Phase I Certification

May 12, 2017

Purpose of this document

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

ACH Certification Phase I: Submission Contact	
ACH	Olympic Community of Health (OCH)
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Table of Contents

Theory of Action and Alignment Strategy

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

The OCH collects data on local community health needs, assets, and inventories. The OCH uses these inputs to agree on regional health priorities and a strategic regional health improvement plan. The priorities and plan align with the inputs, and will continue to align as more data are compiled over the course of the Medicaid Demonstration Transformation Project (MDTP). The Delivery System Reform Incentive Payment (DSRIP) under MDTP is an important lever to help move this plan forward for our Medicaid population. Other resources are identified to provide a population-based approach and to leverage the DSRIP funds.

Milestone	Purpose	Documentation
Regional health priorities	To align needs assessment with priorities	Attachment A
Process to arrive at health priorities	To describe process used to arrive at health priorities	Attachment B
Community asset map of local health improvement initiatives.	To understand what health initiatives are currently underway to address health priorities and crosswalk these with MDTP investment opportunities and goals	Attachment C
List of community coalitions and partner assets	To understand the commitment of community partners and how this aligns with the priorities and MDTP goals	Attachment D
List of local health assessments and their anticipated date of completion	To understand and track old and upcoming assessments to continuously inform our priorities and plan	Attachment E
Regional health needs assessment to establish health priorities	High level summary of assessments and plans reviewed to-date	Attachment F
Strategic health improvement plan to address health priorities	Agree on a five-year plan that aligns priorities and leverages MDTP investment	Attachment G

Addressing health disparities is regional health priority (Attachment A). To do this, we drill down to identify demographic and geographic subcategories that experience poorer health outcomes. We have a contract in place with Public Health Seattle King County to help us visualize “hot spots”, or areas that experience poorer health outcomes, and to stratify our RHNI data down to age-, race-, gender-specific strata. We have also hired a Tribal Liaison to help the OCH to better understand partnering with tribes given the historical misuse of tribal data and hence, sensitive nature.

We are currently underway with our process to select from the optional projects within Initiative 1. In our process, we ask partner organizations to specify their level of commitment, including in-kind contribution. This includes their willingness to provide: a) provide data, b) manage data, c) house intervention(s), c) provide staff, d) provide equipment, e) serve on a committee, f) provide clinical

champion(s), and g) other. We are also asking for budget information, which will provide data on the amount of the in-king contribution.

Theory of Action and Alignment Strategy Attachments	
Description	**Reference Code**
Regional Health Priorities	Attachment A
Regional Health Needs Assessment Work Plan	Attachment B
Health Initiatives Inventory	Attachment C
Inventory of Coalitions	Attachment D
Inventory of Assessments and Planning Documents	Attachment E
Regional Health Needs Assessment	Attachment F
Strategic Health Improvement Plan	Attachment G

Governance and Organizational Structure

ACH Structure

The OCH Board of Directors (Board) consists of 22 directors and is the decision-making entity for the organization. The Board is supported by an Executive Committee (Attachment H), Finance Committee (Attachment I), and Regional Health Assessment and Planning Committee (RHAP) (Attachment J). Each charter documents the purpose, role, responsibility, and authority of each committee. Charters are approved by the Committee and the Board. A visual chart of the OCH governance structure is included (Attachment K).

Board Composition, in alignment with STC 23 [representing (# of directors)]

- primary care (2)
- behavioral health (2)
- health plans [Medicaid Managed Care Organizations (MCOs) caucus within the sector and have a rotating director on the Board (Attachment L)] (2)
- hospital or health system (3)
- public health (2)
- tribes (7)
- housing (1)
- aging social services and supports (1)
- social services (1)
- oral health access (1)

The Board elected to form a nonprofit in August of 2016. In September, the Board approved a six-month transition plan (Attachment M) and employed a dashboard to track progress (Attachment N). The OCH incorporated in December of 2016 (Attachment O), began operations in February 2017 as its own legal entity, and is submitting for 501c3 legal status; expected receipt of IRS Determination Letter is November 2017.

Decision-making

Our decision-making process is governed by a set of bylaws (Attachment P) and the Board has ultimate decision-making authority.

- Voting: Each director has a vote. The act of a majority of directors present at a meeting is the act of the Board. All Board actions require a quorum. Directors can dial-in and vote by phone. *
- Special meetings: Special meetings of the Board may be called at any time by the President or any five directors. *
- Authority: The Board may delegate authority to a committee on a case-by-case basis. *
- Term Limits: After the 1st year of adoption of the bylaws, directors serve an initial one-year term. Following this term, 30% of the directors will serve an additional one-year term and the remaining directors shall serve a two-year term, as determined by lottery. Thereafter, each director's term of office is two years. At the end of three consecutive terms, each sector has the option to nominate the same candidate or to nominate a new candidate to represent the sector on the Board. Term limits do not apply to Tribes.
  Nomination Process: Directors are nominated by each Sector. The nominations are referred directly to the Board for approval. This process is different for Tribes: Tribes may appoint alternate representatives as desired on the Board. Tribal representation on the Board is voluntary.

Composition: Each director shall either represent a Tribe or a designated Sector established by the Board. No Sector shall have more than one director on the Board. A sector may designate an alternate if desired. The Board may add or modify Sectors that should be represented by a vote of the Board. Tribes may alternate directors on the Board.

** These elements of our bylaws allow for flexibility in the decision-making process.*

The Board began as an Interim Leadership Council (September 2015), transitioned into a Leadership Council (February 2016), and then became a Board of Directors (May 2016) (Attachment Q). This process was informed by a governance subcommittee (Attachment R).

If a Board seat is vacant, either because a term limit is reached, a member retires or a member no longer can represent his/her sector, the Board follows a *Policy for New Members* (Attachment S). All directors are required to sign a *Board Member Commitments and Operating Procedures* form (Attachment T), which outlines expectations around:

- Representation of sector or Tribe
- Communication within sector or Tribe
- Confidentiality
- Participation
- Conduct

All Board materials are circulated and posted online at least five business days before the Board meeting. All Board materials are open to the public and we offer an open Go-to-Meeting login if travel poses a hardship.

The Board may choose not to adopt a committee's recommendation; a possible outcome that staff explains at the outset. All Board meetings are open to the public and minutes are posted online; therefore, there is transparency of the Board's deliberation process and ultimate decision. To date the Board has relied heavily and gratefully on the work of its chartered committees.

The RHAP (Regional Health Assessment and Planning) Committee was formed (Attachment U) in acknowledgement that assessment and planning are core accountability functions of the OCH. The RHAP Committee membership includes all sectors and Tribes. (Attachment J)

There are financial limitations placed on the executive director, outlined the bylaws (Attachment P) and the *Fiscal Policies and Procedures Manual* (Attachment V). Briefly, they stipulate that any non-budgeted expenditure in excess of $5,000.00 shall require approval by the Executive Committee. Any material change will be brought to the Board for consideration. A definition of "material" is provided in the bylaws.

Additional attachments that support OCH Governance and Organizational Structure:

- A decision-making flow chart (Attachment X)
- A roster of the Board of Directors (Attachment Y)
- Brief bios of the candidates for the five officer positions on the executive committee (Attachment Z)
- A resume for the executive director (Attachment AA)

- A resume for our data and analytic lead (Attachment AB)
- An organizational chart (Attachment AC) that outlines current and anticipated staff roles (Attachment AD)
- A *Conflict of Interest* policy (Attachment AE)

Executive Director

Name	Elya Moore, MS, PhD (Attachment AA)
Phone Number	(360) 633-9241
E-mail	elya@olympicCH.org
Years/Months in Position	Started April 14, 2016, 14 months in current position, executed a two-year contract on January 31, 2017

Data Capacity, Sharing Agreement and Point Person

Our lead, Siri Kushner, has an MPH in epidemiology and is a trusted data leader across all three counties. She has aided hospitals, clinics, and local health jurisdictions in all three counties on community health assessments and other evaluation projects. We also have two PhD's on staff: the executive director is a trained quantitative epidemiologist and the director of special projects is a qualitative research scientist in psychology. The executive director has served as one of three ACH liaisons to the Analytics, Interoperability, and Measurement (AIM) team at the HCA for the past two years.

Our team provides data and analytic technical assistance, qualitative and quantitative, to project application teams currently working on proposals for optional projects. We also led a six-month assessment of the opioid epidemic in the three counties. Moving forward, we will continue to provide data and evaluation supports to community partners to prepare the project applications and monitor project performance. We will build and support infrastructure development to facilitate dissemination of information, data, and reports to partners and assistance to interpret this information. We will complete the regional health needs inventory and are planning to continually update the RHNI as new data are available. For this, we have executed a contract with Public Health Seattle King County.

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

Data Point Person	
Name	Siri Kushner, MPH (Attachment AB)
Phone Number	(360) 633-9239
E-mail	Siri.kushner@kitsappublichealth.org

Governance and Organizational Structure Attachments	
Description	Reference Code
Executive Committee Charter*	Attachment H
Finance Committee Charter*	Attachment I
Regional Health and Assessment Committee Charter*	Attachment J
Visual of the governance structure*	Attachment K
MCO Sector Representation*	Attachment L
Transition S.B.A.R.	Attachment M
Transition Workplan	Attachment N
Articles of Incorporation*	Attachment O
Bylaws*	Attachment P
Timeline	Attachment Q
Governance Formation S.B.A.R.	Attachment R
Policy to Fill Vacant Seats*	Attachment S
Board Member Commitments and Operating Procedures*	Attachment T
Regional Health Assessment and Planning Committee Formation	Attachment U
Fiscal Policies and Procedures Manual	Attachment V
Decision-Making Flow Chart*	Attachment X
Roster of the Decision-Making Body*	Attachment Y
Brief bios for the Executive Committee Members*	Attachment Z
Resume of the Executive Director*	Attachment AA
Resume of the Data and Analytics Lead	Attachment AB
Future Organizational Chart*	Attachment AC
Brief Description of Anticipated Staff Roles*	Attachment AD
Conflict of Interest Policy*	Attachment AE

** Required Attachment*

*** Recommended Attachment*

Tribal Engagement and Collaboration

Participation and Representation

Engagement with the Tribes is a process and long term commitment of the OCH. We are continually learning how to add value to and learn from their current systems of care. There are seven tribes in the OCH region (see list below). Each tribe is a unique and sovereign nation with different governmental structures and processes. No tribe can speak for another tribe unless authorized to do so by the elected leadership. Therefore, each tribe has a voting seat on the Board of Directors. The OCH bylaws (Attachment P) address tribal representation on the Board, briefly summarized below:

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

The tribes are active partners of the OCH and six of the seven tribes are regularly represented at Board meetings. We are currently working to engage the seventh tribe, Hoh. To date, one of the seven tribal councils has approved a resolution to designate a member and delegate on the Board (Attachment AF). Tribes that have confirmed with staff that they intend to put forward a similar resolution to their councils include: Suquamish, Port Gamble S'Klallam, Makah, Quileute, and Jamestown S'Klallam.

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

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

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

- The Chairman of the Suquamish Tribe serves on the Board and Executive Committee as the Secretary.
- Six of the seven tribes in the region regularly attend the Board meetings.
- Tribes participate on the RHAP Committee.
- Tribal Board members have attended the statewide ACH Convenings and participate on Healthier Washington committees.

- OCH staff are invited to tribal facilities to learn about how tribes provide health care.

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

Policy Adoption

The OCH has strengthened the *Model ACH Tribal Collaboration and Communication Policy* provided by the HCA. The *OCH Tribal Collaboration and Communication Policy* (Attachment AG) describes the roles and obligations of the OCH and the tribes. This policy was developed in collaboration with the American Indian Health Commission of Washington State's executive director and legal consultant; we also sought feedback from the Healthier Washington Tribal Liaison. This policy was presented to the Board April 10th and we aim to have this policy approved by the seven tribes and approved by the Board by September 2017. Importantly, we took great care to ensure that this policy would not hinder our policy that each Tribe is offered a seat on the Board of the Directors.

Board Training

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

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

Ongoing training will be scheduled on a case-by-case basis based on input from directors and the Tribal Liaison. We incorporate training throughout meetings. We do this by asking the Tribal Liaison to educate us or speak up if she feels there is pertinent information for us to know. We also encourage tribal representatives around the table to help us understand issues as they pertain to tribes. Frequently, tribal representatives offer their input unprompted, a reflection of the trust we are building around our table.

Tribal Engagement and Collaboration Attachments	
Description	Reference Code
Appointment of the Director for the Lower Elwha Klallam Tribe to the Olympic Community of Health Board of Directors**	Attachment AF
Tribal Collaboration and Communication Policy with the Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Port Gamble S'Klallam, Quileute and Suquamish Tribes*	Attachment AG

** Required Attachment*

*** Recommended Attachment*

Community and Stakeholder Engagement

Meaningful Community Engagement

The OCH hosts a website and multiple social media accounts (Attachment AH). The website translates into many different languages and offers an easy-to-use search tool within Google for search engine optimization. All OCH Board of Directors are listed on the website, with a link to their organization and email address. The purpose of this is to allow members of the community to identify who is representing their sector or community, and communicate directly with that member. Other website functions:

- Allows people to contact the OCH directly
- Hosts a blog which serves as our electronic newsletter
- Archives previous newsletters, meeting materials, and other materials
- Individuals can easily sign up to receive the electronic newsletter
- Hosts an interactive calendar that allows individuals to view when and where various meetings are held
- Allows people to RSVP for meetings and upload meetings into google or outlook
- Links to social media and surveys

The RHAP Committee developed tools to facilitate a transparent, open community process to select optional projects under the MDT Project. Under the guidance of the RHAP Committee, staff developed and opened a survey to solicit community input on MDP optional projects in January 2017. This survey will remain open until June 2017 to allow adequate time for community input. We have received 76 responses to date: https://www.surveymonkey.com/r/PBVB89Y.

The RHAP Committee also developed tools and a six-month process to gather community input on project ideas. These were in the form of a Request for Letter of Intent and Request for Applications.

TIMELINE for COMMUNITY INPUT on PROJECTS

March 20

Request for Letter of Intent (Attachment AI) open to the public

March 30

Informational Webinar (optional)

April 12

Letters of Intent due 12; all submissions posted online

April 19

Successful Letter of Intent applicants invited to submit full application; technical assistance available [Request for Application (Attachment AJ) with the following attachments: Logic Model (Attachment AK); Project Implementation Timelines (Attachment AL); Partner Commitment Form (Attachment AM); Project Budget (Attachment AN)]

April 24

Mandatory information webinar, 11:00 am to 1:00 pm; at least one person from the Project Application team must participate

May 26

Applications due; all submissions posted online for public comment

June 9

Public comment closes

June 12

Board invites successful applicants to present project idea

July 10

Board hears presentations and selects projects to move forward

July –September

OCH, with technical assistance, will assist project teams in developing full Project Plans

September 12

Board approves Project Plans to the Health Care Authority for Medicaid Demonstration Transformation Projects in our three-county region. Allow one month extension for troubleshooting or gathering additional data as needed.

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

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

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

We continue to work towards authentic community engagement. We are exploring new, innovative ways to allow the Medicaid consumer voice to inform our process. One idea is to leverage the consumer representatives on the board of our federally qualified health care centers.

Partnering Provider Engagement

Board members are expected to actively and regularly communicate within their sector, as agreed in the *Board Member Commitment and Operating Procedures* (Attachment T), which all Board members sign. Starting in August of 2016, the executive director began convening leaders from all four hospitals in our region to identify areas for alignment. The executive director also meets regularly with leadership from provider organizations, both clinical and non-clinical, not currently represented on the Board. The OCH staff have toured nearly all of the tribal health clinics and wellness centers. Please refer to the Clinical Capacity Engagement section below for more details on our plan for enhanced clinical engagement.

The OCH received 35 Letters of Intent from community partners. These were reviewed by the RHAP Committee, and 12 Project Application Teams were formed. Each team, has multiple partner organizations from all three counties and often from tribes. The people and organizations participating on the Project Application teams go well beyond Board members. For example, <u>all</u> hospitals, local health jurisdictions, area agencies on aging, federally qualified health centers, and community action agencies send representatives to the Project Application Team meetings. This

broad partner participation is a reflection on our engagement strategy: **it is working**. Board members take their role seriously and communicate within their sector. RHAP Committee members take their role seriously and get information out to their communities of practice. Finally, OCH staff maintain a growing database of partner contacts.

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

Transparency and Communications

All Board meetings are open to the public. Dates, times, and locations are posted online and recorded. All materials for all meetings are posted online. The OCH has a membership with Go-To-Meeting to allow for 100 participants to participate remotely at our meetings.

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

Community and Stakeholder Engagement Attachments	
Description	Reference Code
Document with links to webpages where the public can access meeting schedules and other engagement opportunities, meeting materials, and contact information*	Attachment AH
Request for Letters of Intent	Attachment AI
Request for Applications (RFA)	Attachment AJ
Logic Model (Attachment for RFA)	Attachment AK
Implementation Timelines (Attachment for RFA)	Attachment AL
Partner Commitment Form (Attachment for RFA)	Attachment AM
Project Budget (Attachment for RFA)	Attachment AN

** Required Attachment*

*** Recommended Attachment*

Budget and Funds Flow

Project Design Funds

In April, the OCH Board approved a series of actions to support Project Design Fund use and planning, (Attachment AO), to be reassessed September 2017 when we know details of our project portfolio and have time to review the budget templates from Manatt. In the interim, the Board approved a two-hundred-thousand-dollar (54%) budget increase for 2017 based on anticipated receipt of Phase I Design Funds. This will allow the OCH to:

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

A high-level summary table is below; a more detailed budget is attached (Attachment AP).

Summary of Budget Approved Increase in Budget

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

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

- Under advisement of the Finance Committee, draft 2018-2021 OCH Budget. Using the budget templates provided by Manatt on May 9th, create a Phase I Certification Design Funds Budget. Create a Phase II Certification Design Funds Budget using any additional templates provided by Manatt. All budgets should wrap up into a single organizational budget to be approved by the Board, who has ultimate fiduciary responsibility over the entirety of the organization.
- Bring the 2018-2021 Budget to Board in August/September, inclusive of budgets for Phase I and Phase II Design Funds, for review and discussion
- Approve 2018-2021 Budget at the annual meeting in November.
- After selecting projects:
    - Under advisement of the Executive Committee, and with ongoing input from the provider community and Manatt, draft a Design Year 1 Allocation Plan. Bring a draft to the Board as soon as possible, no later than October. Target approval at the annual meeting November 2017 contingent on project plan score and total earnable incentives.
- Develop an investment policy

Fiscal Integrity

The Board adopted a *Fiscal Policies and Procedures Manual* (Attachment V), as recommended by the finance committee. Briefly, the purpose of the manual is to establish guidelines for the Board and OCH staff about standards and procedures to be applied when developing financial goals and objectives, making financial decisions and reporting the financial status of OCH. In addition, the policy

providers a guideline for effective management of OCH funds, and delineates roles and responsibilities between staff, finance committee, and Board. The policy describes procedures for cash management, cash operations, independent audit, payroll, and reconciliation, among others.

The OCH has a Finance Committee (Attachment I) and treasurer, Hilary Whittington (Attachment AQ), whose role is to:

- Serve as the chair of the finance committee
- Serve on the executive committee
- Manage, with the finance committee, the Board's review of and action related to the Board's financial responsibilities
- Work with the executive director and relevant administrative staff to ensure that appropriate financial reports are made available to the Board on a timely basis
- Present the annual budget to the Board for approval
- Review the annual audit and answer Board members' questions about the audit
- Other duties outlined in the *Fiscal Policies and Procedures Manual* (Attachment V).

The OCH receives accounting, bookkeeping, and payroll services from Gooding, O'Hara, & Mackey located in Port Townsend, Washington. The accountant meets monthly with the executive director and at least quarterly with the executive director and the treasurer. The accountant also attends all Finance Committee meetings and is invited to attend Board meetings once a quarter to present quarterly financials. On May 5th the accountant agreed to provide CFO-level services as-needed for the OCH.

On April 10, the Board authorized the following activities under advisement of the finance committee:

- begin a draft **2018-2021 OCH Budget** in June. Bring to Board in August/September, for approval at the annual meeting in November.
- bring **investment policy** to the Finance Committee for a recommendation to Board.
- authorize the ED to **rent CFO-level services** ($100/hour with nonprofit discount) from the accounting firm above, not to exceed $5,000.
- the ED solicits bids from ≥ three firms to perform an **independent audit** in early 2018.
- Solicit **audit firms** identified by the Finance Committee for proposals:
    - DZA, Spokane
    - Aiken and Sanders
    - Clark Nuber
    - Cox Gracia
- seek **in-kind donation of financial services** from Board Member organizations.
- **monitor internal financial capacity needs** and make recommendations to the Board as needs evolve.

There is a financial purchase limitation of $5,000 placed on the executive director for non-budgeted expenditures outlined in the bylaws (Attachment P) and *Fiscal Policies and Procedures Manual* (Attachment V). The Board authorizes all non-budgeted expenditures greater than $5,000 and all contracts greater than $50,000, except on a case-by-case basis where they might authorize the Executive Committee or Finance Committee with this authority. Three officers are check signers on record with the bank: President, Vice President, and Treasurer.

The OCH uses Harvest Google, an online timekeeping service that allows us to track separate charts of accounts. Data from Harvest Google is exported each month and sent to the bookkeeper to be integrated into the Profit & Loss Statement by Category. These are produced quarterly for review by the Finance Committee and monthly for the executive director and treasurer.

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

1. **Data and Analytic Capacity** – [Increase of $19,233]
    a. Continue current contract with **Kitsap Public Health District** (KPHD) for $45,872, covering 2017. Authorize Executive Director (ED) to increase up to 25% to $57,340 if additional assistance from KPHD is required.
    b. Explore contract with **Seattle King County Public Health** for additional support to assist KPHD with Regional Health Needs Inventory and data visualization tool, estimating $7,765, covering May – September 2017
    c. Explore opportunities to **collaborate with ACHs** for evaluation of same programs

2. **Financial Capacity -** [Increase of $10,007]
    a. Continue current contract with **accounting firm**. Current budget allows for $9,900 for bookkeeping, $3,129 for payroll services, and up to $7,000 for accounting services. Authorize the Executive Director to increase these, as needed, up to 25% to $25,036 in total.
    b. Under advisement of the finance committee…
        i. authorize the ED to **rent CFO-level services** ($100/hour with nonprofit discount) from the accounting firm above, not to exceed $5,000.
        ii. the ED solicits bids from ≥ three firms to perform an **independent audit** in early 2018.
        iii. seek **in-kind donation of financial services** from Board Member organizations.
        iv. **monitor internal financial capacity needs** and make recommendations to the Board as needs evolve.
    c. Explore **sharing financial services** with other ACHs.

3. **Staffing Capacity** - [Increase of $88,099]
    a. Authorize the ED to **hire a full time Administrative Assistant** as soon as possible. The current budget only authorizes up to 0.5 FTE for 8 months.
    b. **Increase the FTE for the Director of Special Projects** from 0.6 FTE to 1.0 FTE. Broaden this job description to include community engagement, tribal engagement and assistance with project plan development.

4. **Project Plans** - [Increase of $54,698]
    a. **Project Selection**: Authorize up to $11,798 in a professional service contract to assist application teams to develop stellar applications in April and May.
    b. **Project Plan Development**: Authorize up to $42,900 in one or more professional service contracts to assist in the development of project plans between May and September.

5. **Vendors and Contracts** - [Increase of $25,300]
    a. **Legal Consult**: Authorize the ED to increase the approved budgeted amount by up to 50% from $5,000 to $7,500, as needed.
    b. **HR Consult**: Contract with an HR consultant to rapidly set up a performance evaluation system, assist with job description development, internal HR policies and procedures, and help set organizational culture. We have identified someone willing to do this pro-bono or at a greatly reduced rate. Authorize the ED up to expend up to $4,000 for this service.
    c. **Space**: Authorize the ED to lease space and IT support from Jefferson Health Care to support 4 employees. Current contract supports $10,000/year. The amended contract will likely be $18,800/year. Allow flexibility in forming a new arrangement if needed.
    d. **Other Consultants**: Board authorizes the Executive Committee to advise the ED on ad hoc consultant/TA opportunities that may benefit the organization, up to $10,000, as needed.
    e. **Contract Monitoring and Compliance**: Table this for now and reassess in September 2017

6. **Other Adjustments** - [Increase of $6,106]
    a. **Supplies**: Increase from $4,000 to $7,000 (Office furniture, equipment, cell phones)
    b. **Travel/Mileage**: Increase up to 25% from $8,424 to $10,530
    c. **Venue Rental**: Increase from $1,500 to $2,500

Budget and Funds Flow Attachments	
Description	Reference Code
Board Approved Actions to Support Design Funds Spending and Planning	Attachment AO
High-Level Board Approved Budget for Project Design*	Attachment AP
Board Treasurer Resume	Attachment AQ

** Required Attachment*

*** Recommended Attachment*

Clinical Capacity and Engagement

Provider Engagement

In April, the OCH Board approved a Clinical Engagement Strategy (Attachment AR) and timeline. This strategy was designed by a workgroup comprised of a representative from a hospital, community behavioral health clinic, federally qualified health care clinic, and a tribal clinic. The OCH has strong provider engagement, with all the major Medicaid providers, including tribal clinic providers, engaged at the Board or committee level.

Timeline for Provider Engagement

May-June 2017

Activity: Evaluate proposed evidence-based programs
Questions to Run On: Are these projects a good fit for us? Can we implement these well and in the allotted time? Can we really move the dial? Do these move us towards our strategic goal(s)? Are these sustainable?
Organizational Representatives: Executive Leadership and/or Operations

June-July 2017

Activity: Agree on ACH-level and organization-level performance measures and targets
Questions to Run On: Which measures align with our payer contracts? What is our baseline performance? What is our footprint/scalability? How much can we move these measures, as organizations and as a region?
Organizational Representatives: Quality Improvement, Data/Analytics, Population Health Management, Frontline Providers, Contracting, MCOs; technical assistance from Manatt Health

July-September 2017

Activity: Agree on and set organization-level incentive payments based on targets
Questions to Run On: How much do we need to do the work? What incentive payment plan will work (timing, amount, etc…)? What are our contingencies?
Organizational Representatives: Executive Leadership in Finance and/or Business/Operations; technical assistance from Manatt Health

We began moving forward with our clinical engagement strategy; we have a subject matter expert on bi-directional integration contracted to begin work in May (Attachment AS). We have identified and had exploratory conversations with two additional potential contractors, each with a specific niche relative to the MDP; some are local provider champions and others subject matter experts. We meet on May 15th with another potential subject matter expert, this one in the field of health transformation within health facilities.

The Board reviewed a provider engagement plan (Attachment AT) that likely will include one or more provider champions and workgroups depending on the selected projects and input from our partner organizations.

In addition to the above activities, the executive director and director of special projects meets regularly with provider organizations. The executive director convenes a meeting of the CEOs and CFOs from all hospitals in the region on a quarterly basis to discuss alignment. The executive director

presents to the board of hospitals when invited and meets one-on-one with the CEOs of the two federally qualified health centers in the region. The executive director also has visited the tribal health clinics and has developed a relationship with all but one of the health clinic directors. The executive directly checks in regularly (at least once per month) with MCO representatives from the five plans.

The OCH is coordinating a Three-County Opioid Response Project. We currently staff three workgroups and a steering committee. In this capacity, we meet regularly with local substance use providers, mental health providers, primary care providers, emergency medical providers, first responders, law enforcement, dentists, pharmacists, health officers, residency programs, school-based clinics, and other provider networks. This large network of providers has approved an opioid response implementation plan that is currently underway. Provider participants on this project are currently considering responding to a statewide RFP for a hub and spoke opioid treatment modality. The OCH is facilitating this process.

Partnerships

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

We look forward to closer partnership with dental societies in our effort to improve our relationship with the dental community.

Clinical Capacity and Engagement Attachments	
Description	Reference Code
Clinical Engagement Strategy	Attachment AR
Resume of identified clinical subject matter expert*	Attachment AS
Provider Engagement Plan	Attachment AT

** Required Attachment*

*** Recommended Attachment*

Attachments Checklist

Application Section	Attachment Description	Reference Code
Theory of Action & Alignment Strategy	Regional Health Priorities	Attachment A
	Regional Health Needs Assessment Work Plan	Attachment B
	Health Initiatives Inventory	Attachment C
	Inventory of Coalitions	Attachment D
	Inventory of Assessments and Planning Documents	Attachment E
	Regional Health Needs Assessment	Attachment F
	Strategic Health Improvement Plan	Attachment G
Governance & Organizational Structure	Executive Committee Charter*	Attachment H
	Finance Committee Charter*	Attachment I
	Regional Health and Assessment Committee Charter*	Attachment J
	Visual of the governance structure*	Attachment K
	MCO Sector Representation*	Attachment L
	Transition S.B.A.R.	Attachment M
	Transition Workplan	Attachment N
	Articles of Incorporation*	Attachment O
	Bylaws*	Attachment P
	Timeline	Attachment Q
	Governance Formation S.B.A.R.	Attachment R
	Policy to Fill Vacant Seats*	Attachment S
	Board Member Commitments and Operating Procedures*	Attachment T
	Regional Health Assessment and Planning Committee Formation	Attachment U
	Fiscal Policies and Procedures Manual	Attachment V
	Decision-Making Flow Chart*	Attachment X
	Roster of the Decision-Making Body*	Attachment Y
	Brief bios for the Executive Committee Members*	Attachment Z
	Resume of the Executive Director*	Attachment AA
	Resume of the Data and Analytics Lead	Attachment AB
	Future Organizational Chart*	Attachment AC
	Brief Description of Anticipated Staff Roles*	Attachment AD
	Conflict of Interest Policy*	Attachment AE
Tribal Engagement Expectations	Appointment of the Director for the Lower Elwha Klallam Tribe to the Olympic Community of Health Board of Directors**	Attachment AF
	Tribal Collaboration and Communication Policy with the Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Port Gamble S'Klallam, Quileute and Suquamish Tribes*	Attachment AG
Community & Stakeholder Engagement	Document with links to webpages where the public can access meeting schedules and other engagement opportunities, meeting materials, and contact information*	Attachment AH
	Request for Letters of Intent	Attachment AI
	Request for Applications (RFA)	Attachment AJ
	Logic Model (Attachment for RFA)	Attachment AK
	Implementation Timelines (Attachment for RFA)	Attachment AL
	Partner Commitment Form (Attachment for RFA)	Attachment AM
	Project Budget (Attachment for RFA)	Attachment AN

Application Section	Attachment Description	Reference Code
Budget & Funds Flow	Board Approved Actions to Support Design Funds Spending	Attachment AO
	High-Level Board Approved Budget for Project Design*	Attachment AP
	Board Treasurer Resume	Attachment AQ
Clinical Capacity & Engagement	Clinical Engagement Strategy	Attachment AR
	Resume of identified clinical subject matter expert*	Attachment AS
	Provider Engagement Plan	Attachment AT

** Required Attachment*

*** Recommended Attachment*