Olympic Community of Health

Agenda

# Board of Directors Meeting

**March 12, 2018, 1 pm to 3 pm**

***Location Change*** Poulsbo City Hall Chambers, 200 Moe Street NE, Poulsbo, WA

**Web:** https://global.gotomeeting.com/join/937538149

**Phone:** +1 (872) 240-3311

**Access Code:** 937-538-149

## KEY OBJECTIVES

- Review and come to agreement on next steps for allocation of incentives to signed partners
- Come to a shared understanding of the building blocks for operationalizing the Medicaid Transformation Project

## AGENDA (Action items are in red)

| Item | | Topic | Lead | Attachment | Page(s) |
|---|---|---|---|---|---|
| 1 | 1:00 | Welcome and Approve Agenda | Roy | | 1 |
| 2 | 1:05 | Consent Agenda | Roy | 1. DRAFT: Board Minutes 2.12.2018<br>2. HB 2998, B&O Tax Exemption<br>3. Director's Report | 2 |
| 3 | 1:10 | IGT Contributor Funds Transfer | Elya | 4. REVISED SBAR: Approve IGT Contribution | 9 |
| 4 | 1:20 | 2018 & 2019 Incentive Allocation Plan | Elya<br>Dan | 5. SBAR: Funds Flow Workgroup Recommendation | 11 |
| 5 | 2:00 | MTP Building Blocks:<br>- Shared Change Plan<br>- Change Plan | JooRi<br>Elya | *Will be passed out at the meeting* | |
| 6 | 2:45 | OCH Participant Survey Results | Elya | 6. OCH Participant Survey Results | 14 |
| 7 | 3:00 | Adjourn | Roy | | |

## Acronym Glossary

IGT: Intergovernmental Transfer

MTP: Medicaid Transformation Project

SBAR: Situation. Background. Action. Recommendation.

Olympic Community of Health

**Meeting Minutes**

Board of Directors

February 12, 2018

| **Date:** 02/12/2018 | **Time:** 1:00pm-3:00pm | **Location:** Kitsap Regional Library, Poulsbo Community Room |
|---|---|---|

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

**Members Attended:** Anders Edgerton, *Salish BHO*; Bobby Beeman, *Olympic Medical Center*; Hilary Whittington, *Jefferson Healthcare*; Jennifer Kreidler-Moss, *Peninsula Community Health Services*; Joe Roszak, *Kitsap Mental Health Services*; Katie Eilers, *Kitsap Public Health District*; Meriah Gille, *Lower Elwha Klallam Tribe*; Brent Simcosky, *Jamestown Family Health*; Gill Orr, *Cedar Grove Counseling;* Vicki Kirkpatrick, *Jefferson Public Health;* Karol Dixon, *Port Gamble S'klallam Tribe*; Thomas Locke, *Jefferson County Public Health*, Kayla Down, *Coordinated Care*; Dale Wilson, *OlyCAP;* Gary Kriedberg, *Harrison Health Partners*

**Members Attended by Phone:** Jorge Rivera, *Molina Healthcare*

**Non-Voting Members Attended**: Kat Latet, *CHPW*; Caitlin Safford, *Amerigroup*; Laura Johnson, *United Health Care,* Mike Maxwell, *North Olympic Healthcare Network*

**Guests:** Amy Etzel, *Washington State Department of Health;* Stephanie Lewis, Salish BHO

**Contractors:** Maria Klemesrud, *Qualis*; Dan Vizzini, *Oregon Health Sciences University;* Siri Kushner, *Kitsap Public Health District*

**Staff:** Elya Moore, Lisa Rey Thomas, Margaret Hilliard, JooRi Jun

| Person Responsible for Topic | Topic | Discussion/Outcome | Action/Results |
|---|---|---|---|
| Joe Roszak | **Welcome and Introductions** | Joe Roszak called the meeting to order at 1:09 PM. | |
| Roy Walker | **Consent Agenda** | Board approval of consent agenda and minutes from January 8, 2018 Board meeting. | January 8, 2018 Meeting Minutes and Consent Agenda<br>APPROVED unanimously. |
| Roy Walker | **Fill New Board Member Seats** | The Board nominated a lead and alternate to take the place of Larry Eyer.<br>-Dale Wilson, representative.<br>-David Wunderman, alternate. | MOTION to approve new Board members.<br>APPROVED unanimously. |
| Hilary Whittington | **4th Quarter Financials** | -Hilary Whittington presented financial statements as of December 31, 2017.<br><br>-Audit will cover 11 months, starting February 2017. | |

| | | | |
|---|---|---|---|
| | | -$5,000 net loss for 2017 due to meeting expenses and other expenses that could not be charged to HCA grant. | |
| Roy Walker | **Executive Committee (EC) Recommendations to the Board** | Succession Plan<br>Legal counsel recommended it be stand-alone policy.<br>Recommended amendments:<br>- Contact information for positions rather than people.<br>-Stand-alone section for situation when person in Acting ED position is new to their position/the OCH.<br><br>Contract with OHSU<br>EC recommends that BOD authorize Executive to approve OHSU contract for up to $50,000 through 12/31/18.<br>-Dan Vizzini is not the only OHSU contractor we could use, but we have control in how we would utilize the time of a different contractor, if at all.<br>-OCH would pay for Dan travel. Board commented that Dan's time should be used wisely (e.g., Funds Flow). | MOTION to approve Succession Plan with Amendments.<br>APPROVED unanimously.<br><br>MOTION to enter into a contract with OHSU Center for Evidence Based Policy for up to $50,000 for 2018.<br>APPROVED unanimously. |
| Elya Moore | **Shared ACH Reporting Tool** | OCH weighed pros and cons around using CSI Portal or UW Portal, and recommends the use of the CSI Portal. | MOTION to contract with CSI for reporting tool.<br>APPROVED unanimously. |
| Elya Moore | **IGT Strategy Recommendation** | OCH BOD must make a decision about Shared Domain 1 Investments for IGT contributors<br>- This is a core component of the MTP Funding and Mechanics Protocol.<br>-The time period of the IGT funding is 4 years.<br>-OCH must authorize IGT distributions every 6 months.<br>-Starting in December, all funds flow work has been based on IGT projections. | MOTION to approve the funding mechanism for IGT strategy developed by HCA as part of the Medicaid Transformation Project<br>APPROVED by majority. |
| Elya Moore | **Funds Flow Workgroup Update** | OCH recommends signing MTP Change Plans with contractors for 2018-2021, with Scope of Work amended yearly. Payment parameters may include:<br>-Number of Medicaid lives served.<br>-Number of Medicaid encounters.<br>-Number of activities.<br>-Adherence to reporting requirements.<br>-Health equity factor. | |

| | | | |
|---|---|---|---|
| | | OCH hopes to work with MCOs to align reporting requirements. | |
| Siri Kushner | **NCC Convenings: Update and Summary** | Presentation of the content of NCC meetings, partner perceptions, and webform responses. | |
| Roy Walker | **Executive Session** | The 360-degree annual review of the Executive Director was completed in January with Board, some contractors, staff and partner feedback. Executive Committee met and reviewed the results. The Board President met with the Executive Director to discuss those results. The Executive Committee makes the recommendation to increase the Executive Director salary by 3% and pay a one-time lump sum based on the current salary of 3%. | MOTION to proceed with Executive Committee recommendation. APPROVED unanimously. |
| Roy Walker | **Adjourn** | The meeting adjourned at 3:21 PM. | |

**Acronym Glossary**
HCA: Health Care Authority
IGT: Inter-governmental Transfer
NCC: Natural Community of Care
SCP: Shared Change Plan

## Olympic Community of Health

**Executive Director's Report**

Prepared for the March 12, 2018 Board Meeting

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Top 3 Things to Track (T3T) #KeepingMeUpAtNight

1. Alignment of Change Plans with Funds Flow is proving to be extremely complex. You all said, "when the money arrives, this will get real" and they were right!

2. The systems we put in place using DSRIP funding to help partners drive towards value-based, integrated care and healthier communities have the potential create a solid foundation beyond the Transformation. The challenge is in designing the systems now without a crystal ball into the future.

3. The adage "form should follow function", while wise, is posing a challenge on staff capacity as we have made the strategic decision to pause on new hires until the needs of providers are made clear in their Change Plans.

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**OCH Meetings**

- Executive Committee, Tuesday March 27, 12-2 pm, virtual
- Board of Directors, Monday April 9, 1-3, Poulsbo
- Executive Committee, Monday April 23, 12-2, virtual
- Partner Convening, Tuesday April 24, 12-5 (tentative, confirming agenda), Kingston
- Finance Committee, Thursday 1-2 pm

**Staffing Updates**

Margaret (Maggie) Hilliard – Director of Administration

Maggie is honored to move from her previous position at the Office and Administrative Coordinators to become OCH's first Director of Administration. She brings to the position a degree in Business Administration, two years in federal grant billing, and 6 months of experience working on the OCH team. Maggie is dedicated to refining the administrative processes of OCH to help secure the long-term viability of the organization.

Grecia (pronounced "Grace") – Assistant

Grecia is an administrative support professional with experience working in a fast-paced environment – a perfect fit for OCH! She joins us from her most recent position from Kitsap Public Health District to help the OCH team stay organized as we continue with the 3 County Coordinated Opioid Response Project and the Medicaid Transformation Project.

The next hire depends on the scope of work and number of the partner Change Plans and the functionalities offered by the online reporting and contract management tool (CSI).

**Retreat**

Staff is working with the Executive Committee on a concept for an OCH Retreat. The retreat will likely be an extended Board meeting in late fall. The current vision of the retreat is to discuss OCH mission and role beyond the Medicaid Transformation Project.

**B&O Tax Exemption HB 2998**

There is a bill (included in your packet) pertaining to a B&O tax exemption for Accountable Communities of Health and organizations receiving DSRIP funding to perform transformation activities. This bill was heard by the Senate Ways and Means Committee on March 6, 2018 and passed with 15 votes (13 required to pass).

**UPDATE: Natural Community of Care Convenings**
The third convening for each Natural Community of Care (NCC) concluded in early March. Staff has enough input to prepare a draft Shared Change Plan for each NCC. All three NCCs will be convened for a joint NCC-Partner Convening on April 24th in Kingston (agenda under development). The next convening will cover NCC-directed infrastructure investments, targeted investments in upstream community-based organizations, funds flow, Change Plans, and (hopefully) the signing of the Shared Change Plan.

**UPDATE: Independent Audit**
We are expecting DZA, our selected independent audit firm, to be on site for the audit in early April. The Director of Administration has begun preparations, in collaboration with Nathanael O'Hara, our CFO service provider, to prepare for the audit.

**UPDATE: IT Care Coordination**
On March 5th, North Olympic Healthcare Network (a federally qualified health clinic) and Olympic Personal Growth (a substance use disorder treatment organization) piloted the new IT Care Coordination cloud-based platform. OCH staff traveled to Port Angeles to witness the real-time inaugural referral of Mickey Mouse and Minnie Mouse from NOHN to OPG. Rob Arnold, Dr. Kate Weller (NOHN), and Kristina Bullington (OPG) will be attending the April Board meeting to demonstrate the tool and answer Board questions.

**UPDATE: OHSU Contract**
OCH and OHSU entered into a contract for 2018. The cooperating ACHs are working on an interagency agreement to provide ground rules for how we share this asset.

**REMINDER: Executive Director Vacation**
Just a reminder that I will be out of town the 2nd half of March. England here I come!

H-5031.1

# SUBSTITUTE HOUSE BILL 2998

**State of Washington 65th Legislature 2018 Regular Session**

**By** House Finance (originally sponsored by Representatives Robinson, Cody, Jinkins, Tharinger, and Ormsby)

READ FIRST TIME 02/26/18.

AN ACT Relating to providing a business and occupation tax exemption for accountable communities of health; adding a new section to chapter 82.04 RCW; creating new sections; and declaring an emergency.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** (1) This section is the tax preference performance statement for the tax preference contained in section 2, chapter . . ., Laws of 2018 (section 2 of this act). The performance statement is only intended to be used for subsequent evaluation of the tax preference. It is not intended to create a private right of action by any party or be used to determine eligibility for preferential tax treatment.

(2) The legislature categorizes this tax preference as one intended to reduce structural inefficiencies in the tax structure under RCW 82.32.808(2)(d).

(3) The legislature acknowledges the importance of accountable communities of health under RCW 41.05.800 in aligning actions to achieve healthy communities and populations, improving health care quality, and lowering costs. It is the legislature's intent to remedy inconsistencies in the tax structure by allowing accountable communities of health to deduct certain funds as amounts subject to

business and occupation tax in order to ensure accountable communities of health receive tax relief similar to other nonprofit or public-private health care organizations.

NEW SECTION. **Sec. 2.** A new section is added to chapter 82.04 RCW to read as follows:

(1) An accountable community of health may deduct from the measure of tax delivery system reform incentive payments distributed by the Washington state health care authority, as described in Sec. 1115 medicaid demonstration project number 11-W-00304/0, approved by the centers for medicare and medicaid services in accordance with Sec. 1115(a) of the social security act.

(2) A hospital that is owned by a municipal corporation or political subdivision may deduct from the measure of tax delivery system reform incentive payments received through the project described in Sec. 1115 medicaid demonstration project number 11-W-00304/0, approved by the centers for medicare and medicaid services in accordance with Sec. 1115(a) of the social security act.

(3) For the purpose of this section, "accountable community of health" means an entity designated by the health care authority as a community of health under RCW 41.05.800 and any additional accountable communities of health authorized by the health care authority as part of its federal innovation waiver.

NEW SECTION. **Sec. 3.** The deductions in section 2 of this act apply only with respect to amounts received on or after the effective date of section 2 of this act by an accountable community of health or a hospital that is owned by a municipal corporation or political subdivision.

NEW SECTION. **Sec. 4.** The provisions of RCW 82.32.805 and 82.32.808 do not apply to this act.

NEW SECTION. **Sec. 5.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately.

**--- END ---**

## Olympic Community of Health

**S.B.A.R. IGT Strategy**

Approved by the Board of Directors February 12, 2018

Revised and presented to the Board of Directors March 12, 2018 (revisions in grey and ~~strikethrough~~)

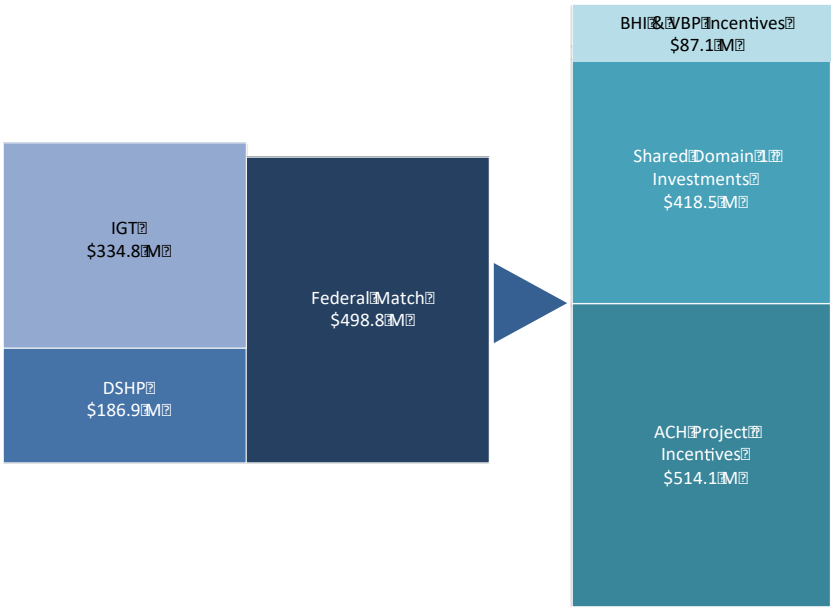
**Situation**

The Medicaid Transformation Project (MTP) is dependent on two sources of matching funds to leverage Delivery System Reform Incentive Program (DSRIP) funding. One of the sources - Intergovernmental Transfers (IGT) – accounts for more than 64% of the state match. To secure IGT matching funds, HCA requires board approval and active participation by ACHs.

**Background**

The IGT Strategy, if fully implemented, produces up to $20.6 million in earnable DSRIP revenue for OCH and its partners. Without the IGT Strategy, the maximum earnable DSRIP revenue falls to $11.9 million, a potential loss of $8.7 million. The amount of earnable DSRIP revenue produced by the IGT Strategy depends on how many ACHs agree to participate. The proportion of MTP funding tied to IGT significantly ramps up in years 2019, 2020 and 2021; therefore, ongoing funding for MTP is dependent on IGT.

**Two Sources of Statewide DSRIP Funding: DSHP and IGT**




If the Board agrees to participate, the executive director will allocate $1,638,436 of DSRIP funding to IGT contributors in 2018. Over the entire course of the MTP, the executive director will allocate up to $16,740,000 to IGT contributors There are three IGT contributors: University of Washington Medicine, Evergreen Healthcare, and Valley Medical Center. ~~and the Association of Washington Public Hospital Districts. The IGT Strategy requires OCH participation in a series of administrative steps that begin on February 21, 2018 and conclude on March 23, 2018. The process will require Board approval of several HCA-required reports. Before these steps are completed, OCH may participate in negotiations with IGT contributors to determine the investment of "Domain 1 Services", defined as Population Health Management, Workforce, and Value-Based Payment, in the region. These investments could be made as a condition of OCH approval payments to IGT Contributors.~~

| Medicaid Transformation Incentives | Full IGT Funding | No IGT Funding |
|---|---|---|
| **OCH Project Incentives** | **$20,563,000** | **$11,883,000** |
| Incentive Payment to IGT Contributors | $16,740,000 | $0 |
| Value-Based Payment Incentives | $2,200,000 | $1,500,000 |
| Behavioral Health Integration Incentives (IMC) | $0 | $0 |
| **Total Medicaid Transformation Incentives** | **$39,503,000** | **$13,383,000** |

**Action**
This topic was discussed by the OCH Executive Committee. There was consensus that OCH should move forward with the State's IGT Strategy because the risk to OCH was small compared to the potential gain in DSRIP revenue. The Executive Committee identified one potential conflict: the public hospitals in the region may not have been given the opportunity to benefit from this strategy. Staff has since learned that all three public hospitals in our region will benefit financially from the IGT Strategy.

Risks and Administrative Burdens
OCH assumes some financial risks from two sources.

1. First, there is the potential loss or refunding of earned revenues due to a successful legal or regulatory challenge to the IGT Strategy. Such challenges would most likely come from potential IGT partners that were excluded from participating in the Strategy. It appears that this risk is reduced by the active participation of Olympics' public hospitals.

2. Second, there is a likely loss of earned revenues due to the imposing of B&O taxes by the Washington Department of Revenue. OCH will want to make sure that such taxes are deducted from any revenues earned by IGT Contributors.

In addition to these risks, the IGT Strategy, while not unusual, is made more complicated by DSRIP funds flow requirements imposed by CMS as a condition of Washington's Medicaid 1115 Waiver. These requirements place signification administrative burdens on OCH staff to determine performance and authorize incentive payments to IGT Contributors. OCH may want to impose administrative fees to recover the costs of processing earned revenue payments to IGT Contributors.

**Revised Recommendation**

The OCH Board of Directors approves the funding mechanism for the Medicaid Transformation IGT strategy developed by the Washington State Health Care Authority in agreement with the Center for Medicaid and Medicare Services as part of the State's Medicaid 1115 Waiver and Transformation project.

The OCH Board of Directors authorizes the executive director to execute any transactions that are needed under the IGT strategy.

## Olympic Community of Health

**S.B.A.R. Funds Flow Recommendation 2018 and 2019**

March 7, 2018

### Situation

The Board needs to make several decisions described in this SBAR so that OCH may enter into contracts with signed partners in June and make payments to them in June and December 2018. This SBAR presents certain assumptions and principles to guide the development of funds flow processes for 2018 and the remaining years of the Medicaid Transformation Project (MTP). Guided by the Board's decisions, the Funds Flow Workgroup will develop final recommendations for a funds flow model once all Change Plans have been received and assessed.

### Background

OCH Board authorized the Funds Flow Workgroup to reconstitute in early 2018 to formulate a recommendation to the Board for 2018 incentives to signed partners. After three meetings, reviewing multiple simulations of funding, the group agreed on several core principles and next steps.

### Action

**2018 Revenue Allocations to Signed Partners**

1. All signed partners will have a Change Plan.
2. **Each Change Plan will incorporate a 2021 health delivery transformation vision statement** that has been reviewed and approved by the Board *(est. May or June)*. The vision statement will address how signed partners will leverage DSRIP investments to:
    a. Prepare for or optimize value-based contracts *(for MCO/BHO-contracted partners only)*
    b. Continually enhance process to integrate mental health care, substance use disorder treatment, primary care, behavioral specialty care and dental care *(for MCO/BHO-contracted partners only)*
    c. Improve patient/client access and health outcomes
    d. Collaborate with partners to in the Natural Community of Care (NCC) coordinate care
    e. Collaborate with partners in the NCC and across NCCs to address social influences of health and improve health equity
3. **Eligibility requirements for revenue allocation**
    a. 1st payment
        i. Sign shared change plan *(est. completion April)*
        ii. Complete and sign change plan; Identify target populations; Identify key personnel; Complete assessment; Sign Standard Partnership Agreement with Financial Executor; Log into reporting platform and upload documents *(est. completion May)*
        iii. Execute Signed Partner Contract with OCH through 2021; initiate first DSRIP allocation of 2018 *(est. June 2018)*
    b. 2nd payment
        i. Create an account and upload data into reporting portal *(est. July 2018)*
        ii. Co-develop Implementation Plan and performance measures *(est. Sept 2018)*
        iii. Participate in at least one committee/workgroup *(anytime in 2018)*
        iv. Begin work on at least one transformation activity *(anytime in 2018)*

v. Sign 2019 contract amendment; initiate second payment of 2018 *(est. Dec 2018)*

4. **The revenue allocation model associated with the Change Plan will differ according to whether the signed partner bills Medicaid** (including HCA, MCOs, and the BHO).
    a. **Revenue allocation for partners that bill Medicaid.** Number of self-attested Medicaid lives served in 2017, adjusted for average number of encounters per life. Written confirmation will be required from the organizations electronic health record system. For the first year, the number of Medicaid lives/encounters completely drives the earnable incentives for this group of partners. This is not the case in 2019 and beyond. Medicaid lives will be weighted by the departments or service lines listed below. This allows one signed partner to count Medicaid lives in more than one category if a Medicaid beneficiary has multiple visits in one year attributed to each respective service line.
        i. Primary care - 100% of total
        ii. Mental health treatment - 100% of total
        iii. Substance use treatment - 100% of total
        iv. Oral health treatment – 75% of total*
        v. Specialty behavioral health treatment - 100% of total
        vi. Hospital inpatient (or observation) and emergency department - 25% of total count**

        **Rationale for the hospital weight: the major driver of Medicaid hospitalizations is childbirth; frequent transitions between ED, inpatient, observation settings; and episodic versus continuous care.*

        ***Rationale for the oral health weight: majority of transformation activities are not oral health-related. We can reconsider this weight in 2020 after the completion of various expansion and integration projects.*
    b. **Revenue allocation for signed partners that do not bill Medicaid.** Social service, education, public health, and housing signed partners will receive $2,000 and $8,000 as the 1st and 2nd payments, respectively, upon completion of the eligibility requirements above.
5. **Payments earned by all signed partners in 2018 are drawn from their total earnable revenue pool** for the four-year transformation period. Each organization will execute a Signed Partner Contract (2018-2021), which explains the funds flow model specific to the organization. This allows partners to flex up or down their Change Plan throughout the MTP.

## Revenue Allocations to Signed Partners in 2019 and beyond

The Funds Flow Workgroup recommends the following principles for funds flow in 2019 and beyond:

1. **Revenue allocation for partners that bill Medicaid**
    a. A proportion of incentives are earned based on number of Medicaid lives, similar to the model in 2018. Unlike 2018, in 2019, encounters will not be considered. This is to help prepare partners for capitation and value-based care, rather than the fee-for-service nature of paying-for-encounters. At the outset, the remainder of incentives are earned based on:
        i. **Complexity of the Change Plan**, as determined by commitment to and progress on transformation activities (41%)
        ii. **Clinical integration**, including mental health care, substance use disorder treatment, primary care, and oral health care (24%)
        iii. **Care Coordination**, as determined by commitment to various activities in the Change Plan that enhance clinical-community linkages for patients/clients (16%)
        iv. **Participation**, including committees, workgroups, response to surveys and assessments, and/or attendance at core meetings (6%)

v. **Reporting** in the OCH reporting tool (6%)
vi. **Health Equity** – this is still under development (6%)

b. Each subsequent year an increasingly larger proportion of incentives will be earned based on performance. Performance metrics will align with measures in Apple Health contracts and prepare signed partners for Medicaid value-based contracts.

2. **Revenue allocation for partners that do not bill Medicaid**
   a. A proportion of incentives will be earned upon completion of milestones that directly support the Shared Change Plan. The remainder of incentives are earned based on performance in the following areas:
      i. Participation (30%)
      ii. Reporting (40%)
      iii. Health Equity (30%)

**Next Steps**

- Develop the two Change Plan templates, one for partners that bill Medicaid and one for partners that do not bill Medicaid. *(est. completion March 2018)*
- Identify partners to pilot the Change Plan template representing the following sectors: primary care, FQHC, mental health, substance use treatment, hospital, and community-based organization; and one tribal health clinic. *(est. completion March 2018)*
- "Pressure test" pilot partner Change Plans against above assumptions and principles. Discuss feasibility with pilot partners. Does it make sense? Does it work? Does anything need to change? *(est. completion April 2018)*
- Revise Change Plan template. Revise funds flow algorithm. Reconvene Funds Flow Workgroup. *(est. completion April 2018)*

Proposed Recommendation

1. The Board accepts the Funds Flow Workgroup recommendation for payments in 2018, contingent on findings from pilot process.
2. The Board authorizes staff to select seven pilot partners to pilot the Change Plan template and funds flow allocation model.

# Olympic Community of Health
# ACH Participant Survey: 2017 Results

Center for Community Health and Evaluation
www.cche.org

## Purpose is to support learning

**As part of the ACH evaluation, CCHE conducts an annual survey of regional stakeholders engaged in each of the ACHs.**

- CCHE worked with your ACH's staff to send the survey to ACH participants that are engaged in activities - on the Board or in committees/work groups.
- The survey is not a report card. It is one source of data about member perceptions that informs the evaluation.

**The survey is intended to support ACH strategic learning and to spark conversations about continuous improvement.**

- It provides a snapshot of ACH participants' opinions and perspectives about how their ACH is developing and functioning.
- It highlights areas of strength and growth to support conversations about how the ACH can continue to improve.
- While it includes responses from many ACH participants, it's important to remember that not everyone answered this survey.

## Continuous Learning from ACH member feedback

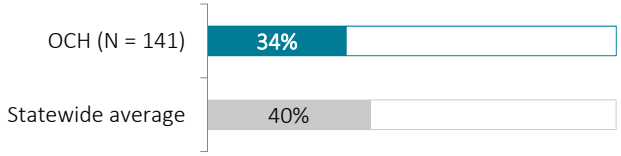
**Discussion questions to keep in mind as you review the data:**

1. What surprises you about this data?
2. What does this data suggest is working? Is not working?
3. How can our ACH build on our strengths and/or address concerns or challenges raised by our members?
4. What topics might we want to discuss further as an ACH to support our growth?

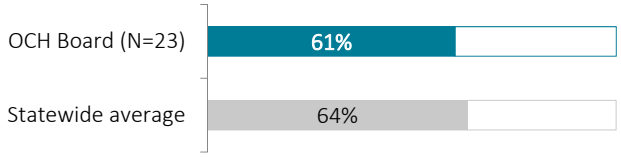


## Understanding who responded to OCH's participant survey

## 141 people from your ACH responded to the survey, with a lower response rate than the statewide average.

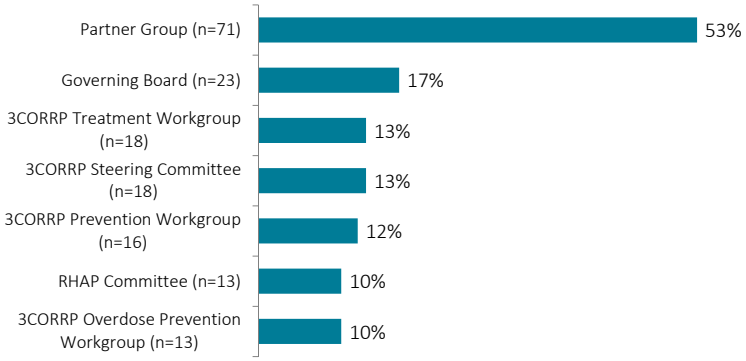



**The response rate for Board members was slightly less than the statewide average response rate for the Board, but higher the overall OCH response rate.**




CENTER FOR COMMUNITY HEALTH AND EVALUATION 5

## Survey respondents represented 7 groups, and most of the respondents were involved in the Partner Group. 20% of respondents selected more than one group.




Notes: The percentages may add up to greater than 100% because respondents could choose more than one group, if they were involved with multiple groups. These groups were chosen by the ACH as the participants from whom they wanted to elicit responses.

CENTER FOR COMMUNITY HEALTH AND EVALUATION 6

## Most respondents identified their sector as behavioral health provider/organization or CBO.

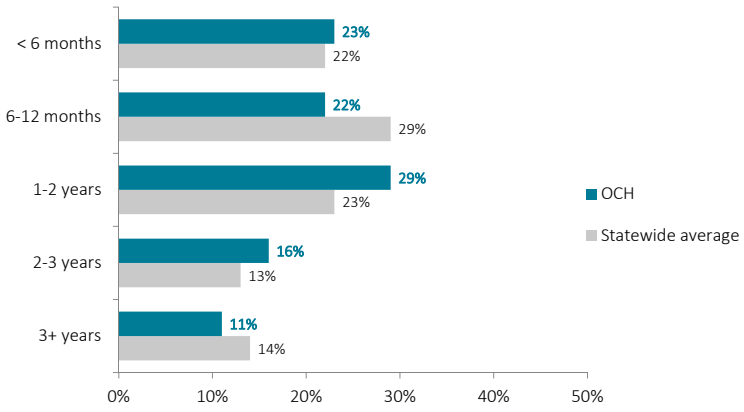
The top 5 most common sectors in order of frequency were:

1. Behavioral health provider or organization
2. Community-based organizations (i.e. transportation, housing, employment services, financial assistance, childcare, veteran services, community supports, legal assistance, etc.)
3. Primary care (including community health centers)
4. Local government (including municipal services and elected officials)
5. Local public health department

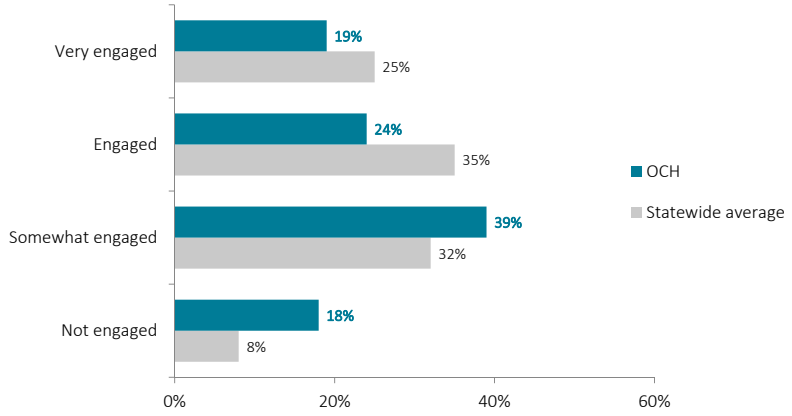
Respondents self-selected which sector(s) they represent. 77% of respondents chose only one sector.



## 45% of survey respondents reported participating in the ACH for less than 1 year.



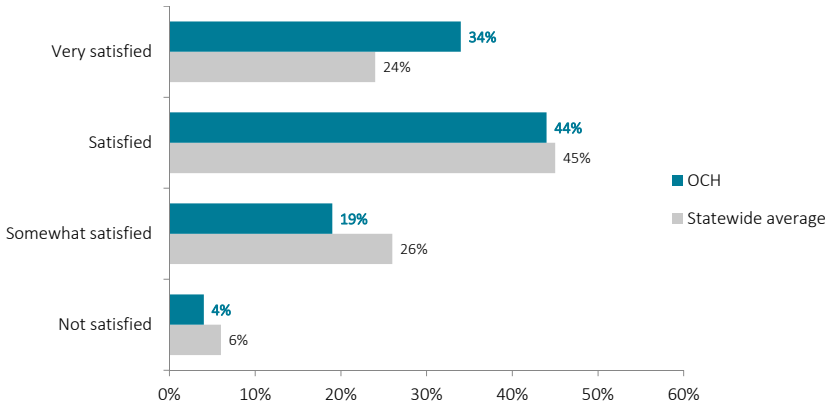
## OCH survey respondents were less engaged in the ACH's work compared to the statewide average.





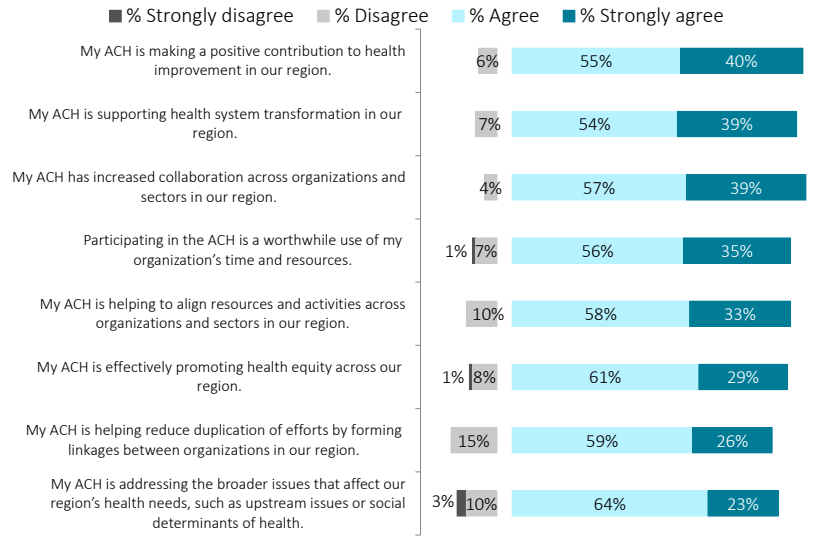

## ACH Functioning & Impact:
How can OCH build on strengths and understand opportunities for improvement?

## Almost 80% of survey respondents reported being satisfied or very satisfied with ACH progress this year.






## Survey respondents thought highly of the ACH's regional impact.



## Respondents rated 23 components in 6 domains of ACH coalition functioning

**Rating scale:** Outstanding=4 Good=3 Adequate=2 Needs improvement=1
Don't know = missing value

### Member participation

- Active engagement from key stakeholders from multiple sectors
- Clearly defined roles and responsibilities for ACH members
- Trust among members
- Members operating in the shared interest of the ACH versus their own personal/organization interest

### ACH governance

- Involves all members in the decision-making process
- Has an effective governance structure to make decisions and plan activities
- Communicates information clearly among members to help achieve ACH goals (via meetings, emails, calls, etc.)
- Has a board that effectively governs the ACH

### Community engagement

- Has support from key community leaders for the ACH's mission and activities.
- Communicates effectively with the broader community about the ACH mission and activities.
- Engages the broader community with opportunities for public comment or participation.
- Engages ethnically and racially diverse communities in ACH activities.

### Mission & goals

- A shared vision and mission
- Agreed on health priorities based on identified regional health needs
- Agreement on how to continue regional collaboration beyond the period of the Medicaid Transformation.

### ACH organizational functioning

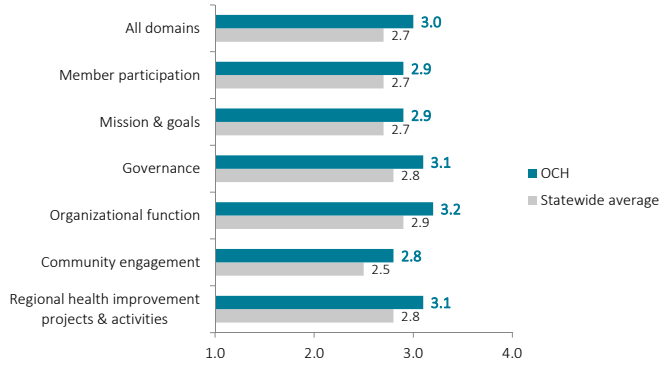
- Effectively provides support for collaboration among ACH member organizations.
- Provides the organization and administrative support needed to maintain ACH operations and activities.
- Has leaders who bring the skills and resources that the ACH most needs.
- Has leadership and staff that work to further the agenda of the collective ACH.

### Regional health improvement projects & activities

- Uses a transparent and collaborative process to design regional projects, including the Medicaid Transformation projects.
- Selected the Medicaid Transformation projects that will address your region's health needs.
- Focuses on regional projects or activities that will achieve the vision and goals of the ACH.
- Provides adequate support to coordinate the implementation of projects, including the Medicaid Transformation projects.



## Looking across domains: Organizational function, governance, and regional health improvement projects domains were rated highly. The community engagement domain is an opportunity for improvement.




Rating scale: 1 = Needs improvement; 2 = Adequate; 3 = Good; 4 = Outstanding; Don't know = Missing value

**OCH 2017 domain scores were consistently higher than statewide average scores.**

## Looking at associations between domain ratings and respondent characteristics: Similarities and differences.

- Length of participation: Respondents who were newer to OCH (participating for <1 year) rated the Regional Impact domain higher compared to those who had participated for 1+ years.
- Satisfaction: All survey domains were rated higher by respondents who were more satisfied than those who were less satisfied.
- Engagement level: All survey domains were rated more highly by those who self-identified as more engaged than those who were less engaged.
- ACH membership group: We analyzed whether the Board, 3CCORP Steering Committee, and other ACH members rated ACH functioning domains similarly. This breakdown was chosen by OCH staff.
  - The different groups rated all 6 of the domains similarly.



## Drilling down to individual survey components: The top three strengths and opportunities for improvement

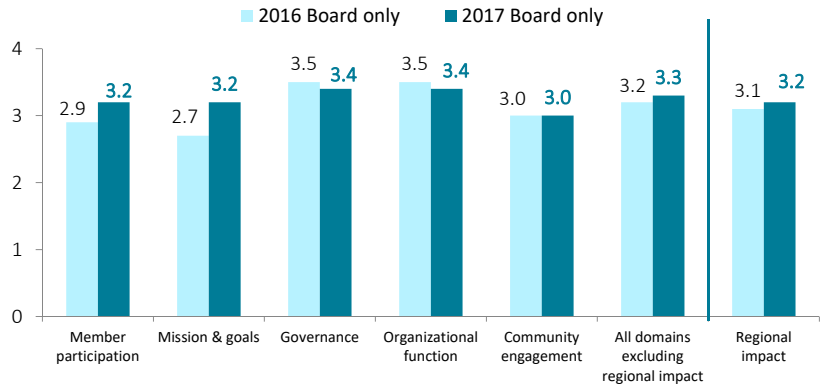
### Strengths

- Has leadership and staff that work to further the agenda of the collective ACH.
  (56% rated as outstanding)
- Has leaders who bring the skills and resources that the ACH most needs.
  (52% rated as outstanding)
- Uses a transparent and collaborative process to design regional projects, including the Medicaid Transformation projects.
  (43% rated as outstanding)

### Opportunities

- Agreement on how to continue regional collaboration beyond the period of the Medicaid Transformation.
  (27% rated as needs improvement)
- Engages the broader community with opportunities for public comment or participation.
  (20% rated as needs improvement)
- Communicates effectively with the broader community about the ACH mission and activities.
  (18% rated as needs improvement)

## *When only looking at indicators that were in both years' surveys -* Board members responding in 2017 rated most domains higher than or similarly to Board members in 2016.




Rating scale for **ACH function** domains:
1 = Needs improvement; 2 = Adequate; 3 = Good; 4 = Outstanding
Don't know = missing value

Rating scale for **regional impact domain**:
1 = Strongly disagree; 2 = Disagree; 3 = Agree; 4 = Strongly agree;
Don't know = missing value

Note: Responses of Board members were compared 2016 to 2017, by domain, but only included survey questions that remained the same year-to-year. The regional health improvement project domain is not included - it was new in 2017.



## Feedback on successes

ACH participants were asked to write about this year's successes and highlighted a range of positive developments. Examples of key themes and quotes include:

- **Successfully meeting the Transformation requirements**
  *"Our ACH was able to quickly respond to emerging information from the HCA and CMS. It was able to implement a robust and inclusive RHAP that developed a project application, solicited proposals, scored them, and developed recommendations to the governing board."*
- **Efforts related to opioid response (cross-sector collaboration, workgroups, summit, etc.)**
  *"Finding consensus for opioid treatment and reaching out to the public to find locations."*

  *"Fostering real and cross-sector regional activities to address the opioid crisis, and creating resources to support the work."*
- **Engaging stakeholders from a range sectors to work collaboratively together**
  *"Transparent process of building the Medicaid Demonstration Project, inviting all stakeholders to participate, focusing on improving the healthcare delivery system by building relationships within natural communities of care."*

  *"Our ACH has done an excellent job of bringing multiple providers/stakeholders together to plan for innovative ways to move forward."*

The full set of responses is included in Appendix B and provides a range of feedback for continuous improvement efforts.

## Suggestions for improvement

ACH participants were asked to write about their suggestions for improvement. Examples of key themes and quotes include:

- **Continue to develop communication and transparency**

  *"I think that it's mission, objectives, needs, plans, need to be more clearly articulated to the common person…there is a problem with transparency not because people are doing something wrong or because they are not of good intent. It is the language that is so indistinct as to purpose and planning that people do not know what is being said."*

- **Continue to reach out and engage key sectors and use their input**

  *"The collaboration with organizations OUTSIDE of heath care must be improved for the ACH to become an effective tool in the three counties."*

  *"More collaboration from the Behavioral Health Organizations, Specifically Substance Abuse Treatment Centers."*

  *"I believe you need to include more clients, those that are struggling with the issues of substance use disorder, have gone through treatment, or have succeeded in dealing with substance use disorder."*

The full set of responses is included in Appendix B and provides a range of feedback for continuous improvement efforts.



## Hopes for next year's accomplishments

ACH participants were asked to write about what they hoped their ACH would accomplish in their region in the next year. Examples of key themes and quotes include:

- **Implementing the Medicaid Transformation projects, including project-specific outcomes**

  *"Move towards project implementation with funds flowing to providers."*

  *"Successful implementation of the selected projects and the early integration of behavioral health into primary care."*

  *"Come up with a standardized prescribing method where we are attempting to prescribe the least amount of opioids and increasing use of more NSAIDS, and alternate pain meds."*

- **Systems transformation and population health improvement**

  *"Sustain investments in the regional priorities and improve people and community health."*

  *"Make broad steps toward creating a healthcare system that looks at a medical condition with the question, 'Is this condition possibly related to behavior and am I making the appropriate referral if that is the case?'"*

The full set of responses is included in Appendix B and provides a range of feedback for continuous improvement efforts.

## Highlighting challenges in the upcoming year

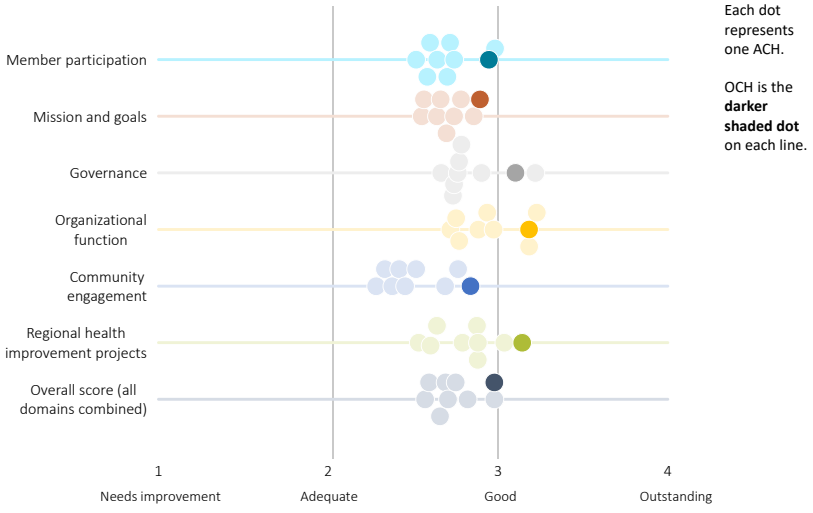
ACH participants were asked to write about the challenges they thought the ACH may address in the upcoming year. Examples of key themes and quotes include:

- **Implementation challenges, including the amount/distribution of funding, need for transparency, project complexity, and maintaining collaboration**
  - *"The difficult reality that the transformation funds are woefully inadequate to facilitate or support true transformation."*
  - *"Successful implementation of all projects in the first year. There is a lot of change happening at one time."*
  - *"The NCCs are incredibly complex, and moving beyond a project-based focus into a comprehensive focus will be very challenging."*
  - *"Olympic's success is dependent on the health and resilience of relationships between the leaders of partnering organizations, community and tribal affiliates, and other stakeholders. Attending to these relationships is time consuming and exhausting work that must be tended to while the small OCH staff is fully preoccupied with implementing the region's transformation projects."*
  - *"Medicaid changes driven by D.C."*

The full set of responses is included in Appendix B and provides a range of feedback for continuous improvement efforts.



## ACHs across the state have similar trends across functional domains, though there is some variation.



## Continuous Learning from ACH member feedback

**Discussion questions:**

1. What surprises you about this data?
2. What does this data suggest is working? Is not working?
3. How can our ACH build on our strengths and/or address concerns or challenges raised by our members?
4. What topics might we want to discuss further as an ACH to support our growth?



## ACH Evaluation Team

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