# Community Health Network of the San Juan Islands

**Draft Project Management Timeline — Network-Wide & By Workgroup**

**Summer 2026**

| Project Area | Goal | Objective | Performance Indicator | By When | Key / Lead Agencies |
|---|---|---|---|---|---|
| **Steering Committee — Network-Wide Work** | | | | | |
| **Network Funding** | Secure sustained funding for Network-wide Project Management | • Finalize and formally document the OIHCD Model C fiscal sponsorship arrangement<br>• Identify and pursue 2–3 funding sources (grants, health district contributions) to sustain the PM role beyond its current term | • Fiscal sponsorship agreement executed<br>• Funding secured or firmly committed to sustain the PM role through at least 2027 | Before September 2026 | • Orcas Island Health Care District (fiscal sponsor)<br>• Steering Committee<br>• All three hospital districts |
| **Governance & Steering Committee Composition** | Formalize the governance framework and confirm Steering Committee membership as the Network matures. | • Adopt the governance framework document<br>• Assess whether additional sectors (e.g., EMS, schools) should be added to the Steering Committee | • Governance framework formally adopted<br>• Any new members recruited and onboarded | Fall 2026 | • Steering Committee (3 hospital districts, 3 resource centers, SJC Health & Community Services) |
| **Monthly Public Reporting** | Keep the community informed with regular, plain-language progress reports. | • Project Manager drafts report per the governance template; workgroup reps review for accuracy before publication | • Reports published on a consistent monthly/bi-monthly cadence<br>• Each report includes both process and concrete wins | Ongoing, monthly | • Project Manager (Trillium)<br>• Steering Committee |
| **Community Convenings** | Sustain broad, cross-sector, cross-island engagement through in-person and hybrid gatherings. | • Hold hybrid community meetings accessible from all three islands<br>• Plan a fall 2026 Network convening to share workgroup progress countywide and gather further input | • Convenings held with representation from all three islands<br>• Community feedback documented and shared with workgroups | Fall 2026 (date TBD) | • Steering Committee<br>• Project Manager |
| **Transportation & Mobile Health Workgroup** | | | | | |
| **Travel to Off-Island Services (Interregional Connectivity)** | Improve reliable transportation to off-island care and coordinated return-home/discharge support. | • Pilot improved discharge-planning coordination with PeaceHealth St. Joseph<br>• Explore a small emergency fund for hotel/taxi costs for patients returning home (likely a fund per island) | • Discharge-planning pilot designed and launched<br>• WSDOT and Port of Orcas grant outcomes known<br>• Decision made on TVP reactivation | Pilot design by fall 2026 | • PeaceHealth St. Joseph<br>• Island Rides<br>• SJC Human Services |

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| | | • Support Island Rides' WSDOT grant (paid Orcas drivers) and Port of Orcas ferry-shuttle grant<br>• Explore reactivating the Transportation Voucher Program (TVP) with anacortes taxi providers (Richard did this, DOA) | | | • Port of Orcas (pending their receiving a WSDOT grant for Orcas-based electronic transit services) |
| **Visiting Health Services (Mobile & Distributed Care)** | Understand current visiting/mobile services and referral pathways across islands, using the county dental program as a model for future expansion. | • Contribute transportation/visiting-service input to the Insurance workgroup's county-wide mapping worksheet<br>• Revisit and define a concrete project once community needs and system readiness are better understood | • Mapping worksheet input complete<br>• Decision made on whether/how to pursue a dedicated visiting-services project | Mapping input by Q3 2026; project decision by Q4 2026 | • Transportation workgroup<br>• Insurance workgroup<br>• Island Hospital, PeaceHealth, Sea Mar |
| **Flight Membership Enrollment & Public Education** | Ensure all residents understand emergency air transport options and can access enrollment support, relieving EMS of this informal burden. | • Publish plain-language public education materials on the three medevac programs, costs, and Medicaid coverage<br>• Establish coordinated enrollment support across islands through resource centers and EMS | • Public education materials published and distributed (e.g., via island fire/EMS websites)<br>• Number of residents assisted with enrollment tracked<br>• Partner commitment secured from EMS and resource centers | Materials published summer 2026 (in progress); enrollment support structure by fall 2026 | • Orcas Fire & EMS<br>• Three air transport companies<br>• Family Resource Centers (all islands)<br>• EMS departments (all islands) |
| **Insurance Access & Health Services Navigation Workgroup** | | | | | |
| **County-Wide Care Landscape Mapping** | Build an evidence base of payer mix, clinic models, services, and referral pathways across all three islands before selecting a project. | • Complete data-gathering worksheet with health systems input (Island Hospital and PeaceHealth completed May)<br>• Incorporate an equity lens for LGBTQ+, uninsured/underinsured, and Medicaid-transition populations | • Completed county-wide mapping dataset<br>• Documented service and coverage gaps by island and population | Complete by summer 2026 (complete) | • PeaceHealth<br>• Island Hospital<br>• SJC Council<br>• Orcas Island Community Foundation<br>• SJC Health Officer |
| **Medicaid Coverage Retention** | Minimize coverage loss by helping at-risk individuals navigate annual documentation updates and work requirement exemptions. | • Map all existing "helper" organizations (health systems, resource centers, Compass Health, etc.) and their current re-enrollment support capacity by __<br>• Identify the top 3–5 recurring causes of preventable coverage loss during re-enrollment<br>• Develop and distribute a shared, cross-agency re-enrollment/exemption-verification toolkit or checklist? | *Still in progress* | | |

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| | | • Track number of individuals assisted through re-enrollment support and resulting coverage retention rate year-over-year? | | | |
| **Preventative Care for the Uninsured** | Identify and deploy consistent, islands-wide access points for vital preventative care, physicals, and specialized screenings (e.g., mammograms, cervical cancer education), with a focus on individuals opted out of the insurance marketplace. | • Inventory current preventative care access points across all islands and identify coverage gaps by island<br>• Establish at least one consistent, recurring access point per island for physicals and key screenings within 12 months?<br>• Set a target number/percentage of uninsured individuals reached with preventative services annually?<br>• Develop outreach materials specifically for individuals who have opted out of the marketplace? | *Still in progress* | | |
| **Marketplace Advocacy** | Partner with state-level advocacy networks and legislative resources to address structural inequalities stemming from the county's single-provider marketplace monopoly. | • Identify and establish contact with relevant state-level advocacy/legislative partners within 6 months<br>• Document specific structural harms caused by the single-provider monopoly to support advocacy efforts?<br>• Draft a shared advocacy position or set of policy recommendations with partner organizations?<br>• Track legislative or regulatory engagement (meetings held, testimony given, proposals submitted) over the year | *Still in progress* | | |
| **Care Coordination Workgroup** | | | | | |
| **Mobile Integrated Health (MIH)** | Connect people with complex or chronic needs to appropriate care before a crisis occurs, reducing ED | • Finalize the Orcas interlocal agreement between OIHCD and Orcas Fire & Rescue | • Orcas interlocal agreement signed<br>• Lopez MIH pilot approved<br>• Cross-island MIH resource-sharing established | Orcas agreement by fall 2026; Lopez pilot decision by | • Orcas Island Health Care District<br>• Orcas Fire & Rescue<br>• Lopez Island Hospital District<br>• Village at Home (San Juan) |

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| | visits, through MIH programs on all three islands. | • Advance the Lopez Island community needs-assessment survey toward pilot approval<br>• Connect to and share learnings between new programs andSJI's existing home-visit model (Village at Home) | | fall/winter 2026 | |
| **Sustainable Funding for CHW Programs** | Move from fragmented, island-by-island CHW grant dependency toward a unified, countywide funding approach. | • Map current funding sources, grant end dates, and anticipated gaps across all three resource centers (completed June '26)<br>• Develop a coordinated countywide funding strategy | • Funding landscape mapping complete<br>• 2–3 viable funding opportunities identified<br>• At least one collaborative grant application submitted | Map complete end of June 2026 (done); opportunities/ ask drafted by August 2026; application submitted by fall 2026 | • Lopez, Orcas & San Juan Family Resource Centers |
| **Countywide CHW Training Structure** | Build an annual, bilingual training structure grounded in what CHWs actually encounter, with room for peer connection across islands. | • Conduct structured capacity interviews with CHWs at each resource center<br>• Develop a coordinated annual training calendar tied to interview findings<br>• Launch the first coordinated training under the new structure | • Interviews complete<br>• Findings shared with CHWs and directors<br>• Training calendar published; first training session held | Interviews by end of June 2026 (done); findings shared July 2026; calendar Aug–Sept 2026; first training fall 2026 | • Family Resource Centers (all three islands)<br>• Community Health Workers |
| **Medicaid/Medicare Reimbursement Readiness** | Position the county for CHW Medicaid/Medicare reimbursement as pathways expand, alongside state-level advocacy. | • Explore a CHW Medicare billing pilot with the San Juan County Public Hospital District (done; currently paused)<br>• Align local CHW training/supervision with WA Health Care Authority (HCA) reimbursement standards (essentially already happening)<br>• Expand OCRC ACH Care Coordination Hub grant (Medicaid dollars from HCA) to Lopez and SJI<br>• Explore point-in-time reimbursement as a medicaid $ capture route | • HCA standards review complete<br>• Advocacy coalition(s) identified and engaged<br>• Billing pilot partnership scoped<br>• All CHWs receiving some funds through ACH grant<br>• Point-in-time Medicaid reimbursement pathways formally explored and documented | HCA review by summer 2026; coalitions identified by fall 2026; work ongoing into 2027 | • San Juan County Public Hospital District<br>• Family Resource Centers<br>• WA State Health Care Authority<br>• NSACH |
| **Behavioral Health Access Workgroup** | | | | | |

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| **Substance use disorder (SUD)** | Close the most significant gap in the behavioral health system by making SUD assessment fast and accessible enough that it no longer serves as the primary barrier to treatment. | • Reduce the average wait time between referral and completed SUD assessment<br>• Identify and document all current SUD assessment pathways available across the islands, including gaps by location<br>• Establish at least one faster, low-barrier assessment option or new/improved relationship with a provider (serving all three islands) | • Average number of days from referral to completed SUD assessment, tracked quarterly<br>• Completion of a countywide SUD assessment pathway map, including identified gaps by island<br>• Number of low-barrier/same-day SUD assessment slots or programs established within 12 months | | |
| **Mental Health Assessment access and speed** | Ensure timely mental health assessment access for all community members, regardless of insurance status, so coverage gaps no longer delay or prevent people from getting care. | • Reduce average time to a completed mental health assessment, particularly for uninsured or underinsured individuals<br>• Identify and document alternate assessment routes for individuals without adequate coverage (e.g., providers who assess regardless of insurance status)<br>• Track number of individuals who experienced a delayed or denied assessment due to coverage gaps | • Average number of days from request to completed mental health assessment, disaggregated by insurance status?<br>• Number of documented assessment options available to uninsured/underinsured individuals<br>• Number of reported cases where assessment was delayed or denied due to insurance status, tracked quarterly | | |
| **Medication management** | Help people stay consistently and safely on needed medications — including MAT — both in ongoing community life and during high-risk transition periods, to reduce relapse, disengagement, and preventable crises. | • Increase the number of individuals connected to MAT within a defined target window of identified need<br>• Establish consistent, coordinated support for medication management during care transitions (e.g., re-entry from jail or psychiatric hospitalization)<br>• Reduce reported instances of medication lapses or mismanagement during the first 30 days post-transition | *Still in progress* | | |