverse outcome (fetal loss, infant death, birth defects, low birthweight, preterm birth, perinatal depression/mood disorder) | ✓ 3 | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | |

Focus
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- ✓ Selected in Change Plan and Focus Period

OrgType
- Community-Based Organization / Social Service
- Hospital
- Mental Health and Substance Use Disorder
- Physical Health
- Physical Health and Behavioral Health
- Substance Use Disorder
- *

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Organization | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Care Transformation / Reproductive Maternal Child Health | Patient reproductive health planning and management is promoted and offered across the life course | Assist all individual patients (male and female) and couples in developing reproductive life plan | ✓ 2 | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Provide consumer-friendly tools to help women self-assess risks, make plans, and take actions that will improve health | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Offer as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy | ✓ 3 | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Screen sexually active females aged 16-24 for chlamydia | ✓ 12 | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Partner with public health and community partners to develop social marketing campaigns to promote healthy pre-conception care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Team members are trained in preconception health and have access to evidence-based guidelines and promising practices | Adopt guidelines, tools, evidence-based practices to improve provider knowledge and practice around preconception care and preconception risk | ✓ 7 | | | | | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | |
| | | Ensure clinicians are trained in assessment around common preconception risk categories (reproductive history, environmental hazards/toxins, teratogens, nutrition/weight, genetic counseling/family history, substance use, chronic disease, infectious disease/vaccine history, family planning and social/me.. | ✓ 4 | | | | | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | |
| | Coordinated, targeted outreach and engagement to increase well-child visits and immunizations rates is conducted | Develop protocols to guide outreach efforts for children overdue for well-child visits and immunizations | ✓ 9 | ✓ | ✓ | | | | ✓ | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Coordinate outreach with MCOs through direct mail, email, phone campaigns, texts | ✓ 8 | ✓ | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Strengthen clinical-community linkages with schools and early intervention programs (child care, preschools, home visiting) to promote well-child visits and immunizations | ✓ 7 | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | | | Organization | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Care Transformation | Reproductive Maternal Child Health | Coordinated, targeted outreach and engagement to increase well-child visits and immunizations rates is conducted | Deploy staff to contact patient families to schedule well-child visits | ✓ 10 | ✓ | ✓ | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Develop or enhance protocols to increase immunization rates in children | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | All patients are offered the full spectrum of contraceptive options and are able to make informed decisions | Train all members of the care team in how to talk about contraception with patients | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Train medical providers in long acting reversible contraception (LARC) procedures | ✓ 5 | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Train billing staff in how to bill for contraception education and LARC | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Educate and offer patients the full spectrum of contraceptive options | ✓ 7 | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Care Infrastructure | Capacity Infrastructure | Access to care is increased | Ensure all patients eligible for health insurance are enrolled | ✓ 14 | | | | | | | | | | ✓ | | | | ✓ | | | | | | ✓ | | | | | | | | | | | | |
| | | | Increase marketing and uptake of a patient portal; patient scheduling through patient portal | ✓ 13 | | ✓ | | ✓ | | | | | ✓ | | | | | | | | | | | | | ✓ | | | | | | | | | | |
| | | | Expand dental care through capital campaign projects | ✓ 5 | | | ✓ | | | | | | ✓ | ✓ | | | | | | | | | | | | | | | | | | | | | | |
| | | | Purchase operatories, supplies, and/or equipment to expand access to care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| | | | | Organization | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Capacity Infrastructure / Care Infrastructure | | Access to care is increased | Host a mobile dental clinic | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Operate a mobile dental clinic | ✓ 2 | | | | | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | |
| | | | Purchase, store, distribute, and dispose of expired naloxone appropriately | ✓ 7 | | | | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | |
| | | | Offer telehealth or telepsychiatry to patients where appropriate | ✓ 10 | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Health information is exchanged securely, appropriately, timely, and efficiently | Explore a common or interoperable EHR (electronic health record) or EBHR (electronic behavioral health record) within Natural Community of Care | ✓ 18 | ✓ | | | | | | | | | | | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | |
| | | | Explore a shared population health management system within Natural Community of Care | ✓ 11 | | | | | | | | ✓ | | | | | | ✓ | | | | | ✓ | | | | | | | | | | | | |
| | | | Explore real-time exchange of health information with partners under the Olympic Digital HIT Commons or other platforms such as PreManage or Consent to Share | ✓ 16 | | | | ✓ | | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | |
| | | | Integrate dental records into the medical EHR | ✓ 4 | | | ✓ | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | |
| | | All staff understand the impact of trauma and health inequities on health | Offer training in health equity | ✓ 20 | | | | | | ✓ | | | | | | | | | | | | ✓ | | | | | | | | ✓ | | | | | |
| | | | Offer training in LGBTQ-inclusive care, | ✓ 18 | | ✓ | ✓ | | | ✓ | | | | | | | | | | | | | | | | | ✓ | | | | | | | | |

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| | | | | | Organization | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Care Infrastructure | Capacity Infrastructure | All staff understand the impact of trauma and health inequities on health | Offer training in NEAR sciences, historical trauma, and trauma-informed care | ✓ 19 | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | ✓ | | ✓ | | ✓ | |
| | | Patients receive the care they need from a trained workforce | Share workforce with another organization | ✓ 11 | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | | |
| | | | Partner with an institute to establish a residency training program | ✓ 12 | | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Partner with community college programs to recruit allied health professionals as they graduate | ✓ 13 | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | | |
| | | | Incorporate telehealth into your practice | ✓ 10 | | | | | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Hire Community Health Worker or similar workforce | ✓ 10 | | | ✓ | | | | | | | ✓ | | | | | | | | | | ✓ | | | | ✓ | | | | | | | |
| | | Quality improvement methods are used to improve care and care delivery | Form and maintain a diverse quality improvement (QI) team of clinical and administrative staff with protected time to examine and improve upon clinical outcomes, quality of care, and patient satisfaction | ✓ 25 | ✓ | | | | | ✓ | | | | | | ✓ | | ✓ | | | ✓ | ✓ | ✓ | | | | ✓ | | ✓ | | | | | | |
| | | Information is exchanged securely, appropriately, timely and efficiently | Implement protocol to obtain shared client records | ✓ 7 | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | | | | | ✓ |
| | | | Sign inter-organizational agreements for access to records of referred and/or shared clients | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Participate in a technology platform (such as Olympic Digital HIT Commons or PreManage) that allows necessary client information to be exchanged between the referee and referral organization | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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**OrgType**

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Organization | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Care Infrastructure | Capacity Infrastructure | Community-based services and supports are timely and accessible | Offer after-hours access | ✓ 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Expand services, hire new workforce or expand capital to meet client demand | ✓ 6 | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | ✓ | | | | | |
| | | Workforce is trained in best practices to provide appropriates services to client population of focus | Staff is provided with resources to refer to crisis intervention services | ✓ 5 | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | | | | | | ✓ |
| | | | Staff is trained in teach-back and/or motivational interviewing | ✓ 5 | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | ✓ | | | | | |
| | | | Staff is trained in de-escalation | ✓ 5 | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | | ✓ | | | | |
| | Sustainability | Transformation is sustained beyond the Medicaid Transformation Project | Offer organization financial or in-kind match of DSRIP funding | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Report on value-based metrics that will be in MCO contracts (not actionable until 2019, when providers will know which metrics will be in the contracts) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Support all-payer collaboration to foster system-wide transformation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Implement value-based payment arrangements with MCOs and/or partners in your NCC | ✓ 29 | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | | | | | | | |
| | Administrative | Organization can exercise effective leadership, [illegible] | Establish and maintain an effective governance structure, and public access/reporting protocols regarding all MTP-related planning and decision-making | ✓ 31 | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | | | |

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- Community-Based Organization / Social Service
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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Care Infrastructi.. Administrative | management, transparency and accountability of MTP activities throughout the duration of its Change Plan | Implement reporting policies and practices to ensure complete and timely reporting of change plan activities to OCH | ✓ 32 | | | | | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | | | |

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Olympic COMMUNITY of HEALTH

January–March 2019 Site Visit Report

**Appendix 2**

Appendix 2 provides additional information of specific projects related to tactics identified as a focus by Implementation Partners, as well as information on the sub-tactic level (Populations of Focus and Partners). The following tables are organized by the Change Plan Domain (Care Coordination, Care Integration, Care Transformation, and Care Infrastructure) and by sector (Behavioral Health, Primary Care, Integrated, Hospital, and CBOSS).

Notes:
• A limited site visit was completed with Discovery Behavioral Health due to key personnel changes.
• One Implementation Partner terminated their contract following site visit. Data from this organization is not included in the Site Visit Report.

## Change Plan Activities: Project Descriptions, Tactic and Sub-Tactic Level

### Care Coordination:

| Focus Area | Behavioral Health | Primary Care | Integrated | Hospital | CBOSS |
|---|---|---|---|---|---|
| Population Health Management | • Four MH agencies (KMHS, WEOS, PBH, DBH) will switch to the EBHR Care Logic enabling transformative tracking of sub-populations<br>• EHR transition to Clinic Tracker (OPG)<br>• PMP pilot program with Qualis Health (OPG)<br>• ReliaTrax EHR allows referents to log into system to send referrals, upload documents, and view status reports (RCSG) | • Upgraded EPIC system (OMP, JFHC, JH)<br>• Transitioned to EPIC (NOHN)<br>• Transitioned to Athena (KMG)<br>• CHW hire planned (JH)<br>• Patient navigators hired (OMC) | • Using ICare as IT solution for client tracking and case management (STIHC)<br>• HIE data sharing between Athena and EPIC (PCHS) | • Upgraded EPIC system (OMC, JH)<br>• Using tool in EPIC to manage high ED utilizers, seeking staffing solution (JH)<br>• Moving to Meditech next year (FCH) | |
| ED/Jail Diversion | • New Start program for high utilizers of the criminal justice system (WSTC)<br>• Pre-Manage pilot with view only (RCSG) | • Pre-Manage fully implemented (KCC) | • Embedding CHW at HMC (PCHS)<br>• Express services (NOHN) | • Seeking standard practice (OMC) | |

| | | | | | |
|---|---|---|---|---|---|
| | • Monthly meetings with clients and family members to provide education on community resources and after-hours care (RCSG) | | | • Emphasizing walk-in clinic (OMC)<br>• Already established EDIE (HMC) | |
| SDOH Screening and Resources | • Questionnaire distributed (WEOS)<br>• Community resource directory (WEOS, RCSG)<br>• Clients screened for housing, employment, transportation needs (WSTC)<br>• Food status needs screened and addressed through Recovery Coaching Program (OPG) | • Exploring SDOH module on EPIC (OMP, JH)<br>• Integration of SDOH screenings into workflows and updated resource directory (KCC) | • SDOH screening built into EHR (PGST)<br>• Exploring SDOH module on EPIC; will start with MAT patient intakes (JFHC, NOHN) | • EPIC upgrade allows to build community list (OMC, JH) | |

*Acronyms used in table: BHA – Behavioral Health Agency, CBOSS – Community Based Organizations and Social Services, CHW – Community Health Worker, DBH – Discovery Behavioral Health, EBHR – Electronic Behavioral Health Record, ED – Emergency Department, EDIE – Emergency Department Information Exchange, EHR – Electronic Health Record, FCH – Forks Community Hospital, HIE – Health Information Exchange, HMC – Harrison Medical Center, IT – Information Technology, JFHC – Jamestown Family Health Clinic, JH – Jefferson Healthcare, KCC – Kitsap Children's Clinic, KMG – Kitsap Medical Group, KMHS – Kitsap Mental Health Services, MH – Mental Health, NOHN – North Olympic Healthcare Network, OMC – Olympic Medical Center, OMP – Olympic Medical Physicians, OPG – Olympic Personal Growth, PBH – Peninsula Behavioral Health, PCHS – Peninsula Community Health Services, PGST – Port Gamble S'Klallam Tribal Health Services, RCSG – Reflections Counseling Services Group, SDOH – Social Determinants of Health, STIHC – Sophie Trettevick Indian Health Center, WEOS – West End Outreach Services, WSTC – West Sound Treatment Center*

## Care Coordination: Sub-tactic: Population of Focus

| Population of Focus | Behavioral Health | Primary Care | Integrated | Hospital | CBOSS |
|---|---|---|---|---|---|
| Substance use disorder | | OMC | PGST, PCHS, JFHC | | |
| Opioid use disorder | | NWFMR, JH, OMP | STIHC, PGST, PCHS, JFHC | | |
| Co-occurring MH and SUD | KMHS, PBH, BoH, WSTC, KRC | KMG | STIHC, JFHC | | |
| BH and chronic disease | WEOS, PBH | NWFMR, OMP | | | |
| Depression | PBH, KRC | NWFMR, JH, OMP | PCHS, JFHC | | |

| | | | | | |
|---|---|---|---|---|---|
| Pediatric oral health | | BCBPCC | PCHS, JFHC | | |
| Adult oral health | | | JFHC | | |
| Asthma | RCSG, KRC<br>Planning: KMHS | | PCHS | | OlyCAP |
| Diabetes | RCSG, KRC<br>Planning: WEOS, PBH | KMG, NWFMR, HHP, BCBPCC | STIHC, PCHS, JFHC | | OlyCAP |
| Hypertension | RCSG<br>Planning: KMHS | KMG, NWFMR, HHP, BCBPCC | STIHC, PCHS, JFHC | | OlyCAP |
| Cardiovascular disease | RCSG<br>Planning: PBH | KMG, NWFMR, HHP | JFHC | | |
| Historical trauma and ACEs | WEOS, KRC | | PGST | | |
| Women of childbearing age (15–44) | KRC | | JFHC | | KPHD |
| Pregnant women | | | | | First Step, KPHD |
| Post-partum women Hepatitis C | Future: BoH | | | | First Step, KPHD |
| Children (0–18) | | | | | KPHD |
| Children overdue for well-child vists | | HHP, BCBPCC, KCC | PCHS, JFHC | | |
| Children under 2 not up to date with immunizations | | BCBPCC, KCC | PCHS, JFHC | | |
| High utilizers of the ED | KMHS, PBH, WEOS, KRC | JH, BCBPCC, KCC | PCHS | JH, FCH | |
| High utilizers of the criminal justice system | KMHS, PBH, WEOS, WSTC, KRC | | | | |
| Experiencing homelessness and/or food insecurity | KRC | KCC | | HMC | OPHCC |
| Low income | | | | | KPHD |
| Other: sexual exploitation | KRC | | | | |
| Other: annual wellness visits | | | JFHC | | |
| Other: chronic pain | | | JFHC | | |
| Other: after-hours care | | | STIHC | | |

*<u>Acronyms used in table:</u> ACEs – Adverse Childhood Experiences, BCBPCC – Bogachiel and Clallam Bay Primary Care Clinics, BH – Behavioral Health, BoH – Beacon of Hope, CBOSS – Community Based Organizations and Social Services, ED – Emergency Department, FCH – Forks Community Hospital, HHP – Harrison Health Partners, HMC – Harrison Medical Center, JFHC – Jamestown Family Health Clinic, JH – Jefferson Healthcare, KCC – Kitsap Children's Clinic, KMG - Kitsap Medical Group, KMHS – Kitsap Mental Health Services, KPHD – Kitsap Public Health District, KRC – Kitsap Recovery Center, MH – Mental Health, NOHN – North Olympic Healthcare Network, NWFMR – Northwest Washington Family Medical Residency, OlyCAP – Olympic Community Action Programs, OMC – Olympic Medical Center, OMP – Olympic Medical Physicians, OPHCC – Olympic Peninsula Healthy Communities Coalition, PBH – Peninsula Behavioral Health, PCHS – Peninsula Community Health Services, PGST – Port Gamble*

*S'Klallam Tribal Health Services, RCSG – Reflections Counseling Services Group, STIHC – Sophie Trettevick Indian Health Center, SUD – Substance Use Disorder, WEOS – West End Outreach Services, WSTC – West Sound Treatment Center*

## Care Integration: *Note: Domain not applicable for CBOSS and Hospital.*

| Focus Area | Behavioral Health | Primary Care | Integrated |
|---|---|---|---|
| PC into BH | • Co-location of primary care on site (KMHS, Planning: PBH, KRC)<br>• Working toward agreement with physical health provider in NCC (WSTC, OPG) | | • BH provider embedded in PC (PGST)<br>• Fundraising for new integrated BH and PC facility in progress (PGST) |
| BH into PC | | • Contracting on-site BH specialists (NWFMR, HHP)<br>• Psychiatrist on site (JH)<br>• New hire of psych ARNP on site (BCBPCC)<br>• Co-located BH specialist on site (OMP)<br>• Co-located MH provider twice monthly (KMG) | • Psych ARNP on site (STIHC)<br>• BH licensure to bill for BH claims (PCHS)<br>• Expanded internal BH services (NOHN)<br>• Reinstituted regular collaborative care team meetings (STIHC) |
| Dental Oral Health | | • Opening dental clinic (NOHN)<br>• Dental providers on site (JH)<br>• Training for pediatric oral health screening (BCBPCC) | |
| IMC | "All hands-on deck" to make this transition | | |

*Acronyms used in table: ARNP – Advanced Registered Nurse Practitioner, BCBPCC – Bogachiel and Clallam Bay Primary Care Clinics, BH – Behavioral Health, HHP – Harrison Health Partners, IMC – Integrated Managed Care, JH – Jefferson Healthcare, KMG – Kitsap Medical Group, KMHS – Kitsap Mental Health Services, KRC – Kitsap Recovery Center, MH – Mental Health, NCC – Natural Community of Care, NOHN – North Olympic Healthcare Network, NWFMR – Northwest Washington Family Medical Residency, OMP – Olympic Medical Physicians, OPG – Olympic Personal Growth, PBH – Peninsula Behavioral Health, PC – Primary Care, PCHS – Peninsula Community Health Services, PGST – Port Gamble S'Klallam Tribal Health Services, STIHC – Sophie Trettevick Indian Health Center, WSTC – West Sound Treatment Center*

## Care Transformation: *Note: Domain not applicable for CBOSS.*

| Focus Area | Behavioral Health | Primary Care | Integrated | Hospital | CBOSS |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| Opioids | • 6BB start (WEOS)<br>• Naloxone training outreach to homeless population (PBH) | • Incorporating 6BB/improving prescribing practices internally (OMP, JH)<br>• 6BB in progress (NWFMR)<br>• 6BB start (BCBPCC) | • Care coordination upon discharge from criminal justice system for MAT services (PCHS)<br>• 6BB in progress (JFHC)<br>• Continuing to expand MAT program and formalize referrals (NOHN) | • Seeking funding information to provide naloxone (OMC, JH)<br>• Potential interest in 6BB for future (JH)<br>• 6BB start (FCH) | |
| Reproductive Maternal/ Child Health | | | • Received Family Planning Title X grant for reproductive and family planning program (PCHS) | • Hired OB (FCH) | • Expansion of MSS and NFP in Kitsap (Answers, KPHD)<br>• NFP program (First Step) |
| Chronic Disease Management | • WHAM training (PBH) | | • Four staff completed CDSM leader training; will hold future workshops for the community (PCHS)<br>• Diabetes coaching program in development; desire to align with OMP and NOHN programs (JFHC) | • Partnering with YMCA (OMP) | |

*<u>Acronyms used in table:</u> 6BB – Six Building Blocks, BCBPCC – Bogachiel and Clallam Bay Primary Care Clinics, CBOSS – Community Based Organizations and Social Services, CDSM – Chronic Disease Self-Management, FCH – Forks Community Hospital, JFHC – Jamestown Family Health Clinic, JH – Jefferson Healthcare, KPHD – Kitsap Public Health District, MAT – Medication Assisted Treatment, NOHN – North Olympic Healthcare Network, NWFMR – Northwest Washington Family Medical Residency, OB – Obstetrics, OMC – Olympic Medical Center, OMP – Olympic Medical Physicians, PBH – Peninsula Behavioral Health, PCHS – Peninsula Community Health Services, WEOS – West End Outreach Services, WHAM – Whole Health Action Management, YMCA – Young Men's Christian Association*

## Care Infrastructure

| Focus Area | Behavioral Health | Primary Care | Integrated | Hospital | CBOSS |
|---|---|---|---|---|---|
| Access | • In-patient unit for co-occurring SMI and SUD (KMHS) | • Increasing telepsychiatry services (OMP) | • New dental services in Poulsbo (PCHS) | • WSU medical residents' rotation (FCH) | • Just expanding to OCH region (Answers) |

| | | | | | |
|---|---|---|---|---|---|
| | • Transition to open access model (PBH)<br>• Expand SUD services (PBH) | | | | |
| Capacity Infrastructure | • Expansion of Recovery Coach program; WA state peer advocacy participation (OPG)<br>• Peer advocate hire (RCSG) | • Dental clinic opening (JH)<br>• New hire of CNM (BCBPCC) | • Fundraising for new integrated BH and PC facility in progress (PGST)<br>• Mobile medical and BH teams serving community (PCHS)<br>• CHW to embed in ED at HMC (PCHS)<br>• MAT facility planning and fund-raising (JFHC) | | • Establishing bi-directional referral pathway in EHR systems (YMCA) |

*Acronyms used in table: BCBPCC – Bogachiel and Clallam Bay Primary Care Clinics, BH – Behavioral Health, CBOSS – Community Based Organizations and Social Services, CNM – Certified Nurse Midwife, ED – Emergency Department, EHR – Electronic Health Record, FCH – Forks Community Hospital, HMC – Harrison Medical Center, JFHC – Jamestown Family Health Clinic, JH – Jefferson Healthcare, KMHS – Kitsap Mental Health Services, MAT – Medication Assisted Treatment, OCH – Olympic Community of Health, OMP – Olympic Medical Physicians, OPG – Olympic Personal Growth, PBH – Peninsula Behavioral Health, PC – Primary Care, PCHS – Peninsula Community Health Services, PGST – Port Gamble S'Klallam Tribal Health Services, RCSG – Reflections Counseling Services Group, SMI – Severe Mental Illness, SUD – Substance Use Disorder, WA – Washington state, YMCA – Young Men's Christian Association*

## Care Infrastructure: Identified Equity Work

| | |
|---|---|
| PBH | Hired three Spanish speaking staff and contracted with ASL online interpreter services |
| KMHS | LBGTQI focus and staff training in child/family/adult outpatient programs |
| OMC | AHA Health Equity pledge |
| JH | Designated as a leader in Healthcare Equality for meeting national criteria for LGBTQ patient centered care |
| YMCA | DIG program |
| PCHS | Mobile healthcare program |

*Acronyms used in table: AHA – American Heart Association, ASL – American Sign Language, DIG – Diversity Inclusion and Global Programs, JH – Jefferson Healthcare, KMHS – Kitsap Mental Health Services, LGBTQI – Lesbian, Gay, Bi-sexual, Transgender, Questioning, Intersex, OMC – Olympic Medical Center, PBH – Peninsula Behavioral Health, PCHS – Peninsula Community Health Services, YMCA – Young Men's Christian Association*

## Care Infrastructure: Status of Quality Improvement Process

| Type | Behavioral Health | Primary Care | Integrated | Hospital | CBOSS |
|---|---|---|---|---|---|
| Actively working with practice transformation coach | BoH, DBH, RCSG, WEOS, WSTC, OPG | KMG, NWFMR, HHP (2 sites), KCC | PGST | | |
| Internal | PBH, OPG, KRC | JH | JFHC, NOHN, PCHS | | First Step, O3A, YMCA, KPHD |
| Minimal/none/no time | | KMG | | | OPHCC, Answers, OlyCAP |
| Re-structuring | KMHS | BCBPCC, OMP | STIHC | OMC, JH, FCH, HMC | |

*Acronyms used in table: BCBPCC – Bogachiel and Clallam Bay Primary Care Clinics, BoH – Beacon of Hope, CBOSS – Community Based Organizations and Social Services, DBH – Discovery Behavioral Health, FCH – Forks Community Hospital, HHP – Harrison Health Partners, HMC – Harrison Medical Center, JFHC – Jamestown Family Health Clinic, JH – Jefferson Healthcare, KCC – Kitsap Children's Clinic, KMG – Kitsap Medical Group, KMHS – Kitsap Mental Health Services, KPHD – Kitsap Public Health District, NOHN – North Olympic Healthcare Network, NWFMR – Northwest Washington Family Medical Residency, O3A – Olympic Area Agency on Aging, OlyCAP – Olympic Community Action Programs, OMC – Olympic Medical Center, OMP – Olympic Medical Physicians, OPG – Olympic Personal Growth, OPHCC – Olympic Peninsula Healthy Community Coalition, PBH – Peninsula Behavioral Health, PCHS – Peninsula Community Health Services, PGST – Port Gamble S'Klallam Tribe Health Services, RCSG – Reflections Counseling Services Group, STIHC – Sophie Trettevick Indian Health Center, WEOS – West End Outreach Services, WSTC – West Sound Treatment Center, YMAC – Young Men's Christian Association*

## Partnerships Across Domains

| NCC | Partner | | Project | Notes |
|---|---|---|---|---|
| Clallam | First Step | OPHCC | Partnering to offer NEAR Sciences training | |
| | First Step | Jefferson County | Nurse Family Partnership program in Clallam County | |
| | JFHC | EMS | Falls program | |
| | OPG | Sequim PD | Jail diversion | Planning |
| | OPG | TAFY, Serenity House | Services at community centers via grant award | |
| | OPG | Sequim schools | Counseling services for students available on site at schools | |
| | OPG | YMCA, Boys and Girls Clubs, Sequim schools | 5210<br>Exercise memberships | |
| | OPHCC | OMC | Meal program for patients discharged from ED | |
| | OPHCC | PBH | Menus<br>Sugar math at pharmacy<br>Behavioral Health food<br>Training on 5210 | |
| | PBH | NOHN, JFHC, OMC | Resumed sending psychiatric visit notes to primary care providers | |
| | PBH | NOHN | Psychiatric consultation to improve NOHN's integrated care model | Agreement pending |
| | PBH | Cedar Grove | Referrals to biofeedback programs | |

| | | | | |
|---|---|---|---|---|
| | STIHC | WEOS | Formalize process of shared clients other than crisis | Early conversations |
| | STIHC | FCH | Emergency department transfers | Conversations |
| | STIHC | OMC | Emergency department transfers | Conversations |
| | WEOS | Hoh Tribe | WEOS provide mental health services | Early conversations |
| **Jefferson** | BoH | DBH | Shared client coordination | Early conversations |
| | BoH | JH | MAT program coordination | |
| | JH | East Jefferson Fire | Home visits for high risk fall prevention population | |
| **Kitsap** | HMC | Benedict House | Medical respite post discharge for homeless | |
| | HMC | PCHS | CHW program | In development |
| | HHP, NWFMR | KMHS | Contracting for behavioral health providers on site | |
| | KCC | One Heart Wild | Animal therapy | |
| | KMHS | KCC | MOA through pTCPi | |
| | KMG | Sound Dental Care (mobile dental services) | Provide mobile dental services on-site at four skilled nursing facilities | |
| | KPHD | PCHS | Form bi-directional referral process | |
| | NWFMR | Pacific Hope and Recovery | Refer MAT patients for SUD treatment services | |
| | PCHS | Calvary Chapel of Silverdale | Mobile medical and behavioral health clinic | |
| | PCHS | Emanuel Apostolic Church | Mobile medical and behavioral health clinic | |
| | PGST | South Central Foundation | Nuka System of Care | |
| | YMCA | PCHS NWFMR | Establish bi-directional referral pathway within EPIC to AthenaNet EHR | |

*Acronyms used in table: BoH – Beacon of Hope, DBH – Discovery Behavioral Health, ED – Emergency Department, EHR – Electronic Health Record, EMS – Emergency Medical Services, FCH – Forks Community Hospital, HHP – Harrison Health Partners, HMC – Harrison Medical Center, JFHC – Jamestown Family Health Clinic, JH – Jefferson Healthcare, KCC – Kitsap Children's Clinic, KMG – Kitsap Medical Group, KMHS – Kitsap Mental Health Services, KPHD – Kitsap Public Health District, MAT – Medication Assisted Treatment, MOA – Memorandum of Agreement, NCC – Natural Community of Care, NEAR – Neuroscience, Epigenetics, Adverse Childhood Experiences [ACEs], and Resilience, NOHN – North Olympic Healthcare Network, NWFMR – Northwest Washington Family Medical Residency, OMC – Olympic Medical Center, OPG – Olympic Personal Growth, OPHCC – Olympic Peninsula Healthy Community Coalition, PBH – Peninsula Behavioral Health, PCHS – Peninsula Community Health Services, PD – Police Department, PGST – Port Gamble S'Klallam Tribal Health Services, pTCPi – Pediatric Transforming Clinical Practice Initiative, STIHC – Sophie Trettevick Indian Health Center, SUD – Substance Use Disorder, TAFY – The Answer for Youth, WEOS – West End Outreach Services, YMCA – Young Men's Christian Association*

Olympic COMMUNITY of HEALTH

January-March 2019 Site Visit Report

**Appendix 3**

Appendix 3 provides detailed requests from Implementation Partners regarding: trainings, technical assistance, and requests for state partners. These requests were used to help assess the needs of the region and inform the recommended action plan.

*Note: A limited site visit was completed with Discovery Behavioral Health due to key personnel changes.*

*Note: One Implementation Partner terminated their contract following site visit, data from this organization is not included in the Site Visit Report.*

## Requests from Implementation Partners

### Training Requests:

| Topic | Applicable Provider Type | Request From |
|---|---|---|
| Social Determinants of Health (best practices for capturing data, using data) | All | 1 BH, 1 Integrated, 1 PC, 3 CBOSS |
| CDSM | All | 1 BH, 1CBOSS |
| Health Equity | All | 1 Integrated, 1 CBOSS |
| Trauma-Informed Care | All | 1 Integrated, 1CBOSS |
| Co-occurring disorders (MH and SUD) | Mental Health and SUD providers | 1 BH |
| Motivational Interviewing for Primary Care | Primary Care providers | 1 Integrated |
| MAT for Chemical Dependency Professionals | SUD providers | 1 BH |
| Education for MAT prescribers around need for referring clients to counseling services | SUD providers | 1 BH |
| Expand community awareness around need for MAT, decreasing stigma | MAT providers, SUD providers | 1 PC |
| Various evidence-based programs | Rural providers with limited access to training opportunities | 1 BH |
| NEAR Sciences | All | 1 CBOSS |
| Serving the LGBTQ community | All | 1 CBOSS |

*Acronyms used in table: BH – Behavioral Health, CBOSS – Community Based Organizations and Social Services, CDSM – Chronic Disease Self-Management, LGBTQ – Lesbian, Gay, Bi-sexual, Transgender, Queer, MAT – Medication Assisted Treatment, MH – Mental Health, NEAR - Neuroscience, Epigenetics, Adverse Childhood Experiences [ACEs], and Resilience, PC – Primary Care, SUD – Substance Use Disorder*

## Technical Assistance Requests:

| Topic | Applicable Provider Type | Request From |
|---|---|---|
| Data collection, IT assistance, and EHR capability | All providers with EHR; technical assistance would be most effective offered by EHR type | 2 Integrated, 1 PC, 1 BH |
| Integrating SDOHs into EHR | All providers with EHR; technical assistance would be most effective offered by EHR type | 1 PC, 1 Integrated |
| Naloxone availability/source | All | 2 BH, 1 PC |
| EPIC view-only access | All Clallam providers not on EPIC | 1 BH, 1 PC |
| Integrated Managed Care transition preparation | All BH providers | 1 BH |
| Health Commons | All | 1 BH |
| Grant writing | Smaller providers | 1 BH |
| Orientation to MTP and Change Plan work for clinical staff | All | 1 PC |
| Facilitation of sector engagement and convening | All | 1 Hospital |
| Shared policies, procedure manuals | All | 1 Integrated |
| Motivational speaking to improve employee morale | All | 1 Integrated |

*Acronyms used in table: BH – Behavioral Health, EHR – Electronic Health Record, IT – Information Technology, MTP – Medicaid Transformation Project PC – Primary Care, SDOH – Social Determinants of Health*

## HCA/MCO Requests:

| Request For | Topic | Applicable Provider Type | Request From |
|---|---|---|---|
| MCOs | Facilitate alignment between MCOs and increase engagement to reduce burden on providers | All providers preparing to enter into contracts with MCOs | 1 Integrated, 1 BH, 1 PC |
| HCA | Clear information on information sharing (care coordination and 42 CFR) | All providers who coordinate care to/from BH agencies | 1 CBOSS, 1 BH |
| HCA | Need clear information on path forward with VBP- what will be included in VBP billing? (IMC/MSS, etc.) | All providers preparing to enter into VBP contracts, CBOSS partners | 2 CBOSS |
| HCA | Need clear information on care codes and gender identifiers for billing purposes | Providers entering into contracts with MCOs, particularly BH and Integrated providers | 1 BH |

| | | | |
|---|---|---|---|
| Pre-Manage | Would like more information on sponsorship, workflow requirements, successes, and challenges | All providers who do not currently have an ER alert system/workflow in place | 1 BH |

*Acronyms used in table: BH – Behavioral Health, CBOSS – Community Based Organizations and Social Services, ER – Emergency Room, HCA – Health Care Authority, IMC – Integrated Managed Care, MCO – Managed Care Organization, MSS – Maternity Support Services, PC – Primary Care, VBP – Value Based Payments*

## Olympic Community of Health

**S.B.A.R. OMC 2018 Payment Correction**
Presented to the Executive Committee May 28, 2019
Edited for presentation at the June 10, 2019 Board of Directors Meeting

### Situation

During the 2019 process to validate scale reporting and schedule June 2019 partner payments, OCH staff recognized that an error regarding the Olympic Medical Center (OMC) primary care payment was made in 2018. Prior to the launch of the ORCA system, staff and partners hand-entered reporting numbers and the scale numbers for OMC's hospital and primary care were inadvertently transposed. As scale is not used to calculate hospital payments, this error only impacts the primary care amount. It does also mean that other primary care partners in the Clallam NCC were overpaid.

| | Original | Revised | Adjustment |
|---|---|---|---|
| 2018-1 | $127,250 | $168,210 | $40,960 |
| 2018-2 | $85,020 | $89,120 | $4,100 |
| Total Award | $212,270 | $257,330 | $45,060 owed to OMC |

### Background

Numbers originally processed for OMC 2018 payment:

- **Olympic Medical Center, Hospital:** 8,155
- **Olympic Medical Physicians (Primary Care):** 5,029

Corrected numbers for OMC 2018 payment:

- **Olympic Medical Center, Hospital:** 5,029
- **Olympic Medical Physicians, Primary Care:** 8,155

### Action

- OMC is owed $45,060 for the 2018 payments.
- Staff have verified all other 2018 scale reports and payment amounts and confirm no other errors were made.
- Staff implemented a reporting validation system and now use the ORCA platform for reporting, which reduces likelihood of future errors.
- Staff propose 3 options for discussion by the Board to correct the mistake:

**Option 1 – Pay OMC out of unallocated DSRIP funds**

- At this time, it is projected (optimistically) that the OCH Board of Directors has yet to allocate approximately $5,000,000. This includes projected income and expenses through 2023.

- $45,000 is 0.9% of $5,000,000
- This option is least burdensome to correct and does not directly impact other partners.
- If this option is approved by the Board, staff will pay OMP and adjust projected available funds for discussion and determination at the August Board retreat.

**********

**Option 2 – Pay OMC out of the OCH 2019 operating budget**

- The Board-approved 2019 OCH operating budget is $1,694,990
- Based on current spending and projections for the rest of the year, staff anticipate coming in at or slightly under budget. At most, we expect to underspend by 2% or ~$34,000.
- If this option is approved by the Board, staff will adjust the operating budget accordingly.

**********

**Option 3 – Pay OMC and correct overpayments to Clallam NCC partners with the June 2019 payment**

- Based on the approved funds flow methodology, partners are paid by NCC. An underpayment to one partner leads to overpayment to others of the same type.
- The below table outlines 2018 actual payments made to the Clallam NCC partners and the variance based on the OMC error.
- If this option is approved by the Board, staff will adjust the June 2019 payment based on the variance column below.

| | 2018 Incentives | | |
|---|---|---|---|
| Implementation Partner | Actual | Corrected | Vairance |
| Bogachiel and Clallam Bay Primary Care Clinics (PC) | $82,300 | $73,000 | ($9,300) |
| Jamestown Family Health Clinic (PC) | $144,290 | $132,690 | ($11,600) |
| Jamestown Family Health Clinic (BH) | $12,810 | $12,810 | $0 |
| North Olympic Healthcare Network (PC) | $181,250 | $162,820 | ($18,430) |
| North Olympic Healthcare Network (BH) | $11,900 | $11,900 | $0 |
| Olympic Medical Center (PC) | $212,270 | $257,330 | $45,060 |
| Olympic Personal Growth (BH) | $49,460 | $49,460 | $0 |
| Peninsula Behavioral Health (BH) | $142,260 | $142,260 | $0 |
| Reflections Counseling Services Group (BH) | $48,160 | $48,160 | $0 |
| Sophie Trettevick Indian Health Center (PC) | $77,580 | $71,850 | ($5,730) |
| Sophie Trettevick Indian Health Center (BH) | $19,710 | $19,710 | $0 |
| West End Outreach Services (BH) | $34,700 | $34,700 | $0 |

**Recommended Motion**
The OCH Board of Directors approves Option ___ and directs staff to administer next steps.

## Olympic Community of Health

**S.B.A.R. 2019 Officer Elections**
Presented to the Board of Directors on June 10, 2019.

## Situation

The OCH bylaws call for a 5-member Executive Committee. Due to changes over the last year, there are two vacancies on this Committee and terms for the 3 current members expire in June 2019.

## Background

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

Director Elections: Per OCH bylaws, "during the first year after adoption of these Bylaws, Directors shall be elected to an initial one-year (1) term. For the purpose of staggering the terms, following the initial one-year term, thirty (30%) of the Board of Directors shall serve a one (1) year term and the remaining Directors shall serve a two (2) year term. The initial groups shall be determined by a lottery. Thereafter, each Director's term of office shall be for two (2) years, which shall end on the latter of the date of the annual meeting or succession of a new director. At the end of three (3) consecutive terms, each sector has the option to nominate the same Candidate or to nominate a new Candidate to represent the sector on the Board. Term of Office does not apply to Tribes."

"Candidates for Board members shall be nominated by each Sector. The nominations will be referred directly to the Board for approval. In the event a Sector cannot nominate a representative within thirty (30) days, the Board, either directly or through Committee, will solicit, receive and vet nominations, and recommend a sector representative to the Board."

Current status of OCH Officers:

- President: Roy Walker, officer term expires 6/2019. Per bylaws, a new seat on the Executive Committee of Past-President replaces the At-Large position, formerly held by Joe Roszak.
- Vice President: Jennifer Kreidler-Moss, officer term expires 6/2019.
- Secretary: Leonard Forsman resigned. Sammy Mabe resigned. Seat is vacant.
- Treasurer: Hilary Whittington, officer term expires 6/2019.
- At-Large: Joe Roszak resigned. Seat is vacant and changes in 7/2019 to Past-President.

## Action

2019 Officer Nominations:

- President: **Wendy Sisk**
- Vice-President: **Jennifer Kreidler-Moss**
- Treasurer: _____
- Secretary: **Andrew Shogren**
- Past President: **Roy Walker**

## Recommended Motion

The Board approves the 2019 officer nominations. This new slate of officers takes over effective immediately after this vote and will follow OCH bylaws and the OCH Executive Committee charter.