Olympic Community of Health

Agenda

Board of Directors Meeting

May 8, 2017

Educational Workshop: 12:00 pm to 1:00 pm

Board Business: 1:00 pm to 4:00 pm

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

Web: https://global.gotomeeting.com/join/380259757

Phone: (571) 317-3122

Code: 380-259-757

KEY OBJECTIVES

1. Come to an understanding of fully integrated managed care (FIMC) and agree on next steps for OCH
2. Agree on invited Project Applications and further Board action

AGENDA (Action items are in red)

Item		Topic	Lead	Attachment
EDUCATIONAL WORKSHOP 12:00 pm to 12:45 pm Orientation of the Salish Behavioral Health Organization (BHO) Orientation led by Anders Edgerton				
BOARD BUSINESS 1:00 pm to 4:00 pm				
1	1:00	Welcome	Roy	
2	1:05	Consent Agenda	Roy	1. DRAFT: Minutes from 3.28.2017 2. Director's Report
3. FULLY INTEGRATED MANAGED CARE (FIMC) DISCUSSION 1:05 pm to 2:15 pm (Attachment 3) 1:05 pm to 1:20 pm **HCA Perspective** – Nathan Johnson, Chief Policy Officer, Health Care Authority 1:20 pm to 1:35 pm **MCO Perspective** – Caitlin Safford, MCO Representative on the OCH Board 1:35 pm to 1:50 pm **BHO Perspective** – Brad Banks, Lobbyist for the Behavioral Health Organizations 1:50 pm to 2:15 pm **Questions, Answers, and Next Steps**- Roy Walker, OCH Board President				
BREAK 2:15 pm to 2:30 pm				
4	2:30	OCH Finances	Hilary	4. Q1: Balance Sheet* 5. Q1: Profit & Loss Budget vs. Actual* ** Will be circulated at the meeting*
5	2:45	Phase I Certification	Elya	6. DRAFT: OCH Phase I Certification Outline
6	3:00	Invited *Optional* Project Applications	Caitlin Vicki	7. Summary of Project Application Teams 8. SBAR: Invited Project Applications
7	3:20	MDP Funds Flow	Elya	9. DRAFT: Scenarios of earnable incentives by project and demonstration year
8	3:50	Oral Health Access Strategic Planning Update	Elya	10. DRAFT: Oral Health Access Strategic Plan
9	4:00	Adjourn	Roy	

Healthier Washington Video: Integrated Physical and Behavioral Health Care

Acronym Glossary

BHO: Behavioral Health Organization
FIMC: Fully Integrated Managed Care
HCA: Health Care Authority
LOI: Letter of Intent
MCO: Managed Medicaid Organization
MDP: Medicaid Demonstration Project
RHAPC: Regional Health Assessment and Planning Committee
SBAR: Situation. Background. Action. Recommendation.

Olympic Community of Health

Meeting Minutes

Board of Directors

April 10, 2017

Date: 02/13/2017	**Time: 1:00pm-3:00pm**	**Location:** Jefferson Health Care Conference Room, Room #302

Chair: Roy Walker, *Olympic Area Agency on Aging.*
Voting Members: Caitlin Safford, *Amerigroup,* Lance Colby, *Elwha Tribe*, Hillary Whittington, *Jefferson Health Care,* Vicki Kirkpatrick, *Jefferson County Public Health*, Anders Edgerton, *Salish BHO*, Jennifer Kreidler-Moss, *Peninsula Community Health Services,* Thomas Locke, *Jefferson County Health Department*, Leonard Forsman, *Suquamish Tribe*, Joe Roszak, *Kitsap Mental Health Services*
Dialed in: Andrew Shogren, *Quileute Tribe*, Eric Lewis, *Olympic Medical*, David Schultz, *Harrison Medical Center*, Doug Washburn, *Kitsap County Human Services*, Katie Eilers, *Kitsap Public Health*, Shelby Brown, *Community Health Plan of Washington,* Tracey Rascon, *Makah Tribe*
Non-Voting Members: Allan Fisher, *United Healthcare,* Jorge Rivera, *Molina*
Staff: Elya Moore, *Olympic Community of Health*, Mia Gregg, *Olympic Community of Health,* Siri Kushner, *Kitsap Public Health District*
Guests: Kelsey Potter, Larry Thompson, Maureen Finnerman, Ally Osborn, Laura Johnson, Kali Klein

Person Responsible for Topic	Topic	Discussion/Outcome	Action/Results
	April Objectives	1. Approve draft tools to select optional projects for Medicaid Demonstration Packet 2. Approve proposed recommendation for Clinical Engagement Capacity 3. Approve proposed recommendation for Organizational readiness	
Roy Walker	**Welcome and Introductions**	Roy called the meeting to order at 1:03pm.	
Board	**March Minutes**	Approval of minutes	March Board Minutes **APPROVED** unanimously.
Board	**Consent Agenda**	Approval of Consent Agenda • BHO workshop/orientation will likely be held, May 8th 3pm-4pm • Review draft certification process. Maintain focus on upcoming imminent April deadline for phase one.	Consent Agenda **APPROVED**. One opposed.
Tracey Rascon	**Tribal Collaboration and Communication Policy**	• Details of OCH tribal collaboration communication policy discussed, noted that each tribe has a governing seat on OCH Board. Agreed that tribal policy is	Board will take action on tribal collaboration policy following review by Tribes in region

		based around good communication and collaboration. • Tracey Rascon attending Portland area Tribal meeting, will report back to Board with follow up/new items.	
Siri Kushner for Katie Eilers	**Selecting MCD Demonstration Transformation Optional Projects**	• Board discussed/reviewed details of request for applications documents in addition to project selection process. • It was noted that conflict of interest is still of concern for members, ideas were discussed, including amending bylaws to accommodate this unique project selection situation. • The OCH awaiting HCA clarification regarding funding distribution details, there will more than likely be a TPA/financial executor assigned.	MOTION for board to approve the process for RHAPC project selection tools. APPROVED unanimously Review state resources regarding COI laws and flexibility.
Jennifer Kreidler Moss	**Clinical Engagement Strategy**	• Discussed how to best engage Medicaid Medical Providers, including private clinics, including importance in determining Medicaid population being served. • Obtaining Medicaid utilization and provider data would be extremely useful, particularly prior to project plans deadline in September.	MOTION to approve Phase I Clinical Engagement Strategy APPROVED unanimously Consider independent providers within all three counties.
Caitlin Safford Hillary Whittington	**Organizational Readiness**	• As expectations and needs grow, flexibility will be necessary to be flexible to accommodate potential funds flow. • Need to determine how to allocate the proper funds to partners/participants, in conjunction with moving projects forward. • Phase funding and milestones were discussed, details clarified amongst the group. • Project quality is of high importance, incentive funds will not flow until applications are approved.	MOTION to approve proposed actions to increase organizational readiness: - enhance Data and Analytic Capacity; Financial Capacity; and Staffing Capacity - develop competitive Project Plans - broaden the scope or number of contracts with vendors to support our work - make minor adjustments to absorb the increased

		• Data plays a key role in project planning, collaboration with other ACH's might be helpful. • OCH currently employs an accounting firm, will be comparing that cost to contracting a CFO, goal to maintain internal control and avoid potential risks. • Reviewed hypothetical OCH organizational flow chart, discussed staffing budget needs, authorized Elya to hire an Administrative Assistant at 100% FTE. • Role of BHO's and potential implementation of FIMC briefly discussed amongst group, many members agreed a more in depth meeting would be helpful.	number of FTE and meetings - begin long term fiscal planning for the organization and strategic planning for our investments in Medicaid Transformation in the region APPROVED 1 abstention, Joe Roszak Schedule/coordinate meeting for May 8th to discuss fully integrated managed care and the behavioral health organization. Invite decision-makers.
Tom Locke	**The future of Oral Health, What's the North Star?**	• Our region has most impaired access to oral health in the state, to address this issue we need to transform system of care and accessibility by integrating Medical and Dental care. • Oral Health best practices and preventive services should be more widely promoted within our communities we need to link these systems to provide better care. • Providing value based care is essential as oral health disease can lead to many other serious illnesses, could potentially obtain mid-level providers such as DHATS to address this need by using an incentive based payment system.	
Roy Walker	**Adjourn**	The meeting adjourned at 3:03pm	
Kristen West	**Oral Health Strategic Planning Session**	Work Session ended at 4:18pm.	

Olympic Community of Health

Director's Report

Prepared for May 8 Board Meeting

Top 3 Things to Track (T3T) #KeepingMeUpAtNight

1. We are supporting up to 12 project application teams so that each can put forward the best possible application. The project applications will form the foundation of our Project Plans that we submit to HCA. The better the quality, the stronger the commitment from partners, the higher our score and hence, the larger the earnable pool of incentives.

2. The Pathways Community-Based Care Coordination Hub discussion continues to swirl. Many ACHs are headed towards selecting this project. We are still uncertain if this is a good fit for our community.

3. The fully integrated managed care conversation is here. While ACHs have no authority over this decision, we are asked to play a role in convening this conversation and there are now incentives on the table for local agencies. It is a highly-politicized conversation that, while important, may undermine the community's trust in our relatively young organization. This trust is vital for the OCH to succeed in our role under the Medicaid Demonstration Transformation Project.

Upcoming OCH meetings:

- OCH Finance Committee Meeting, May 2, 1:30 pm to 3:00 pm
- Pathways Hub Webinar with Dr. Sarah Redding, May 4, 12:30 pm to 1:30 pm
- Board of Directors Meeting, May 8, 1 pm to 4 pm, Port Townsend
- BHO Orientation, May 8, 12 pm to 1 pm, Port Townsend
- OCH Executive Committee Meeting, May 23, 12 pm to 2 pm, virtual
- Opioid Response Project: Overdose Prevention Workgroup, May 23, 12 pm to 2 pm, Blyn/Sequim
- Opioid Response Project: Steering Committee, May 23, 2 pm to 5 pm, Blyn/Sequim
- RHAP Committee Meeting, June 2, 9 am to 1 pm, Port Townsend
- Board of Directors Meeting, June 12, 1 pm to 3 pm, Port Townsend

Upcoming ACH Quarterly Convening

- June 28-29, Chelan

Medicaid Demonstration Transformation Project (MDTP, the "Waiver")

- We received 35 Letters of Intent. All LOIs are posted on our website.
- The Funds Flow meeting in Olympia on April 27th was enlightening (slide deck). I took the liberty of taking these data and updating an excel spreadsheet for the OCH, also included.
- There are many factors that go into how much we can earn over the Demonstration period. For example, we are still awaiting clarity on tribe-specific projects. In the end, it will come down to the score on our Project Plans.
- The draft contract for Phase 1 Design Funds ($1,000,000) will be available this week for comments.

Project 2B: Pathways Care Coordination HUB *"2B OR NOT 2B, THAT IS THE QUESTION…"*

- We are planning a webinar with Pathways co-founder Dr. Sarah Redding for May 4th from 12:30 pm to 1:30 pm. Following this, we will host a discussion about what we learned and identify next steps.
- Questions we submitted to the Health Care Authority to assist our decision-making process:

QUESTION to the HCA	RESPONSE
Is the Pathways HUB the only project that can be submitted under 2B?	The Toolkit uses language "such as the Pathways" which means that any evidence based program we propose must be equivalent to Pathways. A Project Plan that proposes an alternative model is taking a risk that may result in a lower score.

If we DO submit a Pathways HUB project plan, and we do not propose a plan for certification, what would be the consequence?	See above
If we DO NOT submit a project for 2B, what happens to the earnable funds for the OCH?	Earnable incentives would get reallocated to other projects through a weight adjustment (pending CMS approval for this methodology)
Can we build a regional Health Information Exchange that feeds into the state and also serves local population health management needs, especially care coordination?	More discussions needed to strategize the best way to propose this through the project plan portfolio.

Delivery System Reform Incentive Program (DSRIP) Funding Mechanics Protocol

The ACHs received the draft of the Funding Mechanics Protocol. Here are a few highlights from this document. Note, this document is still awaiting final CMS approval and is therefore subject to change.

- *The annual maximum project valuation will be determined based on the attributed **number of Medicaid beneficiaries** residing in the ACHs regional service area(s) and on the Project Plan application **scores***
- *Each project has associated **project metrics** that ACHs must achieve to earn funding associated with that project.*
- *The **maximum amount of incentive funding** that an ACH can earn is determined based on the ACH's **project selection**, the **value of the projects selected** (see table below), the quality and **score** of Project Plan applications, and the size of the ACH's **Medicaid beneficiary population***

Project	Weight
2A: Bi-Directional Integration of Care and Primary Care Transformation	32%
2B: Community-Based Care Coordination	22%
2C: Transitional Care	13%
2D: Diversions Intervention	13%
3A: Addressing the Opioid Use Public Health Crisis	4%
3B: Maternal and Child Health	5%
3C: Access to Oral Health Services	3%
3D: Chronic Disease Prevention and Control	8%

- *An ACH's payment for project implementation will be based on **pay-for-reporting (P4R) in years 1 and 2** and based on both **P4R and pay-for performance (P4P) between in years 3, 4, and 5**:*

Metric Type	Year 1	Year 2	Year 3	Year 4	Year 5
Pay for reporting	100%	100%	75%	50%	25%
Pay for performance	0%	0%	25%	50%	75%

- ***Maximum Statewide Funding by Project** = [Total Statewide ACH Project Funds available] x [Project Weight]*
- ***Maximum ACH Funding by Project** = [Maximum Statewide Funding by Project] x [% of Total Attributed Medicaid Beneficiaries]*
- *This formula will be repeated for all selected projects, and **the sum of selected project valuations equals the maximum amount of financial incentive payments each ACH can earn** for successful project implementation over the course of the demonstration.*
- ***If ACHs choose fewer than the total eight projects**, project weights will be **rebased** proportionately for DY2 through DY5.*
- *Regions that have implemented **fully integrated managed care** will be better positioned to scale project 2A and will be eligible for an enhanced DY1 valuation:*
  ***Integration Incentive** = [$2 million] + [$36 x Total Attributed Medicaid Beneficiaries] x [Phase Weight]*
  Phase 1: Binding Letter of Intent: 40%
  Phase 2: Implementation: 60%

- *the state will set aside no more than **15 percent of annually available DSRIP funds** to reward MCO and ACH partnering providers for provider level attainment and improvement toward **VBP targets**.*
- ***Statewide Accountability Metrics:** Funding for ACHs and partnering providers may be reduced in DY3, DY4, and DY5 if the state fails to demonstrate quality and improvement on the 11 statewide measures listed below. The state will establish a baseline performance for each measure.*
    1. *Mental Health Treatment Penetration*
    2. *Substance Use Disorder Treatment Penetration*
    3. *Psychiatric Hospital Readmission Rate*
    4. *Outpatient Emergency Department Visits per 1000 Member Months*
    5. *Plan All-Cause Readmission Rate (30 days)*
    6. *Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life*
    7. *Antidepressant Medication Management*
    8. *Medication Management for People with Asthma (5 – 64 Years)*
    9. *Controlling High Blood Pressure*
    10. *Comprehensive Diabetes Care - Blood Pressure Control*
    11. *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control*
- *DSRIP funding that is unearned because the ACH failed to achieve certain performance metrics for a given reporting period may be directed toward DSRIP High Performance incentives. Unearned project funds directed to high performers will be used to support the scope of the statewide DSRIP program or to **reward ACHs whose performance substantively and consistently exceeds their targets**. The state does not plan to withhold any amounts to subsidize this reinvestment pool.*

VBP Action Team
Two of our OCH nominees were selected for the VBP Action Team. Congratulations Karol Dixon and Joe Roszak.

OCH Certification Process
We must submit our Phase I Certification application to the HCA no later than Monday May 15th. This document is largely a summary of all the milestones the OCH has reached over the past year. A full draft copy with all attachments can be shared upon request.

501c3 Application Status
Our application is 50% complete. We hope to have a complete application to send out for review by the end of May.

OCH Outreach & Engagement
- Manatt Team, Port Townsend, April 18
- North Olympic Health Network, Port Angeles, April 19
- Serenity House, Port Angeles, April 19
- Washington State Hospital Association, Seattle, April 25
- Performance Measurement Coordinating Committee, Seattle, April 24
- Funding Mechanics Protocol meeting with the HCA, April 27, Olympia
- Project Access NW, April 27

Three-County Coordinated Opioid Response Update
- We received the payment from Amerigroup for $7,000
- We have executed and invoiced our contract with the HCA for $30,000.
- We have a pledge from Molina for $4,000 and CHPW for $3,000 in additional support to cover project operations in April. We received the check from CHPW. Molina has been invoiced.
- Steering Committee and Workgroups (Prevention, Treatment, and Overdose) are underway.

Healthier WASHINGTON

BETTER HEALTH. BETTER CARE. LOWER COSTS.

SPOTLIGHT

Behavioral health administrator critical link to integrated care

On April 1, 2016, Beacon Health Options, Inc. began providing services to residents of Clark and Skamania counties. As the Behavioral Health Administrative Services Organization (BH-ASO) for Southwest Washington, Beacon is responsible for administering behavioral health crisis services for all individuals in these two counties, regardless of their insurance status or income level. The BH-ASO structure is part of the state Health Care Authority's integrated managed care model, which seeks to bring whole-person, integrated care to Washington's Medicaid population.

As the BH-ASO, Beacon provides the following services to **anyone** in the region:

- A 24/7/365 regional crisis hotline to triage, refer and dispatch calls for mental health and substance use disorder crises;
- Mental health crisis services, including a peer-run crisis warm line and the dispatch of mobile crisis outreach teams, staffed by mental health professionals and certified peer counselors;
- Short-term substance use disorder crisis services for people intoxicated or incapacitated in public;
- Access to a designated mental health professional (DMHP) who can apply the Mental Health Involuntary Treatment Act, available 24/7 to conduct Involuntary Treatment Act assessments and file detention petitions;
- Access to a chemical dependency specialist who can apply the substance use disorder involuntary commitment statute, including services to identify and evaluate alcohol and drug involved individuals who may need protective custody, detention, etc.; and
- Access to a behavioral health ombudsman, to assist individuals with grievances and appeals.

This is Healthier Washington

The Healthier Washington initiative is transforming health care to ensure it focuses on the whole person and that care is coordinated and delivered where and when a person needs it. Southwest Washington was the first region to transition to a new integrated payment system for physical health, mental health, and substance use disorder services in the Apple Health program.

Additionally, Beacon provides certain mental health and substance use disorder services to people who are not enrolled in or otherwise eligible for Medicaid. In order to achieve success in this new financing model, Beacon and the two integrated MCOs, Community Health Plan of Washington (CHPW) and Molina, must closely coordinate the delivery of crisis services for Medicaid clients. The following best practices have been identified as contributing to a smooth system transition and continuity of care for individuals in Southwest Washington.

Best Practices: Making Crisis and Non-Medicaid Services Work in an Integrated Managed Care Model

- **Contractual relationship between payers:** CHPW and Molina each have a contract in place with Beacon Health Options, to reimburse Beacon for Medicaid crisis services that are delivered to their members. This contract allows the entities to freely share information and data for care coordination and other purposes, such as:
  - o CHPW and Molina transfer daily eligibility files to Beacon, allowing Beacon to identify which MCO an

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Produced by the Washington State Health Care Authority, March 2017

individual is associated with. This process ensures that close and immediate coordination occurs between payers for any individual who accesses a crisis service.

- CHPW, Molina and Beacon share daily clinical notes. CHPW and Molina each have access to the DSHS Predictive Risk Intelligence System (PRISM)[1] . This access is now delegated to Beacon, allowing Beacon and its network of providers to view client history.
- CHPW and Molina reimburse Beacon for the Medicaid-reimbursable cost of delivering crisis services to the Medicaid population.

- **Significant collaboration between payers and key stakeholders:** CHPW, Molina and Beacon stay in regular contact and coordinate to ensure that individuals in the region are appropriately referred to services, regardless of their Medicaid eligibility status. For example:
  - All three payers have regular crisis care coordination calls at least once per week, to facilitate and ensure appropriate delivery of health care services for Medicaid clients.
  - All three payers have bi-weekly meetings, with a standing item being Western State Hospital (WSH) discharges. There is a high level of communication between WSH liaisons around all discharges and new admissions.
  - A key function of the BH-ASO is to assess Medicaid eligibility and facilitate enrollment, which ensures that as individuals who are not currently enrolled in Medicaid access high-acuity services like crisis, they are immediately assessed for eligibility to maximize Medicaid coverage when appropriate.
  - The BH-ASO is in the process of being deemed a publically administered program, allowing them to use available funds to assist clients in meeting spend-downs and opening Medicaid eligibility.
- **BH-ASO acts as a regional convener:** The BH-ASO plays the role of convener in the region to conduct coordination and resource-building activities, which are aimed at improving service delivery in the region. For example:
  - The BH-ASO has built a stronger partnership between the justice system and the behavioral health system and payers. A process has been established to provide a list to CHPW/Molina three times per week with the names of youth who have entered the juvenile justice system. The MCO care coordinators then follow up with the juvenile justice staff to connect youth with outpatient providers, assist them with accessing services and connecting them to community resources, after release from detention.
  - The BH-ASO created a Youth Crisis System Standing Steering Committee, which includes consumers, youth provider agencies, local hospitals, juvenile justice, crisis providers and allied partners to provide guidance and input into the youth crisis system.

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[1]PRISM is a secure web-based clinical support tool that has client medical risk factors, demographics, eligibility, managed care status, housing, utilization of Medicaid health services (including mental health) provider contact information, and long term care case manager assessments

- The BH-ASO sponsors quarterly focus groups comprised of individuals or families who have had a direct experience with the crisis system as a means to ensure that consumer voices have a direct platform to provide the BH-ASO with their experiences.
- The BH-ASO acts as the convener of the local Children's Long-Term Inpatient Program (CLIP) committee, a function that historically was centralized at the regional support network (RSN). The CLIP Committee evaluates referrals from the region to CLIP services, and offers consultation to families that are struggling to navigate multiple systems while parenting youth with behavioral health challenges.
- The BH-ASO holds the Family, Youth, and System Partner Round Table (FYSPRT) Contract, which provides a forum for families, youth, systems and communities to address challenges and barriers by promoting cohesive behavioral health services for children, youth, and families.

- **New focus on non-Medicaid clients who need services:**
  - The BH-ASO has brought renewed focus to non-Medicaid individuals due to the nature of the contract that includes non-Medicaid services. Through this focus, the BH-ASO has developed strategies to support individuals without Medicaid through designated non-Medicaid allocations while also focusing on supporting individuals, when appropriate, with enrolling in Medicaid plans.
  - Individuals without Medicaid have access to a broad network of providers, through the BH-ASO, who have in depth experience and expertise in behavioral health. The BH-ASO structure allows specific focus on the needs of the non-Medicaid population that are unique from the Medicaid population.
- **Crisis system alerts for PACT/WISe clients:** If an individual participating in WISe or PACT services is referred to the regional crisis hotline, an alert is in place in the Protocall crisis hotline system to immediately refer that individual to the PACT/WISe team for crisis response. This ensures high-risk clients are appropriately and immediately referred to their care provider for follow up.
- **Managing to the lowest level:** If a provider sees an individual who is experiencing a crisis and can be stabilized in their clinic, the provider can still be reimbursed for this service by CHPW, Molina or Beacon, ensuring that providers are able to continue managing their own patients and not referring for mobile crisis outreach or DMHP's unless necessary.
- **Hiring RSN staff:** Beacon Health Options brought on former RSN staff to work in the Vancouver office, which helped preserve knowledge and expertise, and facilitate a smoother transition from the RSN system to the new structure.

Client Success Story

CHPW has a member who was referred from the crisis hotline for case management. This member has a prolonged history of alcohol and drug use, schizophrenia, and homelessness. The person was living in a vehicle at this time, had multiple admissions to substance use disorder residential and detoxification treatment, and multiple emergency department visits for suicidal ideation. Through this referral, the member was connected with CHPW's community health worker for help in finding housing. When it became apparent that his alcohol use was at a level that threatened his health and safety, CHPW, with help from a transitional case management (TCM) team at an evaluation and treatment facility, were able to support the member in choosing to go to detoxification treatment, and connecting the member with a provider. The member completed detoxification treatment and went on to complete residential inpatient substance use disorder treatment. This was the first time the member completed treatment without leaving against medical advice. The member is now living in a healthy housing arrangement, with continued support from a TCM team to assist the member during this transition period (i.e. helping with transportation, applying for financial supports, attending medical appointments with the member

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and getting the member fully engaged with outpatient mental health and substance use disorder treatment). The TCM team are also helping to get insurance for the member's vehicle.

For the member, this story shows great success in that the member successfully completed two levels of treatment, has obtained housing, is participating in outpatient treatment, and is also getting medical needs met. This story also shows great success in ***partnering*** *between multiple entities, with CHPW assisting with coordination between: the initial referral from crisis services, an evaluation and treatment facility, a substance use disorder treatment provider, a federally qualified health center, and social services, to help get the member's needs met.*

Looking Ahead

The BH-ASO is continually looking for ways to improve services and influence the delivery system. Current and upcoming activities that the BH-ASO is working on to assist in continuous quality improvement efforts include:

- Outreaching to physical health free clinics to discuss co-location or stronger coordination pathways.
- Increasing a recovery oriented focus and the skills of peers.
- Working to strengthen/develop a continuum of services (prevention, intervention, diversion), before a person needs the highest level of crisis services.
- Increasing mobile crisis services, including children's mobile crisis.
- Implementing pilot programs at Daybreak Youth Service, based on feedback received through the Family, Youth, and System Partner Round Table (FYSPRT) to address a gap in service for youth.
- Community-based trainings and workforce development.
- The integration of substance use Involuntary Treatment Act with crisis providers and court processes.
- Collaborating and participating in the Accountable Community of Health development.
- Increasing community awareness of the crisis system through outreach efforts.
- Working on crisis system data transparency to providers, partners, and the community.
- Engaging consumers of the crisis system to provide continuous quality improvement in crisis system development efforts.

Learn more by visiting Beacon's website dedicated to Southwest Washington: http://wa.beaconhealthoptions.com/

For more information, visit www.beaconhealthoptions.com and connect with us on www.facebook.com/beaconhealthoptions and https://twitter.com/BeaconHealthOpt

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INCENTIVES FOR MID-ADOPTERS OF INTEGRATED MANAGED CARE

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

How does Medicaid Demonstration incentive funding work?

The information below is dependent on the approval of the Funding and Mechanics Protocol currently under review by the Centers for Medicare and Medicaid Services (CMS), and pending Washington legislative appropriation for the Medicaid Demonstration.

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

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

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

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

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

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

April 6, 2017

A FEW BASIC FACTS

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

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

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

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

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

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

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

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

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

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

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

*University of Washington, Psychiatry & Behavioral Health Sciences Division of Population Health, Center for Advancing Integrated Mental Health Solutions

Next steps for regions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Washington State Health Care Authority

Healthier WASHINGTON

BETTER HEALTH. BETTER CARE. LOWER COSTS.

FAQs

Why change Apple Health to an integrated managed care model?

Under the behavioral health organizations (BHOs) there is a single point of accountability and oversight for behavioral health services in every region, so how could it be better to divide accountability among as many as five entities?

Answer: Today, benefits for Medicaid clients are split between a BHO for behavioral health needs, and a managed care organization (MCO) for medical needs. There is no single point of accountability for the client. For the state Health Care Authority (HCA), integrated managed care is first and foremost about improving health outcomes and client care, and this requires care management through a single accountable insurance plan for the client – not two.

For example, a client may be depressed and approach the BHO system for help but does not meet the Access to Care Standards. They don't know who to turn to for help. On the other side, people with serious mental illness have an average lifespan 25 years shorter than those without, and the reason for this is lack of access to *medical care* to treat the chronic illnesses arising from lifelong need for psychiatric pharmaceuticals. Integrated managed care seeks to improve the current system, by placing a single insurance plan accountable for the full array of physical and behavioral health services and health outcomes.

Under the current system, as clients move around the state, the accountability for their health outcomes could transfer across 14 entities: nine BHOs and five MCOs. When integrated managed care is in place, this will be reduced to no more than five and no more than one at a time.

Counties currently have authority over the behavioral health delivery system because county commissioners sit on the BHO board. How will county authorities be able to respond to calls from constituents to fix problems in the system?

Answer: The transition to integrated managed care does not mean there is no role for the county. Counties will play a significant role, even though they are not the direct contract holder or are not at direct financial risk for providing behavioral health services. Counties will have the ability to shape their role. For example, Southwest Washington created a Regional Advisory Council, which is comprised of county commissioners and state legislators, and meets twice a year with the state, MCOs and the public to evaluate the effectiveness of service delivery in the region. HCA is willing to report to any entity chosen by county officials to ensure effective county involvement.

What role will the BHO have after integrated care is implemented?

Answer: The counties have the first right of refusal to act as the Behavioral Health Administrative Service Organization (BH-ASO). The BH-ASO delivers crisis services, administers certain non-Medicaid funding sources, and manages regional functions, such as employing an ombudsman and managing a community behavioral health advisory board. Additionally, The MCO contracts require that the MCO coordinate with county-managed programs, criminal justice, long-term supports and services, tribal entities, etc. via an Allied System Coordination Plan. This will ensure that those established relationships continue to stay strong as well as encourage the MCO to establish necessary relationships. For more information on the role of the BH-ASO and county options, HCA has developed a document outlining a possible continuum of county options.

Is the state planning to implement the same model statewide that was developed in Southwest Washington?

Answer: No. The Southwest Washington model is not the only model. In mid-adopter regions, HCA is open to discussing regional variations and options with communities. The first step in that discussion is to submit a binding letter of intent to move forward with full integration before 2020.

BHOs are non-profit organizations. Won't this transition to managed care health plans result in less funding for a behavioral health system that is already under-funded?

Answer: Apple Health contracts strictly limit administrative overhead to population enrollment. The range of administrative load is 8.5 percent to 11.8 percent in 2017.
The contract limits the gains MCOs are able to take from premium dollars.

How do we know that funding for behavioral health services won't be diverted to pay for medical care, once the funds for medical and behavioral health services are blended together and the MCOs are working under a global budget?

Answer: There are a number of reasons this will not be an issue:

- The managed care contracts require the MCOs to provide certain behavioral health services and meet certain performance measures and quality of care standards. In order for the MCOs to provide these services and meet performance measures and quality standards, they must invest in behavioral health services.
- If a client's need for services meets level of care guidelines and is medically necessary, the MCO must ensure the client receives the behavioral health services.
- When managing a global budget, MCOs have incentives to invest in downstream services such as primary care and outpatient behavioral health, in order to meet performance measures and to achieve savings on high-cost upstream services such as emergency room visits.
- Behavioral health providers negotiate their payment rates and payment method with the MCO and should expect to be paid no less than what they are paid in the current BHO structure.

How will the managed care plans develop the needed competence to manage these complex services?

Answer: MCOs are already familiar with clients with serious mental illness and substance use disorder. These clients are among their most complex enrollees, and they currently provide care coordination, complex case management, and health home services to this high-risk population. What will require a knowledge transfer period is for the MCOs to learn the new provider network, service delivery, etc. that has been provided through the BHOs. HCA and Division of Behavioral Health and Recovery (DBHR) staff stand ready to assist with this knowledge transfer as MCOs are awarded contracts.

The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

Counties already spend a high percentage of their budgets on their jails. If this transition reduces access to behavioral health services, individuals in need of treatment may end up in the county jail rather than in treatment. How do we monitor for this and make sure this transition does not increase the burden on jails?

Answer: There is no reason to expect reduced access to services for people in need of behavioral health treatment. In fact, the transition to integrated care is intended to improve the delivery of medical and behavioral health services, which may result in **reduced** incarceration of individuals with behavioral health conditions. To help ensure this happens, the Health Care Authority will work with counties to develop an "early warning system" that will track flow into the local criminal justice system. And the state's contract will require MCOs to outline their best practice models for assisting with clients in transition.

This transition to integrated managed care seems to be focused on financial and contracting integration, not on clinical integration. How will the transition to integrated managed care support delivery system reform at the clinical level?

Answer: Integrated managed care is necessary but not sufficient to achieve clinical integration. By integrating the way the state purchases and administers medical and behavioral health services, this sets a foundation for managed care plans and providers to work towards integration at the delivery system level.

For example:

- Physical and behavioral health providers will be contracted with the same payers, and can negotiate payment for integrated clinical services with those payers. This does not exist in the current bi-furcated payment system.
- Integrated MCOs will cover all services and bring a patient's health information and history to one source. This model makes it easier to share information between service providers so providers have a whole-person view of the patient and better understand what services the patient does/does not need. This more seamless sharing of information will facilitate coordination and collaboration between different provider types, thus promoting integration at the clinical level.
- MCOs will assist with client care coordination across the full continuum of services, so that care coordination and care management activity is not bi-furcated across multiple entities for a single client.
- MCOs will have a full network of both medical and behavioral health providers, which will allow them to facilitate referrals across provider types.
- Additionally, the recently approved 1115 DSRIP Waiver will complement the transition to integrated managed care, by making significant regional investments in integrated clinical models.

Is the state really going to be able to meet the January 1, 2020 deadline that was set in legislation E2SSB 6312?

Answer: Yes. All counties will operate in an integrated managed care model by January 1, 2020.

A Salish Perspective on HCA Arguments for FIMC

(Fully [financially] Integrated Managed Care)

1. What does 2ESSB 6312 Really Say About Integration?

6312 requires that physical and Behavioral Healthcare be integrated by 2020. In fact, the bill is silent about the integration of FUNDING for these services. Integrated CARE is the goal, and care integration is being accomplished independent of financial integration. In fact, the effort needed to create Financial integration is actually distracting, by either taking energy away from efforts to integrate clinical care or actually causing services that are currently clinically integrated to become fiscally less stable resulting in less integration rather than more. Integration efforts are numerous today, including behavioral health agencies contracted with BHOs that have physicians practicing on-site, medical practices that have mental health professionals in-house, and nearly every option in between. All of these levels of integration are occurring without any mandated fiscal integration. Furthermore, these examples of current clinical integration are supported by local control and without the proposed fiscal integration.

2. What About These Financial Incentives?

The financial incentives being offered by the HCA are one-time inducements to encourage Counties to sign letters of intent. Yet the financial incentives will not be controlled by signing counties, but by the local Accountable Communities of Health or ACH, which in most cases is a brand-new entity with no track record and little County representation or connection. The ACH is an independent incorporated body with no legislative authority, and no legal responsibility to the local population.

3. What About the Future?

Counties have a serious choice to make. When Healthcare and Behavioral Health are financially integrated, Counties will no longer control over $1,000,000,000 annually in direct care services which is purchased through Behavioral Health Organizations today. Counties will no longer have the authority to make decisions about the mix of programs to address local needs, or have any decision making about programs which are NOT meeting local needs. If a new need, such as the current Opioid crisis appears on the horizon, Counties will not participate in determining the best course of action for their citizens to address the crisis, and will be dependent upon for-profit health insurers to make the decisions when it comes to choosing wise investments in their communities.

Once counties make this decision, it will be forever. Clark and Skamania Counties made the decision in April of 2016, and there has been no time or opportunity to evaluate changes associated with the decision to this date. At the very least, a thorough and impartial evaluation

of integration efforts in that pilot region should take place prior to moving forward.

4. What About Integration Beyond Those Served by BHOs?

BHOs currently are responsible for serving the most chronically ill individuals in our state. In that role, they serve about 10% of the Medicaid population. The HCA and MCO plans could and should integrate care for the rest of the Medicaid population. However, as demonstrated throughout the state, clinical integration is in no way dependent upon the Counties giving up their responsibility and instead should be encouraged.

5. Do the Mentally Ill Have Shorter Lives?

Yes they do, though studies differ as to the magnitude, from the HCA quoted 25 years to another study which determined an 8 year difference. The mentally ill are disproportionately dependent upon the Medicaid healthcare system for care, are disproportionately poor, homeless, unemployed and disconnected from society. They also have virtually no access to dental care. All of these facts together create an environment that makes good health a very difficult thing to achieve. Poor dental care alone has been shown in many studies to lead to shorter life spans, and the integration of behavioral health with physical healthcare will do nothing to solve the dental care crisis. Yet we do have a county that currently has the integration of mental health, substance use disorders, medical care AND dental care for this most difficult to serve population, a feat that has been accomplished without any proposed fiscal integration.

6. Isn't the Opportunity to Become a Behavioral Health Administrative Organization Worth Exploring?

Behavioral Health Organizations (BHO) today are providing managed behavioral healthcare to the entire Medicaid population. As the entity responsible for ALL behavioral health, the BHO can and does spread the risk involved with operating Crisis Services across a very large budget and span of programs. If the BHO were responsible for only Crisis services and certain non-Medicaid funding sources, the risk associated with operating Crisis programs would increase substantially. This option is certainly worthy of exploration, but the risks should be kept in mind.

7. What About Administrative Costs?

While it is true that current Medicaid contracts with the state limit administrative costs to for-profit health insurers between 8.5 to 11.8% of the contract, the Salish Behavior Health Organization (SBHO) spends approximately 3.6% of its funding on administration. For the SBHO alone, this amounts to approximately 3.4 million dollars that currently goes to our provider network and direct client services annually and supports local jobs. Under the proposed fiscal integration model, that money will instead be directed to administrative costs and usually not locally spent. Statewide, the overall effect could be close to $50,000,000 annually. Additionally, when Southwest Washington RSN became fully integrated, the local

region lost all reserves that had been held by the RSN. For the SBHO, as of December 31, 2016, this amounted to $7,700,000, most of which we will re-direct to services over time if the BHO continues to control them.

Phase I Certification

May 15, 2017

Purpose of this document

The information included in this document is intended to certify that the Olympic Community of Health (OCH) is capable of serving as the regional lead entity and single point of performance accountability to the state for transformation projects under the Medicaid Demonstration Transformation Project (MDTP) for Clallam, Jefferson, and Kitsap counties.

ACH Certification Phase I: Submission Contact	
ACH	Olympic Community of Health (OCH)
Name	Elya Moore
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E-mail	elya@olympicCH.org

Table of Contents

Theory of Action and Alignment Strategy

ACH Strategic Vision and Alignment with Healthier Washington Priorities and Existing Initiatives

We began by seeking to understand and measure our region's most complex, pressing health needs. From this understanding, we were then able to agree on a strategic plan to address those needs. The Medicaid Demonstration Transformation Project (MDTP) Delivery System Reform Incentive Payment (DSRIP) is a lever to help move this plan forward for the Medicaid population.

Over the past two years, the OCH has collected data on local community health needs, assets, and inventories.

Milestone	Documentation
Regional health priorities	ATTACHMENT 1. REGIONAL HEALTH PRIORITIES
Process to arrive at health priorities	ATTACHMENT 2. REGIONAL HEALTH NEEDS WORKPLAN
Community asset map of local health improvement initiatives. This is cross-tabulated with the project opportunities in the Medicaid Demonstration Transformation Project (MDTP) Toolkit	ATTACHMENT 3. INITIATIVES LIST
List of community coalitions	ATTACHMENT 4. COALITIONS
List of local health assessments and their anticipated date of completion	ATTACHMENT 5. ASSESSMENT LIST
Regional health needs assessment	ATTACHMENT 6. REGIONAL HEALTH NEEDS ASSESSMENT

After review and discussion of the documents compiled and analyzed above, the OCH Board of Directors agreed on an OCH Strategic Plan, with short-, mid-, and long- term Priorities and Aims (ATTACHMENT 7. STRATEGIC PLAN). In the short term, our priority is the successful planning and implementation of the DSRIP Projects. In the long term, we will work to address other priorities such as housing, obesity, and oral health access, and build a more connected community.

Health equity is a focus. We drill down to identify demographic and geographic subcategories that experience poorer health outcomes. We are in the process of putting a contract in place with Public Health Seattle King County to help us visualize "hot spots", or areas that experience poorer health outcomes, and to stratify our RHNI data down to age-, race-, gender-specific strata.

We hired a Tribal Liaison to help the OCH to better understand partnering with sovereign and unique tribes and the sensitive nature of tribal data. Engagement with the Tribes is a process and long term commitment of the OCH: we are at the beginning stages of understanding how to be respectful partners with Tribes and how to add value to and learn from their current systems of care.

After selecting our portfolio of projects, we will have a better idea of the structure we need to put in place, including in-kind contributions. For now, we are considering in-kind contributions from partner organizations in the form of financial services, space, printing, food costs, loaned executives, data analytics and evaluation, and project management.

Governance and Organizational Structure

ACH Structure

The OCH is governed by a Board of Directors (Board), supported by an Executive Committee (ATTACHMENT 8. EXECUTIVE COMMITTEE CHARTER), Finance Committee (ATTACHMENT 9. FINANCE COMMITTEE CHARTER), and Regional Health Assessment and Planning Committee (RHAP) (ATTACHMENT 10. RHAP COMMITTEE CHARTER). The charter for each committee documents the roles and responsibilities of the committee. Each charter is approved by the Committee and the Board.

The Board is the decision-making entity. The Board may delegate decision-making authority to a committee on a case-by-case basis. For example, in the event a contract greater than $50,000 must be signed before the next Board Meeting, the Board has authorized the executive committee to approve such contracts. Wherever possible, all contracts greater than $50,000 must go to the Board for full approval. If the Executive Committee does not wish to be delegated by this authority, they may call a special meeting of the Board, which is allowable in our bylaws.

The Board is made up of 22 voting seats – 15 sector representatives and 7 Tribal nations, and is governed by a set of bylaws (ATTACHMENT 11. BYLAWS).
OCH Board composition:

- 7/22 (31%) Tribes
- 9/22 (41%) Health care and behavioral health care
- 6/22 (27%) Public health, prevention, oral health, long term supports, housing, and social services

For time-sensitive matters, the Board may call a special meeting (Bylaws):

> *Special meetings of the Board may be called at any time by the President or any five (5) members of the Board, whereupon the Secretary shall give notice as specified by the Board to each Board member.*

Medicaid Managed Care Organizations (MCOs) caucus within the sector and have a rotating seat on the Board (ATTACHMENT 12. MCO SECTOR REPRESENTATION). Please refer to ATTACHMENT 13 for a visual of the OCH GOVERNANCE STRUCTURE.

The OCH incorporated in December of 2016 and is applying for 501c3 legal status. The decision to select a nonprofit as the legal entity was based on several months of deliberation (ATTACHMENT 14. TRANSITION SBAR). Starting in June 2016 through January 2017, the Board monitored a TRANSITION DASHBOARD, ATTACHMENT 15.

Decision-making

Details of our decision-making process are described in our bylaws (ATTACHMENT 11): Sample

> *Each Director, or previously approved alternate, and each Tribe will have one (1) vote. The act of the majority of the Directors present at a meeting at which there is a quorum shall be the act of the Board, unless the vote of a greater number is required by these Bylaws, the Articles of Incorporation or applicable Washington law*.

The OCH decision-making body was selected over a six-month period, beginning first as an Interim Leadership Council (September 2015), transitioning into a Leadership Council (February 2016), and

becoming a Board of Directors (May 2016). This transition process and ultimate recommendation was led by a governance subcommittee (ATTACHMENT 16. GOVERNANCE SBAR). A DETAILED TIMELINE of the evolution of our governance structure is included, ATTACHMENT 17.

The BYLAWS (ATTACHMENT 11) describe our nomination process:

> *Candidates for Board members shall be nominated by each Sector. The nominations will be referred directly to the Board for approval*. This process is different for Tribes: *Tribes may appoint alternate representatives as desired on the Board of Directors. Tribal representation on the Board of Directors is voluntary*.

The BYLAWS (ATTACHMENT 11) describe sector representation*:*

> *Each Board member shall either represent a Tribe or a designated Sector established by the Board... No Sector shall have more than one designated member on the Board of Directors. A sector may designate an alternate member if desired. The Board may add or modify Sectors that should be represented by a vote of the Board. Tribes may alternate designated members on the Board of Directors, with each Tribe represented by one vote on the Board of Directors.*

The Board approved two supporting policies:

1. BOARD MEMBER COMMITMENT AND OPERATING PROCEDURES (ATTACHMENT 18), which details the expectation that Board Members represent their sector and communication within their sector
2. POLICY FOR NEW MEMBERS (ATTACHMENT 19), which explains the process to fill vacant seats

All Board actions require a quorum. All Board materials are circulated at least five business days before the Board meeting and are posted online. There has only been one executive session - to discuss contract negotiations with the executive director. All Executive Committee RHAP Committee materials are circulated at least three business days before the meeting and are posted online.

Each committee and/or workgroup is authorized by a charter from the Board with an explanation of roles and responsibilities. The Board may choose not to adopt a committee's recommendation; a possible outcome that staff explain at the outset. All Board meetings are open to the public and the minutes are posted online; therefore, there is transparency of the Board's deliberation process and ultimate decision. To date the Board has relied heavily and gratefully on the work of its subcommittees.

The RHAP (Regional Health Assessment and Planning) Committee was formed (ATTACHMENT 20. RHAP COMMITTEE SBAR) in acknowledgement that assessment and planning are core functions of the OCH: they keep us grounded and focused on addressing the right health issues. The RHAP Committee membership includes all sectors and Tribes. (ATTACHMENT 10. RHAP COMMITTEE CHARTER)

There are financial limitations placed on the executive director, outlined in two policies:
BYLAWS (ATTACHMENT 11)

> *Any non-budgeted expenditure in excess of $5,000.00 shall require approval by the Executive Committee. Any material change will be brought to the Board for consideration.*

FISCAL POLICIES AND PROCEDURES MANUAL (ATTACHMENT 28)

The Board shall authorize the Executive Director to make whatever purchases are needed for the day-to-day operation of Olympic Community of Health and in accordance with the approved annual organization budget and bylaws, which authorizes non-budgeted expenditures under $5,000.

Executive Director

Name	Elya Moore, MS, PhD (ATTACHMENT 29. ELYA MOORE RESUME)
Phone Number	(360) 633-9241
E-mail	elya@olympicCH.org
Years/Months in Position	14 months in position, two-year contract signed January 31, 2017

Data Capacity, Sharing Agreement and Point Person

The OCH has a dynamite data team. Our lead, Siri Kushner, has an MPH in epidemiology and is a trusted leader across all three counties. She has aided hospitals and local health jurisdictions in all three counties on community health assessments and other evaluation projects. We also have two PhD's on staff: the executive director is a trained quantitative epidemiologist and the director of special projects is a qualitative research scientist in psychology.

Nonetheless, we need to provide adequate data and evaluation supports to community partners to prepare the project applications and monitor project performance. We need to build infrastructure to support rapid dissemination of information to partners and assistance to interpret this information. We also need ongoing staff support to continually update data in the regional health needs inventory. For this, we have executed a contract with Public Health Seattle King County.

Data Sharing Agreement with HCA?			
YES	x	**NO**	

Data Point Person	
Name	Siri Kushner, MPH (ATTACHMENT 30. SIRI KUSHNER RESUME)
Phone Number	(360) 633-9239
E-mail	Siri.kushner@kitsappublichealth.org

Attachment(s) Required and Not Previously Mentioned in the Narrative

A. Visual/chart of the governance structure. (ATTACHMENT 13. GOVERNANCE STRUCTURE)
B. Copy of the ACHs By-laws (ATTACHMENT 11. BYLAWS) and Articles of Incorporation (ATTACHMENT 31. ARTICLES OF INCORPORATION).
C. Decision-making flowchart. (ATTACHMENT 32. DECISION MAKING FLOW CHART)
D. Roster of the ACH decision-making body (ATTACHMENT 33. BOARD OF DIRECTORS ROSTER) and brief bios for the ACH's executive director (ATTACHMENT 29. ELYA MOORE RESUME),

board chair, and executive committee members. (ATTACHMENT 34. EXECUTIVE COMMITTEE NOMINATION BIOS)

E. Conflict of Interest Policy (ATTACHMENT 35)
F. Organizational chart of the OCH once fully operational, depending on the number and scope of selected projects (ATTACHMENT 36. DRAFT FUTURE ORGANIZATIONAL CHART).
G. Staff job descriptions of the OCH (ATTACHMENT 37. BRIEF STAFF JOB DESCRIPTIONS)

Tribal Engagement and Collaboration

Participation and Representation

Engagement with the Tribes is a process and long term commitment of the OCH: we are at the beginning stages of understanding how to be respectful partners with Tribes and how to add value to and learn from their current systems of care. There are seven tribes in the OCH region (see below). Each tribe is a unique and sovereign nation with different governmental structures and processes. No tribe can speak for another tribe unless authorized to by the elected leadership. Therefore, each tribe has a voting seat on the Board of Directors. The OCH bylaws (ATTACHMENT 11. BYLAWS) address tribal representation on the Board:

- Article II. Section 1 establishes the tribes as beneficiaries of the OCH.
- Article III defines "tribes".
- Article IV. Section 3 establishes a seat for each tribe.
- Article IV. Section 4.2 describes the tribe representative nomination process.
- Article IV. Section 4.3 confirms that the OCH does not have authority to deny tribal appointments to the Board.
- Article IV. Section 5 exempts tribes from the Term of Office policy.
- Article IV. Section 8.1 establishes a vote for each tribe on the Board.
- Article VI. Section 2.C establishes representation on the OCH Regional Health Assessment and Planning Committee.

The tribes are active partners of the OCH and six of the seven tribes are regularly represented at Board meetings; we are currently working to engage the seventh tribe. To date, one of the seven tribal councils has approved a resolution to designate a member and delegate on the Board (ATTACHMENT 37. LOWER ELWHA KLALLAM RESOLUTION). Tribes who intend to put forward a similar resolution to their councils include:

- Suquamish
- Port Gamble S'Klallam
- Makah
- Quileute
- Jamestown S'Klallam

We are in the process of engaging with the Hoh Tribe.

The OCH commitment to partnership with the tribes in the region is also demonstrated by:

- The OCH executive director regularly reaches out to each tribe via phone and in person.
- The OCH hired a tribal liaison to dedicate FTE toward engagement and partnership with the tribes in the region.
- OCH staff are invited to visit tribal facilities and reservations to better understand each tribe.
- OCH staff attend tribal events in the region.
- The tribal liaison attends the American Indian Health Commission of Washington State meetings and events to better understand healthcare policy for I/T/U's in Washington and to update I/T/U's about the OCH.

The OCH looks forward to strengthening partnerships with the Tribes. To date the OCH demonstrates partnership successes:

- The Chairman of the Suquamish Tribe serves on the Board and Executive Committee as the Secretary.
- Six of the seven tribes in the region regularly attend the Board meetings.
- Tribes participate on the RHAP Committee.
- Tribal Board members have attended the statewide ACH Convenings to better understand the role of the ACHs in provision of health services.
- OCH staff are invited to tribal facilities to learn about how tribes provide health care.

Although there is much to learn about true partnership with tribes, the most critical lesson learned to date is the importance of in person engagement. Communication via email and telephone is efficient but not sufficient for true collaboration. Therefore, the OCH dedicates time and personnel to allow for staff to visit each of the seven tribes in the region.

Policy Adoption

The OCH has strengthened the "Model ACH Tribal Collaboration and Communication Policy" provided by the HCA. The OCH Tribal Collaboration and Communication Policy (ATTACHMENT 37.5 OCH-TRIBE COLLABORATION AND ENGAGEMENT POLICY) describes the roles and obligations of the OCH and the tribes. This policy was developed in collaboration with the American Indian Health Commission of Washington State's executive director and legal consultant; we also sought feedback from the Healthier Washington Tribal Liaison. This policy was presented to the Board April 10th and we aim to have this policy approved by the seven tribes and approved by the Board by September 2017.

Board Training

The OCH Board of Directors have had two educational workshops from the American Indian Health Commission of Washington executive director, Vicki Lowe (listed below). The purpose of the training is to ensure that the Board understands the federal obligations to federally recognized tribes regarding health and healthcare as well as the complex and integrated health delivery systems of U/T/I's (Urban/Tribal/Indian Health Service). In addition, the Board meets in Tribal facilities when possible which provides opportunities to visit the reservations and facilities of the tribes in the OCH region.

- Anticipated changes to Indian health care and update on the Indian Health Care Improvement Act (February 13, 2017)
- A Brief Overview of Tribal Health Care Financing (September 7, 2017)

Attachment(s) Required:

A. Demonstration of adoption of Model ACH Tribal Collaboration and Communication Policy, either through bylaws, meeting minutes, correspondence or other written documentation. (ATTACHMENT 37.5)

Attachment(s) Recommended:

B. Statements of support for ACH certification from every ITU in the ACH region. (ATTACHMENT 37)

Community and Stakeholder Engagement

Meaningful Community Engagement

The OCH hosts a website and multiple social media accounts. (ATTACHMENT 39. WEBSITE AND SURVEY) The RHAP Committee developed tools to facilitate a transparent, open community process to select optional projects under the MDT Project. Under the guidance of the RHAP Committee, staff developed and opened a survey to solicit community input on MDP optional projects in January 2017. This survey will remain open until June 2017 to allow adequate time for community input: https://www.surveymonkey.com/r/PBVB89Y.

- REQUEST FOR LETTER OF INTENT (ATTACHMENT 21)
- REQUEST FOR APPLICATION (ATTACHMENT 22)
    - LOGIC MODEL (ATTACHMENT 23)
    - PROJECT IMPLEMENTATION TIMELINE (ATTACHMENT 24)
    - PARTNER COMMITMENT FORM (ATTACHMENT 25)
    - PROJECT BUDGET (ATTACHMENT 26)
    - CRITERIA FOR PROJECT SELECTION (ATTACHMENT 27)

The RHAP Committee reviews, vets, and ultimately recommends promising project applications to the Board for consideration. Project applications will be posted online for a two-week public comment period. Public comments will be combined with survey results, RHAP Committee recommendation, and a completed RHNI to inform a Board decision in June.

The RHAP Committee helps plan the OCH Partner Convenings, which occur 3-4 times per year. The purpose of the OCH Partner Convenings are to inform the community about upcoming opportunities, such as the Demonstration, solicit input, collect or update information about community initiatives and assessments, and to offer educational opportunities on important issues. This provides an opportunity for bi-directional learning and guidance between the OCH and the members of the community partners.

The OCH executive director and staff attend numerous local community meetings and boards and present when invited to. A list of our outreach engagements can be found in the monthly Director's Report, which is posted online.

We continue to work towards authentic community engagement, including tribal engagement. We are exploring new, innovative ways to allow the Medicaid consumer voice to inform our process, without limiting that voice to a single person. With are conscientious that we have over 80,000 Medicaid beneficiaries in our region, each with a unique voice that deserves to be heard.

Partnering Provider Engagement

The OCH has strong provider engagement. Board members from the health care industry are active and regularly communicate within their sector, as agreed in the BOARD OPERATING PROCEDURES (ATTACHMENT 18). Starting in August of 2016, the executive director began convening leaders from the four hospitals in our region to identify areas for alignment. The executive director also meets regularly with leadership from provider organizations not currently represented on the Board. The OCH staff have toured nearly all of the tribal health clinics and wellness centers. Please refer to the Clinical Capacity Engagement section below for more details on our plan for enhanced clinical engagement.

A challenge with provider engagement is partner fatigue. Our clinical leaders wear many hats and sit on many committees. Our goal is to use time efficiently: collecting key informant data, presenting multiple scenarios, and developing a plan to start the discussion.

Transparency and Communications

All Board meetings are open to the public. The dates, times, and locations are posted online. When technology behaves, they are recorded. The bylaws allow for special meetings if a decision is needed between public meetings. If this were to occur, this would also be posted online.

The OCH hosts a website and multiple social media accounts. We also disseminate regular e-newsletters and online surveys. We manage several lists of partners to target distribution accordingly.

Attachment(s) Required:

A. Document with links to webpages where the public can access meeting schedules and other engagement opportunities, meeting materials, and contact information. (ATTACHMENT 39. WEBSITE AND SURVEY)

Budget and Funds Flow

Project Design Funds

In April, the OCH Board approved a series of actions to support Project Design Fund use and planning, (ATTACHMNENT 42. SBAR ORGANIZATIONAL READINESS), to be reassessed September 2017 when we know the details of our project portfolio. In summary, the Board approved a two-hundred-thousand-dollar budget increase for 2017.

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

This will allow the OCH to:

- enhance Data and Analytic Capacity; Financial Capacity; and Staffing Capacity
- develop competitive Project Plans
- broaden the scope or number of contracts with vendors to support our work
- make minor adjustments to absorb the increased number of FTE and meetings

Additionally, the Board approved a plan for long term fiscal planning for the organization and strategic planning for our investments in Medicaid Transformation in the region:

- Under advisement of the Finance Committee, begin a draft 2018-2021 OCH Budget. Bring to Board in August/September, for approval at the annual meeting in November. Offer a comparison of the approved budget versus forecasted spend.
- As soon as we select Projects and have general consensus on annual operating budget:
    - Under advisement of the Executive Committee, and with ongoing input from the provider community and Manatt Health, begin a draft of a Design Fund Allocation Plan and/or Design Year 1 Allocation Plan. Bring a draft to the Board as soon as possible, no later than October. Target approval at the annual meeting November 2017 depending on information availability regarding total earnable payments for Projects.
- Charge staff to develop an investment policy and bring to Finance Committee for a proposed recommendation to the Board.

Fiscal Integrity

The OCH receives accounting, bookkeeping, and payroll services from Gooding, O'Hara, & Mackey located in Port Townsend, Washington. The OCH has a Finance Committee (ATTACHMENT 9. FINANCE COMMITTEE CHARTER) and Treasurer, Hilary Whittington (ATTACHMENT 43. HILARY WHITTINGTON RESUME, TREASURER). The role of the Treasurer is to:

- Serve as the chair of the finance committee
- Service on the executive committee
- Manage, with the finance committee, the Board's review of and action related to the Board's financial responsibilities
- Work with the executive director and relevant administrative staff to ensure that appropriate financial reports are made available to the Board on a timely basis

- Present the annual budget to the Board for approval
- Review the annual audit and answer Board members' questions about the audit
- Other duties outlined in the FISCAL POLICIES AND PROCEDURES MANUAL (ATTACHMENT 28).

The Finance Committee has been charged with financial planning, including but not limited to developing the 2018-2021 OCH Budget (ATTACHMENT 44. FINANCE PLANNING).

There is a financial purchase limitation of $5,000 placed on the executive director for non-budgeted expenditures outlined in the BYLAWS (ATTACHMENT 11) and FISCAL POLICIES AND PROCEDURES MANUAL (ATTACHMENT 28). The Board authorizes all non-budgeted expenditures greater than $5,000 and all contracts greater than $50,000, except on a case-by-case basis where they might authorize the Executive Committee or Finance Committee with this authority. Three officers are check signers on record with the bank: President, Vice President, and Treasurer.

The OCH uses Harvest Google, an online timekeeping service that allows us to track separate charts of accounts. Data from Harvest Google is exported each month and sent to the bookkeeper to be integrated into the Profit & Loss Statement by Category. These are produced quarterly for review by the Finance Committee (ATTACHMENT 45. Q1 2017 PROFIT AND LOSS BY CLASS).

In April, the Board approved a plan to enhance capacity for data, clinical, financial, community and program management, and strategic development through enhanced staffing and vendor support. (ATTACHMNENT 42. SBAR ORGANIZATIONAL READINESS)

Attachment(s) Required:

A. ATTACHMENT 46. HIGH-LEVEL BUDGET PLAN for Project Design funds

Clinical Capacity and Engagement

Provider Engagement

In April, the OCH Board approved a CLINICAL ENGAGEMENT STRATEGY, ATTACHMENT 40, and timeline. This strategy was designed by a workgroup comprised of a representative from a hospital, community behavioral health clinic, federally qualified health care clinic, and a tribal clinic. As mentioned previously, the OCH has strong provider engagement already, with all of the major Medicaid providers, including tribal clinic providers, engaged at the Board or committee level.

We have started moving forward with our clinical engagement strategy; we have a subject matter expert contracted to begin work in May. (ATTACHMENT 47. ROCHELLE DOAN RESUME) We have identified and had exploratory conversations with several other potential contractors, each with a specific niche relative to the MDP; some are local provider champions and others subject matter experts. For 2018, we will work towards a longer-term PROVIDER ENGAGEMENT PLAN, 2018, ATTACHMENT 41 that likely will include one or more provider champions and workgroups depending on the selected projects and input from our partner organizations.

Partnerships

The OCH partners with numerous statewide associations. For example, the OCH works closely with the Washington State Hospital Association on opioid interventions in the hospital setting and statewide policies. We also partner with the Department of Health to engage with rural providers and EMS. We partner with the Washington State Medical Association on their join opioid task force with WSHA.

Attachment(s) Required:

A. Bios or resumes for identified clinical subject matter experts (ATTACHMENT 47. ROCHELLE DOAN RESUME)

Application	Category	Counties			Tribe(s)	Lead	Intervention	Primary Partners (Expand as suggested)	Technical Assistance
		Cl	Je	Ki					
1	Care Coordination	x	x	x		OCH	Pathways	Community Action, AAAs, MCOs, FQHCs, Medical groups, EMS, Hospitals, Public Health, Housing, Tribes, Social Service agencies	Elya Moore
2	Chronic Disease	x	x	x		PCHS	Asthma/COPD Environmental Home Assessment	FQHCs, CAPs, Tribes, Housing	Rochelle Doan + Opportunity Council
3	Chronic Disease			x	Suquamish Port Gamble	Suquamish	Diabetes self management	Suquamish, Port Game S'Klallam (Offer combining 3 with 4 below or submitted as a Tribe-specific project)	Rochelle Doan
4	Chronic Disease	x	x	x	all if interested	KPHD	Chronic Care Model, Stanford Model, Million Heart, CDC Diabetes, Primary Care Team Guide, 5210	Community Action, AAAs, MCOs, BHO, Free Clinics, FQHCs, Medical groups, Tribal Clinics, Hospitals, Public Health, Housing, Tribes, Social Service agencies	Rochelle Doan
5	Diversion	x	x	x	all if interested	Jefferson Fire	Community Paramedic	EMS, Hospitals, Public Health, MCOs, FQHCs, Tribal EMS	Rochelle Doan + Robin Fenn
6	Diversion (Outward Bound)	x	x	x	all if interested	PCHS	Community Health Workers in ED/Hospital	FQHCs, Hospitals, Dentists, MCOs, Tribes	Rochelle Doan
7	Diversion	x	x	x	all if interested	PBH (TBD)	LEAD/CLEAN	CMHCs, Law Enforcement, EMS, Hospitals, Courts, Tribes	Rochelle Doan
8	Reproductive, Maternal and Child Health	x	x	x	all if interested	TBD	Parents as Teachers/ Nurse Family Partnership/Bright Futures	Public Health, First Step, Early Learning, Head Start, FQHCs, OESD, Regional Early Learning Coalition, Tribes	Rochelle Doan
9	Oral Health Access		x			JHC	Oral Health Integration, School-based clinics, value, based purchasing,	Hospital, Schools, Sea Mar, Head Start, Tribes, MCOs (Suggest combining 9 and 10)	Rochelle Doan + WDSF
10	Oral Health Access	x		x		PCHS	Oral Health Integration, Oral Health in SNF/Assisted Livings	Hospital, Schools, SNFs, Assisted Livings, Head Start, Tribes, MCOs (Suggest combining 9 and 10)	Rochelle Doan + WDSF
11	Transitions of Care	x	x	x	all if interested	TBD	Care Transitions Intervention and Transitional Care Model	AAAs, Hospitals, Skilled Nursing, Housing, MCOs, Tribes	Elya Moore
12	Transitions of Care (Crossroads)	x	x	x	all if interested	PCHS	Jail Transitions into primary care and behavioral health	FQHCs, BHO, Law Enforcement, Corrections, MCOs, Hospitals, Housing, Tribes	Rochelle Doan

Detailed list of submitted letters of intent

#	Project Title	Clallam	Jefferson	Kitsap	Tribe	Invited Application #	Lead
Care Coordination							
1	Care Coordination		1	1		**1**	**Olympic Community of Health**
2	Case Management in Primary Care	1					
3	Community-Based Care Coordination: Olympic Community of Health	1	1	1			
4	Suquamish Tribe Horizontal Integration of Services			1	Suquamish		
5	Expanding Community Based Care Coordination Services	1	1				
Chronic Disease Prevention and Control							
6	Breath Easy - Kitsap and Clallam	1	1	1		**2**	**Peninsula Community Health Services**
7	Chronic Disease Prevention and Self-Management Program: Diabetes within a Tribal			1	Suquamish Port Gamble	**3**	**Suquamish**
8	Coordinated chronic disease prevention and control in the Olympic Community of Health	1	1	1	all	**4**	**Kitsap Public Health District**
9	Chronic Care Model	1					
10	Club Good Life - Kitsap	1		1			
11	Region Wide Chronic Disease Self-Management Program	1	1	1	all		
12	Improving population health through community-based chronic disease management and disease	1			Jamestown		
13	Population Health Management using iTi and Centerprise	1			Jamestown		

#	Project Title	Clallam	Jefferson	Kitsap	Tribe	Invited Application #	Lead
14	Million and One Hearts – Kitsap			1		No, move to 2A	
Diversion							
15	Community Paramedic	1			Jamestown	**5**	**Jefferson Fire and Rescure**
16	Decreasing Use of Emergency Services and Improving Health through Community Paramedicine	1	1	1	Makah		
17	Emergency Department (ED) Diversion and Transitions of Care Out of ED	1		1	Jamestown	**6**	**Peninsula Community Health Services**
18	Outward Bound – Kitsap			1			
19	Law Enforcement Diversion and Transitional Care Management for People Leaving Incarceratio	1		1	Jamestown	**7**	**Peninsula Behavioral Health (not confirmed)**
20	Criminal Justice Diversion Intervention	1			Lower Elwha Jamestown		
21	Mobile Care Team	1		1	Jamestown	No	
Reproductive and Maternal and Child Health							
22	Nurse-Family Partnership-Bridge Partnership Expansion to Clallam County	1	1	1	Port Gamble	**8**	**KPHD, JPH, First Step**
23	Bright Parents (Parents as Teachers and Bright Futures)			1			
24	Parents as Teachers			1		Exclude, prefer local approach	
25	Improving Reproductive Health: A Partnership between Planned Parenthood and Tribal Nations	1	1	1	all	Board Action, possibly move to 2A, LARC	
Oral Health Access							

#	Project Title	Clallam	Jefferson	Kitsap	Tribe	Invited Application #	Lead
26	Dental Health Rewards			1		No, not an evidence-based model	
27	Improving Access to Dental Care in Jefferson County: A Multipronged Approach		1			**9**	**Jefferson Health Care**
28	FQHCs – Achieving Oral Health Delivery Integration in Primary Care (Kitsap and Clallam)	1		1		**10**	**Peninsula Community Health Services**
29	School Based Health Clinic	1				No, move to 2A	
Transitions of Care							
30	West-End Chronic Disease Prevention and Control, Diversion Intervention and Care Transitions					**Combine with 1, 4, 5, 6, and 7 above**	
31	Regional Care Transitions Project	1	1	1		**11**	**To be determined, OCH for now**
32	Outreach, Stabilization & Economic Growth Program	1	1	1		No, combine housing with other applications	
33	Expanding Transitional Care in Clallam County	1			Lower Elwha Jamestown	No, not an evidence-based model, invite to collaborate with 13 below	
34	Transitional Care for Persons with Health and Behavioral Health Needs After Incarceration			1	Suquamish Port Gamble	No, not an evidence-based model, invite to collaborate with 13 below	
35	Crossroads Kitsap and Crossroads Clallam	1	1	1		**12**	**Peninsula Community Health Services**

Olympic Community of Health

Invited Applications S.B.A.R.

Approved by the RHAP Committee April 14, 2017
Reviewed by the Executive Committee April 25, 2017
Presented to the Board of Directors May 8, 2017

Situation

The Board will determine whether to invite additional Letters of Intent (LOIs) to submit a full application or invite applications from outside the LOI process.

Background

The Board asked the Regional Health Assessment and Planning (RHAP) Committee to review the Letters of Intent (LOIs) and invite promising ideas to submit a full application. Up to 18 full applications were permitted, three from each project area. The LOI deadline was April 12th. Thirty-five LOIs were received and reviewed by the RHAP Committee on April 14th. The RHAP Committee recommended up to 12 Project Application Teams, often combining multiple LOIs into single application and expanding the list of partner organizations and regions. A summary of this list is included in the packet.

Staff invited the 12 Project Application Teams April 18-19. To date, 11 of the 12 invitations have been accepted.

Action

The RHAP Committee recommended that four of the LOIs be considered for the Behavioral Health Integration/Primary Care Transformation *required* project. These included: school-based clinics, mobile care teams, million hearts plus (a partnership between primary care and behavioral health for patients with hypertension), and long-acting reversible contraceptives.

The RHAP Committee excluded four LOIs. Two did not use an evidence-based program from the toolkit. One was a service provider from outside of our service area. One LOI from a housing partner was recommended to be folded into jail and ED diversion and care transitions, rather than a standalone project idea.

Proposed **Recommendation**

The Board approves the RHAP Committee's recommendation of Project Application Teams.

Potential earnable incentives for DSRIP (delivery system reform incentive payment) Projects

Caveats: *The numbers below are under negotiation with CMS and are therefore subject to change*

These are maximum earnable estimates based on receiving perfect scores on Project Plans and submitting maximum number of projects

WASHINGTON STATE: DSRIP PROJECT FUNDING FOR DEMONSTRATION YEARS 1 TO 5

Project	DY1	DY2	DY3	DY4	DY5	Total
Integration/Transformation	$44,000,000	$62,000,000	$60,000,000	$56,000,000	$49,000,000	**$271,000,000**
Pathways	$30,000,000	$42,000,000	$42,000,000	$39,000,000	$33,000,000	**$186,000,000**
Care Transitions	$18,000,000	$25,000,000	$25,000,000	$23,000,000	$20,000,000	**$110,000,000**
Diversions	$18,000,000	$25,000,000	$25,000,000	$23,000,000	$20,000,000	**$110,000,000**
Opioids	$6,000,000	$8,000,000	$8,000,000	$7,000,000	$6,000,000	**$34,000,000**
Maternal and Child Health	$7,000,000	$10,000,000	$9,000,000	$9,000,000	$8,000,000	**$42,000,000**
Oral Health Access	$4,000,000	$6,000,000	$6,000,000	$5,000,000	$5,000,000	**$25,000,000**
Chronic Disease Prevention and Control	$11,000,000	$15,000,000	$15,000,000	$14,000,000	$12,000,000	**$68,000,000**
TOTAL	**$138,000,000**	**$193,000,000**	**$190,000,000**	**$176,000,000**	**$153,000,000**	**$846,000,000**

OLYMPIC COMMUNITY OF HEALTH: DSRIP PROJECT FUNDING FOR DEMONSTRATION YEARS 1 TO 5 FOR ALL 8 PROJECTS

Project	DY1	DY2	DY3	DY4	DY5	Total
Integration/Transformation	$1,980,000	$2,790,000	$2,700,000	$2,520,000	$2,205,000	**$12,195,000**
Pathways	$1,350,000	$1,890,000	$1,890,000	$1,755,000	$1,485,000	**$8,370,000**
Care Transitions	$810,000	$1,125,000	$1,125,000	$1,035,000	$900,000	**$4,995,000**
Diversions	$810,000	$1,125,000	$1,125,000	$1,035,000	$900,000	**$4,995,000**
Opioids	$270,000	$360,000	$360,000	$315,000	$270,000	**$1,575,000**
Maternal and Child Health	$315,000	$450,000	$405,000	$405,000	$360,000	**$1,935,000**
Oral Health Access	$180,000	$270,000	$270,000	$225,000	$225,000	**$1,170,000**
Chronic Disease Prevention and Control	$495,000	$675,000	$675,000	$630,000	$540,000	**$3,015,000**
TOTAL	**$6,210,000**	**$8,685,000**	**$8,550,000**	**$7,920,000**	**$6,885,000**	**$38,250,000**

OLYMPIC COMMUNITY OF HEALTH: DSRIP PROJECT FUNDING FOR DEMONSTRATION YEARS 1 TO 5 FOR ALL 8 PROJECTS EXCEPT PATHWAYS

Project	DY1	DY2	DY3	DY4	DY5	Total
Integration/Transformation	$2,547,692	$3,563,077	$3,507,692	$3,249,231	$2,824,615	**$15,692,308**
Pathways	$0	$0	$0	$0	$0	**$0**
Care Transitions	$1,035,000	$1,447,500	$1,425,000	$1,320,000	$1,147,500	**$6,375,000**
Diversions	$1,035,000	$1,447,500	$1,425,000	$1,320,000	$1,147,500	**$6,375,000**
Opioids	$318,462	$445,385	$438,462	$406,154	$353,077	**$1,961,538**
Maternal and Child Health	$398,077	$556,731	$548,077	$507,692	$441,346	**$2,451,923**
Oral Health Access	$238,846	$334,038	$328,846	$304,615	$264,808	**$1,471,154**
Chronic Disease Prevention and Control	$636,923	$890,769	$876,923	$812,308	$706,154	**$3,923,077**
TOTAL	**$6,210,000**	**$8,685,000**	**$8,550,000**	**$7,920,000**	**$6,885,000**	**$38,250,000**

Olympic Community of Health

Oral Health Access Strategic Plan Update

Presented to the Board of Directors May 8, 2017

PURPOSE

The purpose of this document is to update the Board on the development of a strategic plan to address oral health access in Clallam, Jefferson, and Kitsap counties.

GOALS

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

ANCHOR STRATEGIES

1. **Include oral health in behavioral health and primary care system integration**
   Support rural health clinics, tribal clinics, FQHCs, and behavioral health clinics as they integrate services to provide whole-person care. Support care coordination strategies, such as ABCD, Swift Care, and Pathways to connect people to the appropriate level of care. Expand value-based purchasing arrangements to oral health care.
   Key Partners: rural health clinics, FQHCs, behavioral health clinics, tribal clinics

2. **Increase Capacity!**
   Support the development of new dental chairs, such as a nonprofit dental clinic, expansion of FQHC-offered dental services, development of a rural clinic dental clinic, or co-location of dental services into alternative clinical settings. Also explore expansion Dental Health Aid Therapists (DHAT). Advocate for insurance benefit design to enhance reimbursement and cover specialty procedures.
   Key Partners: rural health clinics, FQHCs, behavioral health clinics, tribal clinics

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

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

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

5. **Behavior Change**
   Identify opportunities to encourage individuals to follow good oral health maintenance practices.
   Key Partners: Providers, schools, coalitions