

KITSAP PUBLIC HEALTH BOARD

*The Kitsap Peninsula is home of sovereign Indian nations, namely the
Suquamish and Port Gamble S’Klallam Tribes*

MEETING AGENDA

April 2, 2024

10:30 a.m. to 11:45 a.m.

Chambers Room, Bremerton Government Center

345 6th Street, Bremerton WA 98337

(Health Board members may participate remotely via Zoom)

- | | | | |
|------------|----|--|--|
| 10:30 a.m. | 1. | Call to Order
<i>Dr. Tara Sell, Chair</i> | |
| 10:31 a.m. | 2. | Approval of March 5, 2024, Meeting Minutes
<i>Dr. Tara Sell, Chair</i> | <i>Page 4</i> |
| 10:32 a.m. | 3. | Approval of Consent Items and Contract Updates
<i>Dr. Tara Sell, Chair</i> | <u>External Document</u> |
| 10:34 a.m. | 4. | Public Comment – <u>Please See Notes at End of Agenda for Remote Attendees</u>
<i>Dr. Tara Sell, Chair</i> | <i>Page 11</i> |
| 10:44 a.m. | 5. | Health Officer and Administrator Reports
<i>Dr. Gib Morrow, Health Officer & Yolanda Fong, Administrator</i> | <i>Page 27</i> |

DISCUSSION ITEMS

- | | | | |
|------------|-----|--|-----------------|
| 10:55 a.m. | 6. | Healthcare System Challenges and Opportunities in Kitsap Report
<i>Board Discussion</i> | |
| 11:05 a.m. | 7. | Kitsap Mental Health Services Presentation
<i>Monica Bernhard, Chief Executive Officer</i> | <i>Page 37</i> |
| 11:15 a.m. | 8. | Connecting Community Members to Care Report
<i>Bonnie Obremski, Olympic Community of Health</i> | <i>Page 57</i> |
| 11:30 a.m. | 9. | St. Michael Medical Center Services Presentation
<i>Chad Melton, President</i> | <i>Page 107</i> |
| 11:45 a.m. | 10. | Adjourn | |

All times are approximate. Board meeting materials are available online at www.kitsappublichealth.org/about/board-meetings.php

Attending/viewing Health Board meetings

Members of the public can attend Kitsap Public Health Board meetings **in person** at the time and location listed at the top of the agenda.

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Providing public comment

Verbal public comment: Members of the public can provide spoken public comment to the Health Board by attending the meeting in person at the time and location listed at the top of the agenda.* Members of the public who attend in person can make verbal comments during the Public Comment agenda item or as specified by the Health Board Chair.

As this meeting is a regular business meeting of the Health Board, the Chair will establish a time limit for public comment to ensure enough time is allowed for all agenda items to occur prior to adjournment. Each public commenter will receive a specific amount of time to address the board as determined by the Chair.

Written comments may be submitted by mail or email to:

Mail:

Kitsap Public Health Board
Attention: Executive Secretary
345 6th Street, Suite 300
Bremerton, WA 98337

Email:

healthboard@kitsappublichealth.org

All written comments received will be forwarded to board members and posted on the Health Board's meeting materials webpage at <https://kitsappublichealth.org/about/board-meetings.php>.

**If you are unable to attend a meeting in person and need to request an accommodation to provide verbal public comment, please email healthboard@kitsappublichealth.org or call 360-728-2235.*

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A schedule of regular Health Board meetings is posted at <https://kitsappublichealth.org/about/files/board-meeting-schedule.pdf>

Materials for each meeting, including an agenda, minutes from the prior Health Board meeting, and informational meeting packet, are posted prior to each scheduled meeting at <https://kitsappublichealth.org/about/board-meetings.php>. Printed materials are available for meeting attendees. A video recording and copies of presentations are posted to the board meetings website after each meeting.

**KITSAP PUBLIC HEALTH BOARD
MEETING MINUTES
Regular Meeting
March 5, 2024**

The meeting was called to order by Chair Tara Sell at 10:30 a.m.

Board members each provided a brief introduction.

UPDATE 2024 BOARD COMMITTEE ASSIGNMENTS

Chair Sell said Bainbridge Island Councilperson Ashley Mathews joined the board after committee assignments were approved and noted she would like to join the board Personnel Committee. Member Stephen Kutz moved and Member Drayton Jackson seconded the motion to approve the Updated 2023 Board Committee Assignments. The motion was approved unanimously.

APPROVAL OF MINUTES

Member Kutz moved and Member Michael Watson seconded the motion to approve the minutes for the February 6, 2024, regular meeting. The motion was approved unanimously.

CONSENT AGENDA

The March consent agenda included the following contracts:

- 2377, *Washington State Department of Health, Acting Health Officer Coverage*
- 2392, *Summit Law Group, Labor and Employment Legal Services*

Member Jackson moved and Mayor Becky Erickson seconded the motion to approve the consent agenda. The motion was approved unanimously.

PUBLIC COMMENT

1. Rosie Apalisok, representing Virginia Mason Franciscan Health (VMFH) and Chief Nurse at St. Michael Medical Center (SMMC), provided several comments regarding the healthcare assessment report on today's agenda. She thanked the Health District and board for partnering with SMMC on this work, agreed with the report that there is a staffing shortage in the healthcare field, and reminded the board of SMMC's residency programs and partnership with Olympic College to increase capacity for training qualified healthcare workers in the area.
2. Melissa Lo, representing SMMC and OBGYN at The Doctors Clinic, made some comments and clarifications on the healthcare assessment report:
 - Any medically necessary care for women is provided with no religious exemptions.
 - Elective sterilizations have always and continue to be done routinely.

- Elective abortions were never done at SMMC or its predecessor Harrison Hospital.
3. Doug Baxter-Jenkins, representing SMMC and Community Health Director at VMFH, noted a long-standing partnership with the Health District on community assessments. He also defined “Community Benefit” and said the healthcare assessment report underreported SMMC’s community benefit contributions. He said SMMC wants to talk about what community investments look like and how SMMC can continue to partner with the community to serve everyone who needs it.
 4. Chad Melton, representing VMFH and President of SMMC, made several comments to the board regarding the healthcare assessment report. He said the report contains misinformation and misperceptions about the care SMMC provides to the community. He said healthcare is an absolute priority and noted his staff and leadership have worked hard to make healthcare accessible to the community.
 5. Jennifer Korjus, citizen, noted she has no affiliation with SMMC. She said the healthcare assessment report shocked her and she encouraged the board to reject this report in its entirety and stated several concerns about it.

ADMINISTRATOR’S REPORT

Administrator Update:

Yolanda Fong, Administrator, shared two updates:

- On February 17, 2024, the Health District posted a request for proposals (RFP) to find a consultant to research and provide recommendations for the District’s classification design and salary schedule. The RFP closes March 15, 2024.
- Written public comment received for this board meeting was forwarded to the full board via email prior to this meeting.

There was no further comment.

Health Officer Update:

Dr. Gib Morrow, Health Officer, provided the board with several updates.

Respiratory Illness in Kitsap County

- Both influenza and RSV are tapering off for this season
- Centers for Disease Prevention and Control (CDC) now says anyone over 65 should get a second 2023-2024 COVID vaccination this spring.

- CDC updated isolation guidance for COVID for the first time since 2021 to bring it into alignment with flu and RSV guidance.

Measles

- Measles is a severe illness that results in hospitalization rates of 25-40% of people infected and occurs overwhelmingly in those who are unvaccinated.
- At least 16 states, including Washington, have seen cases of measles this year.
- The Health District sent out a provider advisory last week reminding local physicians to remain vigilant in vaccinating, testing for and reporting cases to the District's communicable diseases team.

Child Fatality Review (CFR)

- CFR team convened last week to review pediatric suicide and firearm injury
- Kitsap County's firearm death rate is slightly lower than the state
- Deaths due to firearms are primarily suicides, in all ages, and preventable by appropriate locking and storage of firearms.
- Seattle Children's Hospital and Seattle King County Public Health have a toolkit for planning events for safe storage that communities can use to host related events.

Overdose in Kitsap County

- EMS responses to overdose events in Kitsap has nearly tripled in three years.
- Synthetic opioid (fentanyl) overdose deaths in Kitsap are below the state rate but on a steep upward trajectory.
- The highest numbers of overdose deaths in the county occurred in Bremerton and South Kitsap. The per capita death rate is highest in North Kitsap.
- The Health District doing a variety of work to address opioid overdoses in the county.

State Legislature

- E2SHB 1956 – State legislature is putting major funding into opioid prevention, treatment and response work.
- SB 5983 – Bipartisan passage of the bill redefining vaccine to include monoclonal antibodies and all other immunizations approved by the FDA.
- SHB 2295 – Adopting rules that will add hospital at home services for licensed acute care hospitals

Recent Community Health Assessments

- Kitsap Public Health District – Community Health Assessment (Dec 2023)
- Kitsap County Division of Aging and Long-Term Care – Area Plan 2024-2027
- Kitsap Community Resources – Community Needs Assessment (Apr 2023)
- Kitsap Mental Health Services – Community Needs Assessment (Mar 2023)
- St. Michael Medical Center
 - Community Health Needs Assessment (May 2023)
 - Community Health Implementation Strategy (Oct 2023)

- Healthcare System Challenges and Opportunities in Kitsap County (Mar 2024)
- All these assessments inform the 2024-2028 Kitsap Community Health Priorities. Next work group meeting is in the spring.

Member Kutz reminded the board that syphilis is spreading rapidly and noted the highest rates are in Alaska. He also said there is a lot of travel of individuals between Alaska and Washington and that he is advising his providers to consider screening those individuals. He said the healthcare assessment report touches on this topic and encouraged further conversation with the board.

There was no further comment.

CORRECTED ENVIRONMENTAL HEALTH FEE SCHEDULE

John Kiess, Environmental Health Director, reviewed the change to the Environmental Health Fee Schedule and noted it was a clerical oversight.

Commissioner Christine Rolfes moved and Councilperson Mathews seconded the motion to approve the Corrected Environmental Health Fee Schedule.

Councilperson Mathews suggested making the fees easier to decipher by color coding or creating separate documents for each sector of fees.

The motion was approved unanimously by the elected members of the board. Non-elected members cannot vote on fees.

There was no further comment.

HEALTHCARE SYSTEM CHALLENGES AND OPPORUNITITES IN KITSAP REPORT

Commissioner Rolfes introduced the Johns Hopkins Center for Health Security (CHS) team to give a presentation of their healthcare assessment report, Healthcare System Challenges and Opportunities in Kitsap.

Dr. Tener Veenema, Senior Scholar at CHS and Senior Scientist at the Johns Hopkins Bloomberg School of Public Health introduced herself and her team: Dr. Diane Meyer, Senior Scholar at CHS and Assistant Scientist in the Department of Environmental Health and Engineering, and Dr. Sanjana Ravi, Senior Scholar at CHS, as well as other team members not present at the meeting.

Dr. Veenema provided the board with some background information on CHS and said their goal is to help health systems grow stronger and meet the needs of all the people in their communities.

Dr. Meyer gave an overview of the project and methodology. She explained that COVID-19 exposed weaknesses within local healthcare system infrastructure. These challenges are not unique to any one county, but systemic and tailored assessments are critical to understanding where failures are occurring and how to address gaps. The goal of CHS was to conduct a comprehensive assessment and evaluation of Kitsap County's healthcare system and workforce.

Kitsap County Healthcare Analysis Methodology:

- Historical and policy analyses
- Key informant interviews and focus groups
- Modified Delphi study
- Final Recommendations

Advisory Panel

- Members of Kitsap Public Health Board
- Representative from Kitsap County Board of Commissioners' office
- Kitsap Public Health District representatives

Dr. Ravi gave an overview of the Delphi study. The purpose was to identify actionable policy recommendations for solving the healthcare system challenges identified during prior arms of data collection. The study, which occurred in three rounds, included representatives from local public health and healthcare organizations, members of the community and members of the Kitsap Public Health Board.

Dr. Veenema shared key findings, which were informed by the policy analysis, historical analysis, interviews, focus groups and the Delphi study. Kitsap County findings are in line with several intersecting trends in the United States:

- Hospital and health system consolidation
- Growing prevalence of private equity
- Healthcare monopolies
- Catholic healthcare expansion

Additionally, Dr. Veenema noted Kitsap County's healthcare crisis has been compounded by the county's unique geography, lack of affordable housing, limited public transportation options, and rapid population changes caused by the entry and departure of naval base workers and families.

A full list of findings and additional information can be found in the report on the Health District's website.

Dr. Ravi provided a list of goals identified by the Delphi study for the county to achieve by 2035 in the following areas:

- Mental and behavioral health
- Primary healthcare
- Health equity
- Housing

- Reproductive health

Dr. Ravi shared findings and recommendations for SMMC’s charity care and community benefit spending.

Dr. Veenema shared the CHS team’s 13 recommendations to improve the healthcare system in Kitsap County and suggested next steps.

Commissioner Rolfes thanked the CHS team for their report, quality of work and time spent working with community members.

Dr. Morrow shared appreciation for the response this process and report have spurred within the community and noted that change is difficult.

Ms. Fong said this report is an additional tool in the community’s toolbox. She said the community health improvement process has also identified healthcare as an issue in the county. She said this work is broader than any one agency can do alone and we need to come together as a community to work on solutions.

Commissioner Rolfes suggested the board spend some more time reviewing the report and that the policy committee and chair work with Health District leadership on next steps for the April board meeting.

There was no further comment.

ADJOURN

There was no further business; the meeting adjourned at 11:50 a.m.

Dr. Tara Sell
Kitsap Public Health Board

Yolanda Fong
Administrator

Board Members Present: *Mayor* Becky Erickson; *Member* Drayton Jackson; *Member* Stephen Kutz; *Councilperson* Ashley Mathews; *Councilperson* Scott Diener (*alternate for Rob Putaansuu*); *Commissioner* Christine Rolfes; *Member* Dr. Tara Sell; *Member* Jolene Sullivan; *Member* Dr. Michael Watson; *Mayor* Greg Wheeler.

Board Members Absent: None.

Community Members Present: Rosie Apalisok, *VMFH/SMMC*; Doug Baxter-Jenkins, *SMMC*; Monica Bernhard, *Kitsap Mental Health Services*; Stephanie Christensen, *VMFH/SMMC*;

Caylee Coulter, *Olympic College*; Carolyn Ellison, *Naval Hospital Bremerton*; Willa Fisher, *Self*; L. Greene, *Self*; Lukas Harlow, *Olympic College*; Jennifer Korjus, *Self*; Melissa Lo, *SMMC*; Chad Melton, *SMMC*; Badriya Mohammad, *Olympic College Student Nursing*; Anne Presson, *Board of County Commissioners*; Pat Rae, *Self*; Jeff Riggins, *Suquamish Tribe*; Jessica Walker, *Olympic College*; Katie Walters, *Kitsap County*; David Weiss, *VMFH/SMMC*; and Carollynn Zimmers, *Self*.

Scribe: Angie Berger, *Management Analyst, Kitsap Public Health District*.

Staff Present: Nancy Acosta, *Program Manager, Parent Child Health/Nurse Family Partnership*; Amy Anderson, *Community Liaison, Public Health Emergency Preparedness and Response*; Nathan Anderson, *Community Liaison, Public Health Emergency Preparedness and Response*; Katie Baker, *Outreach Specialist, Communications*; Leslie Banigan, *Senior Environmental Health Specialist, Pollution Identification and Correction*; Margo Chang, *Administrative Assistant, Administration*; Yolanda Fong, *Administrator, Administration*; Adrienne Hampton, *Policy, Planning, and Innovation Analyst, Administration*; Isabella Hansen, *Disease Intervention Specialist, Sexually Transmitted Infections*; Anne Howard, *Disease Intervention Specialist, COVID-19*; John Kiess, *Director, Environmental Health Division*; Siri Kushner, *Director, Public Health Infrastructure Division*; Melissa Laird, *Program Manager, Accounting and Finance*; Emily Main, *Program Coordinator 1, Chronic Disease and Injury Prevention*; Martitha May, *Bilingual Community Health Worker, Parent Child Health*; Kaela Moontree, *Public Health Educator, Chronic Disease and Injury Prevention*; Dr. Gib Morrow, *Health Officer, Administration*; Leah Neff Warner, *Epidemiologist 1, Assessment and Epidemiology*; Yolanda Noriega, *Bilingual Secretary/Clerk 2, Support Services*; Sydney Perales, *Community Liaison, Chronic Disease and Injury Prevention*; Quynh Sample, *Community Liaison, Public Health Emergency Preparedness and Response*; Khushnum Sauna, *Public Health Educator, Parent Child Health*; Justin Shoriz, *Disease Intervention Specialist, Communicable Disease*; Nathan Sidell, *Community Liaison, Chronic Disease and Injury Prevention*; Tad Sooter, *Public Information Officer, Program Manager, Communications*; Gabreiel Outlaw-Spencer, *Public Health Educator/Community Liaison, Parent Child Health*; Kelsey Stedman, *Program Manager, Communicable Disease*; Laura Westervelt, *Environmental Health Specialist 1, Pollution Identification and Correction*; and Erica Whares, *Community Liaison, Chronic Disease and Injury Prevention*.

Memorandum for the Record – KPHD Meeting – March 5, 2024

At its core, the JHU Report is a qualitative analysis of the Kitsap health environment with a dose of quantitative analysis related to the tax status of our local hospital. As such, it amplifies and echoes rhetoric and hearsay – whether based in fact or improved, reports consensus opinion driven around that rhetoric through local experts and a modified Delphi study, and adopts the mantle of expert analysis shored up by demographic data and well-known, national trends in health care. Although publicly available, facility- and County-specific health services data from government and other reliable sources calling into question the report’s innuendo or community member opinion was not consulted – even when raised to the study team for consideration. The report’s inclusion, then, among others of (1) a consent decree resolving a tax matter, (2) the easily misunderstood accreditation process (in a year in which even John’s Hopkins University Hospital JCAHO accreditation was at risk for posing a threat to patients), (3) innuendo regarding Catholic affirmations of life, and (4) the sole data analysis included in the report, that of the hospital’s tax status undertaken through a social justice lens – one may reasonably conclude that one purpose of the Report at its core is to sow seeds of disfavor among County residents about our local, secular hospital because of its affiliation with Catholicism. Even should they read only certain news articles about it, the veneer of expert “analysis” of our health environment will leave “goo” in the minds of County voters. Indeed, the report already public, the damage may already be done.

Executive Summary

1. I recommend the County refuse to adopt this report in toto to mitigate risk that Kitsap County be found to be engaging in persecution of St. Michael Medical Center (SMMC) by reason of its association with CommonSpirit Health, a nationwide nonprofit health conglomerate finding roots of its service mission in the Catholic faith.
 - a. By perpetuating readily refutable misperceptions regarding the scope of care and services available at SMMC, the report manifests implicit bias against institutions with religious associations.
 - b. The report, if adopted, would ratify stigmatization of SMMC through its selective recitation of historical information, unsubstantiated rhetoric regarding Catholic health facilities, a social justice assessment of its charitable mission, and apparent wilful disregard of evidence proffered for correction. The resulting smear will set SMMC apart for specific distaste in the public eye. In the context of the totality of the report, SMMC could argue that fueling distaste of it is intentional.
 - c. The report, if adopted, ratifies special persecution of SMMC as a valued member of the community and the perception of it as such, by compelling alteration of its contributions to the community to “justify” its federal tax-exempt status. Kitsap County and Washington State are replete with tax-exempt organizations, including Kaiser Family Foundation and Olympic College, and for profit organizations, including real estate developers, professional sports teams, and aerospace engineering defense corporations that enjoy significant tax benefits and relief. One may only conclude should Kitsap adopt this report that SMMC is

being singled out for specific pressure to alter its charitable undertakings by reason of its affiliation with CommonSpirit Health and the Catholic faith.

2. Several bald assertions in the report are refuted by publicly available data:
 - a. Health care in Kitsap County is among the most accessible of counties in Washington.
 - b. Emergency care at SMMC scores well not only in Washington but in the country for accessibility and care measures.
 - c. Publicly available data and government data available to public health professionals refute any assertion that women's health care is unavailable or compromised at SMMC.
 - d. Publicly available data make plain that elective abortions have been available at Planned Parenthood in Kitsap, not at the acute care hospital in Kitsap, whether before or after the sale of Harrison Hospital.
 - e. Publicly available regulations make plain that Death with Dignity is not an acute care hospital service but a process for terminal patients to obtain a *self-administered* medication following evaluation with a health professional and a waiting period.
3. Washington Medicaid and health professional shortages negatively impact staffing available resources and timely discharging patients to more appropriate levels of care. The challenges that faced SMMC in 2022 were experienced at acute care hospitals throughout the state and nationwide. The near-sighted, egocentric bubble that comes with living on the peninsula created a misperception that this was unique to SMMC.
4. Public hospital districts in Washington generally engage in the direct provision of patient care. As such, they typically derive more than 97% of their budgets from medical reimbursements and patient care delivery charges, not property tax dollars. The fact is that of 59 PHD in Washington, the great majority (38) collected less than \$1M or between \$1M and \$5M (16) from 2023 property tax levies – while delivering direct patient care. Even at Harborview, the highest PHD tax collector, PHD tax dollars represent less than 8% of revenues. Only Harborview's levy would rival the legal limit of tax levy referenced in the report, and its \$26M is less than 10% of its budget. I would welcome walking the KPHD through this data.
5. Hospitals nationwide are strained to this day and are reducing services or closing altogether. Acute care hospitals nationwide are making difficult decisions, including layoffs and declaring bankruptcy. Rural hospital closures in particular have a disparate impact on the poor, underserved, minority populations. Unless one is in the business of pharmaceuticals, the profit margins of engaging in the delivery of health care are quite narrow. In recent years, a teaching hospital closed and another (SUNY – Brooklyn) purports to be closing. Some – like Compass Medical in Boston – closed nearly overnight. This is an outcome Kitsap County cannot afford.
6. Health professional pipelines are constrained by their nature. Recruitment of allied health professionals and physicians alike receive competition from practices, hospitals, nursing homes, rehabilitation hospitals, traveling provider organizations, and more. Teaching institutions themselves experience retirements and departures of needed teachers. More money does not equate to more capacity, whether in facilities or health care professionals.

Timely and Effective Access to Care

Much of Washington state is what our federal government calls a “Health Professional Shortage Area.” What this means is that primary care doctors, OB/GYNs, family practice doctors, internists, geriatricians, psychiatrists, and dentists are in short supply in our state. Kitsap County is a HPSA in all three possible shortage areas: primary care, mental health, and dental. This is not a new phenomenon but a chronic deficit. What compounds this challenge in Washington is the shortfall nationwide now -- and projected -- of physicians and nurses as well as teaching faculty. Our colleges, medical schools, and community colleges are a fulcrum to help, but Washington and Kitsap County compete with others nationwide for a limited number of health care professionals. The solution is neither quick nor cheap and starts in our K12 school system to inspire curiosity, love for learning, and competency, particularly in math and science – and, by any objective measure, our schools are struggling.

The report details some of these struggles, noting quite properly, deficits in maternal/fetal health professionals and the exacerbation of that pressure by the closure of labor and delivery at Bremerton Naval Hospital. But, the report seems to impugn a murky access challenge broadly to SMMC, referencing “data” but neither including it in the report or footnoting the reference.

Longitudinal data regarding SMMC used by Medicare and JCAHO regarding timeliness and effectiveness of care refute this assertion. Long used to gauge “access” to care, these data depict SMMC not as a perfect facility but one that generally meets and beats state and national averages year in and year out. The picture of a wanting facility depicted in the report is not the facility I know or that the [Medicare Care Compare](#) data shares. CMS surveys patients and collects data to rate facilities on access and care. The following table compares SMMC with hospitals in areas more metropolitan and populous than Kitsap County for 2023:

	SMMC	Harborview	MC Puyallup	Johns Hopkins Hospital
ED Volume	Very high	High	Very high	Very high
Leave without being seen WA avg 5% National avg 3%	6%	10%	2%	7%
Timely stroke treatment WA avg 60% National avg 69%	60%	Not available	52%	Not available
Timely sepsis care National avg 60%	61%	41%	56%	59%
Median time spent before leaving ED	203 minutes 197 WA avg 193 National avg (very high volume)	336 minutes 214 WA avg 211 National avg (high volume)	138 minutes 197 WA avg 193 National avg (very high volume)	285 minutes 224 MD avg 193 National avg (very high volume)
Ranking (overall and patient survey)	3 stars overall 3 stars survey	1 star overall 3 stars survey	1 star overall 2 stars survey	4 star overall 4 star survey

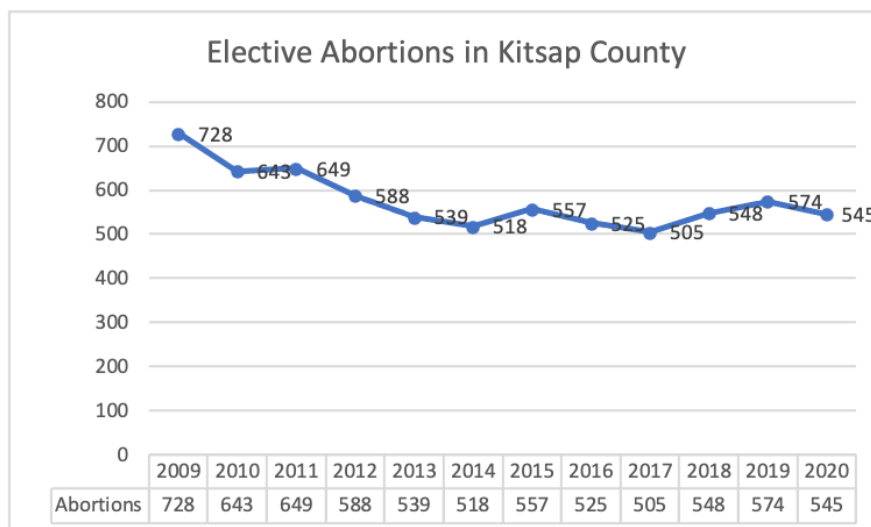
Public health analysts routinely crunch data on a variety of measures to evaluate the health of counties and states. A 2023 analysis by [University of Wisconsin Population Health Institute](#) ranks Kitsap County 6th of all Washington Counties in Health Outcomes and 2nd in Health Factors.

Publicly available data informing these rankings include: (1) premature death by race; (2) fair or poor health; (3) poor physical or mental health days; (4) low birthweight by race; (5) adult smoking, drinking, and obesity; (6) food environment; (7) inactivity and opportunities to exercise; (8) alcohol impaired deaths; (9) sexually transmitted disease; (10) teen births by race; (11) availability of primary care, mental health, and dental professionals per 100,000; (12) preventable hospital stays; (13) mammography; (14) vaccinations; (15) educational obtainment; (16) unemployment; (17) children in poverty; (18) income inequality; (19) children in single parent households; (20) social associations; (21) deaths by injury; (22) air and water integrity; (23) housing; (24) commuting to work.

This is not to suggest that important work need not take place to improve our services to underserved or at-risk populations or to pause any work to develop and attract health professionals to our County. On the contrary, we need to hear the clarion calls of exhaustion of our neighbors in the health professions; we need to work on STEM disciplines in K12; we need to build stronger connections among our health providers and the continuum of care that assures we get care in places most appropriate to our conditions. Pipelines for training are both long and arduous and require a longer planning horizon than we might ordinarily take. Our entire provider community comprises valued partners in this effort.

Elective Abortion, Sterilization, Death with Dignity – “Catholic” Health Constraints

Harrison Medical Center did *not* offer elective abortion. Planned Parenthood has been meeting requests for abortions on demand in Kitsap County since 1993. It opened a second clinic in Silverdale ten years later, only to close it in 2011. The most recent data from the [Washington Department of Health](#) regarding elective abortion is 2020.

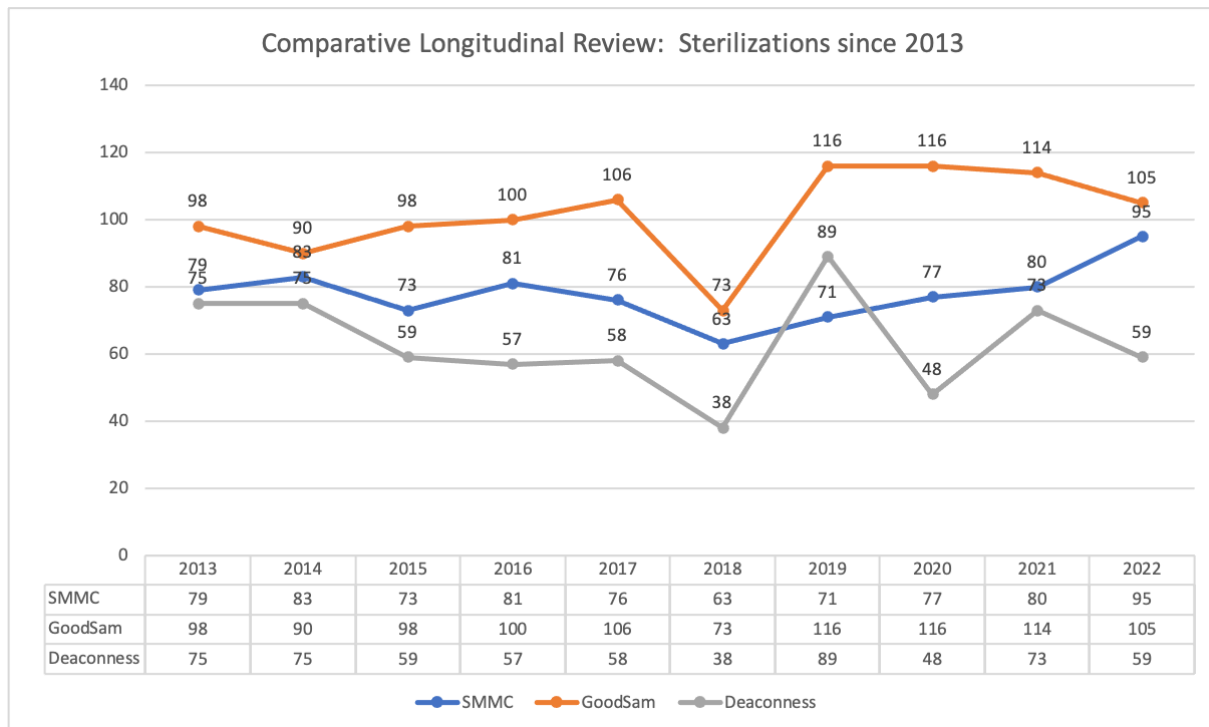


We wax eloquent about the past. Our health infrastructure past cannot be recreated. The fiscal and regulatory environment in health care is, in part, why Harrison spent 20 years evaluating options before affiliating with a larger, Catholic health facility organization to deal with an aging, constrained, and failing infrastructure. But the truth is that the affiliation promised to retain the

secular nature of Harrison Medical Center, the then current President and CEO noting that both elective abortion and “assisted suicide” were *prohibited* at Harrison already. The affiliation became formal on August 1, 2013. ([Central Kitsap Reporter, Page A8, October 19, 2012](#)). The other truth is that SMMC has made good on that promise, despite misimpressions to the contrary.

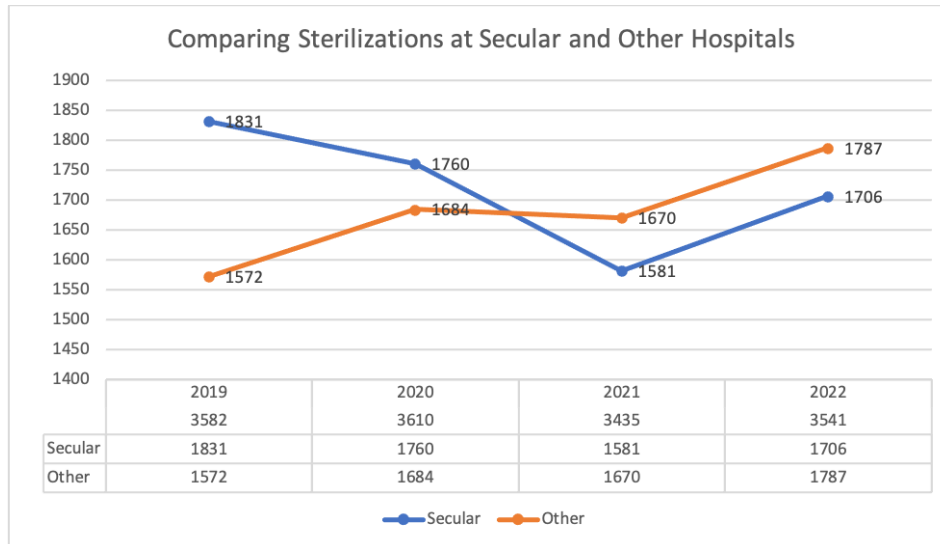
Among the innuendo around SMMC as a “Catholic” institution is that it constrains its medical staff to practice within church interpretations of Ethical and Religious Directives for Catholic Healthcare Services. By those directives, sterilization is banned as inherently immoral. While vasectomies are now more commonly performed outside acute care hospitals, tubal ligations and sterilizations are still performed in hospitals. Indeed, while they are performed outside a delivery context, data in Washington reflect that these procedures most often accompany Caesarian sections.

Based on longitudinal data from the [Washington Department of Health](#), one cannot accurately assert either that women desiring or needing sterilizations may not obtain them at SMMC or their incidence has declined since the transaction with Harrison Hospital.



¹ Assumptions and Disclosures:

1. For patient confidentiality, CHARS reports for any facility reporting less than 10 procedures is depicted as “<10.” Everywhere “<10” was reported, the data below uses only “1.” That assumption understates the data but does so across the board.
2. Because clear sterilization data is available only for years 2019 through 2022, the data preceding 2019 is deduced using the compiled statewide average from accurate 2019 through 2022 [formula: 2019-2022 C-sections w sterilization/(2019-2022 C-sections w sterilization +2019-2022 C sections without sterilization)], resulting in a multiplier of 15.51%.
3. Our birth rate in 2018 was down significantly in reporting hospitals.



These data and other data within discharge reports refute the assertion that the influx of “religious-owned” hospitals has adversely impacted women’s ability to obtain D&C or sterilizations (whether tubal ligations or hysterectomies), and that a statement from any denomination’s faith leadership is negatively impacting access to this care.

It is one thing entirely that members of our community harbor misperceptions and that organizations such as the ACLU make generalized nationwide assertions backed by hyperbole and isolated, local circumstances. It is entirely another thing, however, for a government to have paid for and adopt as its report a document that perpetuates misperceptions locally, particularly when data refute its assertions. It does three things: (1) it lends credence to community misperceptions – and becomes its “truth”; (2) it connotes that the institution that made promises to our community regarding a fulcrum political issue of our time fails to live up to that promise; and (3) by adopting false innuendo in an expert report readily refuted by data, it holds SMMC out for specific disfavor not based on fact but based on its affiliation with a Catholic institution.

There may be anecdotes even in our community where women received care below what they expected and what we wished for our neighbors. Is it possible that women in our community may have felt stress discussing tubal ligation? Certainly. A proper informed consent process can feel awkward. Are our doctors perfect – above engaging in any behavior that results in a poor patient relationship or bad outcomes? Not remotely. Tragically. Doctors want perfect outcomes, too. It is to foster a constructive environment by which we learn from mistakes that we have peer review, accreditation, medical staff credentialing, risk management.

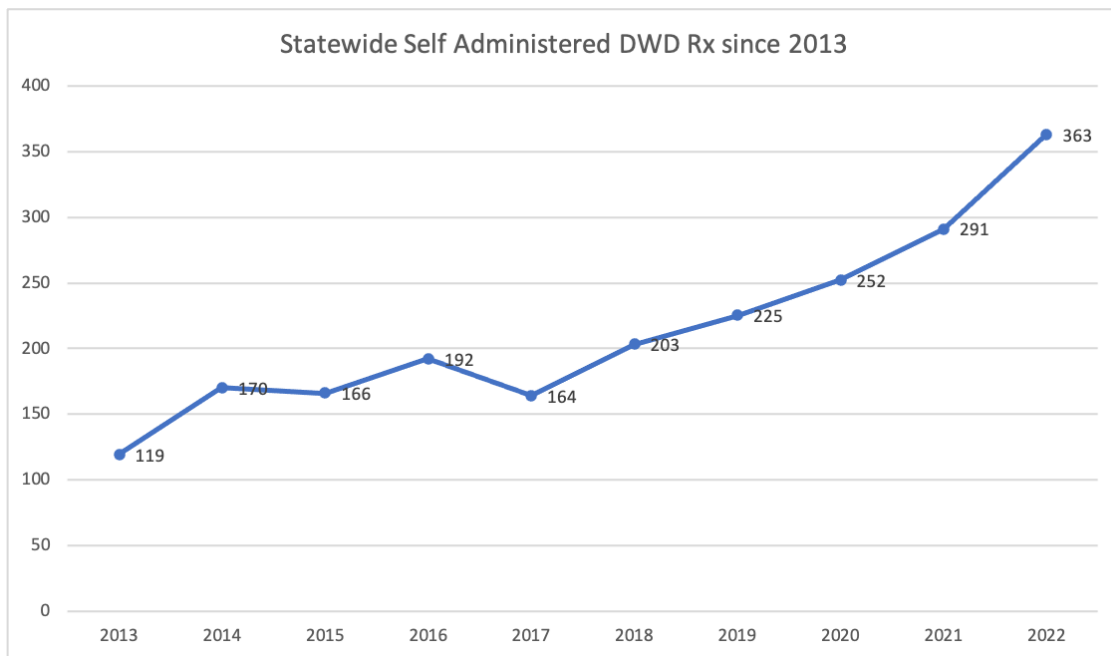
Harrison Medical Center did *not* offer “Death with Dignity.”

Approved by Washington voters, the law permitting DWD went into effect in 2009. It permits those who have less than six months to live to seek a prescription to end their own lives. The process has waiting requirements (15 days between requests) and witnessing requirements, but one thing many may not know is that *it must be self-administered*. No doctor, nurse, aide, or

other person administers it to you; you take the lethal drug yourself. DOH reports that over time, the overwhelming percentage of those taking the medication pass away at home and are working with hospice. This is not a hospital issue, regardless of its categorization as secular or otherwise.

Taking this step not only does not require a hospital, you actually do not want hospital intervention at all. Rather, the process is structured to permit us to surround ourselves with the nurturing environment we prefer. While any authorized prescriber may prescribe these lethal medications, they likewise retain – as they do with abortion -- a personal right not to participate.

[DOH](#) began reporting gross data for County participation in 2021. While the numbers have increased statewide, participation in Kitsap remained constant in these last two years, with a range of 20-29 of our neighbors participating in each of the last two years.



Whatever you think of this process, tagging SMMC as a problem in any community’s access to participate in it is Orwellian: one accesses hospital resources for care to diagnose conditions, improve health, extend life; hospitals take great care with their pharmacies for risk management, declining generally to permit patients to toodle in with their own medications, let alone arrive with privately compounded prescriptions that they might swallow to die on their premises. Patients of course receive palliative care in hospitals and participate in defining any extraordinary measures they may or may not wish to receive – even at SMMC.

Placing History in Context

I appreciate that consultants may wish to look to history to understand the current environment. It is most useful to understand what solution sets may have been explored in

years' past to help map what might work in our environment going forward, what challenges resulted in various closures, and how the environment adapted to changes to identify both needs and effective/ineffective strategies moving forward. The odd thing is, though, that historical facts inserted into this report is nearly bereft of that thoughtful retrospective, contextualized analysis. For example, the report identifies various practice closures across the County. It fails to include efforts of Peninsula Community Health Services to proactively address access gaps resulting from practice closures. Again, there are community perceptions regarding these things that align or do not with reality; it is incumbent upon experts to explore data around anecdote, not to perpetuate rhetoric in a report that then becomes "fact" in our community.

It appears, however, that SMMC is held out for specific disfavor in this regard. Collectively, it reads like an unearned smear. For example, it is a gratuitous recitation of history to amplify SMMC's most recent JCAHO process. The average County resident has no understanding of accreditation, peer review, or quality improvement. It serves only to plant a seed of amorphous disconcertedness. In that same review cycle, JHU Hospital itself was not accredited by JCAHO on its first visit, receiving a citation because it posed "imminent threat to patient health/safety." It found itself, as did SMMC, in the press and sought to reassure its community, minimizing the citation and asserting that the deficiency related to a piece of furniture in the cafeteria. Given all benefit of the doubt, the JHU story subsided, and the hospital received, as did SMMC, accreditation on subsequent review. These things are serious. Accreditation surveys are intended as iterative performance improvement opportunities to assure and raise the level of patient care and experience, and we want and need that ethos to persist rather than supplanting it with one of condemnation. There is a public policy reason that state laws permit peer review – by outside organizations as well – to take place without fear of retribution; it builds better medical delivery partners for our communities. Retrenching this does positively nothing to inform our health environment, the perception of that environment by the community, or the integrity of peer review. If I consulted for Baltimore County's health environment planning and suggested that perhaps the 2022 JCAHO deficiency was a bellwether of something more serious, manifesting in an adverse patient outcome – bladder removal based on pathology contested within the pathology department – what possible constructive implication might that serve? Positively none -- the sole thing including it might do is associate "goo" in the minds of County officials and the community. JHU has worked through medical staff peer review to place the bullying pathologist on leave – the process is doing what we want it to do, to give experts the opportunity to examine what happened, why, and how to set up systems to prevent future recurrence. Footstomping in a report to the County does nothing to help the health environment.

SMMC as a Valued Community Partner

So it is with the assault on SMMC as a §501(c)(3) organization, the sole focus of data analysis included in the report. The report includes a gratuitous reference to a [consent decree](#) that Franciscan Health Initiatives, the then parent of Harrison Hospital, entered into with the State in 2019. The State sought enforcement of its Charity Care body of laws and claimed that the defendants were out of compliance. In reaching the consent decree, Franciscan made no

concession of the State's claims – "2.3 Neither this Consent Decree nor the facts of its entry constitutes evidence or an admission by any party regarding the existence or non-existence of any issue, fact, or violation of any law alleged by the State." Representing the State, our Attorney General gained and is monitoring expressly what it felt most appropriate to Washingtonians: modified practice patterns on the ground in a variety of hospitals. It was not an attack that SMMC or any of the Franciscan facilities were not committed to charity care for Washingtonians; indeed, if a consent decree is evidence of anything, it is that Franciscan is committed to both charity care and to facility processes for it to properly meet the spirit and intent under our laws for it. Just as doctors are not perfect, processes and staff are not perfect. But amplifying anecdote here is no more palatable than is amplifying a poor outcome in a medical malpractice case.

The report goes farther: it extrapolates from regulations implementing the requirements for certain facilities claiming tax exempt status, imposing a social justice organization's formula, a so called "Fair Share Spending" methodology. The justification asserts that a tax exempt organization ought to invest in the community the equivalent of the value of the tax exemption its status affords. In its only dissection of quantitative data, the report marches through Form 990s and arrives on its first conclusion that SMMC and CommonSpirit Health writ large are lacking. It adds a few cherries on top, again impugning the integrity of SMMC in meeting its representations made to the Washington Department of Health in conjunction with the Certificate of Need process then throws in a ranking of SMMC from this social justice methodology developer.

I will leave it to SMMC to address the data itself, as it appears that, despite highlighting informational oversights raised to the consultants, the report stands pat. I trust SMMC is complying with relevant federal and state tax and other laws. What is jarring is that the report fails to acknowledge that there are other methodologies that gauge community benefit,² leaving a layperson to conclude, again, that SMMC is not a good community partner. If consultants venture into an area, it is incumbent on them to share with their clients alternate perspectives that might lead to different conclusions. In this case, longstanding Ernst & Young analysis finds that hospitals contribute far more to their communities than the value of their tax exemptions. In 2019, [it](#) found community benefit of nearly \$9 for every dollar of tax revenue lost due to the exemption.

County officials know well the variety of organizations within our community receiving tax benefits, whether tax exempt. Kaiser is a key part of our health community and is tax exempt. Olympic College is a key part of our health education community and is tax exempt. Both were spared this social justice "Fair Share Spending" analysis in this report. I venture to assume that, not unlike the Seahawks, the Mariners, the Kraken, and Boeing, many for profit enterprises in Kitsap County enjoy tax breaks – we can take notice that communities hold out such a carrot to encourage businesses to locate there. The Department of Justice Manual on Respect for Religious Liberty makes clear that "to avoid the very sort of religious persecution and

² Accounting firms have traditionally evaluated health care organizations in their audits for regulatory compliance, including compliance with the body of laws and regulations governing tax exemption, antitrust, and fraud and abuse.

intolerance that led to the founding of the United States, the Free Exercise Clause of the Constitution protects against government actions that target religious conduct. Except in rare circumstances, government may not treat the same conduct as lawful when undertaken for secular reasons but unlawful when undertaken for religious reasons.” By the same token, this report sends the County down a slippery slope that either imposes similar analysis on businesses County-wide or singles SMMC out by reason of its religious affiliation.

Taken in its entirety, the only reasonable inference I may make from the report is that it was prepared in part with animus toward SMMC by reason of its association with a Catholic health organization. I strongly encourage the County to reject this report and consider requesting return of the funds expended to generate it. Adopting the report perpetuates the inaccuracies and bias in it. The challenge of accepting it and permitting any further public availability of it is that the damage is potentially done: on its face, it parses SMMC, as a Catholic affiliated institution, from other tax exempt participants in our health delivery infrastructure and impugns its community commitment with a “put”: alter how you manifest your charitable commitment or be damned.

I cannot recommend that you accept this report. If any County nationwide is keen to the expense and burden of receiving poor counsel regarding the First Amendment’s protections of our freedom of religion, it is Kitsap County. The fiasco endured in the litigation by Coach Kennedy is lesson enough.

I prepared this memorandum essentially overnight, and I am sure it contains typos and errors. I can flesh out each of its assertions, including those in the summary that I lacked time to elucidate more fully. I welcome further conversation with KPHD or any of its staff seeking clarification of the above.

Kind regards,

Jennifer Korjus
703-927-2025³

³ DISCLOSURE: I am not now and have never been affiliated in any way – other than as a patient and family member of patients – with SMMC, any of its parents, affiliates, or assigns. They have not reviewed or contributed in any way to this memorandum. I am merely a desperately concerned citizen.

Memorandum for the Record, 3/6/2024 – Following JHU Consultant Report Presentation

In addition to urging the County to reject the report of JHU regarding the Kitsap Health Care Environment for the reasons stated in my prior submission, I encourage the County to reject the report for falling short of standard practice of research methodologies in the areas of, at least, bias, overamplification, saturation, verification, and triangulation of conclusions.

We live in a culture now in which ideas uttered often enough and whether true become reality. We live in a culture that places great value on the expert class. With great power comes great responsibility.

Qualitative studies are soft science. They can be powerful tools to understand societal and organizational dynamics. They are often used in fields in which hard data is lacking. They can shed light on behaviors that inform hard data. They are not used to supplant hard data where such data is available.

Reason to Reject No. 1: The report amplifies impression when hard data resolves the question

The spectre of “Catholicism” runs through the report, generally about Catholic “owned” facilities nationwide, those in Washington, and specifically SMMC. The report perpetuates rhetoric that women may not obtain the range of health care they need (sterilization) where Catholic hospitals predominate because of the penetration of Catholic ownership of hospitals in Washington (such a percentage of beds now controlled by Catholic hospitals).

Longitudinal discharge data proves that so called “Catholic” hospitals statewide continue to perform these procedures at the same rate as their so-called secular counterparts. Washington has made [publicly available hospital outpatient and inpatient discharge reports](#) for over a decade, and researchers may request a more robust set of hospital discharge data. These reports detail by facility the number of patients who had sterilizations. If hard data informs a question, it is incumbent on researchers to avail themselves of, analyze, and report this information instead of or, at a minimum, in addition to anecdotal opinion obtained through qualitative interviews. What seems extraordinary, given the presentation, is that it appears that the study team did not even interview the key physicians who could shed experience on this question: local OB/GYNs and urologists. I figured it out without consulting these physicians – skeptical of the resounding rhetoric and not wanting merely to report opposing rhetoric – and reported this data in an article in December 2022 in the [Kitsap Daily News](#). I can walk KPHD through the data that proves, unequivocally, that sterilizations are available for women in our community at SMMC, that they are likewise available at other “religious” hospitals throughout the state, and that they take place with the same rate as they do in so called “secular” hospitals in Washington overall.

In their presentation, the study team emphasized that legal abortions in Washington should be provided at SMMC and that SMMC should provide or make referral for all procedures that are legal. This is a red herring argument – much like the “Fair Share Spending” argument they impose uniquely on our “Catholic” hospital. Elective abortions nationwide are not provided in acute care hospitals. Indeed, even the study team’s hospital, Johns Hopkins University Hospital, is not listed among [elective abortion providers in Maryland](#). So called “secular” hospitals in Washington do not provide elective abortions, either – See [elective abortion providers in Washington](#). Alternatively, they recommended that SMMC be required to make referrals for procedures, such as abortions, that they do not provide. Again, no secular hospital provides abortion or is required to make referrals for all procedures legal in Washington. But, even more egregious, Public Health Service Act § 245 prohibits anyone receiving federal financial assistance from HHS from requiring hospitals that have a conscientious objection from making such referrals. As I noted in my prior memorandum for the record, the study team recommendations hold SMMC out for specific requirements -- and public disfavor should it fall short of ponying up -- by reason of its affiliation with a religious institution.

The underlying rationale proffered by the study team of requiring SMMC to provide or make referrals for all “legal” health care in its facilities is laughable on its face: our continuum of care cannot afford such a luxury. Should SMMC provide liver, lung, kidney, and heart transplants? Should it provide complicated trauma and burn care? Many a hospital in this state do not provide the entire complement of “legal” health procedures. Our care continuum is exactly that – a continuum in which many public hospital district hospitals and others transfer patients to hospitals better equipped with facilities, advanced practice nurses, and specialty physicians. Harborview has a Level I Trauma Center that serves five states. It is specious to suggest that SMMC should become Harborview (which does not provide elective abortions, either), providing Level I Trauma care. The study team would have SMMC put the federally funded Bremerton Planned Parenthood, which has been meeting local elective abortion demand, out of business: SMMC -- “compete with Planned Parenthood or be forced to speak.” Again, this recommendation persecutes SMMC by reason of its affiliation with Catholicism by recommending requirements no other local health care provider or secular hospital statewide need meet and that run counter to law. The recommendation on its face makes manifest researcher bias.

Reason to Reject No. 2: The Qualitative Methodology employed was flawed

Qualitative research has fought for decades for means to have the compelling power that quantitative research has. Journal articles debate how to demonstrate things like “rigor,” “validity,” “trustworthiness.” Qualitative research strives to equate with quantitative research in being replicable – which means that should another study team review the same question, it will achieve the same results.

Qualitative researchers, then, are quite careful in a variety of study design techniques that reinforce replicability, reliability, and power to their work, affording confidence among those relying on it.

Interview techniques, such as that employed here, are very careful in the following:

Selection of interviewees – careful selection is quite important, particularly in qualitative studies with small participant sample sizes. The study team interviewed 41 community members, or .01% of our county population. Small interview sample sizes are not necessarily dispositive of whether a study is flawed; many graduate level studies rely on fewer for power in their qualitative analysis. Other factors inform whether the number of interviewees is sufficient to provide confidence in the study design and results, including:

- Participant Bias
- Self-Selection Bias
- Response Bias
- Sponsor Bias
- Confirmation Bias
- Researcher Bias

A researcher needs to design and iteratively control for these things. Sponsor bias is possible, given the KPHD resolution of a “crisis” in our community; self-selection bias is possible, given the patent local hostilities toward SMMC when its purchase of Harrison Hospital was approved, organizational changes made, COVID endured, and a hotly negotiated contract reached with the nursing union. These realities in our environment inform both participation and response bias. Given the foot stomping recommendations surrounding abortion and the broad brush with which the report characterized Catholic hospital organizations nationwide, researcher and confirmation bias also merited self-reflection and study design controls. In light of ignored comments by two members of our health care environment to a draft version of the report, the public comment by a local OB/GYN, and my own observations, it would appear that these controls were either lacking or absent altogether.

In tailoring qualitative research to control for these things, researchers use the concept of “saturation.” It is self-evident that “saturation” was not employed here in interviews or in collection of regionally relevant new articles informing our health care environment. Saturation is “reached when there is enough information to replicate the study, when the ability to obtain additional new information has been attained, and when further coding is no longer feasible.”

The Qualitative Report 2015 Volume 20, Number 9, How To Article 1, 1408-1416

<http://www.nova.edu/ssss/QR/QR20/9/fusch1.pdf> (accessed March 6, 2024). New (but previously available) information was presented at the KPHD meeting on March 5 regarding sterilization, abortion, death with dignity, and charity care. More robust information informing angst around our emergency department was widely reported in the press coincident with the challenges SMMC experienced. Our Attorney General has been entering into consent decrees with hospital systems around the state since 2019, recently requiring a \$4M payment from PeaceHealth and a \$157M payment from Providence – the hospitals themselves are challenging the state on its interpretation of charity care laws. It is telling that the report appears to have relied precious few “exculpatory” news articles – even to present alternative viewpoint – and to have made no attempt to place its assertions in broader context. These omissions inform both saturation and trustworthiness of the report, its qualitative methodology, and the validity, then, of its recommendations. It would have been a different report altogether to place opinions proffered into context then cite data to issue expert recommendations that reconcile or prefer a path. This is not that report. Instead, it amplifies opinion clearly not “saturated” in our community and seeming not triangulated in any way to assure validity. Even using the word “many” in relationship to our neighbors’ concerns with getting health care in a “Catholic” hospital must be tainted by the failure of interviewee selection, study design, and saturation. The report is unreliable.

Reason to Reject No. 3: A assault on the First Amendment rights of SMMC

My prior submission for the record, prepared before the KPHD meeting, urges the County and KPHD to reject this report in toto. The presentation and the adamant recommendations holding SMMC out for specific disfavor in our community in providing abortions – as highlighted above – underscore and add fuel to my exhortation. Neither the County nor any of its governmental arms may accept a report that holds out an organization for disparate treatment merely because it is or is affiliated with a religious organization. In addition to the many examples of this and the rationale in my memorandum on March 5, the adamant recommendation that would “put” to SMMC a requirement to perform “all legal health procedures,” specifically abortions, is discriminatory on its face. Moreover, our few local OB/GYN practitioners retain a personal and protected right to decline to perform abortions. For so many reasons, this recommended disparate treatment is, indeed, gobsmacking.

Recommendation in addition to Rejection: Conflict of Interest Disclosure

It appears that the Chairman of KPHD has a current affiliation with the study team, the study team’s institution, or both. Traditional research reporting merits disclosure of this conflict of interest in the report itself. If the disclosure is there, it merits more prominence in the report. If this conflict was present during the conduct of the study, the report itself merits elucidation of how the study was designed to minimize sponsor bias, researcher bias, and the interface with those conflicted during the conduct of the study.

A health policy analyst at KPHD can readily inform the board of the layoffs, declarations of bankruptcy, closures, reductions in services of rural and acute care hospitals across the Country. Devastating to the seat-limited and residency quota limited pipeline that is medicine, two teaching hospitals have closed or are closing in recent years (Hahnemann; SUNY Brooklyn). Sources that detail these realities include [Becker’s Hospital Review](#) and [Fierce Healthcare](#). The Washington State Hospital Association reported frequently on the

[financial and operational stresses](#) of hospitals in the year of our own emergency room challenge and is a great source looking forward.

I gather Kitsap County and KPHD will run headlong into consideration of a Public Hospital District on the back of this report. It is an expensive exercise of tilting at windmills. I would welcome serving on such an analysis, as I am certain it will be populated by those already advocating for it and who, as with this effort, like a hammer, see everything as a nail.

I welcome meeting with any KPHD members to further elucidate any of my concerns as you might find helpful. Honestly, the more I digest this report, the more concern it generates for me.

Jennifer Korjus, J.D., M.Ed.
703-927-2025

Margo Chang

From: Susan Brooks-Young <sjbrooksyoung@gmail.com>
Sent: Wednesday, March 27, 2024 11:52 AM
To: Yolanda Fong; Susan Brooks-Young
Subject: A possibility for community collaboration?

Follow Up Flag: Flag for follow up
Flag Status: Flagged

You don't often get email from sjbrooksyoung@gmail.com. [Learn why this is important](#)

[CAUTION]: This email originated from outside Kitsap Public Health District. **Do not click links or open attachments** unless you are expecting this email. If you are unsure please contact IT.

Dear Ms. Fong,

I am writing to members of the Kitsap Public Health Board today on the behalf of the Alliance for Equitable Healthcare, a non-profit 501(c)(4) formed to assist residents of Kitsap County gain increased access to affordable, comprehensive, and equitable healthcare and wanted to share the message with you as well.

Originally an informal grassroots group of community leaders and concerned county residents, we first met on December 9, 2021 and the full group has continued to gather monthly since then. We also have formed working groups to explore a variety of strategies for achieving our overarching goal.

In October 2022, members of the community began asking about the possibility of forming a countywide Public Hospital District (PHD) in Kitsap. We have been exploring the idea of a PHD since that time, taking actions that include, but are not limited to:

- * Speaking with individuals who've been involved in forming other PHDs in the state
- * Talking with small groups of county residents
- * Hosting listening interviews with community leaders throughout the county
- * Learning about the issues around sustainable funding for critically needed healthcare services
- * Studying the requirements for forming a PHD

Many of our members attended the March 5, 2024 Kitsap Public Health Board meeting when the research team from the Johns Hopkins Bloomberg School of Public Health presented its report, *Healthcare System Challenges and Opportunities in Kitsap County, Washington*, which the health board commissioned during the winter of 2023. We were interested to hear that one of the recommendations coming out of the report is: "Within the next year, the Kitsap County Board of Commissioners, the Kitsap Public Health Board, and other relevant stakeholders should launch a formal commission to explore the feasibility of forming a public hospital district in Kitsap County."

We are hoping that this (as well as other recommendations in the report) will be adopted by KPHB, and are volunteering to collaborate with KPHB, KPHD, and the County Commissioners to share what we have already learned and also to help with the on-going work as necessary. Our members care deeply about this task and want to assist in any way we can to see it through. Some of us will be attending the April KPHB meeting in person while others, including myself, will be viewing the BKAT livestream.

Thank you,

Susan Young
Alliance for Equitable Healthcare

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SJ Brooks-Young Consulting
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Web site: www.sjbrooks-young.org
Facebook Business Page: www.facebook.com/SjBrooksYoungConsulting

"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel." Maya Angelou

Kitsap Public Health Board Health Officer Update

Gib Morrow, MD, MPH
Health Officer, Kitsap Public Health District
April 2, 2024



Protecting, Connecting and Thriving We Are All Public Health



Proteger, Conectar y Prosperar Todos Somos Salud Pública



NATIONAL
PUBLIC
HEALTH
WEEK

KITSAP PUBLIC HEALTH DISTRICT



OUR VISION

Our vision is a safe and healthy Kitsap County for all.

OUR MISSION

The Kitsap Public Health District prevents disease and protects and promotes the health of all people in Kitsap County.

OUR GUIDING PRINCIPLES

Prevention

We protect our community by reducing the risks of disease, injury, and early death.

Collaboration

We engage with community, convene diverse partners, and work to ensure our efforts are community oriented and create meaningful impact.

Quality

We are dedicated to continuous quality improvement and our work is guided by evidence from scientific data, best and promising practices, and incorporates community input to produce the best possible outcomes.

Equity

We are committed to all people in Kitsap County having a fair and just opportunity to live safe and healthy lives.

Innovation

We proactively and flexibly deploy creative and novel strategies to address current, evolving, and future public health needs.



2024-2028 KITSAP COMMUNITY HEALTH PRIORITIES*



HEALTHCARE

- Address gaps in healthcare access
- Implement strategies to recruit and retain healthcare workforce



MENTAL & BEHAVIORAL HEALTH

- Expand care options for mental health and substance use disorders



HOUSING & HOMELESSNESS

- Ensure affordable and safe housing
- Address and prevent homelessness

* Final wording will be decided at our Priority Work Group meetings this spring.

- Kitsap Public Health District. December 2023. [Community Health Assessment](#)
- Kitsap County Division of Aging and Long-Term Care. [Area Plan 2024-2027](#)
- Kitsap Community Resources. April 2023. [Community Needs Assessment](#)
- Kitsap Mental Health Services. March 2023. [Community Needs Assessment](#)
- St. Michael Medical Center. May 2023. [Community Health Needs Assessment](#) and October 2023 [Community Health Implementation Strategy](#)
- JHU's -- [Healthcare System Challenges and Opportunities in Kitsap County](#)



Community Public Health Goals

- Health Equity and Improved Population Health

Guiding Principles & Commitments

- Shared Data and Action Plans
- Shared Strengths and Assets
- Accountability and Transparency
- Trusted Partnerships & Strategic Collaboration
- Community Centered and Data Driven
- Flexible and Continuous

Community Health Improvement Planning



synergy
 together work **team** word
teamwork cooperation agreement
 plan goal joint
strategic partner project merger
 connection solution organization joint
 leadership unity vision **strategy** achievement motivation
partnership
 group successful union **business** collaboration alliance
 management success corporate growth manager
 symbol company



Get Involved /
know your partners

Engage
partners early

Incentivize

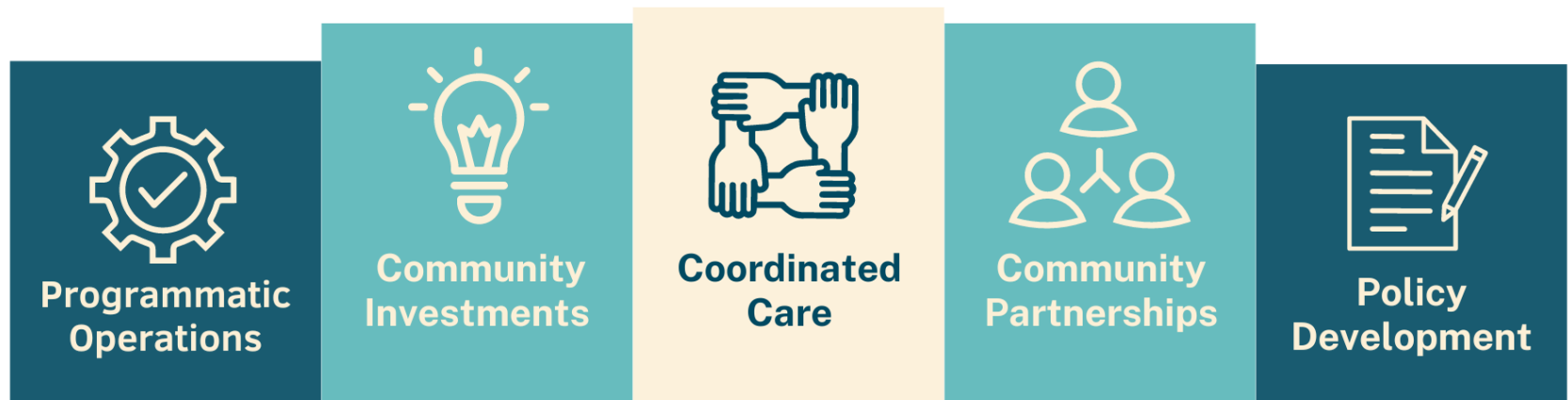
Incorporate in
decision process



NEXT STEPS TO IMPROVE HEALTHCARE ACCESS IN KITSAP COUNTY

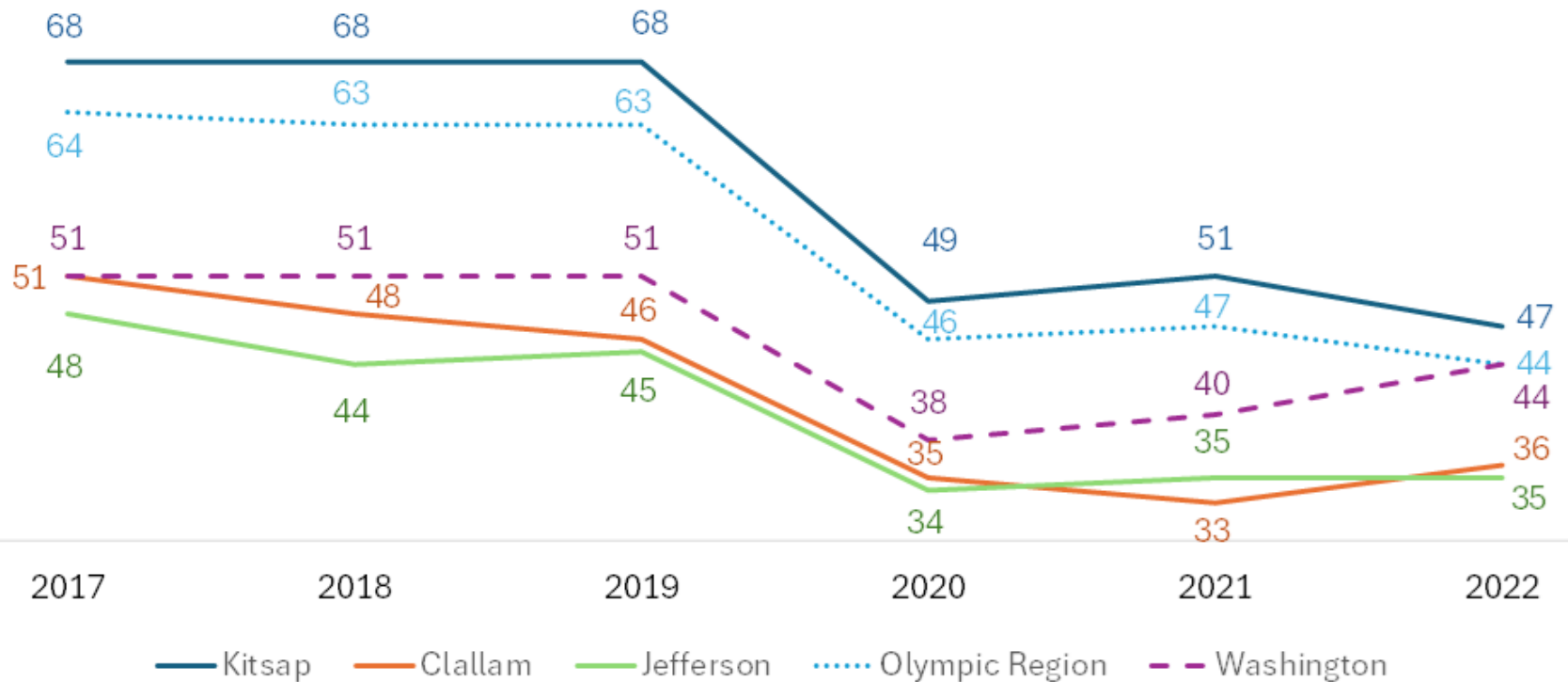
KPHD Next Steps Framework

- Convener of the Kitsap Community Improvement Plan
- Launch of a Healthcare Action Collaborative in response to commitments defined by Resolution 2023-04, John's Hopkins Study Team recommendations, and findings from recent community health assessments
- Solidifying KPHD specific action-oriented strategies in the areas below:



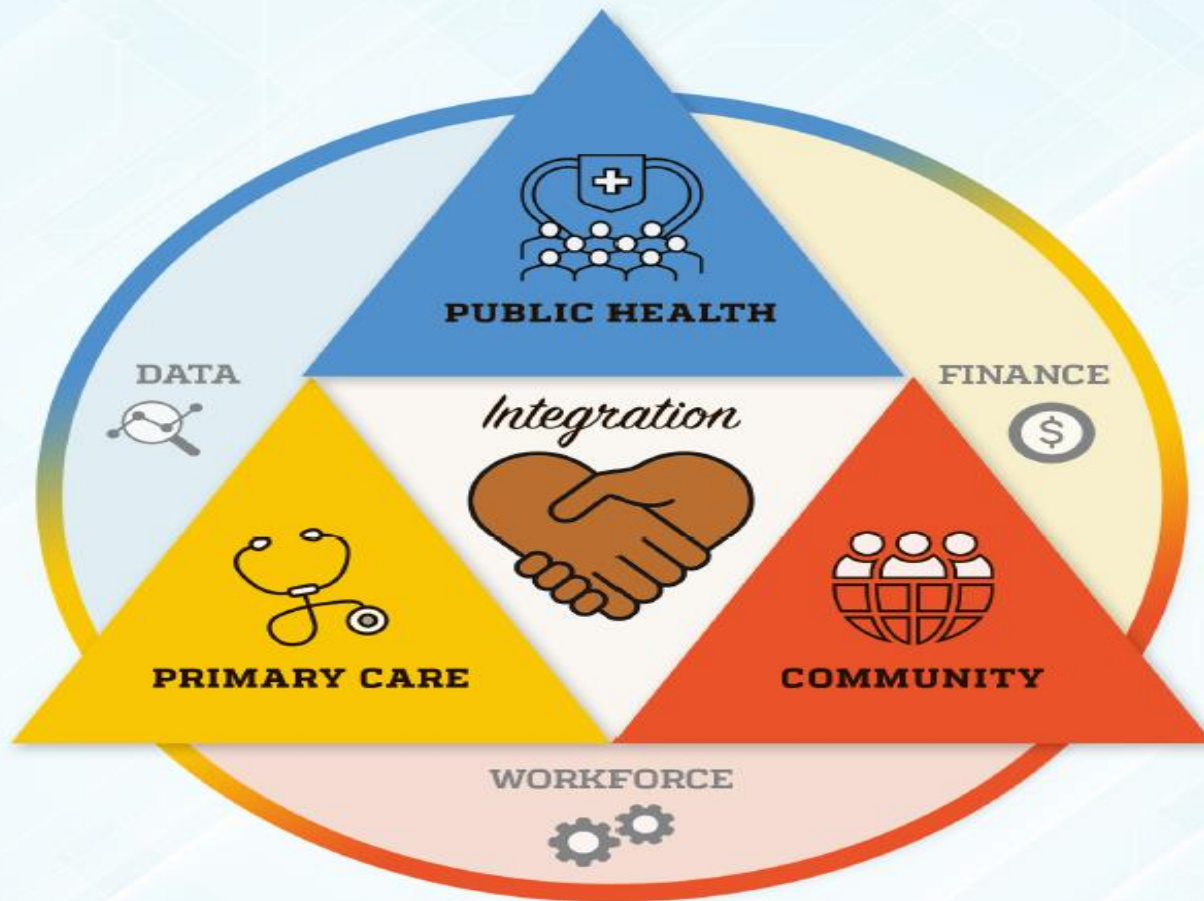
Emergency Department (ED) Visits by Medicaid Beneficiaries for All Reasons

(Average number of ED visits each month for every 1,000 enrolled Medicaid members)





Source: Health Care Authority (HCA) Medicaid Enrollment and Claims Data. Accessed at <https://hca-tableau.watech.wa.gov/t/51/views/HealthierWashingtonDashboard/Measures?%3AisGuestRedirectFromVizportal=y&%3Aembed=y>, March 2024. [Analyzed by Kitsap Public Health District, Assessment & Epidemiology Program].





The Integration of Primary Care, Public Health, and Community-Based Organizations: A Federal Policy Analysis

THE SOCIAL DETERMINANTS SPECTRUM

Roles for Healthcare	 Screening for necessary social, economic, and safety issues in clinical & other settings	 In-house social services assistance (at clinical site where screening is performed)	 Anchor institution promoting equity via hiring, investments, community benefits	 Community-based social and related services: single or multiple programs or services	 Changes to laws, regulations, or community-wide conditions; working across sectors
Roles for Public Health Departments (PHDs)	PHDs can offer best practice screening materials and can aggregate/ analyze data across facilities regarding need.	PHDs can convene community organizations and other sectors to promote linkages, develop materials & advocate for SDOH-related reimbursement.	PHDs can collaborate with one or more anchor institutions, assist them in prioritizing, evidence-based approaches & community-wide strategies.	PHDs can demonstrate need with data, make case for funding for needed services and/ or fund programs themselves.	PHDs can provide evidence of need and demonstrate efficacy of policies and laws at promote health and address the SDOHs.

Primary Care	Public Health
Individual patient focus	Population focus
Diagnosis and treatment emphasis	Prevention or response emphasis
Clinical sciences essential to professional training	Clinical sciences peripheral to professional training
Private sector basis	Public sector basis



Resources

- [Integrating Primary Care and Public Health to Save Lives and Improve Practice During Public Health Crises: Lessons from COVID-19](#)
- [Integration of Primary Care and Public Health \(Position Paper\)](#)
- [The Integration of Primary Care, Public Health, and Community-Based Organizations: A Federal Policy Analysis](#)
- [PBS Documentary The Invisible Shield: Public Health Saved Your Life Today and You Don't Even Know It](#)
- [Medical Debt—An Iatrogenic Epidemic With Mortal Consequences](#)
- [The Improving Social Determinants of Health Act of 2023 \(S./ H.R. \)](#)
- [Kaiser Family Foundation Diagnosis: Debt](#)



MEMO

To: Kitsap Public Health Board

From: Yolanda Fong

Date: April 2, 2024

Re: Kitsap Mental Health Services

Kitsap Mental Health Services (KMHS) is a 501©(3) not-for-profit organization providing a full range of inpatient, outpatient, and residential behavioral health services for children, adults, and families. They serve more than 8,000 clients each year and employ more than 600 caring professionals. A respected leader in the community health and substance use disorder fields since 1978, KMHS became a Certified Community Behavioral Health Clinic (CCBHC) in 2023. This means they have met a federal standard for quality of care and are committed to continuous improvement.

Monica Bernhard is the Chief Executive Officer and will be presenting on KMHS programs, workforce, challenges, and expansion plans.

Recommended Action

None at this time – for information and discussion only.

Please contact me at yolanda.fong@kitsappublichealth.org with any questions or comments.

Attachments (1)



Hope lives here.

Serving Kitsap County for 46 years





Comprehensive Recovery Oriented Services

- Adult Outpatient Mental Health and Co-Occurring Substance Use Disorder Services
- Children Youth and Family Services
- Intensive Wrap-Around Services for Youth and Adults
- School based programs
- Supported Housing and Employment
- Five separate 24/7 programs
- Designated Crisis Responder Services

Convenient Locations Across Kitsap

Bremerton – multiple sites:

- Adult and Children, Youth and Family Outpatient Services
- Five 24/7 units (Crisis Triage, Pacific Hope & Recovery, Keller Residential Day treatment, Adult Inpatient and Youth Inpatient)
- Madrona Day Treatment (*2 sites, up to 44 students, 1st – 12th grades*),
- Pendleton Place, 72 permanent supportive housing facility & 24/7 onsite staff
- Mobile Crisis Outreach teams (youth and adult)

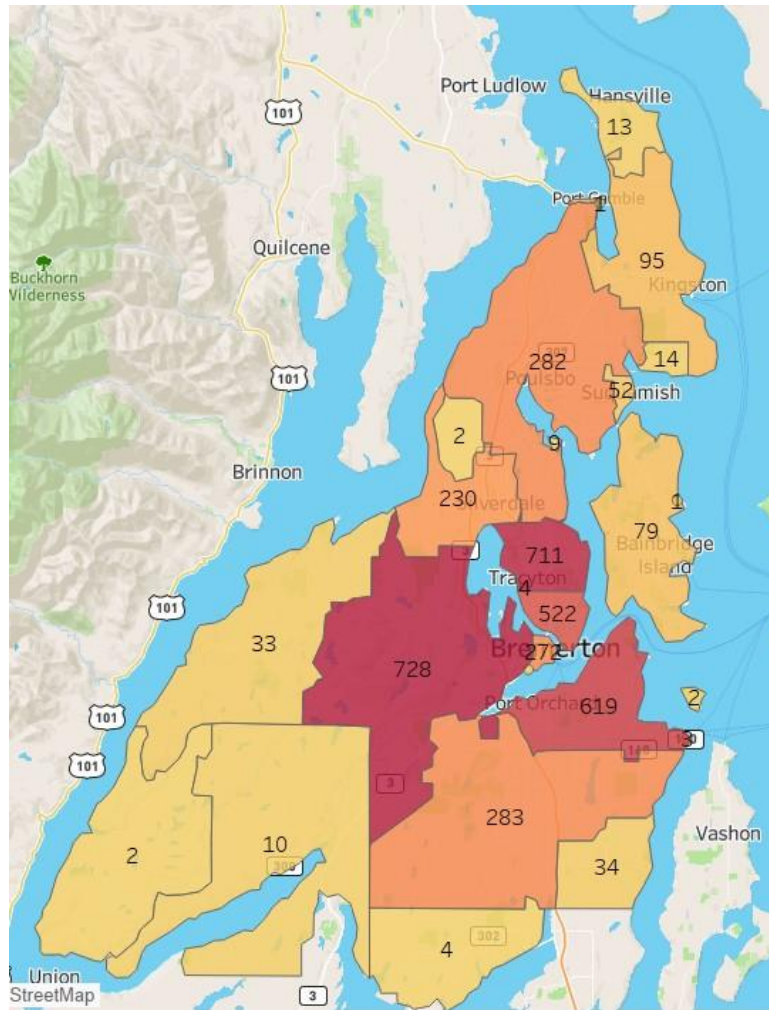
Poulsbo - Hostmark: Adult, Children Youth & Family, and intensive youth services

South Kitsap – Bay St.: Adult, Children Youth & Family, and intensive youth services

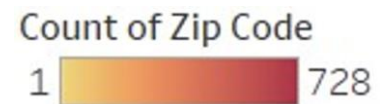
In the schools: 9.5 Therapists support 3 high-schools, 1 middle school and 9 elementary schools across the county.



Serving 4,005 non-duplicated clients from across Kitsap County last year...



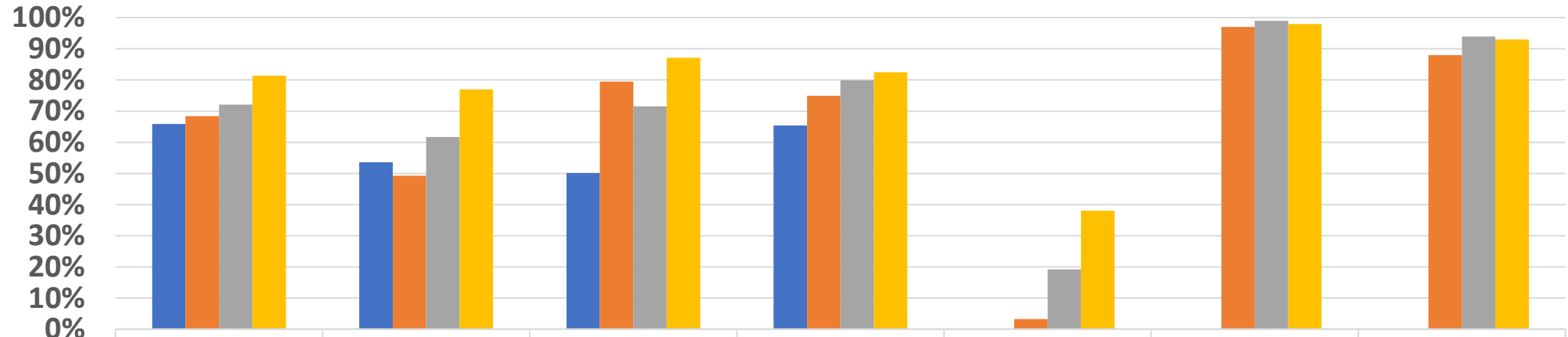
- Bremerton: 39 %
- South Kitsap: 24%
- Central Kitsap: 24%
- North Kitsap: 11%
- Bainbridge Island: 2%



24/7 Average Annual Occupancy Rate

2021 to 2024 YTD By Program

Steady increase since 2021



	Adult Inpatient	Crisis Triage	Pacific Hope & Recovery Occupancy	Keller House	Youth Inpatient	Pendleton Place	KMHS Properties
■ 2021	65.90%	53.60%	50.10%	65.40%	0.00%		
■ 2022	68.40%	49.30%	79.50%	74.90%	3.20%	97.00%	88.00%
■ 2023	72.10%	61.70%	71.50%	79.90%	19.20%	99.00%	94.00%
■ YTD 2024	81.40%	77.00%	87.10%	82.50%	38.00%	98.00%	93.00%

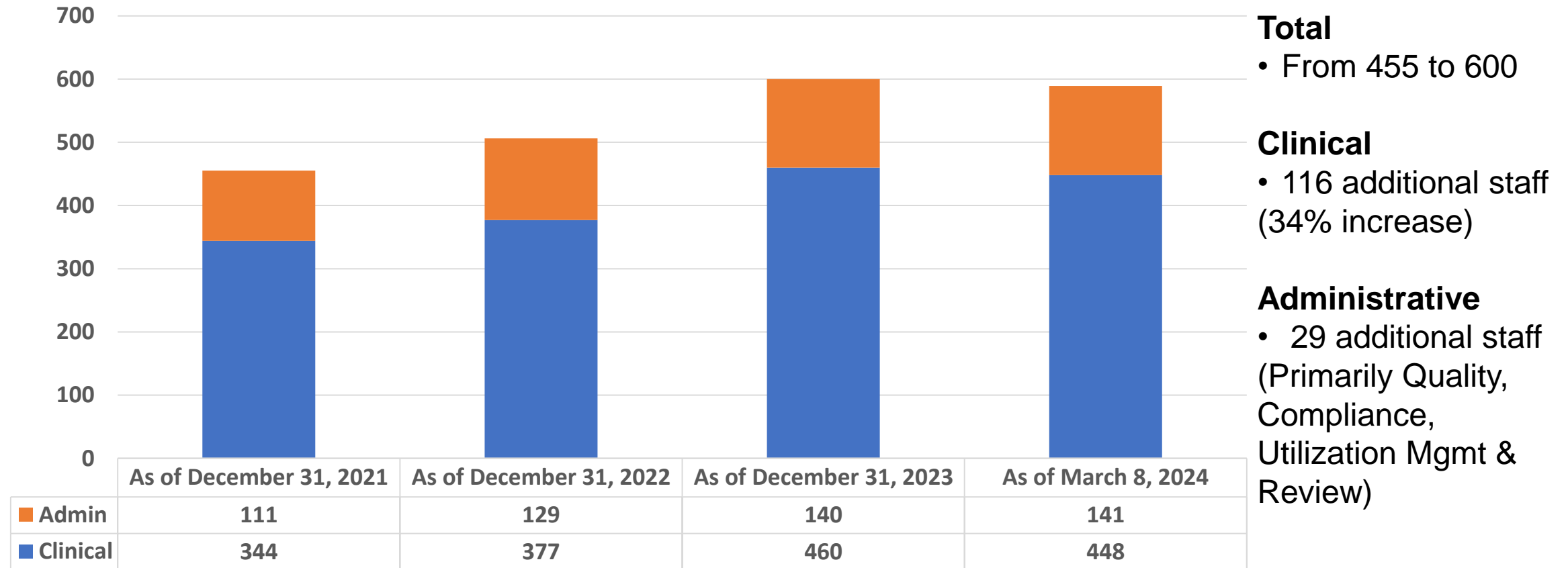
Clinical Staff

Compassionate. Committed. Highly trained.

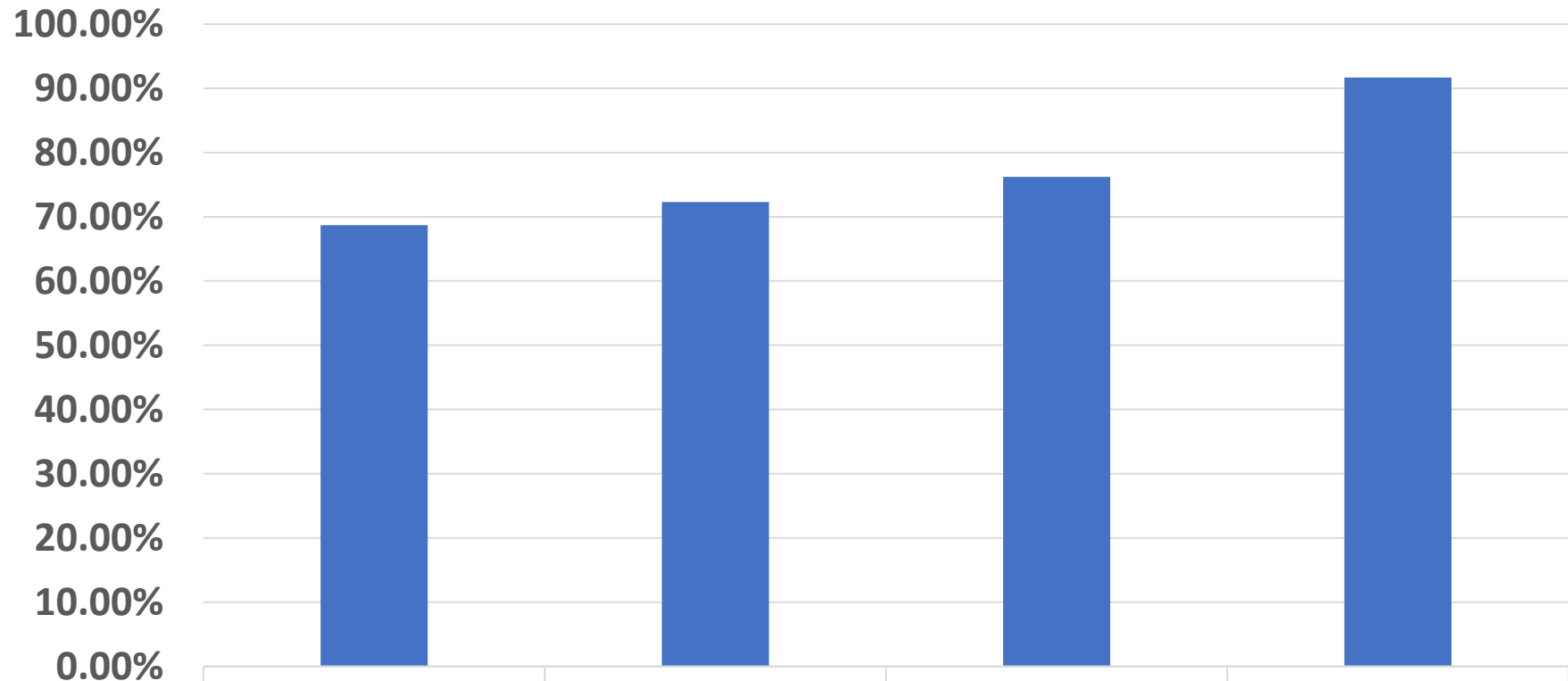


Overall Employee Growth – 29% Increase

2021 – YTD 2024



KMHS Staff Retention – Steady Improvement

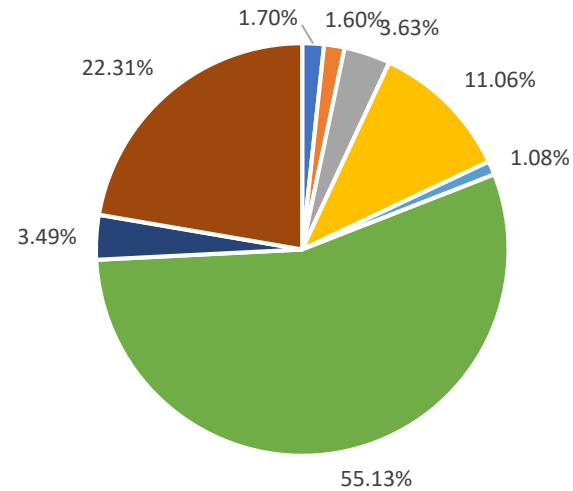


■ Annual Staff Retention	68.70%	72.30%	76.20%	91.67%
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Reflecting Client & Community Diversity

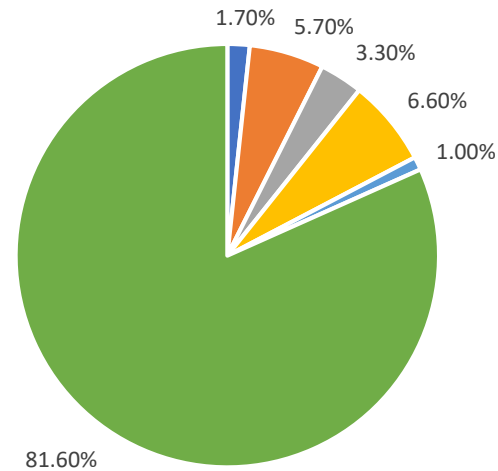
Staff data includes Hispanic or Latino as a separate category so data is not directly comparable.

Clients - 2023



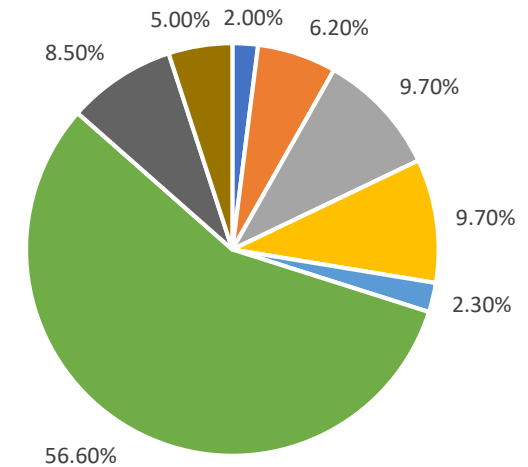
- American Indian or Alaska Native
- Asian or Asian American
- Black or African American
- Multiracial
- Native Hawaiian or Pacific Islander
- White
- Other Race*
- Unknown/undisclosed*

County Residents - 2022



- American Indian or Alaska Native
- Asian or Asian American
- Black or African American
- Multiracial
- Native Hawaiian or Pacific Islander
- White

Staff - 2023



- American Indian or Alaska Native
- Asian or Asian American
- Black or African American
- Multiracial
- Native Hawaiian or Pacific Islander
- White
- Hispanic or Latino
- Not specified

KMHS Priority: Promoting Diversity, Equity, Inclusion & Accessibility Across KMHS

- DEIA Committee, staff led and supported by leadership, determines agency's DEIA priorities
- Newly launched DEIA Council, reporting to CEO, and responsible for monitoring diversity metrics including hiring/termination/compensation, client demographics/diagnosis and discharges, personnel policies.
- 100% staff trained on cultural competency
- Inclusive Communities team, focused on providing services to immigrants, refugees and Hispanic populations
- Wherever possible, KMHS strives to assign clinicians in line with gender, sexual orientation, race/ethnicity preferences of the clients





Evidence-Based Practices

We aim to train all clinicians in at least two evidence-based practices within 2 years of hire. These could include:

- Suicide Risk Assessment
- Motivational Interviewing
- Dialectical Behavior Therapy (DBT)
- Cognitive Behavioral Therapy (CBT)
- Whole Health Action Management (WHAM)



Specialized Evidence Based Practices

Many clinicians have been trained in a variety of other evidence based practices, such as:

- DBT for Eating Disorders
- Eye Movement Desentization & Reprocessing (EMDR)
- Solution Focused Brief Therapy
- Cognitive Behavioral Therapy for Psychosis
- Child-Parent Psychotherapy Training
- Promoting first relationships
- Parent Child Interaction Therapy
- And many others

Challenges



Challenges: Staff Recruitment

Vacancies in Key positions

- Mental Health Professionals: 36 staff + 14 vacancies
- Therapists: 42 staff + 18 vacancies
- Care Coordinators (BA Level): 84 staff + 14 vacancies
- Nurses: 27 staff + 3 on-call Nurse vacancies
- Medical Assistants: 7 staff + 5 vacancies
- Medical Providers: 12 staff + 2 ARNP vacancies

It's Tough Work!!

Often the newest clinicians are serving the highest acuity individuals, with high caseloads.

Move to Private Practice and Community

Often following licensure, many licensed providers move to community positions or open their own practices.



Challenges Facing the Mental Health & Substance Use Disorder System

- **Voluntary nature of services** - The involuntary detainment standard in Kitsap County is exceptionally high. Requires imminent risk of danger to self/others. Gravely disabled is more difficult to prove.
- **System is historically underfunded.** Although definitely improving, reimbursement rates typically do not cover full cost of providing services
- **Significant WAC/RCW/Medicaid/Medicare Administrative burdens** that make barriers to care significantly higher. (2+ hour intakes, multiple assessments that must be repeated every 3-6 months, strict documentation requirements)
- **Youth acuity significantly higher**, often requiring 1:1 care, which generally is hard to accommodate in current staffing models
- **Not licensed to provide care to medically acute individuals**

On the Horizon

Tailoring services to address community needs



Expansion Plan

- Nine Acres of Vacant Land on Almira, adjacent to Main campus in Bremerton
- Youth Intensive Services Campus including substance use and withdrawal services, partial hospitalization, additional youth inpatient services
- 6 Classroom Madrona Academy, serving kids 1st – 12th, indoor/outdoor recreation space, and ample space for staff and therapy
- Differentiated Adult Inpatient Services, creating additional space for voluntary and involuntary clients.
- Long Term – Expand access to Adult substance use treatment and withdrawal services
- Mental Health Health Urgent Care co-located with Crisis Triage facility

Other Highpoints

- Launching Transcranial Magnetic Stimulation Services (TMS) in May (Ribbon Cutting May 16th!)
- Launching a bi-monthly community education series, with first session scheduled for Thursday, April 5th, at Olympic College on the topic of Rethinking Approaches to Substance Use Recovery. Details on the KMHS website.
- Offering free/low-cost community training including Mental Health First Aid for youth and adults, QPR Suicide Prevention (Question, Persuade, Refer), De-escalation approaches for non-clinical staff
- KMHS is now a Certified Community Behavioral Health Center!
- On the path to Facility Accreditation, which means we will be able to serve people on Medicare and Commercial insurance in our 24/7 units

For more information

Monica Bernhard, CEO

monicab@kmhs.org



KITSAP
MENTAL HEALTH
SERVICES

Hope Lives Here

MEMO

To: Kitsap Public Health Board

From: Yolanda Fong

Date: April 2, 2024

Re: Connecting Community Members to Care Report

The Olympic Community of Health (OCH) is the Olympic region's Accountable Community of Health (ACH). ACHs are independent, regional organizations. They work with their communities on specific health care and social needs-related projects and activities. They were created in 2015 with funding through a State Innovation Models grant. The Olympic region includes Clallam, Jefferson, and Kitsap Counties.

Bonnie Obremski is the Communications Specialist for the OCH and is presenting on a recently published Connecting Community Members to Care report (attached). The presentation will introduce the OCH and highlight the regional programs included in the report that provide services to individuals by meeting them where they are.

Recommended Action

None at this time – for information and discussion only.

Please contact me at yolanda.fong@kitsappublichealth.org with any questions or comments.

Attachments (2)



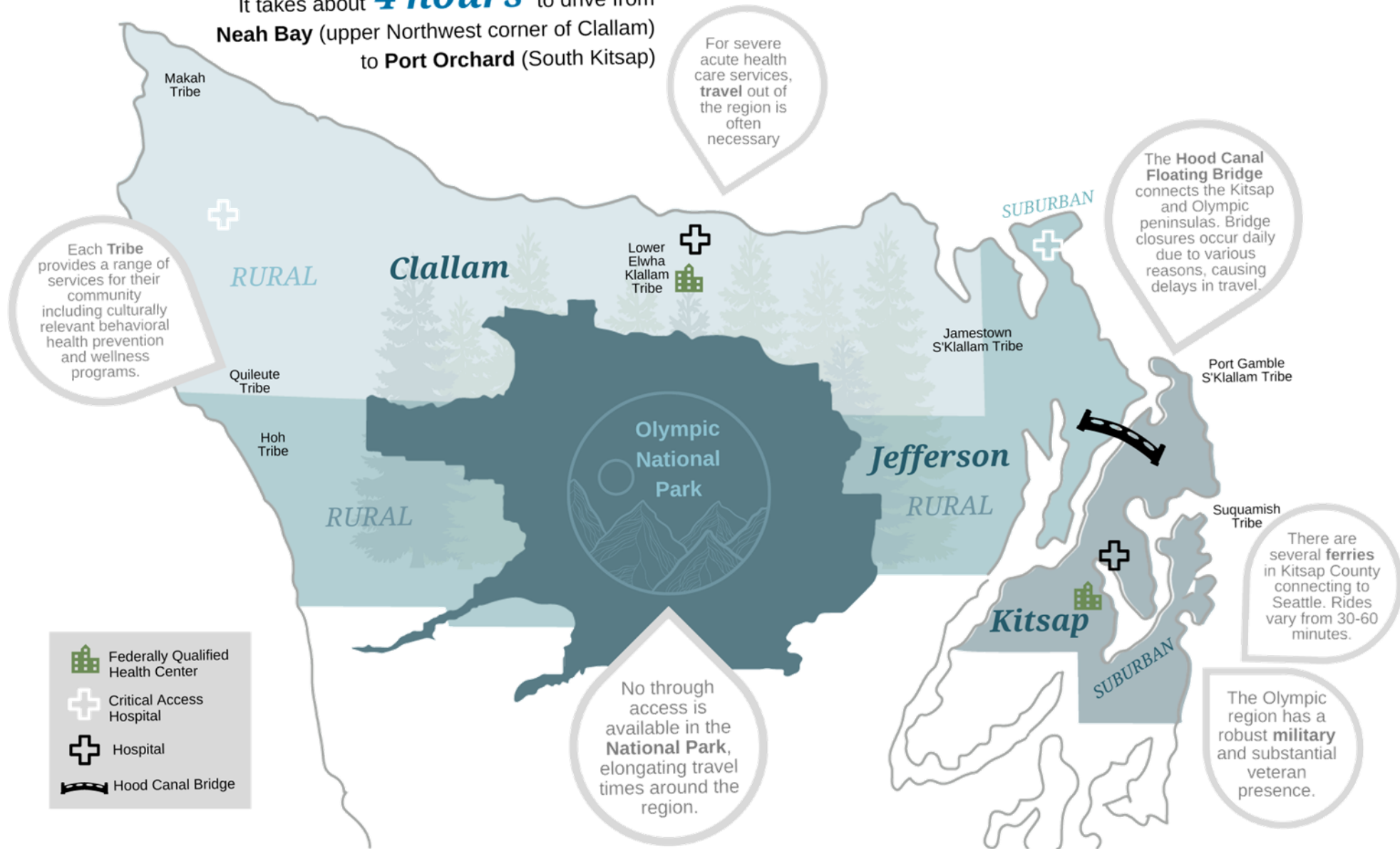
Connecting Community Members to Care

*Collaborative, field-based
approaches across the
Olympic Region*

- **Improving patient experience and outcomes**
- **Preserving emergency services**
- **Reducing costs**

The Olympic Region

It takes about **4 hours** to drive from **Neah Bay** (upper Northwest corner of Clallam) to **Port Orchard** (South Kitsap)





Improve individual and population health and advance **equity** by addressing the **determinants of health**



Reduced stigma of substance use disorder



Access to full spectrum of care



Individual needs are met timely, easily, and compassionately



Long-term, affordable, quality housing

STRATEGIES



Convening, learning, & maximizing



Funding coordination



Advocacy & engagement



Data sharing & transparency



Communication



Place-based approaches

The Connecting Community Members to Care report...

- **Demonstrates the value and impact** of local programs
- **Elevates** creative ideas
- **Advocates** for sustainable solutions
- **Provide a tool** for partners and decision makers
- **Supports regional efforts** to meet individual needs timely, easily, and compassionately



Meeting people where they are to provide timely, compassionate care. Programs and services aim to meet the unique needs of the diverse communities in the Olympic region.

- **Community paramedicine**
- **Co-Response**
- **Mobile-integrated health**



The role of first responders

*“I know I’m not fixing anything; I’ll see them again.
It’s like the same house catching fire every third day.”*

Historically:

Acute intervention
for emergent needs

- Trusted resource
- First and sometimes only point of contact

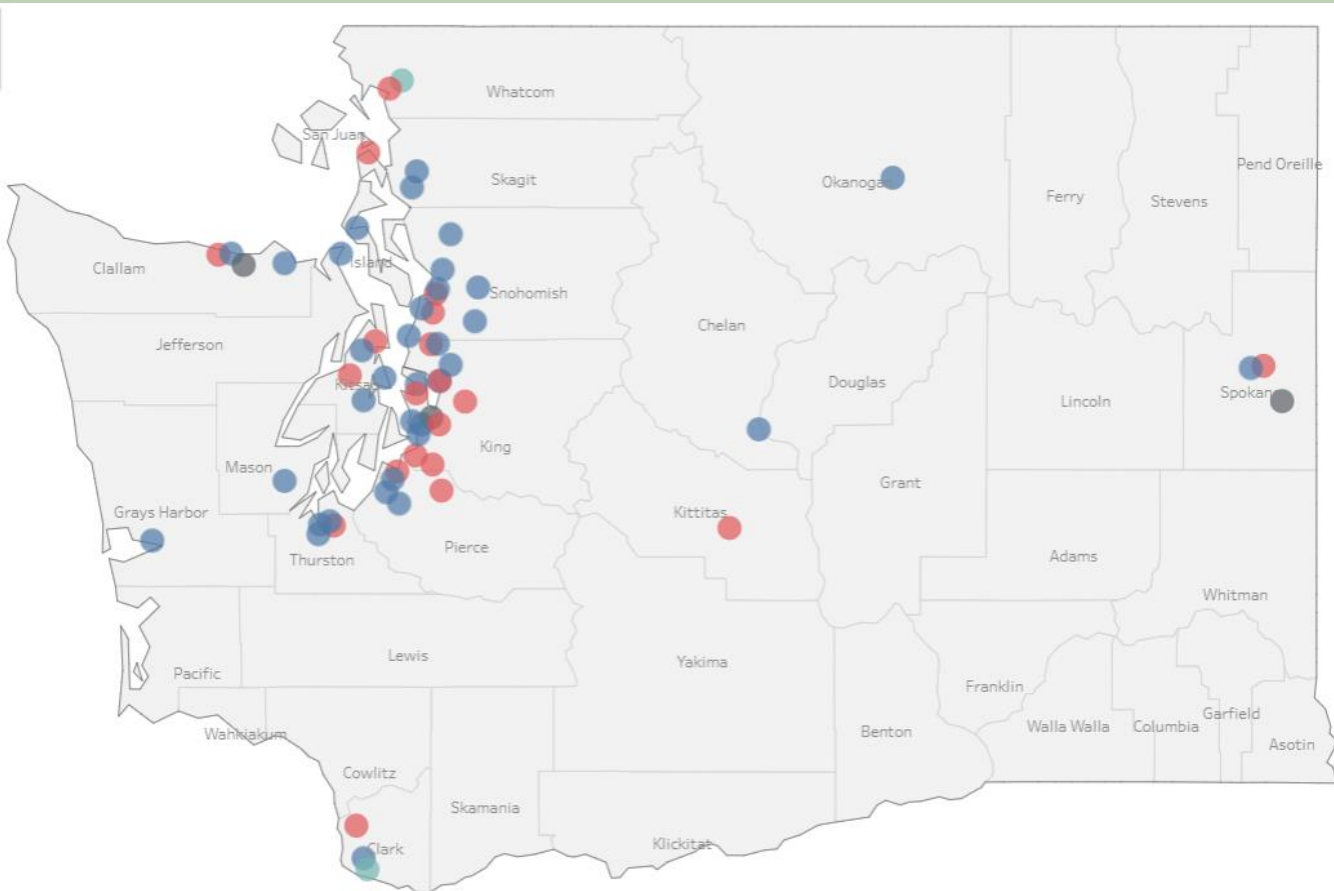
Today:

Higher and more frequent volume of non-emergent calls
Chronic conditions
Unsolvable in single visit

Increased costs
Taxes limited emergency resources

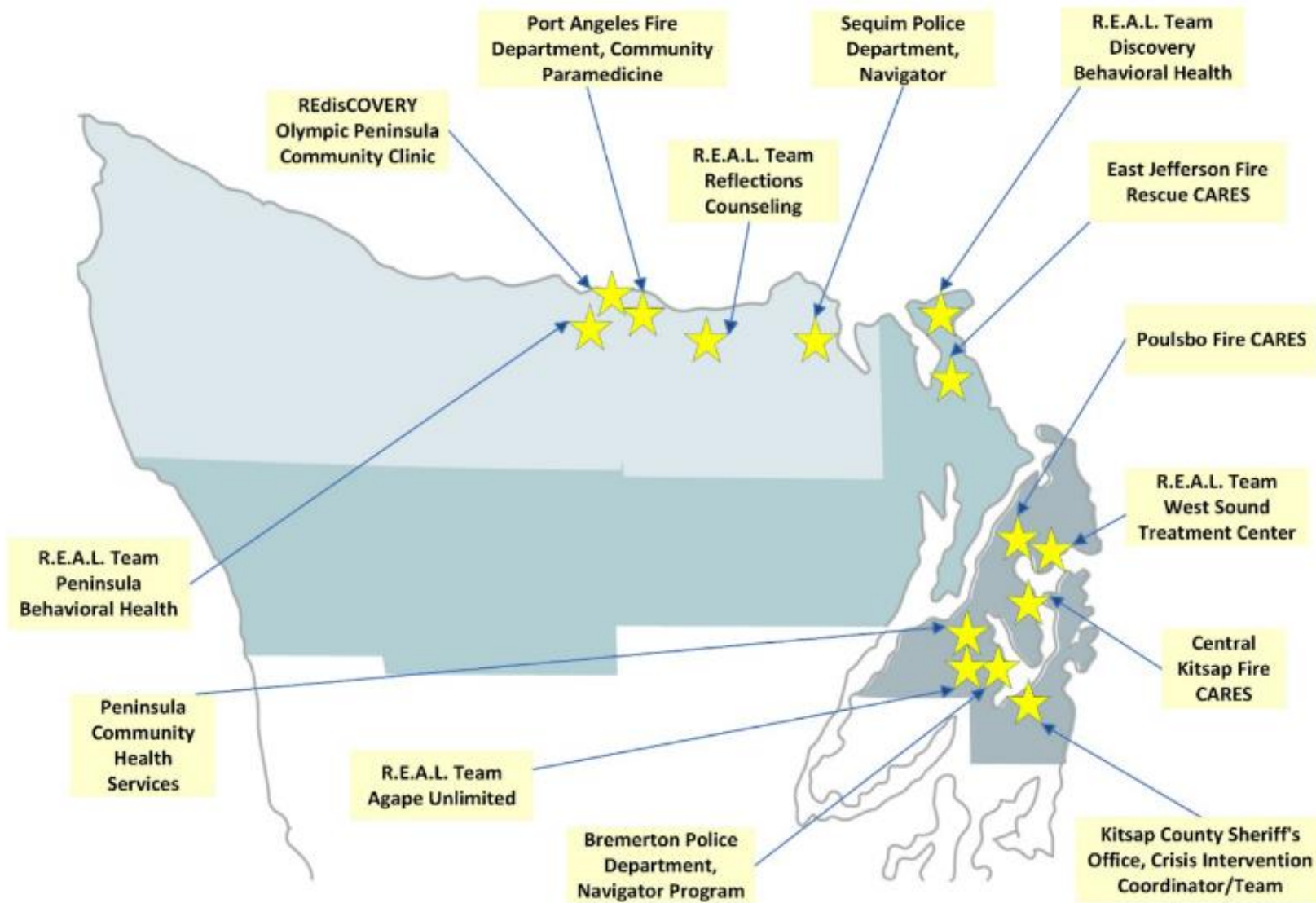
A larger movement

“We can't control what people call 9-1-1 for. We can control how we respond.”



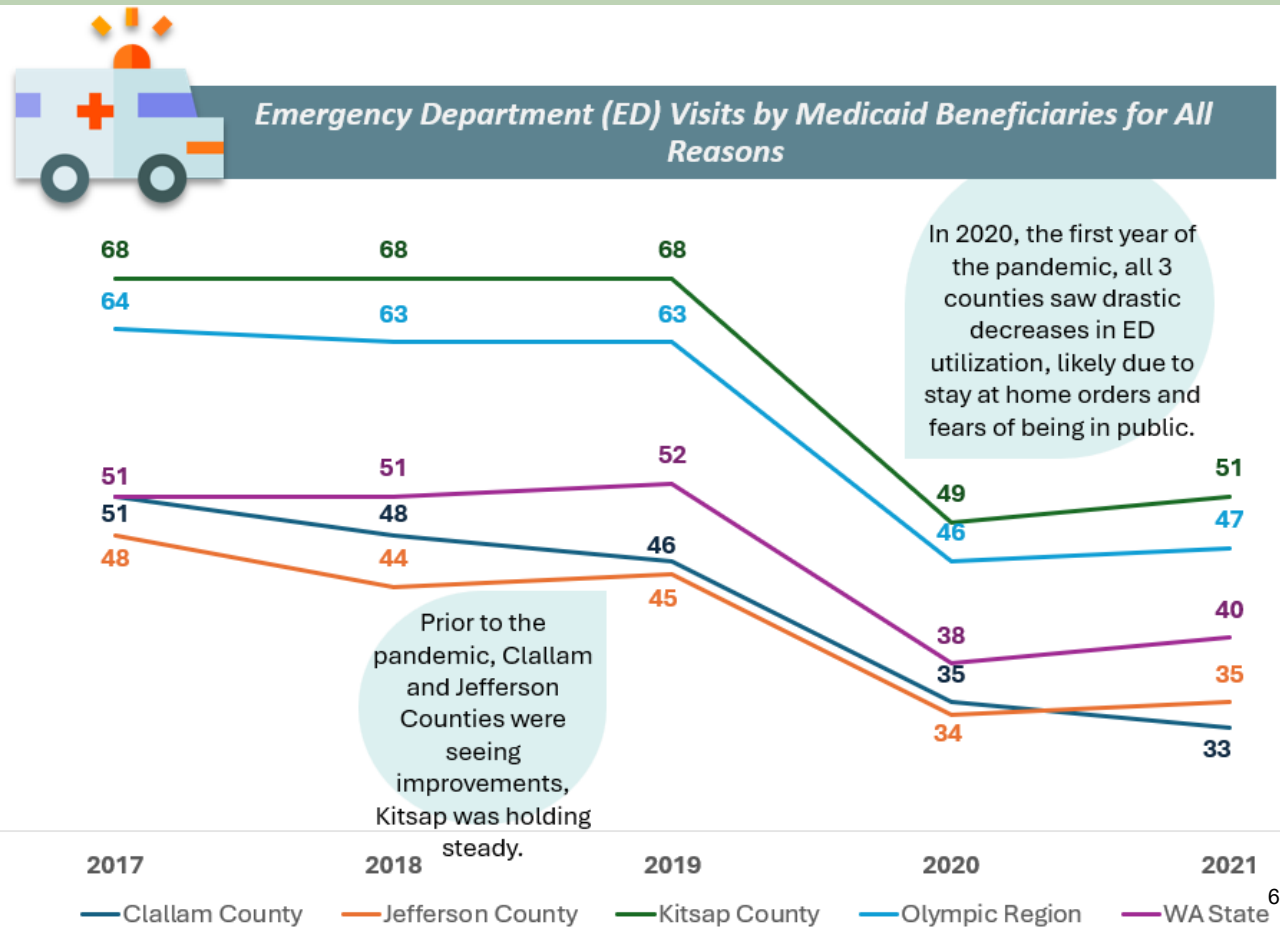
**More than 400 programs
across 40 states (2023)**

Figure 4



Local needs

“Visits are exceeding pre-pandemic levels.”



Source	Health Care Authority
Population Measured	Medicaid Beneficiaries
Definition	The rate of community members enrolled in Medicaid with visits to an emergency department, including visits related to mental health and substance use disorder.
Key Code	A lower rate is better
Measure	Rate is calculated per 1,000 Medicaid Member Month
OCH Focus Area	All Focus Areas

ED utilization is high

- Limited resources:**
- Primary care
- Specialty care
- Behavioral health
- Resources for aging

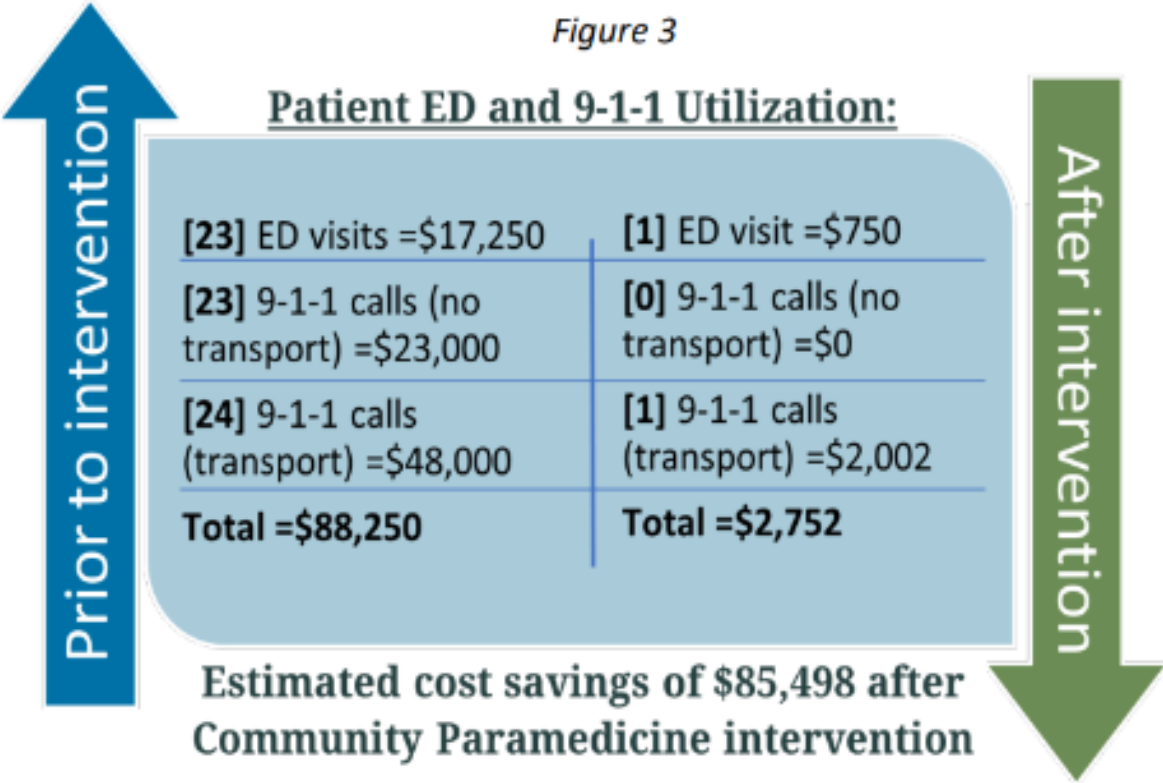
Partner successes:

“Within 1 year of engaging with the community paramedicine program the patient's 9-1-1 calls decreased by 35%.”



Figure 3

Patient ED and 9-1-1 Utilization:



Estimated cost savings of \$85,498 after Community Paramedicine intervention

Partner successes: Central Kitsap Fire & Rescue CARES

This Community Assistance, Referral, and Education Service is a partnership between Central Kitsap Fire & Rescue and the City of Poulsbo that connects people with support and services that meet their individual needs.

- 289 referrals received and 186 people assisted January-June 2023
- 27 individuals connected to care January-June 2023
- 19 avoided 9-1-1 calls because of on-scene activity/home visit and 20 times fire crews relieved in the field January-July 2023



Partner successes: Poulsbo Fire CARES program

Poulsbo Fire CARES is a collaboration between the Poulsbo Fire Department and the City of Poulsbo that serves community members facing behavioral health-related issues and chronic medical conditions.

- 299 referrals received and 257 people assisted January-June 2023
- 88 individuals connected to care January-June 2023
- 74 avoided 9-1-1 calls because of on-scene activity/home visit and 7 times fire crews relieved in the field January-July 2023



Partner successes: Kitsap County Sheriff's Intervention Coordinator

The Crisis Intervention Coordinator (CIC) works to divert people experiencing mental health needs away from the criminal justice system and toward treatment through referrals to the proper social agencies.

In 2022:

- 204 unique community members served
- 391 interactions with clients
- 48 referrals to local R.E.A.L. Teams



Partner successes: Bremerton Police Department Behavioral Health Navigator Program

Navigators collaborate with Bremerton police officers to co-respond to calls that involve individuals experiencing suicide ideation, mental or behavioral health, child protective services, adult protective services, or complex health issues.

In 2022:

- 506 referrals to navigators
- 558 individuals contacted by navigators
- Almost 75% of individuals contacted accepted help

Partner successes: Salish R.E.A.L Teams

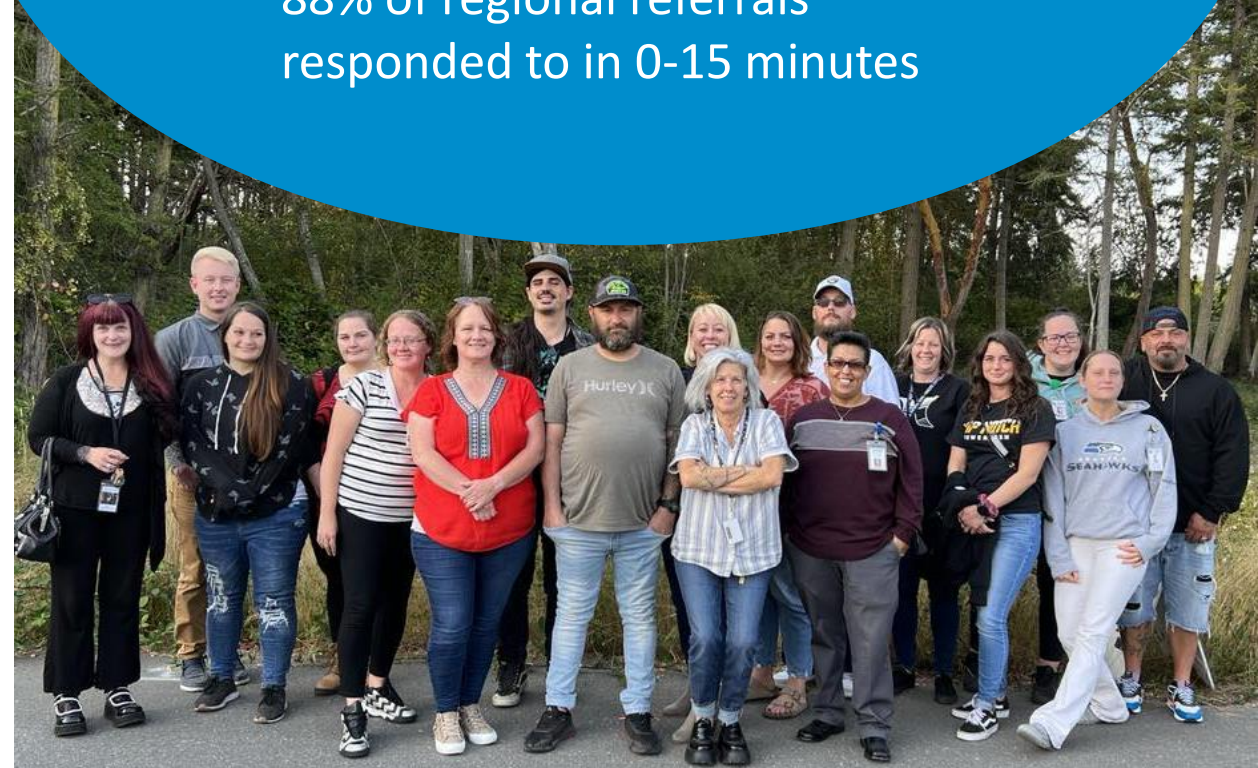
R.E.A.L. (Recovery, Empowerment, Advocacy, and Linkage) Teams are a client-driven, harm reduction model to support individuals along their recovery journey, at their individual pace. Each R.E.A.L. Team consists of a project manager to engage community and conduct outreach, a case manager, and two recovery coaches to directly respond to referrals.

R.E.A.L. Teams provide 24/7 support and respond within 90 minutes to referrals received.

1,731 individuals served 2022-23:

- Clallam: 874
- Kitsap: 700
- Jefferson: 157

88% of regional referrals responded to in 0-15 minutes



Partner successes: Bremerton Ambulatory Team (BAT)

In 2020, Peninsula Community Health Services collaborated with the Bremerton Fire Department to establish the Bremerton Ambulatory Team. That team consists of a medical provider, medical assistant, and community health worker, as well as support from behavioral health professionals. They reduce the number of non-emergent EMS calls by meeting people where they are.



Key takeaways

Successes

- Reduced stress on emergency response systems and improved 9-1-1 response to complex needs
- Collaboration across multi-disciplinary partners and bi-directional referrals
- Collaboration across programs to improve care delivery
- Services tailored to the skills of available workforce

Challenges

- Administrative burden
- High caseloads
- Limited and insecure funding (sustainability)
- Inconsistent standards, training, and measures of success across programs

Suggestions for programs



Invite elected officials to see your work first-hand.



Build up ability to track quantitative data in addition to the qualitative stories.



Collaborate with key community partners such as hospitals, behavioral health teams and programs, Managed Care Organizations, and local referral sources to better coordinate response.



Coordinate with other like programs to standardize data collection and analysis.



Conduct, or partner with, a community needs assessment to understand the unique challenges and needs of the community.



Use a broad spectrum of data, including EMS, to inform program planning and quality improvement.



Plan for program expansions over time to meet increasing referrals.



Consider incorporating telehealth into the broader spectrum of care.

Call to Action

Community partners

- Partner with and make referrals to/from your local program
- See a need? Consider expanding or replicating a program
- Create standards for skills, training, and education across programs
- Advocate to include as a Medicaid reimbursable service

Elected officials

- Learn more and direct connect with programs operating in your district
- Add these services as a Medicaid covered benefit
- Support policies, bills, and laws that create sustainable funding

OCH

- Create opportunities for collaboration
- Elevate regional challenges and opportunities to decision makers
- Partner across ACHs to collaborate and advocate
- Share innovative successes
- Consider these partners in renewal waiver planning

Questions?



We want to partner with YOU.
Sign up for the newsletter at
olympicch.org

Connect with a team member at
OCH@olympicch.org

Connecting Community Members to Care

Collaborative, field-based approaches across the Olympic region

Improving patient experience and outcomes
Preserving emergency services
Reducing costs



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Acknowledgements

Key informant interviews and report reviewers

Alex McCracken, Central Kitsap Fire Rescue
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Executive Summary

Olympic Community of Health (OCH) supports regional efforts to meet individual needs timely, easily, and compassionately. OCH serves as a catalyst for change, seed planter, and bridge builder by elevating community voice, spotlighting local innovation, and advocating for solutions that meet the unique needs of our communities.

Local challenges around high use of costly services for non-emergent needs such as emergency department (ED) visits and 9-1-1 calls as well as gaps in the local healthcare system persist. This report looks at innovative place-based approaches that meet people where they are to improve patient experience and outcomes, preserve emergency services, and reduce costs. Through this report, OCH sought to learn more about and demonstrate the value and impact of local programs, elevate creative ideas, and advocate for sustainable solutions.

The Olympic region is stronger together. There are many opportunities for legislators, policy makers, and community partners to expand, replicate, and sustain these creative solutions to local health issues. OCH intends for this report to serve as a useful tool and resource for partners as well as decision makers.

See page 13 for ways YOU can advance and sustain this life-saving work.

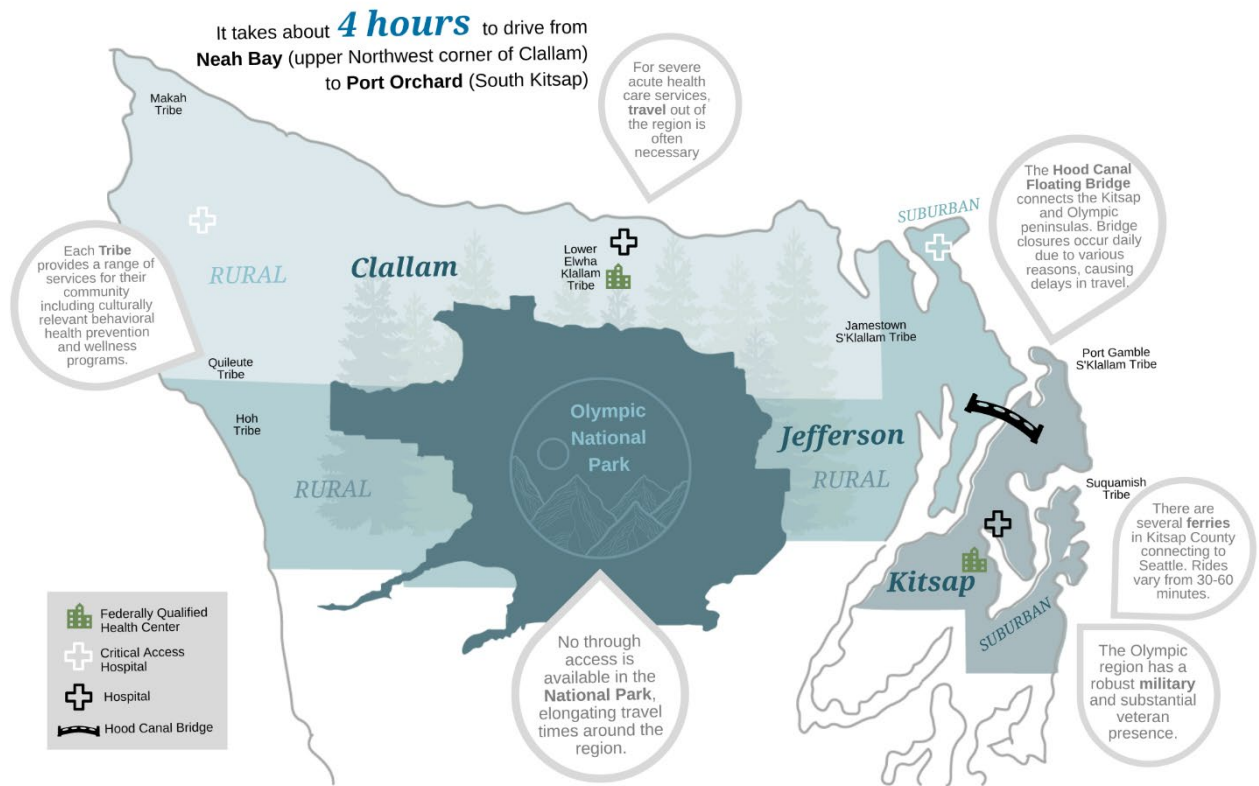
Introduction

Olympic Community of Health

OCH is a regional non-profit organization that brings together partners from many different backgrounds, sectors, communities, and Tribes to collectively achieve the vision of healthy people, thriving communities. OCH fosters an environment to build bridges between and among the community and clinical workforce to create a more person-centered approach to health.

The Olympic Region

The Olympic region spans Clallam, Jefferson, and Kitsap Counties, and includes the seven sovereign nations of the Hoh, Jamestown S’Klallam, Lower Elwha Klallam, Makah, Port Gamble S’Klallam, Quileute, and Suquamish Tribes. The unique communities and diverse geographic landscapes across the region impact the services available and the way individuals and families seek care. Below is a bird’s eye view of the makeup of the Olympic and Kitsap Peninsulas and some key notes to help understand what makes the Olympic region unique.



Definitions

This work goes by many names. The thread that weaves them all together is meeting people where they are to provide timely, compassionate care. The care provided under these programs and services aims to meet the unique needs of the diverse communities in the Olympic region. This work continues to evolve, and programs are providing a range of person-centered services.

See appendix
beginning on page
15 for examples of
local programs.

Common terms and definitions:

Community paramedicine	Co-Response	Mobile-integrated health
<p>A health care model that allows paramedics and emergency medical technicians to operate in expanded roles by assisting with preventative and primary health care services to improve access to care for underserved populations.</p>	<p>A partnership between first responders (including law enforcement, fire/EMS, or EMS agencies) and human services professionals (such as behavioral health professionals, social workers, community health workers, or peer support workers). These teams respond to calls involving people with behavioral health and/or complex medical needs to provide immediate response and follow-up care.</p>	<p>Health care services provided outside of a health care facility by any type of health professional. This term is often used interchangeably with community paramedicine but can be broader to include services provided by nurses, community health workers, and more.</p>

Background

The role of emergency response

Historically, the role of first responders was to provide acute intervention for emergent needs. As one first responder shared, “I’m a fixer. I want to put the fire out, perform CPR, and get you to the hospital – then go out and respond to the next one.” Today, first responders are asked to do much more as they respond to a higher and more frequent number of non-emergent calls for chronic conditions unsolvable in a single visit, such as substance use disorder, mental health, complex medical conditions, homelessness, and others. This shift taxes limited emergency resources and increases costs to the healthcare system. A partner shared, **“I know I’m not fixing anything; I’ll see them again. It’s like the same house catching fire every third day.”** Leveraging the skills and resources of a variety of community partners to help solve healthcare problems is essential to creating change.

A larger movement

First responders are typically seen as a trusted resource in communities, and commonly are the first, and sometimes only, point of contact with individuals. In rural communities, a lack of access to preventative and primary care can create added burden to emergency response services. Across the nation, hundreds of programs intended to lower costs and improve care have been launched. A 2023 study conducted by the National Association of Emergency Medical Technicians identified more than 400 mobile-integrated

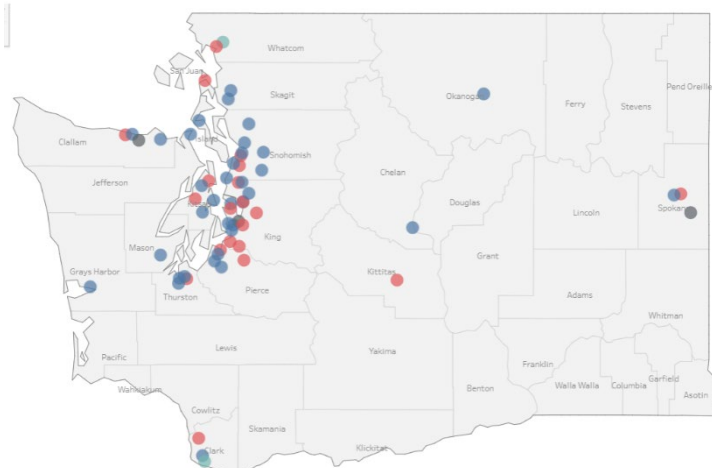
health and/or community paramedicine programs across forty states¹. Co-Responder programs can be found internationally and in recent years information sharing and collaboration across programs has expanded to improve best practices.

“We can’t control what people choose to call 9-1-1 for. We can control how we respond.”

– First responder

Across Washington State many co-responder programs have launched and statewide groups like the [Co-Responder Outreach Alliance \(CROA\)](#) are working to enhance understanding of various programs, spread best practices, and advocate for supportive laws and policies. Figure 1 to the right, created in partnership between CROA and University of Washington in 2022, is a visual landscape analysis of existing co-response programs in Washington State. Programs in blue are affiliated with police, programs in red are affiliated with Fire, and programs in green are affiliated with “other entity.”

Figure 1



Source: Co-Responder Outreach Alliance
Retrieved August 7, 2023 from <https://croawa.com/uw-partnership/>

In the Olympic region

Health transformation provides opportunities for innovative solutions to address gaps in the health care system. Across the Olympic region, innovative



Community paramedicine



Fire CARES (Community Assistance, Referral, and Education Service)



Navigators (partnering with law enforcement)



Community health workers



Peer supports

partnerships continue to grow to address and bridge local barriers and gaps. Through the Medicaid Transformation Project (MTP), OCH provided flexible funding to incentivize innovative health solutions on a local level. Some partners used MTP dollars to pilot various place- and field-based approaches. Partners proactively sought other funding sources outside of MTP to launch, expand, and sustain these approaches. Additionally, statewide funding mechanisms like the state proviso under the Blake Bill have launched opportunities for more programs.

No two programs are the same and, by design, are not a “one-size-fits-all” approach. Approaches to funding,

¹ National Association of Emergency Medical Technicians, (2023) *Mobile Integrated Healthcare and Community Paramedicine (MIH-CP)*. Retrieved August 7, 2023, from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://naemt.org/docs/default-source/community-paramedicine/toolkit/mihcp-presentation_may-2023.pdf?sfvrsn=2f01f593_2

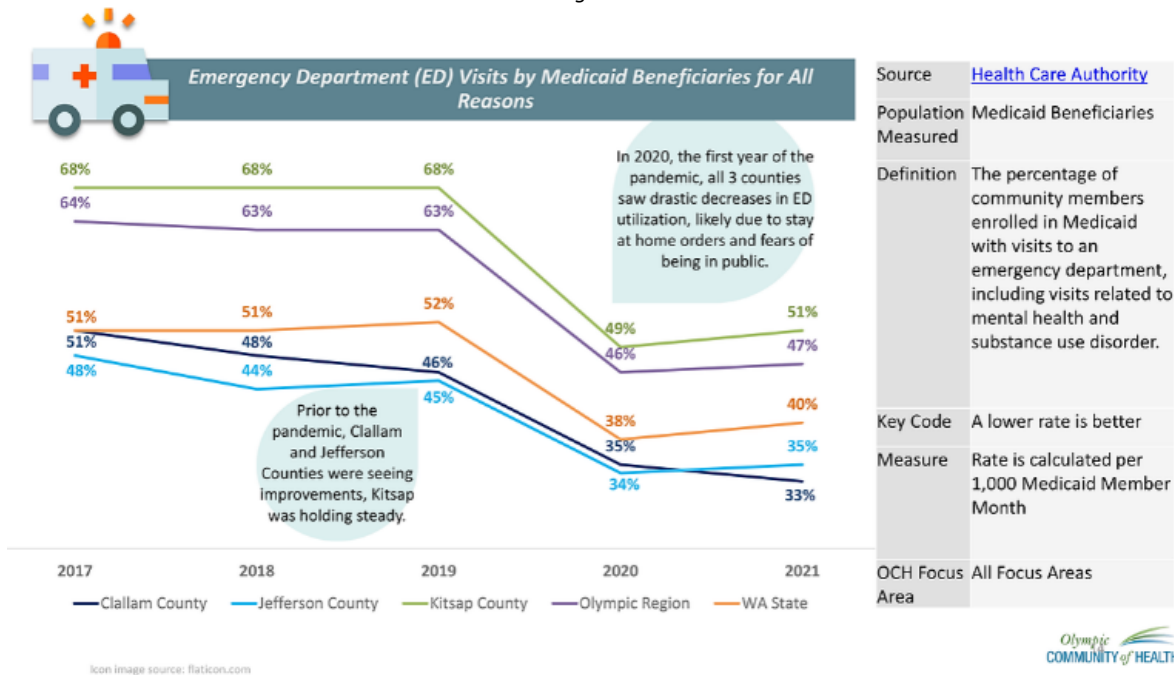
workflows, populations of emphasis, and response differs across programs. Effective programs are developed to meet community needs and do not duplicate or compete with already existing services, rather they fill a gap. These programs have proven to be strong value adds to the community by working to preserve costly and limited emergency resources².

Local needs

The concept of community paramedicine, and other similar programs, began in rural areas. Today, these programs operate in a range of community types. The Olympic region, largely rural, experiences many gaps in the healthcare system and navigating complex care can be especially challenging due to limited services, transportation, and other determinants of health. As retired Port Angeles Fire Department Chief Ken Dubuc shared, **“One, they simply don’t have an alternative. Two, people have alternatives, they just don’t know what they are. Three, there are a lot of folks out there who can’t afford any alternatives, they aren’t insured, they may not have transportation, or the means of accessing services.”**

Across the Olympic region, utilization of emergency departments is high. While the height of COVID-19 led to drastic decreases in emergency department utilization across all three counties, this was likely for the wrong reasons including public fear and stay at home orders. 2021 data show that emergency department utilization started to increase again across all three counties and local hospitals confirm this trend continues today. As Jefferson Healthcare shared, **“visits are exceeding pre-pandemic levels.”** Local hospitals confirm they are consistently at capacity and common non-emergent use of the ED is due to limited resources including primary care, specialty care, behavioral health access, and aging specific resources.

Figure 2



² National Association of Emergency Medical Technicians, (2018) Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey. Retrieved August 7, 2023 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92_2

Limited primary and specialty care

Across all three counties, and particularly in more rural areas, primary care and specialty care is limited. It is common for patients to wait extended periods of time for an appointment. Jefferson Healthcare shared it is not uncommon for patients to seek care in EDs across county lines in hopes of being seen sooner and patients express that it is faster to wait for a few hours in the ED than to wait weeks or months for a scheduled appointment.

East Jefferson Fire Rescue CARES Success Story

The second day the CARES program launched an elderly male was observed in his parked car at the fire station parking lot with a visibly dislocated shoulder. The man indicated that he had fallen a few days ago and was struggling to perform activities of daily living, including bathing, putting his sling back in place, and managing his pain medication. The CARES team connected with the man's primary care provider to refill pain medication and coordinate a referral to the VA for surgery as well as connected to home care. The man received his surgery shortly after the intervention and has since recovered.



See Appendix 4 on page 19 for program spotlight.

Limited behavioral health care

Mental health and substance use disorder services are limited in the Olympic region and workforce shortages further exacerbate barriers to care. Local first responders and hospitals share that individuals are frequently brought to the ED for mental health and/or substance use disorder crises because family members and law enforcement don't know where else to bring them.

Port Angeles Community Paramedicine Success Story

A 37-year-old woman with complex medical conditions including severe mental illness, substance use disorder, and developmental disability was referred to the community paramedicine program by first responders for frequently calling 9-1-1 and visiting the ED for non-emergent behavioral health needs. Prior to engagement with the community paramedicine program, EMS and Fire teams were commonly responding to her one to two times per shift, many times leading to transport to the ED. **Within one year of engaging with the community paramedicine program the patient's 9-1-1 calls decreased by 35%.** Two years after engaging with community paramedics, the patient is successfully engaged in behavioral health treatment and is in recovery for substance use disorder.



See Appendix 6 on page 21 for program spotlight.

Central Kitsap Fire CARES Success Story

Central Kitsap Fire CARES team responded to a 9-1-1 call for a 16-year-old expressing suicidal ideation. The CARES team connected with established mental health treatment providers and supportive family members to coordinate a more effective safety plan. The adolescent was able to stay home in contact with familiar mental health treatment and avoid an unnecessary hospital visit.

Limited resources for aging population

Local hospitals also share they see a high volume of aging patients for needs that could be prevented or addressed at home with appropriate support. In-home caregiving, assisted living, and skilled nursing facilities are all extremely limited in the Olympic region. Patient discharge from the hospital is frequently delayed, up to several weeks, due to lack of home-based services. ED staff frequently encounter families without long-term care plans for aging family members or knowledge of available resources. According to local hospitals, there is a need for increased services for the aging population as well as education for families about resources and end of life care.



Central Kitsap Fire CARES Success Story

Central Kitsap Fire CARES responded to an elderly couple in need of help transferring in and out of bed. The couple had called 9-1-1 for assistance twenty-eight times over a two-week period. The CARES team coordinated with community resources to install a lift and educate the couple on appropriate use. **The couple had zero 9-1-1 calls in the two months following the intervention** and expressed gratitude for the kindness and compassion of the CARES team.

See Appendix 3 on page 18 for program spotlight.

The total cost of care

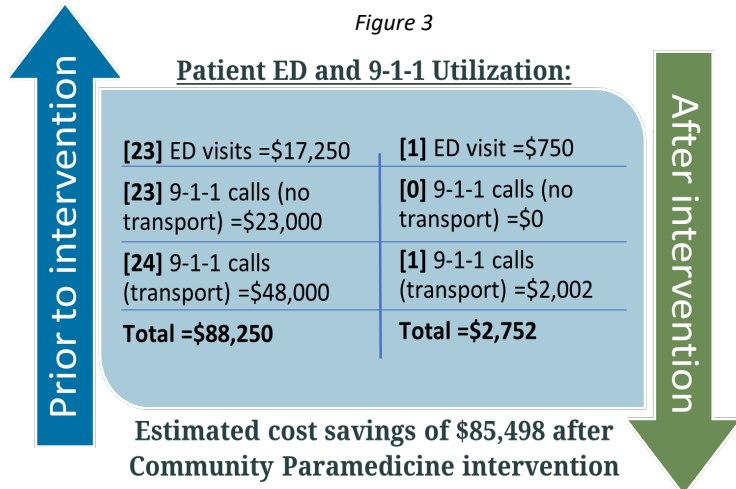
The cost of a visit to the ED is difficult to predict and 9-1-1 response costs vary depending on the services provided. An estimated 13% to 27% of emergency department visits in the United States could be managed in physician offices, clinics, and urgent care centers, saving \$4.4 billion annually³. It is challenging to capture cost savings of these programs as they often prevent calls and visits before they occur.

Working with the Health Care Authority (HCA) and an independent third-party consultant, the Port Angeles Fire Department completed a comprehensive cost of service analysis and determined that the costs to the Port Angeles Fire Department every time a patient is transported to the hospital is \$2,002, which includes first responder time and use of equipment. They further estimated costs to the Port Angeles Fire Department are not much less even when transport does not occur and very conservatively estimate 9-1-1 response without transport costs \$1,000. Considering the above information, **the**

³ Weinick RM, Burns RM, Mehrotra A. How many emergency department visits could be managed at urgent care centers and retail clinics? *Health Aff* 2010;29(9):1630-6. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3412873/>. Accessed June 16, 2016.

Community Paramedicine program conservatively estimated cost savings to the Port Angeles Fire Department in 2021 and 2022 to be over \$850,000⁴.

One example of cost savings can be found from the Port Angeles Fire Department Community Paramedicine Program. A 72-year-old woman with complex medical conditions and SUD, was referred to the program for frequently calling 9-1-1 multiple times a day or week for assistance with nonemergent tasks. Community Paramedics found she was experiencing side effects from conflicting prescriptions and coordinated with her primary care provider to address the issue, including obtaining a new prescription and follow-up to other supportive services such as in-home care. Additionally, the Community Paramedics connected with the patient’s family to increase social supports. **Since intervention by Community Paramedics the patient has had a 95% reduction in emergency department visits and 9-1-1 calls⁴.**



Community-based care coordination

Another area where these programs have demonstrated impact on patient outcomes and costs is through improved community-based care coordination. Place-based programs that meet people in the field have a ripe opportunity to navigate individuals to the best resource at the initial point of contact. This not only improves costs and outcomes, but helps individuals experience better quality of life so they require less intensive care overall.

Poulsbo Fire CARES Success Story

A 62-year old male made six calls to 9-1-1 in the last 12 months related to chronic alcohol use. The CARES Team arranged care and transportation to medical detox. Following discharge from detox, further assistance was needed to secure inpatient treatment. The CARES Team worked with the individual’s private insurance and various treatment facilities to find an affordable treatment solution. The patient successfully completed inpatient treatment and has connected with local outpatient SUD treatment and re-engaged with his primary care doctor and medication management plan. The patient and his wife expressed gratitude for the CARES Team.



See Appendix 7 on page 22 for program spotlight.

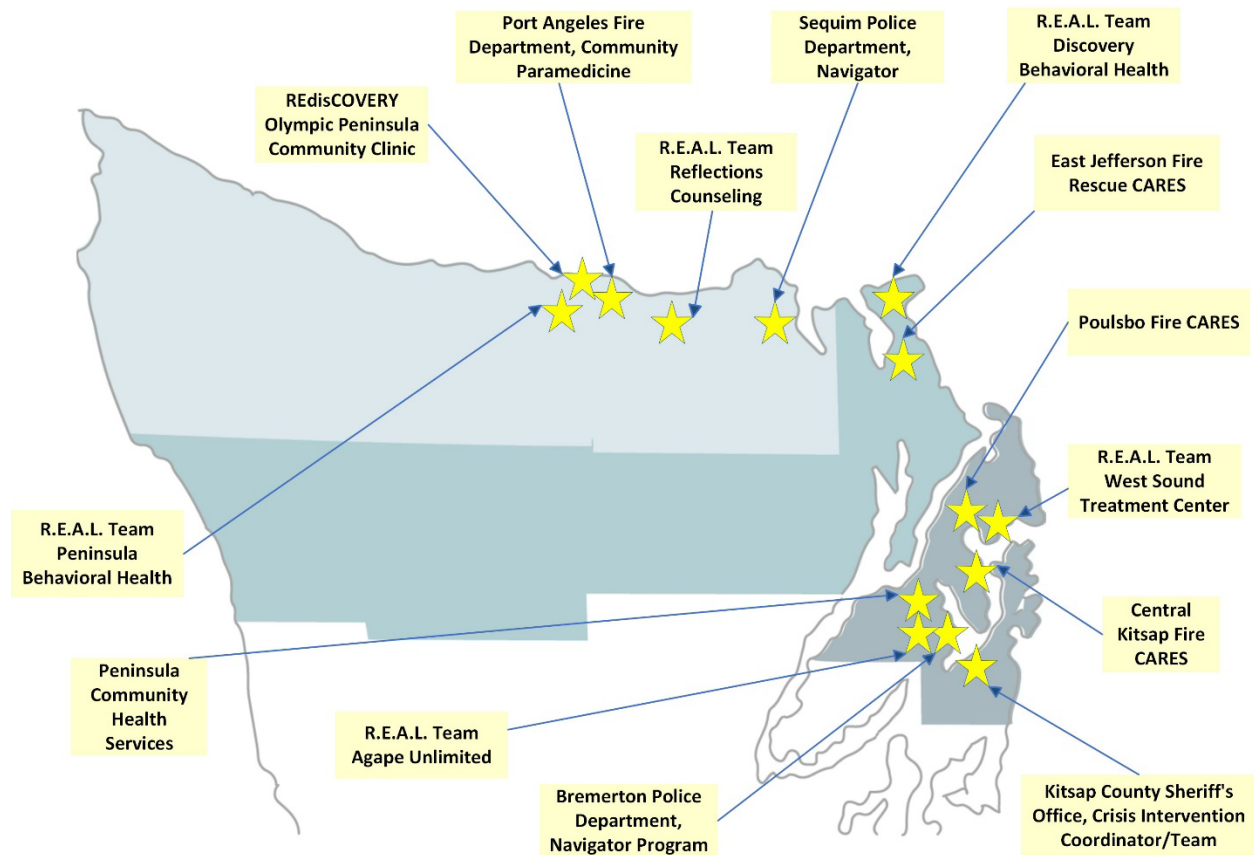
⁴ Port Angeles Fire Department Community Paramedicine Program, (2023) Impact Statement. Supplied by Port Angeles Fire Department May 1, 2023.

Program Deep Dive

Inventory of local programs

OCH explored some of the unique local programs to better understand the various approaches, shared and individual challenges, and to spread successes. There are many field-based services happening across the region and this is not intended to serve as a comprehensive inventory of all programs. The program spotlights take a closer look at different examples of programs to inspire future collaboration and innovation across the Olympic region.

Figure 4



See appendices beginning on page 15 for spotlights on these local programs.

Key takeaways

There are many diverse approaches to this work. No two programs are the same. While each program takes a unique approach to meeting their community needs, commonalities across programs have emerged.

Successes	Challenges
<ul style="list-style-type: none">-Reduced stress on emergency response systems and improved 9-1-1 response to complex needs-Collaboration across multi-disciplinary partners and bi-directional referrals-Collaboration across programs to improve care delivery-Services tailored to the skills of the available workforce	<ul style="list-style-type: none">-Administrative burden-High caseloads-Limited and insecure funding (sustainability)-Inconsistent standards, training, and measures of success across programs

Successes

Collaboration is key. Programs are collaborating within their communities to avoid duplication of services and ensure individual needs are met. Most individuals interacting with these programs experience complex needs that cross spectrums of care. Successful programs include a multi-disciplinary approach that capitalizes on partner's unique expertise and strengths to reduce stress on emergency response systems and improve how individuals with complex needs are being connected to appropriate services.

Robust programs include bi-directional referrals, meaning partners can refer into the program as well as the program referring out to community partners. This approach secures stakeholder buy-in and ensures a no wrong door approach to community members in need receiving care.

More and more programs are collaborating across city, county, and state lines to share lessons learned and best practices. Partners are flexible to adapt to the changing community needs. Innovation means trying things that haven't been done before and these programs are evolving to improve systems and processes.

As the Olympic region, and Washington state, continues to face [health-serving workforce challenges](#), these programs are helping to alleviate some workforce burnout. Many local programs have tailored their scope of services to the skillsets of available staff. For example, some of the Fire CARES models heavily rely on EMT services versus paramedic due to workforce capacity. This balance appreciates responsiveness to community needs and workforce capacity.

Challenges









Many first responder agencies are inexperienced at managing the administrative burdens of seeking funding, reporting to funders, collecting and tracking data, and managing contracts. Administrative constraints detract from the ability to provide direct services. As Central Kitsap Fire CARES shared, **"Firefighters shouldn't be spending 50% of their time chasing grants."** Funding to support these programs in the Olympic region has largely been grant-based and sustainability is unsure from one grant cycle to the next. Most programs are braiding multiple sources of funds.

The need in communities is great and caseloads across programs remain high. Many local programs are limited in how many individuals they can serve to ensure timely and responsive follow-up. Referrals increase as programs continue to demonstrate their value.

Many of these programs are new or recently expanded. Standards for policies, training and measures of success have not been implemented and it can be difficult to compare programs.

Suggestions for programs

As programs work to launch, expand, and continue to refine, partners have identified a set of suggestions for programs to consider:

 <p>Invite elected officials to see your work first-hand.</p>	 <p>Build up ability to track quantitative data in addition to the qualitative stories.</p>
 <p>Collaborate with key community partners such as hospitals, behavioral health teams and programs, Managed Care Organizations, and local referral sources to better coordinate response.</p>	 <p>Coordinate with other like programs to standardize data collection and analysis.</p>
 <p>Conduct, or partner with, a community needs assessment to understand the unique challenges and needs of the community.</p>	 <p>Use a broad spectrum of data, including EMS, to inform program planning and quality improvement.</p>
 <p>Plan for program expansions over time to meet increasing referrals.</p>	 <p>Consider incorporating telehealth into the broader spectrum of care.</p>

Sustainable Solutions

Added value

Innovative approaches to meeting people where they are and directing individuals to the most appropriate and least costly type of care is an important piece of the puzzle to creating a region of healthy people, thriving communities. These programs have significant impacts on improved patient outcomes, experience, costs, and enhancing a community-based care coordination network to direct people to appropriate resources across the full-spectrum of care.

Many gaps in our health care system exist and these programs have proven essential to filling and addressing gaps for individuals to ensure the right care is received at the right time and place. Through collaborative partnership and local innovation, these programs are saving payors thousands of dollars, preserving capacity of essential high needs services, addressing and preventing workforce burnout, and better meeting individual needs with compassionate, timely care.

Sustainability in action

Across the nation and Washington State, first responders, community partners, elected officials, and community members are seeing the value of these programs. The interest of federal, state, and local stakeholders has enabled some programs to secure grants to cover the initial development and operation of their program. Yet most programs launched by local organizations, such as EMS, continue to fund these programs out of their existing budgets.

Minnesota Medicaid Reimbursement²

In 2012, Minnesota became the first state to pass legislation authorizing Medicaid reimbursement of EMS-based community paramedics. The National Association of Emergency Medical Technicians Mobile Integrated Healthcare and Community Paramedicine report highlights one rural community paramedicine program receiving such reimbursement, “the only available reimbursement is for the 15 percent of patients who have Medicaid...in 2014 reimbursements from Medicaid totaled about \$10,000 – not enough to cover costs.” The program mentioned has braided funding from EMS operational budget and local hospitals in addition to receiving reimbursement for Medicaid. They hope to negotiate savings arrangements with commercial insurers in the future.

Tri-County’s tips for success:

1. Start small.

Gradually build acceptance of your program among referral partners.

2. Think local.

“My program wouldn’t work in Ft. Worth, or in New York City, and their program wouldn’t work here. Your program needs to fit local needs.” - Allen Smith, Tri-County Health emergency response manager

Clark Cowlitz Fire and Rescue & Southwest Washington Accountable Community of Health

Southwest Washington Accountable Community of Health (SWACH) partnered with Clark Cowlitz Fire and Rescue to develop and implement community paramedics under the CARES model using MTP funds. SWACH leveraged their community-based care coordination hub and role as a community connector to facilitate meaningful partnership with local hospitals and Area Agencies on Aging who now provide funding to the program as well as funding from the fire district. Community paramedicine has been integrated into the community-based care coordination hub workflow which has allowed the program to track outcomes and is a piece of the larger care coordination puzzle. SWACH’s Director of Community & Clinical Linkages, Eric McNair Scott shared, **“There is no end of need that this program is meeting. It’s not in any way duplicating efforts.”**

Moving forward, Clark Cowlitz Fire and Rescue hopes to expand the CARES program to include additional local fire departments. SWACH plans to support community paramedicine programs through outcome-based payments under their community-based care coordination hub, which will continue under the next MTP renewal waiver.

SWACH's tips for success		
1. Talk to your first responder agencies that are doing the work to understand what the local opportunities are.	2. Facilitate connections to share best practices and move towards more standardization across programs.	3. Integrate programs with other community-based care coordination work to create an effective system for tracking data and closing the loop on outcomes.

Acadian Ambulance partnership with Medicaid Managed Care²

In 2013, Acadian Ambulance, one of the largest private ambulance providers in the nation serving areas of Texas and Louisiana, launched a mobile integrated health/community paramedicine program. After successes seen under a series of pilots, Acadian partnered with Louisiana Healthcare Connections, a Medicaid Managed Care Organization (MCO), on a pediatric asthma intervention. “After six months, we’ve seen better management of asthma for the children in this program. Their emergency room utilization has decreased, and their medication compliance has improved,” shares Louisiana Healthcare Connections. Under this partnership, Acadian medics receive a fee per visit from the MCO. Acadian supplements the additional costs to run the program and plans to approach local hospital systems and other public and private payers with results as proof of concept.

Acadian's tips for success		
1. Use data to identify 'frequent user' groups to start developing targeted interventions.	2. Tap into local 'community health worker' network for outreach, social support, informal counseling, and screenings for social needs.	3. Understand every patient group is unique. The needs for children with asthma will differ from other frequent user groups.

Call to Action

OCH intends for this report to serve as a useful tool and resource for partners as well as decision makers. The Olympic region is stronger together, and programs like these are another step towards fostering a healthier, more equitable 3-county region. Here are ways YOU can advance and sustain this life-saving work:

Community partners:

- Partner with and make referrals to and from your local program. *Find examples of local programs, including contact information, in the program deep dive section of this report (pages 11-20).*
- See a need in your community? Connect with partners and consider expanding or replicating a program to meet the unique needs of your area.
- Collaborate across programs to create standards for skills, training, and education.
- Advocate to the Washington State legislature to include mobile services as a Medicaid reimbursable service. *Call the Toll-Free Hotline and leave a brief message for your senator or representative 1-800-562-6000 (TTY for Hearing Impaired 800.833.6388, interpreter services available).*

Elected officials:

- Learn more and directly connect with the programs operating in your district.
- Add these programs and services as a Medicaid covered benefit.
- Support policies, bills, and laws that create sustainable funding for field-based approaches.

OCH solutions:

OCH serves as a supportive backbone that creates opportunities for collaboration across Clallam, Jefferson, and Kitsap Counties, and seven Tribal Nations. Below are commitments that OCH makes to continue to support meeting individual needs timely, easily, and compassionately in the Olympic region.

- Create opportunities for collaboration
- Elevate regional challenges and opportunities to local elected officials and advocate for sustainable funding paths
- Partner with ACH's across Washington State to create opportunities for collaboration and advocate for sustainable solutions
- Share innovative successes
- Include this work as a component of community-based care coordination hub work under the MTP renewal waiver

Do you have a program you would like to share with the OCH network?

Email OCH@olympicch.org

Resources

- [Co-Responder Outreach Alliance \(WA\)](#)
- [Mobile Integrated Health/Community Paramedicine Program Toolkit](#)
- [National Association of Emergency Medical Technicians](#)
- [OCH Coffee Break Video Series: Community-Clinical Partnerships](#)
- [Rural Health Information Hub - Community Paramedicine](#)
- [Stronger Together: Community-based Care Coordination](#)

Acronyms

- CARES – Community Assistance, Referral, and Education Service
- CROA – Co-Responder Outreach Alliance
- ED – Emergency department
- EMS – Emergency Medical Services
- MCO – Managed Care Organization
- MTP – Medicaid Transformation Project
- OCH – Olympic Community of Health
- SUD – Substance use disorder
- SWACH – Southwest Washington Accountable Community of Health


Appendix

OCH explored some of the unique local programs in order to understand the various approaches, shared and individual challenges, and to spread successes. There are many field-based services happening across the region and this is not intended to serve as a comprehensive inventory of all programs. The program spotlights, beginning on page 15, take a closer look at different examples of programs to inspire future collaboration and innovation across the Olympic region.

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Bremerton Ambulatory Team

Kitsap County, WA

Description	Populations of emphasis
<p>In the Spring of 2020, Peninsula Community Health Services (PCHS) collaborated with the Bremerton Fire Department (BFD) to establish the Bremerton Ambulatory Team (BAT). The BAT consists of a medical provider, medical assistant, and community health worker, as well as support from behavioral health professionals, working to reduce the number of non-emergent EMS calls by meeting people where they are.</p>	<p>BAT serves individuals who experience barriers to accessing care in a traditional setting including, but not limited to:</p> <ul style="list-style-type: none"> • Homelessness and/or isolation • Limited mobility/access to transportation • Mental illness and/or SUD concerns • Cultural and/or linguistic barriers • Health literacy and/or lack of familiarity with existing resources 

How it works

1. BFD sends referral to PCHS when unique, non-emergency support is needed.
2. BAT reaches out to the client to assess individual needs.
3. BAT deploys mobile healthcare services to client residence.
4. BAT helps client address acute needs as well as connects them with existing services.
5. BAT provides some case management, often helping clients navigate insurance, transportation, housing, food, clothing, etc.








Tips for success

- | | |
|--|--|
| <ol style="list-style-type: none"> 1. Complete a needs assessment and outline what specific problems the program will address. | <ol style="list-style-type: none"> 2. Consider multiple ways to deploy field services (mobile clinic, co-locating with a community partner, etc.). |
|--|--|

Funding	Contact information
<ul style="list-style-type: none"> • Services billed to patient insurance • PCHS has income-based sliding-scale fee and financial assistance programs 	<p>PCHS, Assistant Medical Director Anthony Lyon-Loftus, PA-C, MPH, aelyonloftus@pchsweb.org</p> <p>Website www.pchsweb.org/mobile-locations/mobile-bremerton-ambulatory-team-bat-/</p>





Bremerton Police Department Behavioral Health Navigator Program

City of Bremerton, WA

Description		Populations of emphasis
<p>The Bremerton Police Department Behavioral Health Navigators collaborate with Bremerton police officers to co-respond to calls that involve individuals experiencing suicide ideation, mental or behavioral health, child protective services, adult protective services, or complex health issues. The Navigators act as a community liaison to connect their clients to community resources that meet their individual needs. Navigators work closely with partners to avoid duplication of services and ensure individual needs are met timely easily and compassionately. Key partners in this work include:</p> <ul style="list-style-type: none"> • Bremerton Fire Department • Kitsap Mental Health Services • Peninsula Community Health Services • Kitsap Community Resources • St. Michael Medical Center • Local R.E.A.L. Teams 		<p>Anyone in need of resources with emphasis on people experiencing:</p> <ul style="list-style-type: none"> • behavioral health • complex health • and/or child protective services related call 
How it works	Data	
<ol style="list-style-type: none"> 1. Bremerton police officers co-respond with navigators on calls involving individuals experiencing behavioral health, complex health, child protective services, and/or adult protective services. 2. Once the scene is secured, navigator works with client to identify needs. 3. Navigator connects client with appropriate resources. 4. If navigator is not available to co-respond, police officers send internal referral and navigator follows up with individuals. 	 506 referrals to Navigators in 2022  558 individuals contacted by Navigators in 2022  Almost 75% of individuals contacted accepted help <p><i>Source: Bremerton Police Department 2022 Annual Report</i></p>	
Tips for success		
1. Clearly define what you want your program to accomplish and the parameters of the program.	2. Hire the right people for the job.	3. Identify what data is important to demonstrate the value of your program and way to track and report.
Funding	Contact information	
<ul style="list-style-type: none"> • Kitsap County 1/10th • Navigators are included in the police department budget 	<p>Bremerton Police Department Sergeant Tim Garrity, timothy.garrity@ci.bremerton.wa.us</p>	

Central Kitsap Fire Rescue CARES

Central Kitsap Fire District, including Silverdale, Seabeck, and East Bremerton

Description	Populations of emphasis
<p>Central Kitsap Fire CARES (Community Assistance, Referral, and Education Service) is a partnership between Central Kitsap Fire and the City of Poulsbo that connects people with support and services that meet their individual needs. This program addresses the underlying issues contributing to non-emergent 9-1-1 calls and ED visits by providing education and making referrals to local services. Central Kitsap Fire CARES closely collaborates with and refers to community partners such as:</p> <ul style="list-style-type: none"> • Kitsap Mental Health Services • Knights of Columbus • Fishline • Kitsap Division of Aging and Long-Term Care • St. Michael Medical Center • Local substance use disorder providers • Local school districts 	<p>Anyone in fire district</p> 
How it works	Data
<ol style="list-style-type: none"> 1. 9-1-1 call triage identifies cases appropriate to refer to Fire CARES 2. Referrals are received through Julota 3. Phone call or in-person visit by CARES team paramedic and social worker 4. CARES team refers individuals to appropriate community resources 5. Discharge from program after individual needs are met 	<p> 289 referrals received and 186 people assisted January-June 2023</p> <p> 27 individuals connected to care January-June 2023</p> <p> 19 avoided 9-1-1 calls because of on-scene activity/home visit and 20 time fire crews relieved in the field January-July 2023</p> <p><i>Source: City of Poulsbo</i></p>
Tips for success	
<ol style="list-style-type: none"> 1. Utilize a common data system for referral and data collection. 	<ol style="list-style-type: none"> 2. You can mix and match approaches that will work best for your community. You don't have to re-invent the wheel. There are many other programs to learn from.
Funding	Contact information
<p>Braided funding from multiple sources including:</p> <ul style="list-style-type: none"> • Kitsap County 1/10th • WA Association of Cities Grant administered through the City of Poulsbo • Central Kitsap Fire Department operational support including vehicles, office space, employee time/benefits, administrative support 	<p>Central Kitsap Fire Rescue, Chief Medical Officer Alex McCracken, amccracken@ckfr.org</p> <p>CARES team Jesse Graham, Paramedic/Firefighter, jgraham@ckfr.org Kloe Tran, MSW, ktran@ckfr.org</p> <p>Website www.ckfr.org/cares/</p>

East Jefferson Fire Rescue CARES

East Jefferson County

Description	Populations of emphasis
<p>East Jefferson Fire Rescue (EJFR) CARES works to reduce the impact of low acuity/non-emergency incidents to the 9-1-1 system and identify solutions to clients by connecting them to appropriate services. EJFR CARES refers community members to the most appropriate local services including:</p> <ul style="list-style-type: none"> • Believe in Recovery • Jefferson Healthcare • Local R.E.A.L. team • Jefferson County Public Health • Local community-based organizations 	<ul style="list-style-type: none"> • Elders over 65 • Veterans • Unhoused individuals/families • People with unmet behavioral health needs, including substance use disorder 
How it works	Data
<ul style="list-style-type: none"> • Referrals received from 9-1-1 providers and other local partners. • EMS assesses individual needs (emergent or not) and refers appropriate cases to CARES. • Cases prioritized by referral urgency. • CARES responds to referral (in-person and/or phone), completes assessment, and develops tailored care plan to meet individual needs. • Limited flexible funding is available to meet immediate needs such as food, clothing, prescriptions, etc. • CARES team provides follow-up as needed to ensure connections to appropriate resources is made. 	 217 new contacts  85% of elder contacts ended with successful connections to senior services  89% of veteran contacts ended with successful connections to veteran and military services <p><i>Source: EJFR Fire CARES, Jan 17-April 30, 2023</i></p>
Tips for success	
<p>1. Stay flexible and nimble to best meet the community needs. The program will evolve.</p>	<p>2. Mix and match approaches to find what works for your community. Look at other programs for lessons learned and ideas.</p>
Funding	Contact information
<p>Braided funding of multiple sources.</p> <ul style="list-style-type: none"> • Association of WA Cities (Port Townsend holds grant) • Jefferson County 1/10th • Jefferson Behavioral Health Consortium • EJFR supports partial operational costs 	<p>East Jefferson Fire & Rescue, Fire Chief Bret Black, bblack@ejfr.org</p> <p>EJFR CARES Team Video https://youtu.be/mLPGITzRc4I</p> <p>Website www.ejfr.org/uncategorized/fire-cares/</p>

Kitsap County Sheriff's Crisis Intervention Coordinator

Kitsap County, WA

Description	Populations of emphasis
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The Crisis Intervention Coordinator (CIC) works to divert people experiencing mental health needs away from the criminal justice system and toward treatment through referrals to the proper social agencies, whenever available and appropriate. The CIC uses understanding and skills gained through specific training and experience to identify and provide a safe, effective, and compassionate response to law enforcement situations involving people in mental health crisis. The CIC works with law enforcement, community partners, and community members to conduct proactive behavioral health outreach and follow up.

Anyone experiencing mental health crisis.



How it works

1. Patrol officers create log of reports that would benefit from follow-up to meet individual mental health needs and promote public safety.
2. Crisis Intervention Coordinator prioritizes reports based on urgency and capacity.
3. Coordinator follows up with individuals to better understand their needs.
4. Coordinator connects individual with various community resources to best meet their needs.
5. Coordinator assists patrol officers for high priority events in addition to responding to referrals.



Data

In 2022:



204 unique community members served



391 interactions with clients



48 referrals to local R.E.A.L. Teams

Note: 2022 data reflects 1 full-time (4 days/week) CIC.

Source: 2022 1/10th report, Kitsap Public Health District and Kitsap County Sheriff's Office

Tips for success

1. **Choose a focus area** topic in order to maximize efforts.

2. **Create a plan** for the program **and share** with city and county elected officials and boards to obtain support and funding.

3. **Plan for administrative** and reporting **support** to allow responders as much time as possible in the field.

Funding

- Kitsap County 1/10th funds one CIC position

Contact information

Kitsap County Sheriff's Department, Crisis Intervention Coordinator/Patrol Deputy
Casey Jinks, cjinks@kitsap.gov


Port Angeles Fire Department Community Paramedicine Program

Port Angeles, WA

Description		Populations of emphasis
<p>The Community Paramedicine Program’s mission is to improve the overall health of the community and utilize a combination of medical and behavioral health training, multi-agency collaboration, and point-of-care treatment to help solve complicated issues. Key partners include:</p> <ul style="list-style-type: none"> • North Olympic Healthcare Network • Olympic Medical Center • Peninsula Behavioral Health • Jamestown Family Health Clinic • Lower Elwha Tribal Clinic • Port Angeles Police Department • Olympic Peninsula Community Clinic 		<p>Underserved members of the community including people experiencing:</p> <ul style="list-style-type: none"> • high use of 9-1-1 and/or emergency department • behavioral health problems including substance use disorder, • low-income status, • and other social and medical needs
		
How it works	Data	
<ol style="list-style-type: none"> 1. Partner organizations and Tribes refer individuals with high 9-1-1 and/or ED use. 2. Community paramedic contacts the individual. 3. Community paramedic connects the individual with appropriate services based on their needs. 4. The individual is equipped with supportive services. 	<p> 748 unique community members served in 2022</p> <p> 80% decline in ED visits by enrolled patients in 2021</p> <p> 69% reduction in 9-1-1 calls by enrolled patients in 2021</p> <p> \$850,000 cost savings in 2021-2022</p>	
<p><i>Source: Port Angeles Fire Department Community Paramedicine Program</i></p>		
Tips for success		
<ol style="list-style-type: none"> 1. Observe and learn from other programs. 	<ol style="list-style-type: none"> 2. Start small. Remember change is slow. It’s okay to reiterate and refine as you go. 	<ol style="list-style-type: none"> 3. Create a plan to meet administrative requirements like grant writing and reporting. Learn about funding requirements upfront.
Funding	Contact information	
<ul style="list-style-type: none"> • City of Port Angeles covers benefits • Clallam County 1/10th provides funding for 1 FTE • North Olympic Healthcare Network provides funding for 2 FTE 	<p>Port Angeles Fire Department, Fire Chief Derrell Sharp, dsharp@cityofpa.us</p> <p>Community Paramedics Brian Gerdes, bgerdes@cityofpa.us Kristin Fox, kfox@cityofpa.us</p> <p>Website https://www.olympicch.org/post/shifting-from-reactive-to-proactive</p>	

Poulsbo Fire CARES

Poulsbo, WA and broader areas of North Kitsap including service to Suquamish and Port Gamble S’Klallam Tribes

Description	Populations of emphasis
<p>Poulsbo Fire CARES is a collaborative project between the Poulsbo Fire Department and the City of Poulsbo with the goal of serving community members facing behavioral health-related issues and chronic medical conditions. CARES primarily responds to referrals from first responders (fire, EMS, police) but also accepts referrals from some social service partners. Through CARES, individuals are connected to resources that meet their individual needs and assisted with system navigation.</p>	 <ul style="list-style-type: none"> • People with behavioral health needs • People with chronic medical conditions • People using 9-1-1 to address non-emergent conditions • Approximately 60% of calls are for elderly/aging
How it works	Data
<ol style="list-style-type: none"> 1. Referral received. 2. Referrals prioritized based on crisis and time-sensitivity. 3. Team makes follow up calls and/or field visits; works with individuals, caregivers, health and social service providers. 4. Warm handoff to needed resources (ensuring connections are made). 5. Continue case management as needed (limited). 	<p> 299 referrals received and 257 people assisted January-June 2023</p> <p> 88 individuals connected to care January-June 2023</p> <p> 74 avoided 9-1-1 calls because of on-scene activity/home visit and 7 time fire crews relieved in the field January-July 2023</p> <p><i>Source: Poulsbo Fire CARES</i></p>
Tips for success	
<ol style="list-style-type: none"> 1. Hire a program manager, or someone who can hold the reporting, grants, and building partnerships pieces of this work. 	<ol style="list-style-type: none"> 2. Consider community context and available resources. This work is not impactful if we don’t have resources to refer to that meet people’s needs-and close working relationships with partners.
Funding	Contact information
<p>Braided funding through various grants including:</p> <ul style="list-style-type: none"> • Department of Commerce • Salish Behavioral Health Administrative Services Organization • Kitsap County 1/10th • City of Poulsbo and Poulsbo Fire offer in-kind funding for core staffing 	<p>City of Poulsbo, Program Manager Kim Hendrickson, kimberlyh@cityofpoulsbo.com</p> <p>Poulsbo Fire, Captain and CARES Operational Manager Jake Gillanders, jgillanders@poulsbofire.org</p> <p>Website</p> <ul style="list-style-type: none"> • https://cityofpoulsbo.com/poulsbo-fire-cares/ • https://www.olympicch.org/post/poulsbo-fire-cares


REdisCOVERY Program



Port Angeles, WA and surrounding areas

Description	Populations of emphasis
<p>Olympic Peninsula Community Clinic’s (OPCC) REdisCOVERY program strives to reduce overdose, reduce non-emergent EMS, and ensure every member of the community has access to care. The REdisCOVERY team has found success by collaborating with:</p> <ul style="list-style-type: none"> • Clallam County Corrections Facility • Clallam County Health and Human Services • Clallam County Sheriff's Office • Department of Transportation • City of Forks Jail • Forks Police Department • Olympic Personal Growth • Peninsula Behavioral Health • Port Angeles Community Paramedicine Program • Port Angeles Police Department • Reflections Counseling • Sequim Police Department • Washington State Patrol 	<ul style="list-style-type: none"> • Individuals who are un and/or under insured • Individuals experiencing homelessness • Individuals identified needing assistance accessing services  
How it works	Data
<ul style="list-style-type: none"> • Outreach teams visit community spaces to proactively reach vulnerable populations. • Partners send referrals and the team responds within 24 hours. • The team provides care coordination to meet individual needs. 	 946 individuals served  437 individuals received bridge medical and/or behavioral health care <p><i>Source: Olympic Peninsula Community Clinic, Jan-Jun 2023</i></p>
Tips for success	
<p>1. Outreach teams need to feel supported by leadership in order to support the community.</p>	
Funding	Contact information
<p>Braided funding through various contracts and grants including:</p> <ul style="list-style-type: none"> • HCA • WA Association of Sheriffs and Police Chiefs • WA Association of Cities • Clallam County 1/10th • ARPA funding through Clallam County Health and Human Services 	<p>Olympic Peninsula Community Clinic, Director of Programs and Personnel Helen Kenoyer, hkenoyer@opccclinic.org</p> <p>Website https://www.vimoclinic.org/rediscovery_program.php</p>

Salish R.E.A.L. Teams

5 teams covering Clallam, Jefferson, and Kitsap counties

Description	Populations of emphasis
<p>R.E.A.L. (Recovery, Empowerment, Advocacy, and Linkage) Teams are the Salish region’s approach to implementing local Recovery Navigator Programs as required across WA State as a result of the Blake decision. R.E.A.L. is a client driven, harm reduction model to support individuals along their recovery journey, at their individual pace. Each R.E.A.L. Team consists of a project manager to engage community and conduct outreach, a case manager, and two recovery coaches to directly respond to referrals.</p> <p>R.E.A.L. Teams provide 24/7 support and respond within 90 minutes to referrals received.</p>	<p>People presenting with SUD or co-occurring AND legal system/law enforcement nexus AND who have not been successful engaging with treatment in the past.</p> 

How it works	Data
<ol style="list-style-type: none"> 1. Referral to R.E.A.L. Team by law enforcement or community members. 2. R.E.A.L. Team responds according to individual client’s needs with the goal to support people towards recovery at their own trajectory. 3. Warm handoff referrals as needed. 4. Flexible funding is available to meet the client’s needs. 5. Operational Workgroup gathers local boots on the ground to problem solve around individual cases as well as community barriers. 6. Operational Workgroups meet regularly to coordinate care and avoid duplication across involved partners. 7. Policy Coordination Group (PCG) engages higher level leadership who can support system change. 	<p>1,731 individuals served regionally:</p> <ul style="list-style-type: none"> • Clallam: 874 • Jefferson: 157 • Kitsap: 700 <p>88% of regional referrals responded to in 0-15 minutes</p>   <p><i>Source: Salish R.E.A.L. Program data July 2022-May 2023</i></p>

Tips for success



1. **Be mindful of duplicaton.** Create and maintain open communication with community partners.

Funding	Contact information
<p>The Salish Behavioral Health Administrative Services Organization funds 5 programs covering the Olympic region.</p> <ul style="list-style-type: none"> • \$1.2 million/year provided via state proviso • An additional \$600k provided via state general funds to support transition to 24/7 coverage 	<p>Salish Behavioral Health Administrative Services Organization, Deputy Administrator Jolene Kron, jkron@kitsap.gov</p>



Sequim Navigator Program

Sequim, WA

Description	Populations of emphasis	
<p>The Sequim Navigator program is intended to expand needed in-the-field crisis response and services to the Sequim area. Designated Crisis Responders (DCR) work closely with community partners and law enforcement to respond to people with a behavioral health need, assess for appropriate intervention and solutions, and make referrals to needed services. The DCR also educates community members about the crisis system and what services are available to community members experiencing concerns.</p>	<p>Anyone currently in Sequim experiencing mental health and/or substance use disorder</p> 	
How it works	Data	
<ul style="list-style-type: none"> • DCR is available T-Th, 12 hour days • DCR rides along with Sequim Police Department, checks on people of concern, and responds to referrals • Referrals are primarily received from local crisis line, law enforcement, Jamestown Healing Clinic. Any community member may make a referral. • Each referral is assessed for appropriate intervention. Interventions may range from involuntary or voluntary hospitalization to brief crisis counseling and referral to appropriate community partner. • DCRs engage with community to provide education about the program and broader behavioral health crisis system. 	 180 encounters <p><i>Source: Peninsula Behavioral Health, September 2022-June 2023</i></p> <p><i>If you have concerns about someone who may be experiencing a behavioral health crisis, please contact Volunteers of America 24/7 crisis line: 1-888-910-0416</i></p>	
Tips for success		
<p>1. Build strong relationships with community partners. The work is made better by many people working together.</p>	<p>2. Be bold, write up an idea, and get started. Don't be afraid to think outside the box.</p>	<p>3. Make sure you have the right person where and when they are needed to meet the unique needs of your community.</p>
Funding	Contact information	
<ul style="list-style-type: none"> • Funding from Jamestown S'Klallam Tribe through the City of Sequim • Crisis services are reimbursed through the Salish Behavioral Health Administrative Services Organization 	<p>Peninsula Behavioral Health, Crisis Intervention Services Supervisor Monica Vanderheiden, monicav@peninsulabehavioral.org</p> <p>Website https://peninsulabehavioral.org/get-immediate-help/</p>	



MEMO

To: Kitsap Public Health Board

From: Yolanda Fong

Date: April 2, 2024

Re: St. Michael Medical Center

St. Michael Medical Center (SMMC) is part of the Virginia Mason Franciscan Health healthcare system. SMMC serves as the county's only fully functioning hospital and regional hub for Kitsap's healthcare industry. SMMC is a level III Trauma Center with 56-bay Emergency Services department. The hospital has 248 beds, including 144 new critical and acute beds. They are the largest private employer in Kitsap with 2,500 employees.

Chad Melton is the President of SMMC and will be presenting on SMMC services, investments, challenges, and commitments to Kitsap.

Recommended Action

None at this time – for information and discussion only.

Please contact me at yolanda.fong@kitsappublichealth.org with any questions or comments.

Attachments (1)

St. Michael Medical Center

Chad Melton

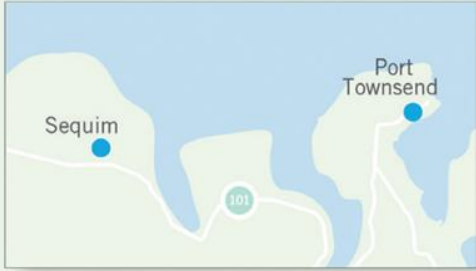
President

St. Michael Medical Center



April 2, 2024

SMMC at a Glance



- H** Hospitals: **10**
- Total Bed Count: **1,776**
- Outpatient Centers: **235**
- Urgent Care Clinics: **13**
- Franciscan Hospice House: **1**
- Bailey-Boushay House: **1**
- Benaroya Research Institute: **1**

Caring for Our Community

We provide convenient access to high-quality, cost-effective health care facilities and providers.

While that includes access to hospital care, we also work hard to provide health care services outside our hospital, keeping residents healthy closer to home.



336-bed Medical Center, new Medical Tower, Level II Trauma Center, Cancer Center, Medical Pavillion



Expanding access to primary care with new **Family Medicine Clinic** in Bremerton; **family medicine + obstetrics residency program**



24/7 **hybrid ED/urgent care centers**



Partnered with Contessa to operate **VMFH Home Recovery Care**, currently at St. Joseph Medical Center, with plans to expand

Tower Expansion Project Underway

- Groundbreaking ceremony on Oct 4, 2023
- 74 additional acute care beds
- **Total capital investment ~\$105M**
- Expansion enables SMMC to support more acute services in Kitsap
- Decompress emergency room boarding



SMMC Operational Improvements



Leapfrog 'A' safety grade for 12 consecutive cycles



Added **100 new RNs** in 2023; **96% nurse residency retention** rate (yr 1) since 2020



CMS 4-star rating; improvement in 4 of 5 categories



Lower staff turnover
15.2% vs 22.1%



Improved patient experience from 18th percentile to 49th in 2023



Improved nursing turnover of 10% in FY24 vs 20.5% in year prior

An Economic Growth Engine

Health care systems are community-building engines. Talented potential employees considering moving to a new area prioritize foundational resources like the quality of schools and availability of medical care. Not only that, but **high-quality health care is something our communities deserve.**

Annually in Kitsap, VMFH and SMMC support:



1,800 births



13,200 surgical procedures performed



\$54.6M in community benefit



14,400 admissions



360,000 outpatient visits



2,500 employees; largest private employer in Kitsap



80,000 ER visits; busiest ED in Wash.



Fastest door-to-balloon times for heart attacks



\$252M annual payroll

Investing in the Kitsap Community

Investing in the Kitsap Community

Community benefit reflects our responsibility to improve the overall health of the community by **providing care for all and making meaningful investments necessary for a healthy population.**

Another way we invest in Kitsap is through our **support of patients enrolled in Medicare and Medicaid.**

- **80% of our patients** are covered by these programs
- Medicare reimburses **only 75%** of the cost of their care; Apple health **reimburses at 48%**
- SMMC nonetheless ensures these patients have **access to all the high-quality care we provide.**

COMMUNITY BENEFIT



\$2.5 Million
Charity Care



\$37.5 Million
Uncompensated Care
(Unreimbursed cost of providing Medicaid services)



\$54.6 Million
Community Benefit
(Charity care + uncompensated care + community programs)

Investing in the Kitsap Community

In keeping with our mission of caring for all in the community, we dedicate significant resources to programs and services that **increase access to health care for the vulnerable and uninsured and improve the health of our community**. VMFH donated a total of **\$1.7M** to community organizations in FY23, including the following:

IN-HOME & RESPITE CARE

\$190,000+

- Benedict House
- Bremerton Medical Respite Center
- KC Help

Investing in the Kitsap Community

MENTAL & BEHAVIORAL HEALTH

\$150,000+

- North Kitsap Fishline Counseling
- Olympic Community of Health
- Pacific Hope and Recovery Center
- Wellfound Behavioral Hospital
- Kitsap Mental Health Services

Investing in the Kitsap Community

HEALTH EQUITY & PRIMARY CARE

\$380,000+

- Project Access Northwest
- Peninsula Community Health Services
- Marvin Williams Recreation Center
- Kitsap Immigrant Assistance Center
- YMCA of Pierce and Kitsap Counties

Building Tomorrow's Healthcare Workforce

Partnership with Olympic College and Kitsap County

- **Virginia Mason Franciscan Health donated \$2.5M to Olympic College** in support of building a new regional health sciences campus at the college's Poulsbo location
- Partnership will **add capacity for more than 600 students annually** to health sciences programs over the next four years



Advancing Health Equity

More in Common Alliance

- CommonSpirit's **10-year, \$100M initiative** to address health inequities
- **Partnership with Morehouse School of Medicine** will address lack of representation among care providers
- Hosted event in Bremerton in Feb.



Challenges.

Challenges Facing Healthcare



Commitment to Kitsap

Commitment to Kitsap

- **CARES program** with local fire departments to see patients in their homes
- **Toy drives** for kids in the hospital
- **Port Orchard Food Bank** disaster relief, VMFH first to respond
- **Equipment donations** to local organizations



Commitment to Kitsap



Thank you.