Olympic Community of Health

Agenda

Board of Directors Meeting

June 12, 2017

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

Web: https://global.gotomeeting.com/join/458665557

Telephone: (872) 240-3311

Access Code: 458-665-557

KEY OBJECTIVES

- Agree on next iteration of the OCH Project Portfolio under the Demonstration Project
- Advise organizational governance and staffing models to inform financial planning and hiring for Phase II Certification

AGENDA (Action items are in red)

Item		Topic	Lead	Attachment
1	1:00	Welcome	Roy	
2	1:05	Consent Agenda	Roy	1. DRAFT Minutes 5.08.2017 2. Executive Director's Report 3. Opioid Project Director's Report
3	1:10	Contract for the first year of the MDP Demonstration	Elya	4. Design Funds Contract for Phase I
4	1:15	Quarterly Financials	Hilary	5. Jan-Apr: Balance Sheet 6. Jan-Apr: Profit & Loss Budget vs. Actual
5	1:25	Legal Counsel	Roy	7. Legal Counsel S.B.A.R. 8. Heather Erb Resume 9. Heather Erb Engagement Letter
6	1:35	Executive Committee Term	Elya	10. Executive Committee Membership S.B.A.R.
7	1:45	Motion to submit a letter to county commissioners regarding Mid-Adopter	Roy	11. Letter to Commissioners S.B.A.R. 12. Revised Incentives for Mid Adopters from the HCA
8	2:00	OCH Medicaid Demonstration Project Portfolio	Katie Elya	13. Project Portfolio SBAR 14. Apple Integrator Concept 15. Project Portfolio Summary Table 16. Project Score Summary Table 17. Public Comment*
9	2:40	Phase II Certification Readiness	Elya	18. Design Fund Spend and Budget 19. Proposed Organizational and Governance Visuals 20. Phase II Certification Requirements
10	3:00	Adjourn	Roy	

***** *Will be passed out at the meeting*

Acronym Glossary

FIMC: Fully Integrated Managed Care
HCA: Health Care Authority
MDP: Medicaid Demonstration Project
SBAR: Situation. Background. Action. Recommendation.

Olympic Community of Health

Meeting Minutes

Board of Directors

May 8th, 2017

Date: 5/8/2017	**Time:** 1:00pm - 4:00pm	**Location:** Jefferson Health Care Conference Room

Chair: Roy Walker, *Olympic Area Agency on Aging*
Members Attended: Mike Maxwell, *Olympic Medical Center*, Caitlin Safford, *Amerigroup*, Leonard Forsman, *Suquamish Tribe*, Hilary Whittington, *Jefferson Healthcare*, Anders Edgerton, *Salish BHO*, Gill Orr, *Cedar Grove Counseling*, Gary Kreidberg, *Harrison Health Partners,* Larry Eyers, *Kitsap Community Resources*, Chris Frank, *Clallam County Public Health*, Brent Simcosky, *Jamestown S'Klallam Tribe*, Joe Roszak, *Kitsap Mental Health Services,* Darryl Wolfe, *Olympic Medical Center*
Non-Voting Members: Allan Fisher, *United Healthcare,* Jorge Rivera, *Molina,* Kat Latet, *CHPW,* Kayla Down, *Coordinated Care*
Phone Members: David Shultz, Jim Jackson, Tracey Rascon, *Makah Tribe*, John Miller, Andrew Shogren, *Quileute Tribe*, Karol Dixon (arrived in person), *Port Gamble S'Klallam Tribe*
Staff: Elya Moore, *Olympic Community of Health,* Lisa Rey Thomas, *Olympic Community of Health,* Mia Gregg, *Olympic Community of Health*
Guests: Nathan Johnson, *Health Care Authority*, Brad Banks, *BHO Lobbyist,* Maria Klemusrud, *Qualis Health,* Christine Quinata, *Health Care Authority,* Laura Johnson, *United Health Care,* Ann Donovan, *Suquamish Tribe*, Denine Johnson, Brian Enslow, *Amerigroup,* Ru Kirk, *Discovery Behavioral Health*, Wendy Sisk, *Peninsula Behavioral Health,* Dan Vizzini, *Oregon Health Sciences University,* Kathleen Kler, *Jefferson County Commissioner,* Doug Washburn, *Kitsap County Dept. of Human Services,*

Person Responsible for Topic	Topic	Discussion/Outcome	Action/Results
	May Objectives	1. Come to an understanding of fully integrated managed care (FIMC) and agree on next steps for OCH 2. Agree on invited Project Applications and further Board action	
Roy Walker	**Welcome and Introductions**	Roy called the meeting to order at 1:11 pm.	
Roy Walker	**Consent Agenda**	Approval of minutes	April Board Minutes APPROVED unanimously
OCH, MCO's, BHO	**Fully Integrated Managed Care**	• It was voiced that there are distinct systems of care currently within our region, causing a large gap of care within our communities when addressing mild, moderate and severe health issues. • FIMC could properly support necessary integrated care models, including behavioral health needs, providing the ability to serve a broader patient base.	

		• SB6312-2013-14 was discussed, details including early and mid-adopter incentives for FIMC implementation prior to 2020. • Concerns regarding crisis services, payer designation and service rate changes were discussed.	
Hillary Whittington	**OCH Finances**	• As of February 1st, 2016, The Olympic Community of Health is its own organization, due to this fact, January costs were not included when calculating 2017 expenses, keeping in mind that we want all funds the board is using to reflect accurately and transparently. • The Finance Committee is considering details of roll over funds from KPHD. • Moving forward, the OCH will most likely be adopting a zero-based budget.	Quarterly financials will be presented at the June Board meeting.
Elya Moore	**Phase I Certification**	• Phase I certification comes with a contract, from sub-award to sub-contract. • OCH will share contract once received	MOTION for Executive Committee, informed with technical assistance, to review and approve Phase I contract. APPROVED unanimously
Caitlin, Vicki	**Invited *Optional* Project Applications**	• The RHAPC met for four hours on Friday April 14th to review 35 letter of intent submissions received by the OCH. During this meeting, the RHAP committee broke into small groups for more thorough review, addressing potential proposal combinations. Creating a final project count of twelve to recommend to the BoD at the June 12th meeting. • MTDP project submission deadline has been extended by one month, however our primary goal remains to submit a robust and thoughtful project portfolio, inclusive of all interested community partners.	MOTION for accept the RHAPC recommendation to the Board for full applications. APPROVED unanimously

		• RHAPC recommended that OCH take an interim lead on the Pathways project due to interoperability between health care delivery system	
Elya Moore	**MDP Funds Flow**	• Certification timeline and project plan due dates discussed, Phase I binding LOI date is September 15th. • ACH's are the coordinating entities that will determine DSRIP funds flow, all funds, once released will be distributed directly to the CMS appointed Financial Executor, other than Design Funds which will flow directly to the ACH's to assist in the MTDP preparation efforts. • Tribe specific project funding discussed, not enough information at this time. • It was noted, ACH's that submit all eight projects over those who submit less have the potential to earn more funding in year 1. Additionally, ACH's that have higher scores stand to earn more money, including potential funds from other low scoring ACH's, this information is promoting strong incentives to submit high quality project plans. Not mid adopting FIMC could potentially affect scores and funding as well. • Project metrics discussed, pay for reporting versus pay for performance.	Dan Vizzini, regional coordinator from Manatt Health, will offer a Funds Flow 101 webinar with more information.
Elya Moore	**Oral Health Access Strategic Planning Update**	• In April, OCH held a strategic planning session with Washington Dental Service Foundation in which five MTDP anchor strategies were discussed including needs for different resources. • OCH will be considering ABCD (children's dental program) for Jefferson and Clallam counties.	
Roy Walker	**Adjourn**	The meeting adjourned at 4:37 pm.	

Olympic Community of Health

Executive Director's Report

Prepared for June 12 Board Meeting

Top 3 Things to Track (T3T) #KeepingMeUpAtNight

1. We are on our back foot with staffing. To meet the deliverables over the next six months, the OCH must hire key staff positions quickly.

2. Phase II certification will be a heavy lift. I will be asking the Board to rise to the challenge, reviewing and acting on new policies, revised budgets, and new strategies at every meeting between now and October.

3. For the 3rd thing I will squeeze in two issues that keep me up at night: clinical engagement and community engagement. At the speed we are moving, it makes it challenging to do both and do them well. Our success is tied to our authenticity in the community.

Upcoming OCH meetings:

- OCH Partner Convening, June 19, 12:30 to 3:30, Jamestown Tribal Center, Red Cedar Hall, Sequim
- OCH RHAP Committee Meeting, June 26, 1:00 pm to 3:00 pm, Kitsap Public Health District, Bremerton
- OCH Executive Committee Meeting, June 27, 12:00 pm to 2:00 pm, teleconference
- OCH Finance Committee Meeting, July 10, 11:30 am to 12:45 pm, Remax Building, Port Townsend
- OCH Board Meeting, July 10, 1:00 pm to 3:00 pm, Remax Building, Port Townsend
- ACH Quarterly Convening, June 28-29, Chelan; Attendees: Elya Moore, Lisa Rey Thomas, Siri Kushner, and Roy Walker

OCH Certification

We passed our Phase I certification! Phase II certification is due August 14th. Standby for requests from staff to address weak areas of the application over the next two Board meetings.

Project Plan Template

Last week we received the Project Plan template that will be required for the project portfolio on October 23rd. The template will be open for public comment June 15-30. The final template will be released July 10th and away we go!! If you would like a pre-draft version, please email me and I will send it to you.

501c3 Application Status

We are working on populating the budget section of the 501c3 application and have engaged Larry Thompson to review the full document. Our accountant, who is providing CFO-level services, and our legal counsel, will also review the document. We hope to have a complete application to send out for review by mid-July.

Tribal Engagement

We received resolutions from two tribal governments to have participation on the Board: Lower Elwha Klallam and Suquamish. Jamestown, Quileute, and Port Gamble S'Klallam are all in active process. Makah has confirmed an intention to complete this process as well. We are waiting to hear back from Hoh.

Vendor Services

- In late May, we started regular, meetings with our accountant, now also providing CFO-level services to staff and Finance Committee – two meetings per month on site. This arrangement appears to be working well.
- In May and June, we are working with our HR consultant to assist in putting in place performance review systems, job description templates, and recruitment advice.

OCH Outreach & Engagement

- Mental Health Court graduation, Port Townsend, May 2
- Jefferson County Mental Health/Substance Abuse Advisory Committee meeting, Port Townsend, May 2
- American Indian Health Commission (AIHC) Tribal Centric Behavioral Health Summit planning committee (weekly via phone)
- Peninsula Community Health Services clinic grand opening, Belfair, May 4
- SBHO Advisory Committee meeting, Sequim, May 5
- Chief Medical Officer, Jefferson Healthcare, Port Townsend, May 18
- BHO Executive Meeting, May 19, Sequim
- Monthly Tribal/HCA/DBHR meeting, May 22, Olympia (via telephone)
- WA State Hospital Association, May 24, Seattle (via telephone)
- WA State Hospital Association and statewide ACH, Seattle, May 25
- United Way Kitsap, May 30, Bremerton
- Funds Flow Webinar, May 31
- Vice President Network Strategy and Contracting, Catholic Health Initiatives, telephone, June 5
- AIAN DBHR Substance Abuse Prevention Gathering, Suquamish, June 7
- American Indian Health Commission Bi-monthly delegates meeting, Spokane (via webinar), June 8
- Summit on Reducing Illicit Opioids in WA, UW, June 15-16
- Graduate Kitsap, Olympic Community College, Bremerton, June 21
- West End Providers meeting, Neah Bay, June 21
- Peninsula Community Health Services Board, Bremerton, June 22
- AIHC Tribal Centric Behavioral Health Summit, Puyallup, June 23
- Monthly Tribal/HCA/DBHR meeting, June 26, Olympia (via telephone)
- WA State Hospital Association, Seattle, July 11

Three County Coordinated Opioid Response Project

Opioid Project Director's Report

Presented to the Board for the June 12, 2017 Board Meeting

- **Steering Committee** (SC) meetings have resumed and are guiding the refining and implementation of the regional plan. SC meeting dates so far are March 23, May 25, June 27, 2017.
- **Three workgroups** have been formed, each aligned with one of the regional plan's goals:
    - **Prevention of opioid misuse and abuse** chaired by SC members Susan Turner and Josh Jones. Meeting dates so far are April 17 and June 20, 2017**. Priority goals** are: 1) increasing number of providers accessing PMP; 2) educating providers on guidelines and resources for prescribing and tx of chronic pain (include what insurance will pay for); 3) increase awareness and education regarding OUD and OUD treatment for patients, families, and communities.
    - **Improved access to best practices for Opioid Use Disorder** chaired by Wendy Sisk and Alethea Fournier. Meeting dates so far are May 10 and June 12, June 27. **Priority goals** are: 1) supporting the region in submission of an application in response to the State Targeted Response RFP to bring funds to support a hub and spoke system; 2) Assess what is already available in our region for treatment for OUD and recovery support; 3) align primary care and SUD providers in treatment of OUD; and 4) gather, develop, and adapt educational materials for community members regarding OUD, OUD treatment, and recovery.
    - **Prevention of opioid overdose** chaired by Jean Riquelme and Mike Lasnier. Meeting dates so far are May 23 and June 27, 2017. **Priority goals** are: 1) assess where naloxone is available currently; 2) increase the number of agencies/sites where naloxone is available; and 3) initiate a "train the trainer" model to increase the number of providers, social service agencies, etc. who know how to recognize an overdose and respond appropriately, including the administration of naloxone.
- The **Washington State Hospital Association** (WSHA) is convening statewide meetings with other ACH's and subject matter experts to coordinate efforts in the regional response plans, toolkits, and metrics. There have been two meetings, April 25 and May 25, 2017. The **six collaborative priority** areas are: 1) increase use of Prescription Monitoring Program (PMP) and integrate into Electronic Medical Record; 2) use PMP prescribing data to identify prescribing patterns to support quality improvement; 3) develop low barrier Medication Assisted Treatment (MAT) access; 4) Implement protocols in Emergency Departments (ED) for overdose education and take home naloxone; 5) develop and implement a tool kit to support providers in increasing the number of patients treated with MAT; and 6) develop and implement a tool kit to support initiation of MAT in ED when a patient presents with a near fatal overdose.

Washington State Health Care Authority	**CONTRACT** for Accountable Community of Health	HCA Contract Number: *******

THIS AGREEMENT is made by and between Washington State Health Care Authority, hereinafter referred to as "HCA," and the party whose name appears below, hereinafter referred to as the "Contractor."

CONTRACTOR NAME		CONTRACTOR DOING BUSINESS AS (DBA)		
Accountable Community of Health				
CONTRACTOR ADDRESS	STREET	CITY	STATE WA	ZIP CODE
CONTRACTOR CONTACT	CONTRACTOR TELEPHONE	CONTRACTOR E-MAIL ADDRESS		

IS CONTRACTOR A SUBRECIPIENT UNDER THIS CONTRACT?	CFDA NUMBER(S):	FFATA Form Required
☐YES ☒NO		☒YES ☐NO

HCA PROGRAM	HCA DIVISION/SECTION
Medicaid Transformation Demonstration	Healthier Washington/PPP
HCA CONTACT NAME AND TITLE	HCA CONTACT ADDRESS
Chase Napier, Contract Manager	Health Care Authority PO Box 45502 Olympia, WA 98504
HCA CONTACT TELEPHONE	HCA CONTACT E-MAIL ADDRESS
(360) 725-0868	Chase.napier@hca.wa.gov

CONTRACT START DATE	**CONTRACT END DATE**	**TOTAL MAXIMUM CONTRACT AMOUNT**
Date of execution	December 31, 2021	**$**6,000,000
PURPOSE OF CONTRACT:		
Accountable Communities of Health		

The terms and conditions of this Contract are an integration and representation of the final, entire and exclusive understanding between the parties superseding and merging all previous agreements, writings, and communications, oral or otherwise, regarding the subject matter of this Contract. The parties signing below warrant that they have read and understand this Contract, and have authority to execute this Contract. This Contract will be binding on HCA only upon signature by HCA.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
HCA SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED

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Attachments

Attachment A: Federal Compliance, Certifications and Assurances

Attachment B: Federal Funding Accountability and Transparency Act Data Collection Form

Attachment C: Tribal Collaboration and Communication Policy

Schedules

Schedule A: Statement of Work (SOW)

IN CONSIDERATION of the mutual promises as set forth in this Contract, the parties agree as follows:

RECITALS

1. The Centers for Medicare and Medicaid Services (CMS) approved Washington State's five-year Medicaid Transformation Project No. 11-W-00304/0 (Demonstration) on January 9, 2017. The Demonstration is a waiver project approved under section 1115(a) of the federal Social Security Act. In part, the demonstration aims to transform the health care delivery system through regional, collaborative efforts led by Accountable Communities of Health (ACH), and will test changes to payment, care delivery models and targeted services. The demonstration will provide Delivery System Reform Incentive Payment incentives (DSRIP) to providers tied to projects coordinated by AHCs, based on achievement of milestones and outcomes.
2. This Contract will set forth the requirements and obligations of Contractor as the administrative lead for receipt of DSRIP funds, to include, but not be limited to, reporting requirements, data sharing agreements, performance standards, compliance with the federal Special Terms and Conditions of the Demonstration, and agreement to participate in state oversight and audit activity to ensure program integrity.
3. Separate and apart from this Contract, the Contractor currently receives federal grant funding through the State Innovation Models (SIM) Initiative pursuant to HCA Contract No. *****(SIM Contract). All of the Contractor's requirements under the SIM grant and the SIM contract remain in full force and effect. This Contract does not supplant or augment anything in the SIM grant or the SIM contract.

IN CONSIDERATION of the mutual promises as set forth in this Contract, the parties agree as follows:

1. **STATEMENT OF WORK**

   The Contractor will provide the services and staff as described in the Statement of Work, attached as Schedule A.

2. **DEFINITIONS**

   "**Accountable Community of Health"** means a regional coalition consisting of leaders from a variety of different sectors working together to build capacity to work collaboratively, develop regional health improvement plans, jointly implement or advance local health projects, and advise state agencies on how best to address health needs within its region.

   "Authorized Representative" means a person to whom signature authority has been delegated in writing, acting within the limits of his/her authority.

   "Allowable Cost" shall mean an expenditure which meets the test of the appropriate OMB Circular.

   "Business Days and Hours" means Monday through Friday, 8:00 a.m. to 5:00 p.m., Pacific Time, except for holidays observed by the state of Washington.

   "Centers for Medicare and Medicaid Services" or **"CMS"** means the federal office under the Secretary of the United States Department of Health and Human Services, responsible for the Medicare and Medicaid programs.

"Certification" means the process whereby HCA acknowledges that an ACH has met all necessary prerequisites for the receipt of DSRIP funds pursuant to this Contract.

"CFR" means the Code of Federal Regulations. All references in this Contract to CFR chapters or sections include any successor, amended, or replacement regulation. The CFR may be accessed at http://www.ecfr.gov/cgi-bin/ECFR?page=browse.

"Confidential Information" means information that may be exempt from disclosure to the public or other unauthorized persons under chapter 42.56 RCW or chapter 70.02 RCW or other state or federal statutes. Confidential Information includes, but is not limited to, any information identifiable to an individual that relates to a natural person's health, finances, education, business, use or receipt of governmental services, names, addresses, telephone numbers, social security numbers, driver license numbers, financial profiles, credit card numbers, financial identifiers and any other identifying numbers, law enforcement records, HCA source code or object code, or HCA or State security information.

"Contract" means this Contract document and all schedules, exhibits, attachments, and amendments.

"**Contractor"** means any firm, provider, organization, individual or other entity performing services under this Contract.

"DSRIP funds (Delivery System Reform Incentive Payments)," means those moneys potentially available to the Contractor from HCA through the Demonstration.

"Effective Date" means the Contract Start Date, as specified ion the cover page of this Contract.

"HCA Contract Manager" means the individual identified on the cover page of this Contract as HCA Contact who will provide oversight of the Contractor's activities conducted under this Contract.

"HCA Director" means the Director of the Health Care Authority.

"Health Care Authority" or **"HCA"** means the Washington State Health Care Authority, any division, section, office, unit or other entity of HCA, or any of the officers or other officials lawfully representing HCA.

"Overpayment" means any payment made by HCA to the Contractor to which the Contractor is not entitled by statute, rule, or this Contract (including the amount in dispute).

"Proprietary Information" means information owned by Contractor to which Contractor claims a protectable interest under law. Proprietary Information includes, but is not limited to, information protected by copyright, patent, trademark, or trade secret laws.

"RCW" means the Revised Code of Washington. All references in this Contract to RCW chapters or sections include any successor, amended, or replacement statute. Pertinent RCW chapters can be accessed at: http://apps.leg.wa.gov/rcw/.

"Subcontractor" means one not in the employment of Contractor, who is performing all or part of the business activities under this Contract under a separate contract with Contractor. The term "Subcontractor" means subcontractor(s) of any tier. Notwithstanding the foregoing, the execution of a partner agreement with a provider participating in a project as contemplated by Section E of the Statement of Work, attached as Schedule A, does not constitute such a provider a Subcontractor of the Contractor.

"USC" means the United States Code. All references in this Contract to USC chapters or sections shall include any successor, amended, or replacement statute. The USC may be accessed at http://uscode.house.gov/

"WAC" means the Washington Administrative Code. All references to WAC chapters or sections will include any successor, amended, or replacement regulation. Pertinent WACs may be accessed at: http://app.leg.wa.gov/wac/.

3. SPECIAL TERMS AND CONDITIONS

3.1 PERFORMANCE EXPECTATIONS

Expected performance under this Contract includes, but is not limited to, the following:

3.1.1 Certification of Contractor according to the two-part HCA certification process;

3.1.2 Knowledge of applicable state and federal laws and regulations pertaining to subject of Contract;

3.1.3 Collaboration with HCA staff as set forth in the Statement of Work, Schedule A, including all Attachments thereto.

3.2 TERM

3.2.1 The initial term of the Contract will commence on final signature, and continue through December 31, 2021, unless terminated sooner as provided herein.

3.2.2 HCA, in consultation with the Contractor, may extend the term of this Contract in accordance with the terms of the Demonstration.

3.2.3 Work performed without a contract or amendment signed by the authorized representatives of both parties will be at the sole risk of the Contractor. HCA will not pay any costs incurred before the effective date of the contract or any subsequent amendment(s).

3.3 COMPENSATION AND COSTS

3.3.1 The maximum compensation payable to Contractor for the performance of all things necessary for, or incidental to, the performance of work under this Contract is as set forth in Schedule A.

3.3.2 Federal funds disbursed through this Contract will be received by HCA through the Demonstration. Contractor agrees to comply with applicable rules and regulations associated with these federal funds and have signed Attachment A, Federal Compliance, Certification and Assurances, attached.

The obligation of HCA to make payments is contingent on the receipt of federal funds during the term of the Demonstration. If federal funds are not available, then HCA will not make any payments. In addition, the Contractor's failure to perform any obligation required by this Contract may result in HCA refusing to pay any further funds hereunder and/or terminate this Agreement by giving written notice of termination as provided in Section 4.30.1, Termination for Default.

Contractor must follow all Federal Cost Principles and Uniform Administrative Requirements associated with these federal funds and have signed Attachment A., as well as all requirements of this Demonstration regarding incentive payments

contained in Schedule A and all attachments thereto. Failure to do so may result in funds being returned/withheld.

3.3.3 Costs must be necessary and reasonable; allocable; authorized or not prohibited under federal, state, or local laws and regulations; and documented.

3.4 INVOICE AND PAYMENT

3.4.1 Contractor shall comply with all requirements set forth in Schedule A.

3.4.2 Upon expiration of the Contract, any claims for payment for costs due and payable under this Contract that are incurred prior to the expiration date must be submitted by the Contractor to HCA within sixty (60) calendar days after the Contract expiration date. Belated claims will be paid at the discretion of the HCA and are contingent upon the availability of funds.

3.5 CONTRACTOR AND HCA CONTRACT MANAGERS

3.5.1 Contractor's Contract Manager will have prime responsibility and final authority for the services provided under this Contract and be the principal point of contact for the HCA Contract Manager for all business matters, performance matters, and administrative activities.

3.5.2 HCA's Contract Manager is responsible for monitoring the Contractor's performance and will be the contact person for all communications regarding Contract performance and deliverables. The HCA Contract Manager has the authority to reject any services that the HCA Contract Manager reasonably determines do not comply with the terms of the Contact.

3.5.3 The contact information provided below may be changed by written notice of the change (email acceptable) to the other party.

CONTRACTOR Contract Manager Information		**Health Care Authority Contract Manager Information**	
Name:		*Name:*	Chase Napier
Title:	Executive Director	*Title:*	HW Community Transformation Manager
Address:		*Address:*	PO Box 45502 Olympia, WA 98504
Phone:		*Phone:*	360-725-0868
Email:		*Email:*	Chase.napier@hca.wa.gov

3.6 LEGAL NOTICES

Any notice or demand or other communication required or permitted to be given under this Contract or applicable law is effective if it is in writing and signed by the applicable party, properly addressed, and either delivered in person, or by a recognized courier service, or deposited with the United States Postal Service as first-class mail, postage prepaid

certified mail, return receipt requested, to the parties at the addresses provided in this section, or sent electronically to the email address provided in this section.

3.6.1 In the case of notice to the Contractor:

Physical Address:

Mailing Address:

E-mail Address:

3.6.2 In the case of notice to HCA:

Attention: Contract Administrator
Health Care Authority
Division of Legal Services
Post Office Box 42702
Olympia, WA 98504-2702

3.6.3 Notices are effective upon receipt or four (4) Business Days after mailing, whichever is earlier.

3.6.4 The notice address and information provided above may be changed by written notice of the change given as provided above.

3.7 INCORPORATION OF DOCUMENTS AND ORDER OF PRECEDENCE

Each of the items or documents listed below is by this reference incorporated into this Contract. In the event of an inconsistency, the inconsistency will be resolved in the following order of precedence:

3.7.1 Applicable Federal and State of Washington statutes and regulations;

3.7.2 Special Terms and Conditions;

3.7.3 General Terms and Conditions;

3.7.4 Schedule A

3.7.5 Attachment A: *Federal Compliance, Certifications and Assurances*;

3.7.6 Attachment B: *Federal Funding Accountability and Transparency Act Data Collection Form*;

3.7.7 Any other provision, term or material incorporated herein by reference or otherwise incorporated.

3.8 INSURANCE

Contractor must provide insurance coverage as set out in this section. The intent of the required insurance is to protect the State should there be any claims, suits, actions, costs, damages or expenses arising from any negligent or intentional act or omission of Contractor or Subcontractor, or agents of either, while performing under the terms of this Contract. Contractor must provide insurance coverage that is maintained in full force and effect during the term of this Contract, as follows:

3.8.1 Commercial General Liability Insurance Policy - Provide a Commercial General Liability Insurance Policy, including contractual liability, in adequate quantity to protect against legal liability arising out of contract activity but no less than $1 million per occurrence/$2 million general aggregate. Additionally, Contractor is responsible for ensuring that any Subcontractors provide adequate insurance coverage for the activities arising out of subcontracts.

3.8.2 Business Automobile Liability. In the event that services delivered pursuant to this Contract involve the use of vehicles, either owned, hired, or non-owned by the Contractor, automobile liability insurance is required covering the risks of bodily injury (including death) and property damage, including coverage for contractual liability. The minimum limit for automobile liability is $1,000,000 per occurrence, using a Combined Single Limit for bodily injury and property damage.

3.8.3 Professional Liability Errors and Omissions – Provide a policy with coverage of not less than $1 million per claim/$2 million general aggregate.

3.8.4 Industrial Insurance Coverage- Prior to performing work under this Contract, Contractor must provide or purchase industrial insurance coverage for the Contractor's employees, as may be required of an "employer" as defined in Title 51 RCW, and must maintain full compliance with Title 51 RCW during the course of this Contract.

3.8.5 The insurance required must be issued by an insurance company/ies authorized to do business within the state of Washington. The Commercial General Liability and the Business Automobile Liability policies must name HCA and the state of Washington, its agents and employees as additional insured's under the insurance policy/ies. All policies must be primary to any other valid and collectable insurance. In the event of cancellation, non-renewal, revocation or other termination of any insurance coverage required by this Contract, Contractor must provide written notice of such to HCA within one (1) Business Day of Contractor's receipt of such notice. Failure to buy and maintain the required insurance may, at HCA's sole option, result in this Contract's termination.

Upon request, Contractor must submit to HCA, a certificate of insurance that outlines the coverage and limits defined in this section. If a certificate of insurance is requested, Contractor must submit renewal certificates as appropriate during the term of the Contract.

4. GENERAL TERMS AND CONDITIONS

4.1 ACCESS TO DATA

In compliance with RCW 39.26.180 (2) and federal rules, the Contractor must provide access to any data generated under this Contract to HCA, the Joint Legislative Audit and Review Committee, the State Auditor, and any other state or federal officials so authorized by law, rule, regulation, or agreement at no additional cost. This includes access to all information that supports the findings, conclusions, and recommendations of the Contractor's reports, including computer models and methodology for those models.

The Contractor must provide right of access to its facilities to HCA, or any of its officers, or to any other authorized agent or official of the state of Washington or the federal government, at all reasonable times, in order to monitor and evaluate performance, compliance, and/or quality assurance under this Contract.

4.2 ADVANCE PAYMENT PROHIBITED

No advance payment will be made for services furnished by the Contractor pursuant to this Contract.

4.3 ASSIGNMENT

Contractor may not assign or transfer this Contract or any of its rights hereunder, or delegate any of its duties hereunder without the prior written consent of HCA, which HCA may grant or deny in its sole discretion. A permitted assignment will not operate to relieve Contractor of any of its duties and obligations hereunder, nor will such assignment affect any remedies available to HCA that may arise from any breach of the provisions of this Contract or warranties made herein including but not limited to, rights of setoff. HCA may assign this Contract to any public agency, commission, board, or the like, within the political boundaries of the State of Washington. Any attempted assignment, transfer or delegation in contravention of this section will be null and void. This Contract will inure to the benefit of and be binding on the parties hereto and their permitted successors and assigns.

4.4 ATTORNEYS' FEES AND COSTS

In the event of litigation, dispute resolution or any other action brought between the parties to enforce the terms of this Contract or related in any way to this Contract, each party agrees to bear its own attorneys' fees and costs.

4.5 CHANGE IN STATUS

In the event of substantive change in the legal status, organizational structure, or fiscal reporting responsibility of the Contractor, Contractor will notify the HCA of the change. Contractor must provide notice as soon as practicable, but no later than ten (10) calendar days after such a change takes effect.

4.6 CONTRACTOR'S PROPRIETARY INFORMATION

Contractor acknowledges that HCA is subject to chapter 42.56 RCW, the Public Records Act, and that this Contract will be a public record as defined in chapter 42.56 RCW. Any specific information that is claimed by Contractor to be Proprietary Information must be clearly identified as such by Contractor. To the extent consistent with chapter 42.56 RCW, HCA will maintain the confidentiality of Contractor's information in its possession that is marked Proprietary. If a public disclosure request is made to view Contractor's Proprietary Information, HCA will notify Contractor of the request and of the date that such records will be released to the requester unless Contractor obtains a court order from a court of competent jurisdiction enjoining that disclosure. If Contractor fails to obtain the court order enjoining disclosure, HCA will release the requested information on the date specified.

4.7 COVENANT AGAINST CONTINGENT FEES

Contractor warrants that no person or selling agent has been employed or retained to solicit or secure this Contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee, excepting bona fide employees or bona fide established agents maintained by the Contractor for the purpose of securing business. HCA will have the right, in the event of breach of this clause by the Contractor, to annul this Contract without liability or, in its discretion, to deduct from the contract price or consideration or recover by other means the full amount of such commission, percentage, brokerage or contingent fee.

4.8 DEBARMENT

By signing this Contract, Contractor certifies that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded in any Washington State or Federal department or agency from participating in transactions (debarred). Contractor agrees to include the above requirement in any and all subcontracts into which it enters, and also agrees that it will not employ debarred individuals. Contractor must immediately notify HCA if, during the term of this Contract, Contractor becomes debarred. HCA may immediately terminate this Contract by providing Contractor written notice, if Contractor becomes debarred during the term hereof.

4.9 DISPUTES

The parties will use their best, good faith efforts to cooperatively resolve disputes and problems that arise in connection with this Contract. Both parties will continue without delay to carry out their respective responsibilities under this Contract while attempting to resolve any dispute. When a dispute arises between HCA and the Contractor regarding the terms of this Contract or the responsibilities imposed herein and it cannot be resolved between the parties' Contract Managers, either party may initiate the following dispute resolution process.

4.9.1 The initiating party will reduce its description of the dispute to writing and deliver it to the responding party (email acceptable). The responding party will respond in writing within thirty (30) Business Days (email acceptable). If after thirty (30) additional Business Days the parties have not resolved the Dispute, it will be submitted to the HCA Director, who may employ whatever dispute resolution methods the Director deems appropriate to resolve the Dispute.

4.9.2 A party's request for a dispute resolution must:

4.9.2.1 Be in writing;

4.9.2.2 Include a written description of the dispute;

4.9.2.3 State the relative positions of the parties and the remedy sought;

4.9.2.4 State the Contract Number and the names and contact information for the parties;

4.9.3 This dispute resolution process constitutes the sole administrative remedy available under this Contract. There is no right to an adjudicative proceeding under this Contract. The parties agree that this resolution process will precede any action in a judicial tribunal.

4.10 FEDERAL FUNDING ACCOUNTABILITY & TRANSPARENCY ACT (FFATA)

4.10.1 This Contract is supported by federal funds that require compliance with the Federal Funding Accountability and Transparency Act 0f 2006 (Transparency Act, Public Law 109-282). The purpose of the Transparency Act is to make information available online so the public can see how federal funds are spent.

4.10.2 To comply with the act and be eligible to enter into this Contract, Contractor must have a Data Universal Numbering System (DUNS®) number. A DUNS® number provides a method to verify data about your organization. If Contractor does not already have one, a DUNS® number is available free of charge by contacting Dun and Bradstreet at www.dnb.com.

4.10.3 Information about Contractor and this Contract will be made available on www.uscontractorregistration.com by HCA as required by the Transparency Act. HCA's Attachment B: *Federal Funding Accountability and Transparency Act Data Collection Form*, is considered part of this Contract and must be completed and returned along with the Contract.

4.11 FORCE MAJEURE

A party will not be liable for any failure of or delay in the performance of this Contract for the period that such failure or delay is due to causes beyond its reasonable control, including but not limited to acts of God, war, strikes or labor disputes, embargoes, government orders or any other force majeure event.

4.12 FUNDING WITHDRAWN, REDUCED OR LIMITED

If HCA determines that the funds it relied upon to establish this Contract have been withdrawn, reduced or limited, or if additional or modified conditions are placed on such funding, then HCA, in its sole discretion, may:

4.12.1 Terminate this Contract pursuant to Section 4.30.3, *Termination for Non-Allocation of Funds*;

4.12.2 Renegotiate the Contract under the revised funding conditions; or

4.12.3 Suspend Contractor's performance under the Contract by written notice of five (5) calendar days to Contractor. HCA will use this option only when HCA determines that there is reasonable likelihood that the funding insufficiency may be resolved in a timeframe that would allow Contractor's performance to be resumed prior to the normal completion date of this Contract.

4.12.3.1 During the period of suspension of performance, each party will inform the other of any conditions that may reasonably affect the potential for resumption of performance.

4.12.3.2 When HCA determines that the funding insufficiency is resolved, it will give Contractor written notice to resume performance. Upon the receipt of this notice, Contractor will provide notice to HCA informing HCA whether it can resume performance and, if so, the date of resumption.

4.12.3.3 If the Contractor's proposed resumption date is not acceptable to HCA and an acceptable date cannot be negotiated, HCA may terminate the Contract by giving notice to Contractor. The parties agree that the Contract will be terminated retroactive to the date of the notice of suspension. HCA will be liable only for payment in accordance with the terms of this Contract for services rendered prior to the retroactive date of termination.

4.13 GOVERNING LAW

This Contract is governed in all respects by the laws of the state of Washington, without reference to conflict of law principles. The jurisdiction for any action hereunder is exclusively in the Superior Court for the state of Washington, and the venue of any action hereunder is in the Superior Court for Thurston County, Washington.

4.14 HCA NETWORK AND SITE SECURITY

Contractor agrees not to attach any Contractor-supplied computers, peripherals or software to the HCA network without prior written authorization from HCA's Chief Information Officer. Unauthorized access to HCA networks and systems is a violation of HCA Policy and will be considered by HCA as computer trespass in the first degree pursuant to RCW 9A.90.040. Violation of any of these laws or policies could result in termination of the Contract and other penalties.

Contractor will have access to the HCA visitor Wi-Fi Internet connection while on site.

While on HCA premises, Contractor, its agents, employees, or Subcontractors must conform in all respects with physical, fire or other security policies or regulations. Failure to comply with these regulations may be grounds for revoking or suspending security access to these facilities. HCA reserves the right and authority to immediately revoke security access to Contractor staff for any real or threatened breach of this provision. Upon reassignment or termination of any Contractor staff, Contractor agrees to promptly notify HCA.

4.15 INDEMNIFICATION

HCA and Contractor shall each be responsible for their own acts and omissions, and the acts and omissions of their agents and employees. Each party to this Contract shall defend, protect and hold harmless the other party, or any of the other party's agents, from and against any loss and all claims, settlements, judgments, costs penalties, and expenses, including attorney's fees, arising from any willful misconduct, or dishonest, fraudulent, reckless, unlawful, or negligent act or omission of the first party, or agents of the first party, while performing under the terms of this Contract except to the extent that such losses result from the willful misconduct, or dishonest, fraudulent, reckless, unlawful or negligent act or omission on the part of the second party.
Each party agrees to notify promptly the other party, in writing, of any claim and provide the other party the opportunity to defend and settle the claim. If applicable, Contractor waives its immunity under Title 51 RCW to the extent it is required to indemnify, defend, and hold harmless the State and its agencies, officials, agents or employees.

4.16 INDEPENDENT CAPACITY OF THE CONTRACTOR

The parties intend that an independent contractor relationship will be created by this Contract. Contractor and its employees or agents performing under this Contract are not employees or agents of HCA. Contractor will not hold itself out as or claim to be an officer or employee of HCA or of the State of Washington by reason hereof, nor will Contractor make any claim of right, privilege or benefit that would accrue to such employee under law.

4.17 LEGAL AND REGULATORY COMPLIANCE

4.17.1 During the term of this Contract, Contractor must comply with all local, state, and federal licensing, accreditation and registration requirements/standards, necessary for the performance of this Contract and all other applicable federal, state and local laws, rules, and regulations.

4.17.2 While on the HCA premises, Contractor must comply with HCA operations and process standards and policies (e.g., ethics, Internet / email usage, data, network and building security, harassment, as applicable). HCA will make an electronic copy of all such policies available to Contractor.

4.17.3 During the performance of this Contract, the Contractor must comply with all federal and state nondiscrimination laws, regulations and policies, including but not limited to: Title VII of the Civil Rights Act, 42 U.S.C. §12101 et seq.; the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. §12101 et seq., 28 CFR Part 35; and Title 49.60 RCW, Washington Law Against Discrimination. In the event of Contractor's noncompliance or refusal to comply with any nondiscrimination law, regulation or policy, this Contract may be rescinded, canceled, or terminated in whole or in part under the Termination for Default sections, and Contractor may be declared ineligible for further contracts with HCA.

4.17.4 Failure to comply with this section may result in HCA's termination of the Contract.

4.18 LIMITATION OF AUTHORITY

Only the HCA Director or a representative authorized by the Director has the express, implied, or apparent authority to alter, amend, modify, or waive any clause or condition of this Contract. Furthermore, any alteration, amendment, modification, or waiver or any clause or condition of this Contract is not effective or binding unless made in writing and signed by the HCA Authorized Representative.

4.19 NO THIRD-PARTY BENEFICIARIES

HCA and Contractor are the only parties to this contract. Nothing in this Contract gives or is intended to give any benefit of this Contract to any third parties.

4.20 OVERPAYMENTS TO CONTRACTOR

In the event that an Overpayment has been made to the Contractor under this Contract, HCA will provide written notice to Contractor and Contractor shall refund the full amount to HCA within thirty (30) calendar days of the notice. If Contractor fails to make timely refund, HCA may charge Contractor one percent (1%) per month on the amount due, until paid in full. Any dispute arising under this section is governed by the "Disputes" section of this Contract and not by RCW 41.05A.

4.21 PUBLICITY

4.21.1 The award of this Contract to Contractor is not in any way an endorsement of Contractor or Contractor's Services by HCA and must not be so construed by Contractor in any advertising or other publicity materials.

4.21.2 Contractor agrees to submit to HCA, all advertising, sales promotion, and other publicity materials relating to this Contract or any Service furnished by Contractor in which HCA's name is mentioned, language is used, or Internet links are provided from which the connection of HCA's name with Contractor's Services may, in HCA's judgment, be inferred or implied. Contractor further agrees not to publish or use such advertising, marketing, sales promotion materials, publicity or the like through print, voice, the Web, and other communication media in existence or hereinafter developed without the express written consent of HCA prior to such use.

4.22 RECORDS AND DOCUMENTS REVIEW

4.22.1 The Contractor must maintain books, records, documents, magnetic media, receipts, invoices and other evidence relating to this Contract and the performance of the services rendered, along with accounting procedures and practices, all of which sufficiently and properly reflect all direct and indirect costs of any nature expended in the performance of this Contract. At no additional cost, these records including materials generated under this Contract, are subject at all reasonable times to inspection, review, or audit by HCA, the Office of the State Auditor, and state and federal officials so authorized by law, rule, regulation, or agreement. The

Contractor must retain such records for a period of six (6) years after the date of final payment.

4.22.2 If any litigation, claim or audit is started before the expiration of the six (6) year period, the records must be retained until all litigation, claims, or audit findings involving the records have been resolved.

4.23 REMEDIES NON-EXCLUSIVE

The remedies provided in this Contract are not exclusive, but are in addition to all other remedies available under law.

4.24 RIGHTS IN DATA/OWNERSHIP

4.24.1 HCA and Contractor agree that all data and work products (collectively "Work Product") produced pursuant to this Contract will be considered work made for hire under the U.S. Copyright Act, 17 U.S.C. §101 *et seq*, and will be owned by HCA. Contractor is hereby commissioned to create the Work Product. Work Product includes, but is not limited to, discoveries, formulae, ideas, improvements, inventions, methods, models, processes, techniques, findings, conclusions, recommendations, reports, designs, plans, diagrams, drawings, Software, databases, documents, pamphlets, advertisements, books, magazines, surveys, studies, computer programs, films, tapes, and/or sound reproductions, to the extent provided by law. Ownership includes the right to copyright, patent, register and the ability to transfer these rights and all information used to formulate such Work Product.

4.24.2 If for any reason the Work Product would not be considered a work made for hire under applicable law, Contractor assigns and transfers to HCA, the entire right, title and interest in and to all rights in the Work Product and any registrations and copyright applications relating thereto and any renewals and extensions thereof.

4.24.3 Contractor will execute all documents and perform such other proper acts as HCA may deem necessary to secure for HCA the rights pursuant to this section.

4.24.4 Contractor will not use or in any manner disseminate any Work Product to any third party, or represent in any way Contractor ownership of any Work Product, without the prior written permission of HCA. Contractor shall take all reasonable steps necessary to ensure that its agents, employees, or Subcontractors will not copy or disclose, transmit or perform any Work Product or any portion thereof, in any form, to any third party.

4.24.5 Material that is delivered under this Contract, but that does not originate therefrom ("Preexisting Material"), must be transferred to HCA with a nonexclusive, royalty-free, irrevocable license to publish, translate, reproduce, deliver, perform, display, and dispose of such Preexisting Material, and to authorize others to do so. Contractor agrees to obtain, at its own expense, express written consent of the copyright holder for the inclusion of Preexisting Material. HCA will have the right to

modify or remove any restrictive markings placed upon the Preexisting Material by Contractor.

4.24.6 Contractor must identify all Preexisting Material when it is delivered under this Contract and must advise HCA of any and all known or potential infringements of publicity, privacy or of intellectual property affecting any Preexisting Material at the time of delivery of such Preexisting Material. Contractor must provide HCA with prompt written notice of each notice or claim of copyright infringement or infringement of other intellectual property right worldwide received by Contractor with respect to any Preexisting Material delivered under this Contract.

4.25 RIGHTS OF STATE AND FEDERAL GOVERNMENTS

In accordance with 45 C.F.R. 95.617, all appropriate state and federal agencies, including but not limited to the Centers for Medicare and Medicaid Services (CMS), will have a royalty free, nonexclusive, and irrevocable license to reproduce, publish, translate, or otherwise use, and to authorize others to use for Federal Government purposes: (i) software, modifications, and documentation designed, developed or installed with Federal Financial Participation (FFP) under 45 CFR Part 95, subpart F; (ii) the Custom Software and modifications of the Custom Software, and associated Documentation designed, developed, or installed with FFP under this Contract; (iii) the copyright in any work developed under this Contract; and (iv) any rights of copyright to which Contractor purchases ownership under this Contract.

4.26 SEVERABILITY

If any provision of this Contract or the application thereof to any person(s) or circumstances is held invalid, such invalidity will not affect the other provisions or applications of this Contract that can be given effect without the invalid provision, and to this end the provisions or application of this Contract are declared severable.

4.27 SUBCONTRACTING

4.27.1 Contractor may not enter into subcontracts for any governance requirements established in the Statement of Work, Schedule A, Section C. In no event will the existence of a subcontract for performance of Contractor's obligations under this Contract operate to release or reduce the liability of Contractor to HCA for any breach in the performance of Contractor's duties.

4.27.2 Contractor is responsible for ensuring that all terms, conditions, assurances and certifications set forth in this Contract are included in any subcontracts.

4.27.3 If at any time during the progress of the work HCA determines in its sole judgment that any Subcontractor is incompetent or undesirable, HCA will notify Contractor, and Contractor must take immediate steps to terminate the Subcontractor's involvement in the work.

4.27.4 The rejection or approval by the HCA of any Subcontractor or the termination of a Subcontractor will not relieve Contractor of any of its responsibilities under the Contract, nor be the basis for additional charges to HCA.

4.27.5 HCA has no contractual obligations to any Subcontractor or vendor under contract to the Contractor. Contractor is fully responsible for all contractual obligations, financial or otherwise, to its Subcontractors.

4.28 SURVIVAL

The terms and conditions contained in this Contract that by their sense and context, are intended to survive the completion, cancellation, termination, or expiration of the Contract will survive. In addition, the terms of the sections titled *Confidential Information Protection, Confidential Information Breach – Required Notification, Contractor's Proprietary Information, Disputes, Overpayments to Contractor, Publicity, Records and Documents Review, Rights in Data/Ownership, and Rights of State and Federal Governments* will survive the termination of this Contract.

4.29 TAXES

HCA will pay sales or use taxes, if any, imposed on the services acquired hereunder. Contractor must pay all other taxes based on Contractor's income or gross receipts, or personal property taxes levied or assessed on Contractor's personal property. HCA, as an agency of Washington State government, is exempt from property tax.

Contractor must complete appropriate state and federal registrations and is responsible for payment of all taxes due on payments made under this Contract.

4.30 TERMINATION

4.30.1 TERMINATION FOR DEFAULT

In the event HCA determines that Contractor has failed to comply with the terms and conditions of this Contract, HCA has the right to suspend or terminate this Contract. HCA will notify Contractor in writing of the need to take corrective action. If corrective action is not taken within five (5) Business Days, or other time period agreed to in writing, the Contract may be terminated. HCA reserves the right to suspend all or part of the Contract, withhold further payments, or prohibit Contractor from incurring additional obligations of funds during investigation of the alleged compliance breach and pending corrective action by Contractor or a decision by HCA to terminate the Contract.

In the event of termination for default, Contractor will be liable for damages as authorized by law including, but not limited to, any cost difference between the original Contract and the replacement or cover Contract and all administrative costs directly related to the replacement Contract, e.g., cost of the competitive bidding, mailing, advertising, and staff time.

If it is determined that Contractor: (i) was not in default, or (ii) its failure to perform was outside of its control, fault or negligence, the termination will be deemed a "Termination for Convenience."

4.30.2 TERMINATION FOR CONVENIENCE

When, at HCA's sole discretion, it is in the best interest of the State, HCA may terminate this Contract in whole or in part by providing thirty (30) days' notice. If this Contract is so terminated, HCA will be liable only for payment in accordance with the terms of this Contract for services rendered prior to the effective date of termination. No penalty will accrue to HCA in the event the termination option in this section is exercised.

4.30.3 TERMINATION FOR NONALLOCATION OF FUND

If funds are not allocated to continue this Contract in any future period, HCA may immediately terminate this Contract by providing written notice to the Contractor. The termination will be effective on the date specified in the termination notice. HCA will be liable only for payment in accordance with the terms of this Contract for services rendered prior to the effective date of termination. HCA agrees to notify Contractor of such non-allocation at the earliest possible time. No penalty will accrue to HCA in the event the termination option in this section is exercised.

4.30.4 TERMINATION FOR WITHDRAWAL OF AUTHORITY

In the event that the federal government cancels or modifies the Demonstration, or if the authority of HCA to perform any of its duties is withdrawn, reduced, or limited in any way then HCA may immediately terminate this Contract by providing written notice to the Contractor. The termination will be effective on the date specified in the termination notice. HCA will be liable only for payment in accordance with the terms of this Contract for services rendered prior to the effective date of termination. HCA agrees to notify Contractor of such withdrawal of authority at the earliest possible time. No penalty will accrue to HCA in the event the termination option in this section is exercised.

4.30.5 TERMINATION FOR CONFLICT OF INTEREST

HCA may terminate this Contract by written notice to the Contractor if HCA determines, after due notice and examination, that there is a violation of the Ethics in Public Service Act, Chapter 42.52 RCW, or any other laws regarding ethics in public acquisitions and procurement and performance of contracts. In the event this Contract is so terminated, HCA will be entitled to pursue the same remedies against the Contractor as it could pursue in the event Contractor breaches the contract.

4.31 TERMINATION PROCEDURES

4.31.1 Upon termination of this Contract HCA, in addition to any other rights provided in this Contract, may require Contractor to deliver to HCA any property specifically

produced or acquired for the performance of such part of this Contract as has been terminated.

4.31.2 HCA will pay Contractor the agreed upon price, if separately stated, for completed work and services accepted by HCA and the amount agreed upon by the Contractor and HCA for (i) completed work and services for which no separate price is stated; (ii) partially completed work and services; (iii) other property or services that are accepted by HCA; and (iv) the protection and preservation of property, unless the termination is for default, in which case HCA will determine the extent of the liability. Failure to agree with such determination will be a dispute within the meaning of Section 4.9 *Disputes*. HCA may withhold from any amounts due the Contractor such sum as HCA determines to be necessary to protect HCA against potential loss or liability.

4.31.3 After receipt of notice of termination, and except as otherwise directed by HCA, Contractor must:

4.31.3.1 Stop work under the Contract on the date, and to the extent specified in the notice;

4.31.3.2 Place no further orders or subcontracts for materials, services, or facilities except as may be necessary for completion of such portion of the work under the Contract that is not terminated;

4.31.3.3 Assign to HCA, in the manner, at the times, and to the extent directed by HCA, all the rights, title, and interest of the Contractor under the orders and subcontracts so terminated; in which case HCA has the right, at its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts;

4.31.3.4 Settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, with the approval or ratification of HCA to the extent HCA may require, which approval or ratification will be final for all the purposes of this clause;

4.31.3.5 Transfer title to and deliver as directed by HCA any property required to be furnished to HCA;

4.31.3.6 Complete performance of any part of the work that was not terminated by HCA; and

4.31.3.7 Take such action as may be necessary, or as HCA may direct, for the protection and preservation of the records related to this Contract that are in the possession of the Contractor and in which HCA has or may acquire an interest.

4.32 WAIVER

Waiver of any breach of any term or condition of this Contract will not be deemed a waiver of any prior or subsequent breach or default. No term or condition of this Contract will be held to be waived, modified, or deleted except by a written instrument signed by the

parties. Only the HCA Authorized Representative has the authority to waive any term or condition of this Contract on behalf of HCA.

Schedule A
STATEMENT OF WORK

The Contractor must provide services and deliverables, and otherwise do all things necessary for or incidental to the performance of work as set forth below.

A. Region

The geographic population designated to the recipient for all activities contained herein is:*******.

B. ACH Decision-Making and Management.

Contractor must identify a primary decision-making process, a process for conflict resolution, and structure (e.g., a Board or Steering Committee). The ACH management approach and decision-making structure must align with the State Innovation Model (SIM) sub-award contract and related requirements within that contract. Full compliance with the SIM contract over the duration of SIM is prerequisite to satisfactory performance under this demonstration Contract.

1. The primary decision-making body will be the final decision-maker for Contractor regarding the selection of projects and participants based on the regional needs assessment.
2. Contractor and the state will collaborate and agree on Contractor's approach to its decision-making structure.
3. The overall organizational structure established by Contractor must demonstrate compliance with its Project Plan and have the capability to make decisions and be accountable for the following five domains:

    a) *Financial*, including decisions about the allocation methodology, the roles and responsibilities of each partner organization, and budget development.
    b) *Clinical*, including appropriate expertise and strategies for monitoring clinical outcomes. Contractor will be responsible for monitoring activities of providers participating in care delivery redesign projects and should incorporate clinical leadership, which reflects both large and small providers and urban and rural providers.
    c) *Community*, including an emphasis on health equity and a process to engage the community and consumers.
    d) *Data*, including the processes and resources to support data-driven decision making and formative evaluation.
    e) *Program management and strategy development.* Contractor must have organizational capacity and administrative support for regional coordination and communication on behalf of Contractor.

C. ACH Decision-Making Body Composition.

Contractor's decision-making body must include voting partners from the following categories:

1. One or more primary care providers, including practices and facilities serving Medicaid beneficiaries;
2. One or more behavioral health providers, including practices and facilities serving Medicaid beneficiaries;
3. One or more health plans, including but not limited to Medicaid Managed Care Organizations; if only one opening is available for a health plan, it must be filled by a Medicaid Managed Care Organizations;
4. One or more hospitals or health systems;

5. One or more local public health jurisdiction;
6. One or more representatives from the tribes, IHS facilities, and UIHPs in the region, as further specified in [the tribal protocol];
7. Multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in the region. This includes, but is not limited to, transportation, housing, employment services, education, criminal justice, financial assistance, consumers, consumer advocacy organizations, childcare, veteran services, community supports, and legal assistance.

To ensure broad participation in the [ACH] and prevent one group of Contractor partners from dominating decision-making, at least 50 percent of the primary decision-making body must be non-clinic, non-payer participants. In addition to balanced sectoral representation, where multiple counties exist within Contractor's region, a concerted effort to include a person from each county on the primary decision-making body must be demonstrated.

D. Consumer Engagement Plan

Contractor must create and execute a consumer engagement plan as part of the ACH Project Plan. The consumer engagement plan will detail the multiple levels of the decision-making process to ensure Contractor is accurately assessing local health needs, priorities and inequities. As part of the ACH Project Plan, Contractor must provide documentation of at least two public meetings detailing how their proposal incorporates feedback from the public comment process.

E. Tribes

Contractor shall adopt either HCA's Model ACH Tribal Collaboration and Communication Policy, incorporated as Attachment C, or a policy agreed upon in writing by Contractor and every tribe and Indian Health Care Provider (IHCP) in Contractor's region. In addition to adopting a Tribal Collaboration and Communication Policy, Contractor's governing board must make reasonable efforts to receive ongoing training on the Indian health care delivery system with a focus on their local tribes and IHCPs and on the needs of both tribal and urban Indian populations. Contractor will collaborate and communicate with tribal governments, IHS facilities, and UIHPs in a manner that respects the tribes' status as sovereign nations and the IHS facilities' and UIHPs' status as congressionally established entities charged with meeting the federal trust responsibility and U.S. treaty obligations to American Indians/Alaska Natives (AI/ANs).

F. ACH Project Agreements under DSRIP

Contractor shall establish partner agreements with the providers participating in projects. Partnering Providers participating in projects are not deemed to be contractors of the Health Care Authority. Partner agreements shall contain a compliance agreement program to prevent, detect, and address compliance issues that arise with respect to Contractor's projects and operations. Contractor shall comply with HCA's compliance program, including the designation of an individual to oversee Contractor's partnering providers' compliance programs.

G. Project Objectives.

Contractor will design and implement projects that further Medicaid transformation objectives elaborated in the DSRIP Planning Protocol, which are:

1. *Health Systems and Community Capacity.* Contractor must create health systems capacity in order to expand effective community based-treatment models; reduce unnecessary use of intensive services and settings without impairing health outcomes;

and support prevention through screening, early intervention, and population health management initiatives.

2. *Financial Sustainability through Participation in Value-based Payment.* Medicaid transformation efforts must contribute meaningfully to moving the state forward on value-based payment (VBP). Contractor will be required to design project plan activities that enable the success of Alternative Payment Models required by the state for Medicaid managed care plans.
3. *Bi-directional Integration of physical and behavioral health.* Contractor must integrate physical and behavioral health services through new care models, consistent with the state's path to fully integrated managed care by January 2020. Contractor must establish an information technology system which supports the sharing of clinical record and enables the integration of care. Contractor's IT system development must be supported by training for providers to adopt new technology and protocols. The state will provide increased incentives for regions that commit to and implement fully integrated managed care prior to January 2020.
4. *Community-based Whole-person Care.* Contractor must use or enhance existing services in the community to promote care coordination across the continuum of health for beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health. Contractor will devise projects to promote evidence-based practices that meet the needs of a region's identified high-risk, high-needs target populations.
5. *Improve Health Equity and Reduce Health Disparities.* Contractor must implement prevention and health promotion strategies for targeted populations to address health disparities and achieve health equity.

H. Project Milestones

HCA will assess Contractor's Progress towards achieving Medicaid Transformation goals based on achievement of specific milestones and measured by these milestones. Milestones will be developed by the state in consultation with stakeholders and members of the public and approved by CMS. Generally, progress milestones will be organized into the following categories:

1. *Project planning progress milestones.* This includes plans for investments in technology, tools, stakeholder engagement, and human resources that will allow Contractor to build capacity to serve target populations and pursue Contractor's project goals in accordance with community-based priorities.
2. *Project implementation progress milestones.* This includes milestones that demonstrate progress towards process-based improvements, as established by the state, in the implementation of projects consistent with the demonstration's objectives of building health and community systems capacity; promoting care delivery redesign through bidirectional integration of care and care coordination; and fostering health equity through prevention and health promotion.
3. *Scale and sustain progress milestones.* This includes milestones that demonstrate project implementation progress, as established by HCA, related to efforts to scale and sustain project activities in pursuit of the demonstration objectives. HCA will identify a sub-set of project-level and system-wide measures that will transition to pay for performance.

I. DSRIP Planning Protocol

Contractor must fulfill all obligations as set forth in the DSRIP Planning Protocol which will become part of this Contract upon approval by CMS.

J. DSRIP Program Funding and Mechanics Protocol

Contractor must fulfill all obligations as set forth in the DSRIP Program Funding and Mechanics Protocol which will become part of this Contract upon approval by CMS. DSRIP payments for Contractor's partnering providers are contingent on the partnering providers fully meeting project metrics defined in the approved Contractor Project Plan. In order for providers to receive incentive funding relating to any metric, Contractor must submit all required reporting, as outlined in the Program Funding and Mechanics Protocol.

K. ACH Project Plans

Contractor must develop a Project Plan that is consistent with the transformation objectives of this demonstration and describes the steps Contractor will take to achieve those objectives. The plan must be based on the DSRIP Planning Protocol and further developed by Contractor to be directly responsive to the needs and characteristics of the communities that it serves. In developing its Project Plan. Contractor must solicit and incorporate community and consumer input to ensure it reflects the specific needs of its region. Contractor Project Plans must be approved by HCA and may be subject to additional review by CMS. In accordance with the DSRIP Program Funding and Mechanics Protocol, HCA and the assigned independent assessor must review and approve Contractor's Project Plans in order to authorize DSRIP funding for DY1 and DY 2 and must conduct ongoing reviews of Contractor's Project Plans as part of a mid-point assessment in order to authorize DSRIP funding for DY 3-5. The Health Care Authority is responsible for conducting these reviews for compliance with approved protocols. The independent assessor recommendations should be considered final and not subject to CMS review. The DSRIP Planning Protocol will provide a structured format for Contractor's use in developing its Project Plan submission for approval. At a minimum, Contractor's Project Plan will include the elements listed below.

1. Contractor's Project Plan must identify the target populations, projects, and specific milestones for the proposed project, which must be chosen from the options described in the approved DSRIP Planning Protocol.
2. Goals of Contractor's Project Plan should be aligned with each of the objectives as described in Section F. above.
3. Milestones should be organized as described above in Section G. above, reflecting the overall goals of the demonstration and subparts for each goal as necessary.
4. Contractor's Project Plan must describe the needs being addressed and the proposed period of performance, beginning after January 9, 2017.
5. Based on the proposed period of performance, Contractor must describe its expected outcome for each of the projects chosen. Contractor must also describe why it selected the project, and should discuss the size and significance of the target population in relation to the project goals, the expected impact on that population, and the timing of the impact.
6. Contractor's Project Plan must include a description of the processes it will use to engage and reach out to stakeholders including a plan for ongoing engagement with the public, based on the process described in the DSRIP Planning Protocol.
7. Contractor must demonstrate how the projects support sustainable delivery system transformation for the target populations. The projects must implement new, or significantly enhance, existing health care initiatives.
8. Contractor's Project Plans must include a Budget Plan. Contractor may not receive credit for metrics achieved prior to approval of its Project Plans. The Budget Plan shall include funding support for Contractor's administrative management activities as a percentage of allocated project funding.

L. ACH Reporting Requirements

Two times per year, ACHs seeking payment under the demonstration shall submit reports that include the information and data necessary to evaluate ACH projects using a standardized reporting form developed by the state. ACHs will use the document to report on their progress against the milestones and metrics described in their approved Project Plans. Based on these reports, as well as data generated by the state on performance metrics, the state will calculate aggregate incentive payments in accordance with the DSRIP Funding and Mechanics Protocol. The ACH reports will be reviewed by state and the Independent Assessor. Upon request, ACHs will provide back-up documentation in support of their progress. These reports will be due as indicated below after the end of each reporting period:

- For the reporting period encompassing January 1 through June 30 of each year; the semi-annual report and the corresponding request for payment must be submitted by the ACH to the state before July 31.
- For the reporting period encompassing July 1 through December 31 of each year; the semi-annual report and the corresponding request for payment must be submitted by the ACH to the state before January 31.

The state shall have 30 calendar days after these reporting deadlines to review and approve or request additional information regarding the data reported for each milestones/metric and measure. If additional information is requested, the ACH shall respond to the request within 15 calendar days and the state shall have an additional 15 calendar days to review, approve, or deny the request for payment, based on the additional information provided. The state shall schedule the payment transaction for each ACH within 30 calendar days following state approval of the semi-annual report. Approved payments will be transferred to the Financial Executor until the
ACH provides direction for payment distribution to partnering providers.

M. Learning Collaboratives

With funding available through this demonstration, HCA will support regular learning collaboratives, which will be a required activity for Contractor.

ATTACHMENT A

FEDERAL COMPLIANCE, CERTIFICATIONS, AND ASSURANCES

In the event federal funds are included in this agreement, the following sections apply: I. Federal Compliance and II. Standard Federal Assurances and Certifications.

I. FEDERAL COMPLIANCE - The use of federal funds requires additional compliance and control mechanisms to be in place. The following represents the majority of compliance elements that may apply to any federal funds provided under this contract. For clarification regarding any of these elements or details specific to the federal funds in this contract, contact the Health Care Authority

a. *Source of Funds:* This agreement is funded in full through Washington State's five-year Medicaid Transformation Project approved under section 1115(a) of the federal Social Security Act by the Centers for Medicare and Medicaid Service (CMS) on January 9, 2017, No. 11-W-00304/0.

b. *Period of Availability of Funds:* Funds will become available to Contractor commencing on the date of final signature of the Contract to which this document is attached, and continuing through December 31, 2021.

c. *Modifications:* This agreement may not be modified or amended, nor may any term or provision be waived or discharged, including this particular Paragraph, except in writing, signed upon by both parties.
   1. Examples of items requiring Health Care Authority prior written approval include, but are not limited to, the following:
      i. Any changes in the Project plan.
      ii. Change in scope or objective of the agreement.
      iii. Change in a key person specified in the agreement.
      iv. The absence for more than three months or a 25% reduction in time by the Project Manager/Director.
      v. Need for additional funding.
      vi. Inclusion of costs that require prior approvals as outlined in the appropriate cost principles.
      .
   2. No changes are to be implemented by Contractor until a written notice of approval is received from the Health Care Authority.

d. *Sub-Contracting:* If sub-contractors are approved by the Health Care Authority, the subcontract shall contain, at a minimum, sections of the agreement pertaining to Debarred and Suspended Vendors, Lobbying certification, Audit requirements, and/or any other project Federal, state, and local requirements.

e. *Condition for Receipt of Health Care Authority Funds:* Funds provided by Health Care Authority to Contractor under this agreement may not be used by Contractor as a match or cost-sharing provision to secure other federal monies without prior written approval by the Health Care Authority.

f. *Unallowable Costs:* The Contractor's' expenditures shall be subject to reduction for amounts included in any invoice or prior payment made which HCA determines not to constitute allowable costs on the basis of audits, reviews, or monitoring of this agreement.

g. *Citizenship/Alien Verification/Determination:* The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (PL 104-193) states that federal public benefits should be made available only to U.S. citizens and qualified aliens. Entities that offer a service defined as a "federal public benefit" must make a citizenship/qualified alien determination/ verification of applicants at the time of application as part of the eligibility criteria. Non-US citizens and unqualified aliens are not eligible to receive the services. PL 104-193 also includes specific reporting requirements.

h. *Federal Compliance:* The Contractor shall comply with all applicable State and Federal statutes, laws, rules, and regulations in the performance of this agreement, whether included specifically in this agreement or not.

i. *Civil Rights and Non-Discrimination Obligations* During the performance of this agreement, the Contractor shall comply with all current and future federal statutes relating to nondiscrimination. These include but are not limited to: Title VI of the Civil Rights Act of 1964 (PL 88-352), Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681-1683 and 1685-1686), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. §§ 6101-6107), the Drug Abuse Office and Treatment Act of 1972 (PL 92-255), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (PL 91-616), §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290dd-3 and 290ee-3), Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), and the Americans with Disability Act (42 U.S.C., Section 12101 et seq.) http://www.hhs.gov/ocr/civilrights

HCA Federal Compliance Contact Information
Federal Grants and Budget Specialist
Health Care Policy
Washington State Health Care Authority
Post Office Box 42710
Olympia, Washington 98504-2710

II. STANDARD FEDERAL CERTIFICATIONS AND ASSURANCES - Following are the Assurances, Certifications, and Special Conditions that apply to all federally funded (in whole or in part) agreements administered by the Washington State Health Care Authority.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the contracting organization) certifies to the best of his or her knowledge and belief, that the contractor, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a) is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

b) has not within a 3-year period preceding this contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

c) is not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

d) has not within a 3-year period preceding this contract had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the contractor not be able to provide this certification, an explanation as to why should be placed after the assurances page in the contract. The contractor agrees by signing this contract that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in

all lower tier covered transactions (i.e., transactions with contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the contracting organization) certifies that the contractor will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

b) Establishing an ongoing drug-free awareness program to inform employees about
(1) The dangers of drug abuse in the workplace;
(2) The contractor's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c) Making it a requirement that each employee to be engaged in the performance of the contract be given a copy of the statement required by paragraph (a) above;

d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the contract, the employee will—
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every contract officer or other designee on whose contract activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted—
(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, Authority has designated the following central point for receipt of such notices:

Legal Services Manager
WA State Health Care Authority
PO Box 42700
Olympia, WA 98504-2700

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant

or cooperative agreement must disclose lobbying undertaken with non-Federal (nonappropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the contracting organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subcontracts at all tiers (including subcontracts, subcontracts, and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the contracting organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the contracting organization will comply with the Public Health Service terms and conditions of award if a contract is awarded.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the contracting organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor

facility used for the provision of services for children as defined by the Act.

The contracting organization agrees that it will require that the language of this certification be included in any subcontracts which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Public Health Services strongly encourages all recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

6. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS INSTRUCTIONS FOR CERTIFICATION

1) By signing and submitting this proposal, the prospective contractor is providing the certification set out below.
2) The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. The prospective contractor shall submit an explanation of why it cannot provide the certification set out below. The certification or explanation will be considered in connection with the department or agency's determination whether to enter into this transaction. However, failure of the prospective contractor to furnish a certification or an explanation shall disqualify such person from participation in this transaction.
3) The certification in this clause is a material representation of fact upon which reliance was placed when the department or agency determined to enter into this transaction. If it is later determined that the prospective contractor knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause of default.
4) The prospective contractor shall provide immediate written notice to the department or agency to whom this contract is submitted if at any time the prospective contractor learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
5) The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549. You may contact the person to whom this contract is submitted for assistance in obtaining a copy of those regulations.
6) The prospective contractor agrees by submitting this contract that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by Authority.
7) The prospective contractor further agrees by submitting this contract that it will include the clause titled ``Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion -- Lower Tier Covered Transaction," provided by HHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
8) A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Non-procurement List (of excluded parties).
9) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
10) Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded

from participation in this transaction, in addition to other remedies available to the Federal Government, Authority may terminate this transaction for cause or default.

7. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS -- PRIMARY COVERED TRANSACTIONS

1) The prospective contractor certifies to the best of its knowledge and belief, that it and its principals:
   a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
b) Have not within a three-year period preceding this contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
   c) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification; and
   d) Have not within a three-year period preceding this contract had one or more public transactions (Federal, State or local) terminated for cause or default.

2) Where the prospective contractor is unable to certify to any of the statements in this certification, such prospective contractor shall attach an explanation to this proposal.

CONTRACTOR SIGNATURE REQUIRED

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Please also print or type name:	
ORGANIZATION NAME: (if applicable)	DATE

Attachment B

Federal Funding Accountability and Transparency Act (FFATA) Data Collection Form

This Contract is supported by federal funds that require compliance with the Federal Funding Accountability and Transparency Act (FFATA or the Transparency Act). The purpose of the Transparency Act is to make information available online so the public can see how federal funds are spent.

To comply with the act and be eligible to enter into this contract, your organization must have a Data Universal Numbering System (DUNS®) number. A DUNS® number provides a method to verify data about your organization. If you do not already have one, you may receive a DUNS® number free of charge by contacting Dun and Bradstreet at www.dnb.com.

Required Information about your organization and this contract will be made available on USASpending.gov by the Washington State Health Care Authority (HCA) as required by P.L. 109-282. As a tool to provide the information, HCA encourages registration with the Central Contractor Registry (CCR) because less data entry and re-entry is required by both HCA and your organization. You may register with CCR on-line at https://www.uscontractorregistration.com/.

Contractor must complete this form and return it to the Health Care Authority (HCA).

CONTRACTOR

1. Legal Name	2. DUNS Number
3. Principle Place of Performance	
3a. City	3b. State
3c. Zip+4	3d. Country

4. Are you registered in CCR (https://www.uscontractorregistration.com/)? ☐YES (skip to page 2. Sign, date and return) ☐NO

5. In the preceding fiscal year did your organization:
   a. Receive 80% or more of annual gross revenue from federal contracts, subcontracts, grants, loans, subgrants, and/or cooperative agreements; **and**
   b. $25,000,000 or more in annual gross revenues from federal contracts, subcontracts, grants, loans, subgrants, and/or cooperative agreements; **and**
   c. The public does not have access to information about the compensation of the executives through periodic reports filled with the IRS or the Security and Exchange Commission per 2 CFR Part 170.330

☐ NO (skip the remainder of this section - Sign, date and return)

☐ YES (You must report the names and total compensation of the top 5 highly compensated officials of your organization).

Name Of Official	Total Compensation
1.	
2.	
3.	
4.	
5.	

Note: "Total compensation" means the cash and noncash dollar value earned by the executive during the Contractor's past fiscal year of the following (for more information see 17 CFR 229.402 (c)(2)).

By signing this document, the Contractor Authorized Representative attests to the information.

Signature of Contractor Authorized Representative	Date

HCA will not endorse Contractor until this form is completed and returned.

FOR HEALTH CARE AUTHORITY USE ONLY

HCA Contract Number: _____
Project Description

ATTACHMENT C: TRIBAL COLLABORATION POLICY

Olympic Community of Health
Balance Sheet
As of April 30, 2017

	Apr 30, 17	
ASSETS		
Current Assets		
Checking/Savings		
First Federal Checking		255,834.14
First Federal Savings		1.00
Total Checking/Savings		255,835.14
Accounts Receivable		
Accounts Receivable		7,000.00
Total Accounts Receivable		7,000.00
Other Current Assets		
Prepaid Expenses		705.85
Total Other Current Assets		705.85
Total Current Assets		263,540.99
TOTAL ASSETS		**263,540.99**
LIABILITIES & EQUITY		
Liabilities		
Current Liabilities		
Accounts Payable		
Accounts Payable		500.00
Total Accounts Payable		500.00
Other Current Liabilities		
Deferred Grant Revenue		
HCA	20,010.02	
KPHD	221,779.63	
Opioid	14,000.00	
Total Deferred Grant Revenue		255,789.65
Payroll Taxes Payable		6,162.82
SEP Payable		1,088.52
Total Other Current Liabilities		263,040.99
Total Current Liabilities		263,540.99
Total Liabilities		263,540.99
TOTAL LIABILITIES & EQUITY		**263,540.99**

Olympic Community of Health
Profit & Loss by Class
January through April 2017

	1 - Administration & Governance		2 - Health Improvement Planning		3 - Health & Delivery System		3a - Opioid Project		Unclassified		TOTAL	
Ordinary Income/Expense												
Income												
Grant Income	61,626.46		8,958.07		21,952.71		662.86		0.00		93,200.10	
Total Income	61,626.46		8,958.07		21,952.71		662.86		0.00		93,200.10	
Expense												
Administrative Services												
Payroll & Bookkeeping expense	904.00		0.00		0.00		0.00		0.00		904.00	
Total Administrative Services		904.00		0.00		0.00		0.00		0.00		904.00
Computer and Internet Expenses		0.00		0.00		0.00		0.00		0.00		0.00
Employee Benefits												
Health Insurance	5,816.88		0.00		0.00		0.00		0.00		5,816.88	
SEP Expense	1,088.52		0.00		0.00		0.00		0.00		1,088.52	
Total Employee Benefits		6,905.40		0.00		0.00		0.00		0.00		6,905.40
Insurance Expense		302.49		0.00		0.00		0.00		0.00		302.49
Office Expense												
Supplies	1,075.85		0.00		0.00		0.00		392.23		1,468.08	
Communcations	535.10		297.41		0.00		0.00		0.00		832.51	
Office Space	3,636.00		0.00		0.00		0.00		0.00		3,636.00	
Postage	91.57		0.00		0.00		0.00		0.00		91.57	
Information Technology	386.27		0.00		0.00		0.00		0.00		386.27	
Office Expense - Other	0.00		0.00		0.00		0.00		0.00		0.00	
Total Office Expense		5,724.79		297.41		0.00		0.00		392.23		6,414.43
Payroll Expenses												
Wages												
Executive Director	25,307.80		5,747.26		3,173.83		227.32		0.00		34,456.21	
Staff Salaries	10,347.07		1,047.85		7,598.09		377.66		0.00		19,370.67	
Total Wages		35,654.87		6,795.11		10,771.92		604.98		0.00		53,826.88
Payroll Taxes												
FICA	1,734.85		218.80		562.38		46.28		0.00		2,562.31	
FUTA	74.70		9.42		24.22		1.99		0.00		110.33	
SUTA	270.33		34.09		87.63		7.22		0.00		399.27	
L&I	89.59		11.30		29.04		2.39		0.00		132.32	
Total Payroll Taxes		2,169.47		273.61		703.27		57.88		0.00		3,204.23
Total Payroll Expenses		37,824.34		7,068.72		11,475.19		662.86		0.00		57,031.11
Professional Development		29.00		0.00		0.00		0.00		0.00		29.00
Professional Services												
Contract Services	4,484.93		1,521.44		10,324.07		0.00		0.00		16,330.44	
Total Professional Services		4,484.93		1,521.44		10,324.07		0.00		0.00		16,330.44
Telephone Expense		392.23		0.00		0.00		0.00		-392.23		0.00
Travel Expense		5,059.28		70.50		153.45		0.00		0.00		5,283.23
Total Expense		61,626.46		8,958.07		21,952.71		662.86		0.00		93,200.10
Net Ordinary Income		0.00		0.00		0.00		0.00		0.00		0.00
Net Income		**0.00**		**0.00**		**0.00**		**0.00**		**0.00**		**0.00**

Olympic Community of Health
Profit & Loss Budget vs. Actual
January through April 2017

	KPHD Jan 17	OCH Feb - Apr 17	OCH Feb - Apr Budget
Ordinary Income/Expense			
Income			
Grant Income	26,909.94	66,290.16	57,750.00
Partner Contributions	0.00	0.00	19,999.98
Waiver Administrative Ramp-Up	0.00	0.00	37,500.00
Designated Reserve	0.00	0.00	60,734.25
Total Income	26,909.94	66,290.16	175,984.23
Expense			
Administrative Services			
CPA services	0.00	0.00	3,545.52
Payroll & Bookkeeping expense	0.00	904.00	3,553.40
Total Administrative Services	0.00	904.00	7,098.92
Emplolyee Benefits			
Health Insurance	0.00	5,816.88	6,109.12
SEP Expense	0.00	1,088.52	2,688.28
Emplolyee Benefits - Other	0.00	0.00	
Total Emplolyee Benefits	0.00	6,905.40	8,797.40
Events			
Food	0.00	0.00	1,500.00
Rental (venue, A/V)	0.00	0.00	409.12
Total Events	0.00	0.00	1,909.12
Insurance Expense	0.00	302.49	704.43
Miscellaneous	0.00	0.00	409.08
Office Expense			
Supplies	27.17	1,440.91	1,083.55
Communcations	57.54	774.97	529.82
Office Space	1,278.50	2,357.50	305.90
Postage	0.00	91.57	
Information Technology	386.27	0.00	2,037.61
Total Office Expense	1,749.48	4,664.95	3,956.88
Payroll Expenses			
Wages			
Executive Director	13,622.87	20,833.34	25,865.01
Staff Salaries	6,079.00	13,291.67	22,525.12
Total Wages	19,701.87	34,125.01	48,390.13
Payroll Taxes			
FICA	0.00	2,562.31	4,112.70
FUTA	0.00	110.33	176.52
SUTA	0.00	399.27	1,590.56
L&I	0.00	132.32	200.52
Total Payroll Taxes	0.00	3,204.23	6,080.30
Total Payroll Expenses	19,701.87	37,329.24	54,470.43
Professional Development	0.00	29.00	1,704.56
Professional Services			
Legal	0.00	0.00	1,363.68
Contract Services	4,925.48	11,404.96	12,583.80
Total Professional Services	4,925.48	11,404.96	13,947.48
Travel Expense	533.11	4,750.12	2,152.09
Total Expense	26,909.94	66,290.16	95,150.39
Net Ordinary Income	0.00	0.00	80,833.84

Olympic Community of Health

Legal Counsel S.B.A.R.

Presented to the Board of Directors June 12, 2017

Situation

The OCH is a new corporation that is about to enter into multiple contracts with many organizations for millions of dollars. This will bring substantial legal risk.

Background

The Executive Committee requested options for legal support for the organization. The OCH interviewed two law firms based on experience in nonprofit and tribal law and is recommended the top choice to the Board for consideration.

Action

Counsel will provide the following services at $200/hour for a maximum of $10,000 per year:

- Legal review of board policies, procedures, and governance documents to ensure compliance with state and federal guidelines for 501(c)(3) organizations.
- Board legal training on compliance with state and federal guidelines for 501(c)(3) organizations.
- Assistance with filing IRS Form 1023 as needed, and dependent upon client budget.
- Legal review of Client's contracts as needed, and dependent upon client budget.
- General legal guidance on day-to-day legal issues as needed, and dependent upon client budget.

The OCH may terminate the agreement at any time.

The contract is between the Board of Directors and legal counsel. While the executive director will be the primary point-of-contact for counsel, counsel will be directly accountable to the Board of Directors.

Proposed **Recommendation**

The Board authorizes the executive director to engage Heather Erb as the OCH's legal counsel for 2017.

HEATHER M. ERB, ESQ.
P.O. Box 5918 · Bellingham, WA · 98227
heather@erblawfirm.com · (360) 220-1519
www.erblawfirm.com

LICENSES

Washington Bar Association, Active
Florida Bar Association, Inactive

EDUCATION

Florida State University College of Law — **Tallahassee, FL**
Juris Doctorate — 08/01-05/04

Honors: FSU Public Service Fellowship, 2002-2003
Beverly Stout McLear Scholarship Recipient, 2003-2004

Activities: Public Interest Law Student Association, Vice President

Journals: *Journal of Land Use & Environmental Law*
Journal of Transnational Law and Policy

University of West Florida — **Pensacola, FL**
B.A., English, *Magna Cum Laude* — 08/95-08/99

EXPERIENCE

American Indian Health Commission (AIHC) — 07/12-Present
Contract Attorney
Currently providing ongoing legal representation for the AIHC regarding the implementation of the American Indian/Alaska Native (AI/AN) provisions of the Patient Protection and Affordable Care Act, the Indian Health Care Improvement Act and statewide Medicaid transformation efforts. Areas of concentration include AI/AN income exemptions, consultation policy development, drafting proposed WAC revisions, data sharing agreements with university research institutions, and qualified health plan contracting requirements with Indian health care providers.

Lummi Indian Business Council — **Bellingham, WA**
Staff Attorney — 09/07-05/12
Assigned to represent the Lummi Nation in matters concerning health care, education, and housing. Responsibilities included representing the Nation health programs at the local, state and federal levels; providing employee training to professional staff in the area of HIPAA (Health Insurance Portability and Accountability Act); representing the schools in special education and inter-district and state matters; representing the Nation in tribal court regarding landlord-tenant matters; negotiation and drafting of contracts; drafting tribal code and governmental policies and procedures; and serving as the tribal prosecutor.

Office of the State Attorney, 10th Judicial Circuit — **Bartow, FL**
Assistant State Attorney — 08/04-08/07
Felony trial attorney. Conducted twenty felony jury trials and numerous misdemeanor jury trials. Handled a felony caseload of 100-150 cases including armed robbery, sexual assault, DUI manslaughter, second-degree murder, and drug trafficking. Received specialized training in DUI manslaughter and methamphetamine cases. Gained extensive experience in writing and arguing motions including motions to suppress, motions for the introduction of similar fact evidence, motions in limine, and motions for pretrial detention.

Department of Business & Professional Regulation **Tallahassee, FL**
Law Clerk, Division of Alcoholic Beverages and Tobacco 09/02-4/04
Responsibilities included articulating governmental agency policy as well as drafting appellate briefs and final agency orders.

Bay Area Legal Services, Inc., Senior Advocacy Unit **Tampa, FL**
FSU Public Service Fellow 05/02-08/02
Conducted legal research and drafted motions in the areas of bankruptcy law, consumer law, and landlord tenant law. Interviewed clients, engaged in public speaking, and created promotional materials for the organization.

PUBLICATIONS

"The ACA, the Service, and Indian Health Care Delivery System," American Bar Association Section of Taxation News Quarterly, Vol. 34 No. 4, Summer 2015.

"Washington Insurance Issuer Requirements for American Indian/Alaska Native Enrollees and Enrollees Seeking Services at Indian Health Care Providers," American Indian Health Commission, March 1, 2015.

"Indian Health Care Reform Manual for Washington State – American Indian Health Commission," American Indian Health Commission, August 1, 2014.

"Guidance for American Indian and Alaska Native Income Exemptions for Modified Gross Income-Based Washington Apple Health (Medicaid)," American Indian Health Commission, August 1, 2015.

Washington Health Benefit Exchange Tribal Consultation Policy, January 2013.

PRESENTATIONS

"Best Practices for Contracting with Indian Health Care Providers," Washington Office of the Insurance Commissioner, May 5, 2015.

"The ACA, the IRS, and the Indian Health Care Delivery System," American Bar Association Section of Taxation Midyear Meting, Houston Texas, January 31, 2015.

Indian Health Care Law CLE, Washington Office of the Insurance Commissioner, August 24, 2015.

"Maintaining a Successful Nonprofit: Avoiding Legal, Tax, and Leadership Pitfall," Nonprofit Workshop, Bellingham, WA, April 24, 2014.

PROFESSIONAL LEADERSHIP

Whatcom County Bar Association
American Bar Association Section on Taxation
Washington State Bar Association Health Law Section
Washington State Bar Association Indian Law Section

COMMUNITY INVOLVEMENT

Wayfind 2014-Present
Law Advocates, Street Law 2008**-**Present
Sehome High School Mock Trial Coach 2008-2011
Washington State Bar Association Pro Bono Public Service Commendation 2008

REFERENCES

Washington Superior Court Judge Raquel Montoya-Lewis
P.O. Box 28982
Bellingham, WA 98228
(360)306-1220

Dan Raas, Emeritus Attorney
1503 E St.
Bellingham, WA 98225
(360) 647-0234

David Neubeck, Former Lummi Assistant Reservation Attorney
Elder Law Offices of Barry Meyer
2828 Northwest Avenue
Bellingham, WA 98225
(360)738-2025

Peter Sternlicht, Division Chief
State Attorney's Office
10th Judicial Circuit
255 N. Broadway Ave.
Bartow, FL 33830
(863)534-4800

HEATHER ERB, PLLC
ATTORNEY AT LAW

PHONE: (360) 220-1519
EMAIL: heather@erblawfirm.com
WEBSITE: www.erblawfirm.com

June 5, 2017

ENGAGEMENT LETTER AND FEE AGREEMENT (FOLLOW-UP LETTER TO INITIAL INTERVIEW)

Elya Moore, Director
Olympic Community of Health
2500 W. Sims Way
Port Townsend, WA 98368

Re: Fee Agreement

Dear Ms. Moore:

Per our discussion on May 25, 2017, I am sending you a copy of my fee agreement for performing various nonprofit legal services for the Olympic Community of Health (OCH). My fees for legal services are $200 per hour. I will bill you approximately monthly, depending on the amount of work that was done on your file during that period of time. At this point, it is difficult to provide the exact amount of time and expense that will be necessary to perform the various services we discussed. However, the fee agreement will provide a cap on the amount of fees that could be charged. I will also advise you before I do any work that would substantially increase the amount of fees.

With OCH's permission, I communicated with my current client, the American Indian Health Commission (AIHC), regarding the possibility of my representing the OCH on nonprofit legal issues. The purpose of this conversation was to confirm that no current conflicts of interest exists between the OCH and the AIHC. I have confirmed that no current conflict exists and have received approval from the AIHC board to move forward with representing the OCH should the OCH choose to hire me. However, please note that if I subsequently learn that an adversarial situation exists between you and other clients or a conflict impairs my ability to adequately represent another client's interest, including the AIHC, I reserve the right to withdraw from representation if reasonable steps cannot be taken to resolve the conflict.

The attached Legal Fee Agreement will become effective once you have returned the signed Attached agreement. My goal is to provide you with excellent legal services. I also want to protect your interests in the event of my unexpected death, disability, impairment, or incapacity. In order to accomplish this, I have arranged with another attorney to assist with closing my practice in the event of my death, disability, impairment, or incapacity. In such event, my office staff or the assisting attorney will contact you and provide you with information about how to proceed.

I will send you documents, correspondence, and other information throughout this matter. These copies will be your file copies. I will also keep the information in a file in my office. The file in my office will be my file. When I have completed all the legal work necessary for your case, I will close my file and return

the original documents to you. I will then store the file for approximately 10 years. I will destroy the file after that period of time unless you instruct me in writing now to keep it longer.

I have included a copy of this letter and the Client Fee Agreement for you to review, sign, and return to me. If any of the information in this letter is not consistent with your understanding of our agreement, please contact me before signing the letter. Otherwise, please sign this letter and the enclosed copy of the Fee Agreement and return it to me.

On behalf of the firm, I appreciate the opportunity to represent you in this matter. If you have any questions, please feel free to call.

Very truly yours,

Heather Erb

I have read this letter and consent to it.

_____ _____

[Client] Date

Enclosure: Fee Agreement

June 5, 2017

ATTORNEY-CLIENT FEE AGREEMENT

HEATHER M. ERB ("Attorney") and **Olympic Community of Health** ("Client") hereby agree that Attorney will provide legal services to Client from _____ to December 31, 2017 on the terms set forth below.

1. **CONDITIONS.** This Agreement will not take effect, and Attorney will have no obligation to provide legal services, until Client returns a signed copy of this Agreement.

2. **SCOPE OF SERVICES**. Client hires Attorney to provide legal services in connection with the following:

    a. Legal review of board policies, procedures, and governance documents to ensure compliance with state and federal guidelines for 501(c)(3) organizations.

    b. Board legal training on compliance with state and federal guidelines for 501(c)(3) organizations.

    c. Assistance with filing IRS Form 1023 as needed, and dependent upon client budget.**

    d. Legal review of Client's contracts as needed, and dependent upon client budget.

    e. General legal guidance on day-to-day legal issues as needed, and dependent upon client budget.

    Attorney will provide those legal services reasonably required to represent Client. Attorney will take reasonable steps to keep Client informed of progress and to respond to Client's inquiries. Services in any matter not described above will require a separate written agreement.

    **If complex tax issues arise, Attorney will consult with Ceci Lopez, LLM in taxation. Such consultation will be charged at the same billable hour rate defined in Section 4 of this Agreement.

3. **CLIENT'S DUTIES.** Client agrees to be truthful with Attorney, to cooperate, to keep Attorney informed of any information or developments which may come to Client's attention, to abide by this Agreement, to pay Attorney's bills on time, and to keep Attorney advised of Client's address, telephone number and whereabouts. Client will assist Attorney in providing necessary information and documents.

4. **LEGAL FEES AND BILLING PRACTICES**. Client agrees to pay by the hour at Attorney's prevailing rates for all time spent on Client's matter by Attorney. Current hourly rate for the undersigned Attorney is $200 per hour. **The maximum chargeable under the term of the contract shall not exceed $10,000.** The time charged will include the time Attorney spends on telephone calls relating to Client's matter, including calls with Client and other individuals relevant to this matter. Attorney will charge for waiting time at

assigned meeting places and for travel time, both local and out of town. Time is charged in minimum units of one-tenth (.1) of an hour.

5. **COSTS AND OTHER CHARGES.**

   a. Attorney will incur various costs and expenses in performing legal services under this Agreement. Client agrees to pay for all costs, disbursements and expenses in addition to the hourly fees. Costs and expenses will be charged at Attorney's cost unless otherwise specified. The costs and expenses commonly include, facsimile charges, long distance telephone charges, messenger and other delivery fees, postage, photocopying ($.15 per page) and other reproduction costs, travel costs including parking, mileage ($0.56 per mile), transportation, meals and hotel costs (not to exceed $61 a day for meals and $180 a day for lodging unless otherwise agreed upon in writing). Large photocopying projects as defined by parties on a case-by-case basis will be billed at actual cost of third-party copying services.

   b. Travel. Whenever possible, time spent in traveling will be devoted to doing substantive work for Client and will be billed (at the usual rate) to the Client. Up to 2 hours of travel time (each way and each day) to and from a Client related matter that cannot be devoted to substantive work will be charged at the lawyer's hourly rate. Time spent in long-distance travel above the 2-hour limit each way that cannot be devoted to substantive work, will be charged at one-half of the Attorney's hourly rate.

   c. The hourly rate for performing secretarial/clerical services (i.e. photocopying, mail delivery, faxing) will be charged at a rate of $60 per hour.

6. **BILLING STATEMENTS**. Attorney will send Client periodic statements for fees and costs incurred. Each statement will be payable within 30 days of its mailing date. Client may request a statement at intervals of no less than 30 days. If Client so requests, Attorney will provide one within 10 days. The statements shall include the amount, rate, basis of calculation or other method of determination of the fees and costs, which costs will be clearly identified by item and amount. Invoices shall be submitted to the address listed below.

7. **DISCHARGE AND WITHDRAWAL**. Client may discharge Attorney at any time. Attorney may withdraw with Client's consent or for good cause. Good cause includes Client's breach of this Agreement, refusal to cooperate or to follow Attorney's advice on a material matter or any fact or circumstance that would render Attorney's continuing representation unlawful or unethical. When Attorney's services conclude, all unpaid charges will immediately become due and payable. After services conclude, Attorney will, upon Client's request, deliver to Client all documents and other uncompleted work on the date of termination.

8. **CONFLICT OF INTEREST.** I have performed a formal conflict of interest check to determine whether accepting representation of Client in this matter creates either an ethical or a business conflict. Presently, no conflict of interest appears to exist, but if I subsequently learn that an adversarial situation exists between you and other clients or a conflict impairs my ability to adequately represent Client's interest, I reserve the right to withdraw from representation if reasonable steps cannot be taken to resolve the conflict.

9. **DISCLAIMER OF GUARANTEE AND ESTIMATES**. Nothing in this Agreement and nothing in Attorney's statements to Client will be construed as a promise or guarantee about the outcome of the matter. Attorney makes no such promises or guarantees. Attorney's comments about the outcome of the matter are expressions of opinion only. Any estimate of fees given by Attorney shall not be a guarantee. Actual fees may vary from estimates given.

10. **ENTIRE AGREEMENT**. This Agreement contains the entire agreement of the parties. With the exception stated in Section Two (2) above, No other agreement, statement, or promise made on or before the effective date of this Agreement will be binding on the parties.

11. **SEVERABILITY IN EVENT OF PARTIAL INVALIDITY**. If any provision of this Agreement is held in whole or in part to be unenforceable for any reason, the remainder of that provision and of the entire Agreement will be severable and remain in effect.

12. **MODIFICATION BY SUBSEQUENT AGREEMENT**. This Agreement may be modified by subsequent agreement of the parties only by an instrument in writing signed by both of them, or an oral agreement only to the extent that the parties carry it out.

13. **EFFECTIVE DATE**. This Agreement will govern all legal services performed by Attorney on behalf of Client commencing with the date Attorney first performed services. The date at the beginning of this Agreement is for reference only. Even if this Agreement does not take effect, Client will be obligated to pay Attorney the reasonable value of any services Attorney may have performed for Client.

THE PARTIES HAVE READ AND UNDERSTOOD THE FOREGOING TERMS AND AGREE TO THEM AS OF THE DATE ATTORNEY FIRST PROVIDED SERVICES. IF MORE THAN ONE CLIENT SIGNS BELOW, EACH AGREES TO BE LIABLE, JOINTLY AND SEVERALLY, FOR ALL OBLIGATIONS UNDER THIS AGREEMENT. CLIENT SHALL RECEIVE A FULLY EXECUTED DUPLICATE OF THIS AGREEMENT.

DATED: _____

_____

PRINT NAME TITLE
Authorized Board Representative
Olympic Community of Health

_____

Signature

DATED: _____

_____

HEATHER ERB
Attorney at Law
P.O. Box 5918
Bellingham, WA 98227-5918
P:(360)220-1519
WSBA#: 38839

Olympic Community of Health

Executive Committee SBAR

Presented to the Executive Committee May 17, 2017
Presented to the Board of Directors June 12, 2017

Situation

The executive committee officer term limits are up July 2017.
The executive committee charter is up for review in May 2017.

Background

Bylaws

> *The officers of the OCH Board shall be President, Vice President, Secretary, Treasurer, and At-Large. At the end of the President's term, the At-Large office will be replaced by the Past-President. The Board may approve additional officers as it deems necessary for the performance of the business of the OCH. The term of office shall commence on July 1 and each officer shall hold office for one (1) year or until he or she shall have been succeeded or removed in the manner hereinafter provided. Such offices shall not be held for more than three (3) consecutive terms. Such officers shall hold office until their successors are elected and qualified. A vacancy in any office may be filled by the Board for the unexpired portion of the term.*

Executive Committee Membership

Member	Officer Position	Representation
Roy Walker	President	Long-term care
Jennifer Kreidler Moss	Vice President	Primary care
Hilary Whittington	Treasurer	Rural health
Leonard Forsman	Secretary	Suquamish Tribe
Joe Roszak	At-Large	Mental health

Action

All Executive Committee members are willing to continue in their current officer positions for another one-year term. Other Board Members may wish to be nominated for an officer position.

Proposed **Recommendation**

1. The Board invites interested candidates for officer positions to submit a case statement and brief bio to staff for consideration and election by ballot in July 2017.
2. If no new nominations come forward, the Board approves the current slate of officers to serve a second one-year term.

Olympic Community of Health

Mid-Adopter Fully Integrated Managed Care S.B.A.R.

Presented to the Board of Directors June 12, 2017

Situation

The OCH has discussed the state's model of fully integrated managed care (FIMC) at the last two Board meetings and received presentations from both the MCOs and BHO to understand their positions. Should the OCH Board encourage the county commissioners to submit a letter-of-intent to the HCA obligating the region to become a mid-adopter of FIMC?

Background

The HCA is moving forward to meet the legislative direction under Senate Bill 6312 that requires all regions statewide to achieve FIMC no later than January 1, 2020. The HCA is incenting regions to become a mid-adopter a year early, January 1, 2019. For the OCH, this incentive is $4.9 million dollars, to be dispensed directly to community partners doing the integration. Two additional incentives from the HCA to move towards FIMC:

- Demonstration dollars in the 4th and 5th year for the State are dependent on all regions doing FIMC by 2020. For the OCH, this is up to $14.8 million dollars in DSRIP funding for the Demonstration projects.
- The project plan template includes an attestation about FIMC, which could potentially impact our project score and therefore earnable incentive dollars.

Legislation (HB 1388) is currently being considered to allow each region to establish an interlocal leadership structure that will be responsible for designing and implementing a FIMC model for the region that "assures clients are at the center of care delivery and support integrated delivery of physical and behavioral health care at the provider level." This structure must have the following entities serving on it:

- Counties
- Managed care entities (MCOs and BHO)
- Physical Health and Behavioral HealthProviders
- Tribes
- Other entities serving the region in integration

Action

There are two approaches that a region can choose to become a "mid adopter":

- Integrated managed care plans assume all funding and functions for Medicaid covered behavioral health services by January 1, 2019; or
- Integrated managed care plans assume all funding for Medicaid covered behavioral health services by January 1, 2019, with certain functions subcontracted for one year to the regional Behavioral Health Organization/counties as agreed to by the county inter-local leadership structure

The decision to become a mid-adopter, and the choice of approach of mid-adopter, is not the OCH's. It is entirely up to the county commissioners of our three counties.

Proposed **Motion** to the Board from the Executive Committee

The Executive Committee recommends that the Board of Directors votes on sending a letter to the county commissioners of Clallam, Jefferson, and Kitsap encouraging them to submit a binding letter of intent to the Health Care Authority to become a "mid-adopter" of FIMC.

If so moved and approved, the Executive Director recommends this letter include language requesting the Executive Director and Board President serve on any interlocal leadership structure the counties choose to establish to ensure alignment with Project 2A (the integration project) of the Demonstration.

INCENTIVES FOR MID-ADOPTERS OF INTEGRATED MANAGED CARE

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

How does Medicaid Demonstration incentive funding work?

This information is dependent on the approval of the Funding and Mechanics Protocol currently under review by CMS, and pending Washington legislative appropriation for the Medicaid Demonstration:

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

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

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

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

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

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

Red text on this page indicates text updated May 22, 2017.

A FEW BASIC FACTS

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

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

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

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

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

Senate Bill 6312 allows the county authority or authorities within a region to elect to move forward with integrated managed care on an earlier timeline if desired. Under the Medicaid Demonstration, regions that implement integrated managed care by January 1, 2019 will be eligible for additional incentive payments through their Accountable Community of Health. There are two approaches that a region can choose to becoming a "mid adopter":

- Integrated managed care plans assume all funding and functions for Medicaid covered behavioral health services by January 1, 2019; or
- Integrated managed care plans assume all funding for Medicaid covered behavioral health services by January 1, 2019, with certain functions subcontracted for one year to the regional Behavioral Health Organization/counties as agreed to by the county inter-local leadership structure specified in active legislation (HB 1388), which is currently pending.

These "mid-adopter" regions can earn these particular incentive dollars. The incentive would be in addition to funds ACHs and regional partners can receive for implementing a set of projects selected from the Demonstration Project Toolkit, pending legislative appropriation of these incentives.

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

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

Next steps

Red text on this page indicates text updated May 22, 2017.

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

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

1. The county submits binding letter(s) of intent to the state Medicaid director no later than ~~September 1, 2017~~ September 15, 2017.
2. Implementation of new integrated MCOs in the region begins on ~~November 1, 2018, OR~~ January 1, 2019.

Regions are eligible for an incentive payment for completion of each phase, pending legislative appropriation of these incentives.

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

Regions are eligible to earn the Demonstration incentives if they elect to move forward with integrated managed care through either of the approaches described in Question 3 above by January 1, 2019.

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

1. Submission of a binding letter of intent signed by the county authority or authorities in the region to the Washington State Health Care Authority **by ~~September 1, 2017~~ September 15, 2017**;
2. Implementation of integrated managed care effective ~~November 1, 2018, or~~ January 1, 2019.

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

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

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

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

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

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

Additionally the incentive payments can further support and build upon the region's work to implement integrated clinical models.

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

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

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

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

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

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

Olympic Community of Health

OCH Demonstration Project Portfolio S.B.A.R.

Presented to the Board of Directors June 12, 2017

Situation

The OCH must agree on a portfolio of projects that: 1. will address our regional health needs, 2. we can deliver, and 3. will measurably move the dial on health improvement. The portfolio should be a cohesive, mutually supportive collection of projects and infrastructure investments optimizing our region's chance for a truly transformational change that is long-lasting and leverages the Demonstration investment beyond the five-years.

Background

Under the Board's authorization, staff have been working with the Regional Health Assessment and Planning Committee (RHAPC) to reach consensus on a Project Portfolio.

- January 31 OCH Convening to discuss optional projects in the toolkit, survey opens
- March 20 Request for Letter of Intent open to the public
- April 19 Successful Letter of Intent applicants invited to submit full application
- May 26 Applications due; all submissions posted online for public comment
- June 19 OCH Convening to discuss project portfolio

The attached *Project Portfolio Summary Table* captures the highlights and interrelatedness of the applications. The *Project Scores Summary Table* summarizes the scores from the RHAP Committee reviewers.

The RHAP Committee asked the OCH to examine whether we should submit a project application for the Pathways Hub ™ (Pathways), the only evidence-based model available in the toolkit. Ultimately, community partners advised the OCH not to submit a project application for Pathways and asked the OCH to convene community partners to identify an alternative. A concept piece, *Apple Integrator,* is included in the packet.

Action

On Friday June 2, the RHAP Committee reviewed 10 applications resulting from 35 Letters of Intent. Three key themes emerged that need to be addressed for the RHAP Committee to make a thoughtful project portfolio recommendation to the Board:

1. There is considerable overlap across projects, making it difficult to make recommendations without a deeper understanding of budget and staffing models that create efficiencies across projects
2. The two required projects, opioid response and bi-directional integration, are missing components that need to be woven into the portfolio
3. There is a shared need for clinical-community linkage and workforce development across all projects

Another consideration that we are monitoring closely is the timing and development of the tribal protocol and tribe-specific projects. Regardless of timing, there is a need for increased tribal engagement and collaboration across all projects.

OCH staff connected with the HCA about submitting *Apple Integrator* as a care coordination project (2B) in our portfolio. The only project allowed under 2B is Pathways. Here are several options for consideration:

1. Do not move forward with *Apple Integrator* and focus on the other seven projects
2. Move forward with *Apple Integrator*, weaving it throughout the portfolio, not as a separate project
3. Submit a proposal for Pathways using the *Apple Integrator* technology, focusing on one or two pathways

Proposed Recommendation from RHAP Committee to Board
OCH staff works with application leads to better define a portfolio of projects that addresses budgeting, overlap, and capacity issues across projects. Bring a portfolio to the RHAP Committee (June 26) for a recommendation to the Board (July 10).

Proposed Recommendation from Executive Director to Board
Form a workgroup to pursue *Apple Integrator*: evaluate interrelationship with other projects, identify key partners, select pilot test case, and recommend a path forward.

Olympic Community of Health

Apple Integrator (A.I.) Concept Piece

May 25, 2017

Brief Project Description

A.I. PROJECT DESCRIPTION: Apple Integrator (A.I.) will connect health and social service providers into a cloud-based e-referral management network. A.I. is flexible, community-driven, and low cost. One benefit of this design is, should the community desire it, is that it can be transitioned into the Pathways Hub ™ model later. There are three components to the model:

- The *integrator*– a coordinating entity at the community level – will ensure coordination and communication across services by engaging partners, recommending policy and practice changes, promoting information exchange, and analyzing data. The role of an integrator includes aligning leadership at the community level that bridges disciplines and programs; clarifying roles and ensuring accountability; arranging for appropriate, sustainable financing and infrastructure support for the work; and managing change.
- Once referred into the A.I. *network* – an IT care referral system and subsequent IT platform - each party can reserve and refer services as well as know the status of each referral. A.I. will be built on a modern, secure, HIPPA compliant *cloud network* – such as Amazon AWS or Microsoft Azure - with roles-based access control enabling easy and reliable service and connectivity for all involved.
- A *sentinel* – or a point of presence – will be appointed in each partner organization to onboard and route referrals and act as the primary point-of-contact for the integrator. Sentinels are expected to receive referrals and enter data into the cloud network. Sentinels can be shared across organizations with proper operating agreements.

DENTAL LINKAGE PILOT DESCRIPTION: Link Medicaid beneficiaries presenting to the emergency department (CHI Harrison) for a non-traumatic dental need to a Medicaid dental provider (Peninsula Community Health Services) in the community.

Project Goal Statement

- A.I. GOAL: Streamline clinical-community linkages, emphasizing social determinants of health, resulting in improved whole-person care
- A.I. END USER GOAL: Reduce and streamline data entry steps and workload for Sentinels in the field as well as automate reporting for each referral encounter that runs through the AI's e-referral system.
- A.I. CONSUMER GOAL: All my providers work together to take care of me and help me reach my goals.

DENTAL LINKAGE PILOT GOAL: We suggest that we pilot A.I. with a linkage that is relatively well-established and easy to measure. Therefore, the first application of A.I. will be dental referrals from the ED to a Medicaid dental provider. The GOAL for this pilot will be to avoid unnecessary ED utilization for dental needs and to connect Medicaid beneficiaries with a dental home. [1]

[1] OCH partner organizations can advise an alternative use-case depending on the project portfolio and community needs.

Case Statement

A.I. CASE STATEMENT: Health is largely driven by factors outside the health system. In the current system, linkages between health care providers and community providers are not streamlined, resulting in failed connections and lost opportunities to intervene and improve health outcomes, frustrating both providers and consumers of care.

DENTAL LINKAGE PILOT CASE STATEMENT: In Oregon, dental visits account for 2.5% of ED visits and represent the second-most-common discharge diagnosis in adults aged 20 to 39 years. Dental visits are associated with having Medicaid insurance (odds ratio = 4.0; 95% confidence interval = 3.7, 4.2), [reference: commercial insurance], often result in an opioid prescription (56%), and generate $402 (95% CI = $396, $408) in hospital costs per visit. In 2018, Washington will have an all-payer claims database to reproduce this Oregonian study.[2]

Example of an Apple Integrator Referral Network

[2] Sun et. al. Emergency Department Visits for Nontraumatic Dental Problems: A Mixed-Methods Study. *American Journal of Public Health*. (2015).[2]

Role of I.T. Network (ideas developed by CoMotion at the University of WA, University of WA Primary Care Innovation Lab and Quad+Aim Partners)**:**

1. Single point for one-time data collection; able to monitor a feedback loop if client does not "show" for referred services and can conduct follow-up with the client or client's care coordinator so that the individual is less likely to "fall through the cracks."
2. E-referral "reservations system" creates single shared "onboarding process" for new clients thus eliminating redundant and incomplete data collection. The system will have three levels of authorized use to ensure HIPPA, tribal data protections, and 42 CFR part 2 protections are in place.
3. E-referral reservation system "closes loop" for referrals so it's understood what services are being delivered
4. Analytics from the system will enable better allocation of precious resources and improves value/appropriateness of care delivered for each dollar spent as well as improved care and outcomes for the consumers
5. E-referral reservation system could be a catalyst for multiple waves of downstream innovation (see what SABRE ticket reservation system did for American Airlines and travel industry)

Role of Integrator (ideas developed by the Nemours Foundation)**:**

1. Engage partners from multiple sectors to integrate services and mobilize interventions to address upstream determinants of health.
2. Serve as a trusted leader in the community that accepts accountability for and strategically drives the integration functions.
3. Facilitate agreement among multi-sector partners on shared goals and metrics to improve the health outcomes of a population in a geographic area
4. Assess the community resources, including workforce capabilities, that are available to reach shared goal(s); determine gaps to be filled and duplication to be reduced; work with partners to make appropriate adjustments; identify and document successful services and interventions
5. Work at the systems level to make policy and practice changes in both the public and private sectors that impact populations and/or support partners or connect with other integrators in making these changes to scale up what works so that the entire population can benefit.
6. Serve as a source for diffusing components that are successful at both the policy/systems level and at the practice level to reach sufficient scale.
7. Sustain change by impacting policies and practices in collaboration with institutions and community partners at the local, community, state, and tribal levels.
8. Pursue financial sustainability via various methods, including leveraging existing and new sources of funding, developing innovative uses of current sources, and testing payment reforms that promote value and incentivize disease prevention and healthy development.
9. Gather, analyze, monitor, integrate and learn from data at the individual and population level. Evaluate progress, and ensure that resources are targeted most efficiently, based on actual needs of communities and consumers.
10. Identify and connect with system navigators (those roles intended to help individuals coordinate, access and manage multiple services and supports) so the integrator can harvest and aggregate data from individual cases and use the data to promote population-level solutions.
11. Develop a system of ongoing and intentional communication and feedback at multiple levels including with affected sectors, systems and communities.

Apple Integrator DRAFT Work Plan
Lean and Agile Adaptive Process

This process uses a disruptive, data driven innovation model that is team-based and collaboratively oriented. Problems are solved quickly. We do not need to commit to a platform. We iteratively test one prototype to the next, starting the most minimally viable e-referral system. The goal is to keep the process lean and compact.

Expected Completion	Activity	Output
May-August 2017	Partner education and feedback on AI concept; Confirm "user requirements" and "success measures" with partner organization(s)	List of must-haves and non-negotiables; list of early-, mid- and late- adopter partner organizations
May-August 2017	Assessment of current IT systems in use among partner organizations. Identify minimally viable test case (referral pathway) for e-referral system for our region, include at least one social service organization	Included with regional health needs inventory in project plan portfolio
July-August 2017	Complete systems mini spec; research systems interfaces and design automated reporting modules. Set up and certify Cloud. Install and configure system for pilot test.	Complete dry run of minimally viable e-referral test case.
August – October 2017	Enroll Pilot Users, Run E-Referral tests, refine/debug system as required. Review test results from the prototype. Collect partner feedback. Line up back-up vendors. Review 2-1-1 database and identify integration and improvement opportunities	Prototype of system and begin tangible reporting using a temp system. List of desired improvements. Agreement on next use case(s).
September 2017	Develop and release Request for Information (RFI) for: - IT care e-referral system and subsequent IT platform - Integrator	RFI for care e-referral system RFI for integrator
October 23	**Submit Project Plans to the HCA**	**Project Plan Portfolio**
November 2017	Complete pilot project and write up project findings (what worked, what didn't, what improvements should be made to production system). Convene panel of community partners to vet:	Select vendor [3] and integrator

[3] Competitive process to select e-care referral I.T. products such as: Athena, Clarity Health, Healthy Planet (Epic), I2I, PreManage (EDIE), Strata

	- IT care e-referral system and subsequent IT platform - Integrator	
December 2017	Meet with team to review pilot status and present options for scale up.	Outline of scale up plan
Scale and Sustain Stage[4] – move toward health information exchange, data governance, and population health management		
December 2017 -	Integrate into EHR(s); begin with early-adopters, then move to mid- and late- adopters	EHR integration status report
December 2017 –	Partner with the HCA to connect Apple Integrator and OneHealthPort; streamline submissions to OneHealthPort	OneHealthPort integration status report
December 2017 -	Connect A.I. to other systems for look-ups and automated reporting, such as HMIS and 2-1-1	Community systems integration status report
December 2017 –	Development of additional use cases, as prioritized by community partners	New referral linkage pathways, new partners
March 2018 -	Development of local data governance structure; public utility option	Work plan for future role and sustainability of A.I. beyond the Demonstration
March 2018 -	Build out of HIE/systems components	Work plan to move towards health information exchange

[4] Scale/sustain steps will depend on data collected from the prototype stage.

IT Draft Work Plan, Timeline and Mock Budget for E-Referral Pilot June 2017 – December 2017

Date	Activity
June 2017	Confirm User Requirements and Success Measures with Dental Project Stake Holders
July/August 2017	Complete Systems Mini Spec, Research systems interfaces and design automated reporting modules. Set up and certify Cloud. Install and configure system for pilot test. Complete dry run of MVE-referral dental test case.
September/ October/ November 2017	Enroll Pilot Users, Run E-Referral tests, refine/debug system as required.
December 2017	Complete pilot project and write up project findings (what worked, what didn't, what improvements should be made to production system). Meet with team to review pilot status and present options for scale up.
Total cost for pilot test	$36,000 IT Project Management and UX design (Quad+Aim Partners) $20,000 Community and economic impact measures-UW Primary Care Innovation Lab $70,000 E-referral set up, configuration and IT integration-Strata Corp $47,500 HIPPA/Cloud Hosting-Datica Corp **Budget: $173,500**

Olympic Community of Health
Characteristics and Criteria for Proposed DSRIP Projects - May/June 2017

Version: 6/7/2017

Category Title:	**2C Transitional Care**		**2D Diversion**			**3B Maternal/Child Hlth**	**3C Access to Oral Health Services**		**3D Chronic Disease Prevention & Control**	
Year 2 $ available:	**$1,125,000**		**$1,447,000**			**$557,000**	**$3,340,000**		**$890,000**	
Ave. RHAP Score	84.6	72.6	90.2	87.17	87.0	70.0	89.0	63.8	88.3	91.8
Project Title	**1. Crossroads**	**2. Regional Care Transitions**	**3. LEAD**	**4. Community Paramedicine**	**5. Outward Bound**	**6. Healthy Beginnings**	**7. FQHC Dental**	**8. Jefferson County**	**9. Breathe Easy**	**10. Chronic Care Model**
Lead	PCHS	KC AAA	PBH	JHC	PCHS	TBD	PCHS	JHC	PCHS	KPHD
Year 1 Counties	C,J,K	C,J,K	C, J	?	C,J,K	C,J,K	C,J,K	J	CKJ	C,J,K
Year 3 Counties	C,J,K	C,J,K	C,J,K	C,J,K	C,J,K	C,J,K	C,J,K	J	C,J,K	C,J,K
Signed Partner Tribes	2	0	2	1	0	0	0	0	0	1
# Collaborating Orgs	8+	8+	8+	8+	8+	5-7	8+	8+	8+	8+
Medicaid #/year	4,551	3,384	3,000-6,000	8,000	28,320	238	2,800	1163	1,799	11,880
Medicaid #/4 yrs	18,204	13,536	12,000-24,000	32,000	113,280	952	11,200	4,650	7,196	47,520
1-year Budget	$390,354	$632,093	$859,100	$2,969,590	$506,360	$545,104	$463,552	$39,677	$372,167	$1,161,261
PP Cost/year	$85.77	$186.79	$143.18-$286.37	$371.20	$17.88	$2,290.35	$165.55	$34.13	$206.87	$97.75
ROI TBD										
Delivery Site	at jail & reentry	acute care to home	prejail div/community	home & community	ED redirect to PCP	home & community	community site & LTC	schools	home	multiple clinics & community
Project Partners	PCHS	KC AAA	PBH	Org 1	PCHS	PCHS	PCHS	JHC	PCHS	PCHS
	NOHN		WEOS	Org 2	NOHN	JPHD	ALTC	?	KCR	HCM
	OLYCAP		DBH	Org 3	KCR	1stStep		JPHD	CHHS	Oly AAA
	KCR		KMHS	Org 4		KPHD			KC ALTC	YMCA
				Org 5					NOHN	PGST
				Org 6						Suquamish
				Clallam Fire						OMC
										JHC
										Forks CH
										NOHN
Staffing	PCHS .25 Proj Mgr	KC AAA .5 FTE ProjMgr	PBH 1.5 ProjMgr	Org 1 1 CHW	PCHS .25 Proj Mgr	PCHS .25 CHW ProgSupr	PCHS .25 ProgMgr	JHC .1 Proj Mgr	PCHS .25 Proj Mgr	PCHS .25 CDSM CHW Coord
	.25 CHW Coord	4 CTI Coach	2 MS Clinicians	.5 ARNP	.25 CHW Coord	3 CHW	2 Dentist	.05 Clinical Mgr	.25 CHW Prog Coord	PCHS/HMC 4 shared CHW
	5 CHW	.5 Data Analyst	2 BA CsMgr	Org 2 .5 Med Asst	5 CHW	JPHD 1 NFP Nurse	2 Hygenist	.? Dental Hygenist	2 CHW	OAAA .5 CDSMP Proj Coord
	NOHN 1 CHW		WEOS 1. MS Clinician	Org 3 5 ED SW or RN	NOHN 2 CHW	.55 CHW/CsFinder	7 Dental Asst	JPHD .5 ProjMgr	KCR .33 Hsg Navigator	Master Trainer
	OLYCAP 1 CHW		.5 BA CsMgr	Org 4 .6 Paramedic	KCR .33 Hsg Navigator	1st Step .75 Parent Ed	2 Dental Recpt		CHHS .5 EH Spec.	Lay Leaders
	.33 Hsg Navigator		DBH 1 MS Clinician	.6 EMT		.? PAT ProgSupv	1 Dental Coord		KC ALTC .25 Case Mgr	YMCA .14 Assoc Dir Healthy Lifestyle
			.5 BA CsMgr	Org 5 .5 ED SW or RN		.?PAT Supv	ALTC 1 Case Mgr		NOHN 1 CHW	.5 Chr Dis Prog Ed.
			KMHS 2 MS Clinician	Org 6 1 Paramedic		.?PAT DataMgr				PGST .2 Director
			1 BA CsMgr	1 EMT		.?PAT ProgSuppt				.2 Nurse Mgr
				Clallam Fire 1 Paramedic		.5 Case Finder				Suquamish .5 CDSM Data Analyst
				.? MDP		KPHD .25 BiLg NFP Nurse				OMC 1 Diabetes Ed
				.? Scheduler		.5 CHW/Case Finder				1 CHW Navigator
				.? QA						JHC 1 CHW
										.25 Data Analyst
										1 Nurse Care Coord
										FCH 1 Dec. Support Nurse
										1 Care Coord Nurse
										1 CHW
										NOHN 1 CHW
										1 Pop Hlth Nurse Care Mgr
Total systemwide and/or P4P Metrics	3 of 7	3 of 7	4 of 4	4 of 4	3 of 4	5 of 9	3 of 3	3 of 3	6 of 9	5 of 9

Olympic Community of Health
Characteristics and Criteria for Proposed DSRIP Projects - May/June 2017

Version: 6/7/2017

Category Title:	2C Transitional Care		2D Diversion			3B Maternal/Child Hlth	3C Access to Oral Health Services		3D Chronic Disease Prevention & Control	
System Impacts (systemwide metrics listed as doable in application) 0 represents system wide metrics that are missing but covered by other project submitted in category	Outpt ED Visits per 1000 MM	Outpt ED Visits per 1000 MM	Outpt ED Visits per 1000 MM	Outpt ED Visits per 1000 MM	Outpt ED Visits per 1000 MM		Outpt ED Visits per 1000 MM	Outpt ED Visits per 1000 MM	Outpt ED Visits per 1000 MM	Outpt ED Visits per 1000 MM
	% homeless-narrow def	0	% homeless-narrow def	% homeless-narrow def	% homeless-narrow def					
	0	Inpt utilization per 1000 MMM							Inpt utilization per 1000 MMM	Inpt utilization per 1000 MMM
	0	Plan All-Cause Readmit 30d								
			Adult Access Prev/Amb Care	Adult Access Prev/Amb Care	Adult Access Prev/Amb Care				Adult Access Prev/Amb Care	Adult Access Prev/Amb Care
	Follow-up After ED Discharge for MH, Alc or Other Drug Dep	0								
							Oral Health Services Utiliz by Medicaid Beneficiaries	Oral Health Services Utiliz by Medicaid Beneficiaries		
						Low Birth Weight Rate				
			Percent Arrested	Percent Arrested	0	Well child visits 3,4,5,6 yrs			Well child visits 3,4,5,6 yrs	0
						Well child visits 1st 15 mo			0	0
							Primary Caries Prev Intervent Part of Well/Ill Child Care PCP	Primary Caries Prev Intervent Part of Well/Ill Child Care PCP		
						Prenatal care 1st trimester				
						Rate Teen Pregnancy (15-19)				
									0	Comp Diab Care - Eye Exam
									0	Comp Diab Care - Nephopathy
									Med mgmt 5-64 w/asthma	0
									Child & Adult Access to PCP	0
Other Missing System Metrics in Category	Psych Hosp Readmit Rate; Follow-up after MI Hospitalization					MH Tx Penetration; SUD Tx Penetration; Chlymydia Scrn wom, 16-24; Unintended preg			Well child visits 1st 15 mo	
Bi-Directional Impacts	Outpt ED Visits / 1000 MM	Inpt utilization / 1000 MM	Outpt ED Visits / 1000 MM	Outpt ED Visits / 1000 MM	Outpt ED Visits / 1000 MM	Outpt ED Visits / 1000 MM	Outpt ED Visits / 1000 MM	Outpt ED Visits / 1000 MM	Outpt ED Visits / 1000 MM	Outpt ED Visits / 1000 MM
System level metrics		Plan All-Cause Readmit 30d								Plan All-Cause Readmit 30d
? Can project/s also address these metrics?	*Diabetes, HBP, MH Status*	*psych hospital readmit*		*psych hospital readmit, diabetes, HBP, adult MH status*	*Inpt utilization, plan all cause readmit, diabetes, HBP, adult MH status*	*Adult MH status*			*Inpt utilization, A1C, HBP, Adult MH Status*	*Inpt utilization, A1C, HBP, Adult MH Status*
Opioid Impacts System level metrics	Opioid Related Deaths Med Enrollees & Total Pop per 100,000	Opioid Related Deaths Med Enrollees & Total Pop per 100,000	Opioid Related Deaths Med Enrollees & Total Pop per 100,000	Opioid Related Deaths Med Enrollees & Total Pop per 100,000						Opioid Related Deaths Med Enrollees & Total Pop per 100,000
? Can project/s also address these?	Non-fatal OD involv RX opioids	Non-fatal OD involv RX opioids	Non-fatal OD involv RX opioids	Non-fatal OD involv RX opioids	Non-fatal OD involv RX opioids		*Rx practices, not 3A metrics*	*Rx practices, not 3A metrics*		Non-fatal OD involv RX opioids
	SUD Tx Penetration -Opioid	SUD Tx Penetration -Opioid	SUD Tx Penetration -Opioid	SUD Tx Penetration -Opioid	SUD Tx Penetration -Opioid	SUD Tx Penetration -Opioid				SUD Tx Penetration -Opioid

Score extraction sheet, 6/2/2017, 6:30 am

	Section												
	I.a.	I.b.	II.a.	II.b.	II.c.	III.i.	III.ii.	IV	V	VI	VII	Total	Averge
	15	5	4	10	6	5	15	10	10	10	10		
Application	# Medicaid	# providers	# org'ns	# counties	# tribes	measurable	movable	capacity	transform-ational	budget	need		
1. Crossroads	12	5	4	10	2	5	12	10	10	8	10	**88**	
1. Crossroads	12	5	4	10	2	3	11	7	8	6	7	**75**	
1. Crossroads	12	5	4	10	2	4.5	9	10	9	10	9	**84.5**	**84.6**
1. Crossroads	12	5	4	10	2	3	15	7	8	7	10	**83**	
1. Crossroads	12	5	4	10	2	4.5	15	10	10	10	10	**92.5**	
2. Regional Care Transitions	12	1	4	10	0	3	5	5	5	6	5	**56**	
2. Regional Care Transitions	12	1	4	10	0	4	11	6	6	7	7	**68**	
2. Regional Care Transitions	12	1	4	10	0	5	8	10	7	10	7	**74**	**72.6**
2. Regional Care Transitions	12	1	4	10	0	5	12	10	8	10	10	**82**	
2. Regional Care Transitions	12	1	4	10	0	5	15	8	8	10	10	**83**	
3. LEAD	15	5	4	10	2	5	12	10	10	9	10	**92**	
3. LEAD	15	5	4	10	2	4	12	7	8	7	8	**82**	
3. LEAD	15	5	4	10	2	5	10	10	8	10	10	**89**	**90.2**
3. LEAD	15	5	4	10	2	5	13	10	10	10	10	**94**	
3. LEAD	15	5	4	10	2	5	15	10	8	10	10	**94**	
4. Community Paramedic	15	5	4	10	2	3	10	10	10	5	10	**84**	
4. Community Paramedic	15	5	4	10	2	5	12	10	8	9	10	**90**	
4. Community Paramedic	15	5	4	10	2	5	8	7	8	7	8	**79**	**87.17**
4. Community Paramedic	15	5	4	10	2	5	13	10	10	8	10	**92**	
4. Community Paramedic	15	5	4	10	2	5	13	8	10	10	10	**92**	
4. Community Paramedic	15	5	4	10	2	5	15	7	7	6	10	**86**	
5. Outward Bound	15	5	4	10	0	5	13	10	8	10	10	**90**	
5. Outward Bound	15	5	4	10	0	5	10	10	10	10	10	**89**	
5. Outward Bound	15	5	4	10	0	4.5	10	8	10	7	10	**83.5**	**87**
5. Outward Bound	15	5	4	10	0	4.5	11	9	9	8	9	**84.5**	
5. Outward Bound	15	5	4	10	0	4	13	8	8	8	8	**83**	
5. Outward Bound	15	5	4	10	0	5	14	10	9	10	10	**92**	
6. Healthy Beginnings	6	5	3	10	0	4	10	8	6	7	7	**66**	
6. Healthy Beginnings	6	5	3	10	0	5	12	7	7	8	7	**70**	**70**
6. Healthy Beginnings	6	5	3	10	0	5	12	7	8	8	10	**74**	
7. Oral Health Access, FQHC Dental	15	5	4	10	0	5	12	10	10	10	10	**91**	**89**
7. Oral Health Access, FQHC Dental	15	5	4	10	0	5	12	9	9	8	10	**87**	
8. Oral Health Access, Jefferson County	12	5	4	0	0	4	12	6	6	8	9	**66**	**63.75**
8. Oral Health Access, Jefferson County	12	5	4	0	0	3.5	10	5	8	7	7	**61.5**	
9. Breathe Easy	15	5	4	10	0	5	15	10	10	10	9	**93**	
9. Breathe Easy	15	5	4	10	0	4.75	12	10	8.5	9.5	10	**88.75**	**88.25**
9. Breathe Easy	15	5	4	10	0	5	13	8	8	7	8	**83**	
10.Chronic Care Model	15	5	4	10	2	4	14	10	10	10	9	**93**	**91.75**
10.Chronic Care Model	15	5	4	10	2	4.5	12	10	9	10	9	**90.5**	

Planning for Design Funds for January 1 to December 31 2017, June 7, 2017

2017		2017		2017	
Approved November 2016		**Approved April 2017**		**Presented June 2017**	
2017 Budget		**AUTHORIZED Increased Spend**		**DESIGN FUNDS Phase II Application**	
Personnel	**Total**	**Personnel**	**Total**	**Personnel**	**Total**
Personnel and Benefits	251,683	Personnel and Benefits	339,782	Personnel and Benefits	437,370
Non-Personnel	**Total**	**Non-Personnel**	**Total**	**Non-Personnel**	**Total**
Professional Services:		Professional Services:		Professional Services:	
Legal Counsel	5,000	Legal Counsel	7,500	Legal Counsel	10,000
Data and Evaluation	45,872	Data and Evaluation	65,105	Data and Evaluation	75,105
Opioid Contractor	5,194	Opioid Contractor	5,194	Opioid Contractor	5,194
		Project Plan Selection	11,798	Project Plan Selection	25,575
		Project Plan Development	42,900	Project Plan Development	92,800
		HR Consultant	4,000	HR Consultant	4,000
		Financial Advisor/CFO Services	5,000	Financial Advisor/CFO Services	5,000
		Other Consultant	10,000	Other Consultant	10,000
				Financial Modeler	15,000
				Apple Integrator	123,929
Administrative Services		Administrative Services		Administrative Services	
Financial services	20,029	Financial services	25,036	Financial services	25,036
Audit	6,000	Audit	6,000	Audit	6,000
Office Space, IT, Printing	10,000	Occupancy	18,800	Occupancy	37,000
Professional Development	6,250	Professional Development	6,250	Professional Development	6,250
Travel/Mileage	8,424	Travel/Mileage	10,530	Travel/Mileage	12,840
Communications	2,000	Communications	2,000	Communications	3,000
Supplies	4,000	Supplies	7,000	Supplies	9,600
Events	1,500	Events	2,500	Events	2,500
Food and beverage	5,500	Food and beverage	5,500	Food and beverage	5,500
Liability Insurance	2,583	Liability Insurance	2,583	Liability Insurance	2,583
				B&O Tax	90,000
Miscellaneous	1,500	Miscellaneous	1,500	Miscellaneous	1,500
Subtotal Non-Personnel Costs	**123,852**	**Subtotal Non-Personnel Costs**	**239,196**	**Subtotal Non-Personnel Costs**	**568,412**
TOTAL EXPENDITURES	**375,535**	**TOTAL EXPENDITURES**	**578,978**	**TOTAL EXPENDITURES**	**1,005,782**

Financal Services: Bookkeeping, accounting, taxes, payroll

Occupancy: includes rent and IT

Events: venue rental, audio/visual rental

Communications: Go-To-Meeting, Survey Monkey, Mail Chimp, web hosting, stock photo, cards

Supplies: Computer, cell phone, software packages (one-time cost), electronics, office supplies

Miscellaneous: Books, subscriptions, memberships, other

Initial Planning for Design Funds for 2018, 2019, 2020, & 2021, June 7, 2017

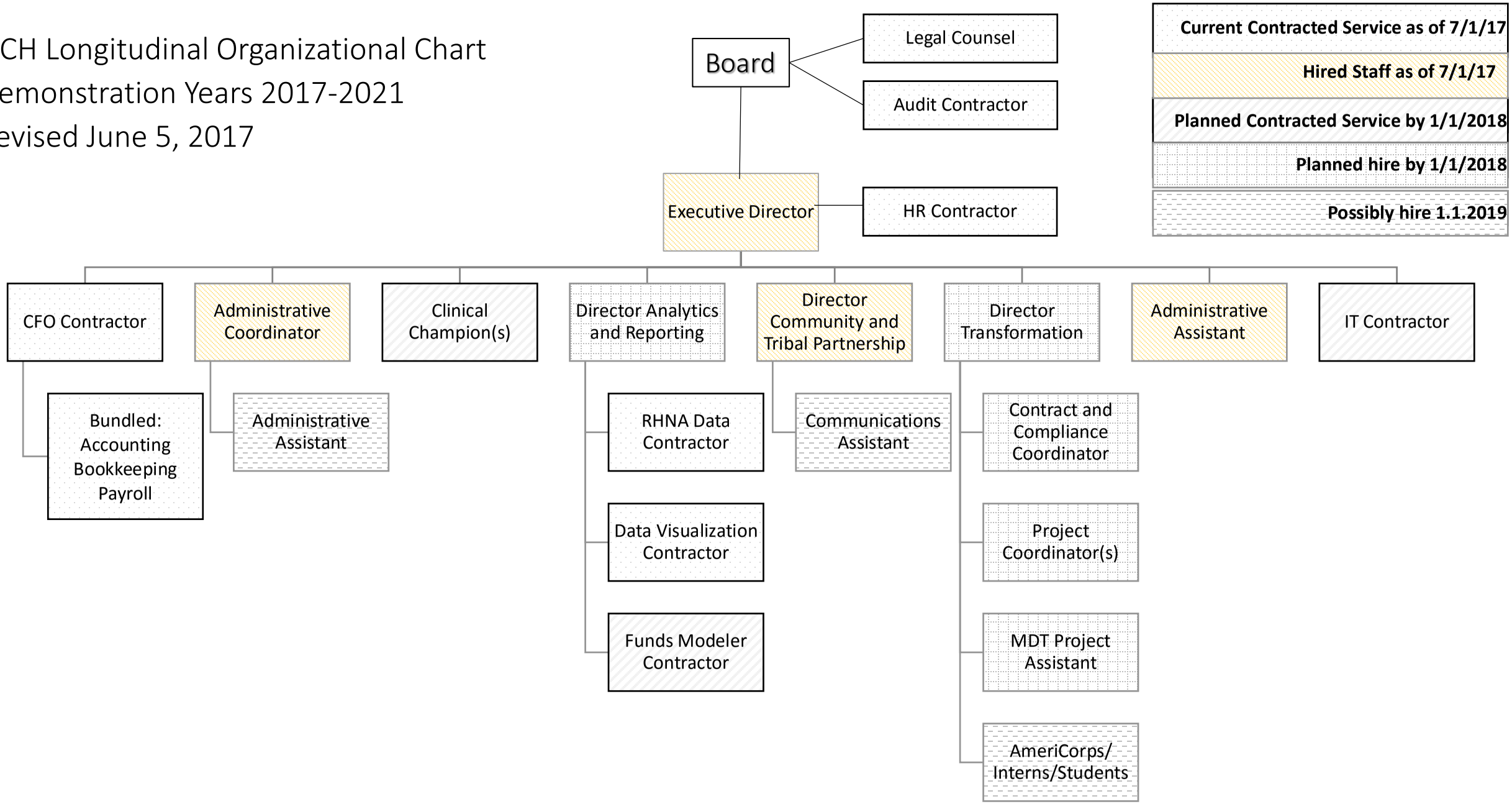
2018		2019		2020		2021	
Work in Progress		**Work in Progress**		**Work in Progress**		**Work in Progress**	
DESIGN FUNDS Phase II Application		**DESIGN FUNDS Phase II Application**		**DESIGN FUNDS Phase II Application**		**DESIGN FUNDS Phase II Application**	
Personnel	**Total**	**Personnel**	**Total**	**Personnel**	**Total**	**Personnel**	**Total**
Personnel and Benefits	893,970	Personnel and Benefits	1,134,073	Personnel and Benefits	1,148,715	Personnel and Benefits	1,153,238
Non-Personnel	**Total**	**Non-Personnel**	**Total**	**Non-Personnel**	**Total**	**Non-Personnel**	**Total**
Professional Services:		Professional Services:		Professional Services:		Professional Services:	
Legal Counsel	15,000	Legal Counsel	20,000	Legal Counsel	25,000	Legal Counsel	30,000
Data and Evaluation	70,000	Data and Evaluation	70,000	Data and Evaluation	70,000	Data and Evaluation	70,000
HR Consultant	4,500	HR Consultant	5,000	HR Consultant	4,000	HR Consultant	3,000
Financial Advisor/CFO Services	15,000	Financial Advisor/CFO Services	15,000	Financial Advisor/CFO Services	15,000	Financial Advisor/CFO Services	15,000
Other Consultant	50,000	Other Consultant	50,000	Other Consultant	50,000	Other Consultant	50,000
Financial Modeler	30,000	Financial Modeler	20,000	Financial Modeler	10,000	Financial Modeler	10,000
Apple Integrator		Apple Integrator	0	Apple Integrator	0	Apple Integrator	
Administrative Services		Administrative Services		Administrative Services		Administrative Services	
Financial services	30,000	Financial services	30,000	Financial services	30,000	Financial services	30,000
Audit	10,000	Audit	13,000	Audit	13,000	Audit	13,000
Occupancy	38,000	Occupancy	40,400	Occupancy	40,400	Occupancy	40,400
Professional Development	7,000	Professional Development	9,000	Professional Development	9,000	Professional Development	9,000
Travel/Mileage	29,750	Travel/Mileage	43,125	Travel/Mileage	43,125	Travel/Mileage	43,125
Communications	4,000	Communications	6,000	Communications	6,000	Communications	6,000
Supplies	20,000	Supplies	30,000	Supplies	30,000	Supplies	30,000
Events	5,500	Events	6,000	Events	6,000	Events	6,000
Food and beverage	10,000	Food and beverage	10,000	Food and beverage	10,000	Food and beverage	10,000
Liability Insurance	5,000	Liability Insurance	6,000	Liability Insurance	6,500	Liability Insurance	6,500
B&O Tax	7,500	B&O Tax	7,500	B&O Tax	7,500	B&O Tax	7,500
Miscellaneous	5,000	Miscellaneous	5,000	Miscellaneous	5,000	Miscellaneous	5,000
Subtotal Non-Personnel Costs	**356,250**	**Subtotal Non-Personnel Costs**	**386,025**	**Subtotal Non-Personnel Costs**	**380,525**	**Subtotal Non-Personnel Costs**	**384,525**
TOTAL EXPENDITURES	**1,250,220**	**TOTAL EXPENDITURES**	**1,520,098**	**TOTAL EXPENDITURES**	**1,529,240**	**TOTAL EXPENDITURES**	**1,537,763**

TOTAL EXPENDITURES	
TOTAL Demonstration	$ 6,339,594
TOTAL State Innovation (SIM)	$ 503,508
TOTAL	$ 6,843,102

State Innovation Model (SIM) REVENUE	
SIM 2017 Revenue	$ 231,000
SIM 2017 Opioid Revenue	$ 30,000
SIM 2018 Revenue	$ 99,000
SIM 2016 Carryover from KPHD	$ 220,000
Total SIM Revenue	$ 580,000

DEMONSTRATION REVENUE	
Phase I	$1,000,000
Phase II	$5,000,000
Total Demonstration Revenue	$6,000,000

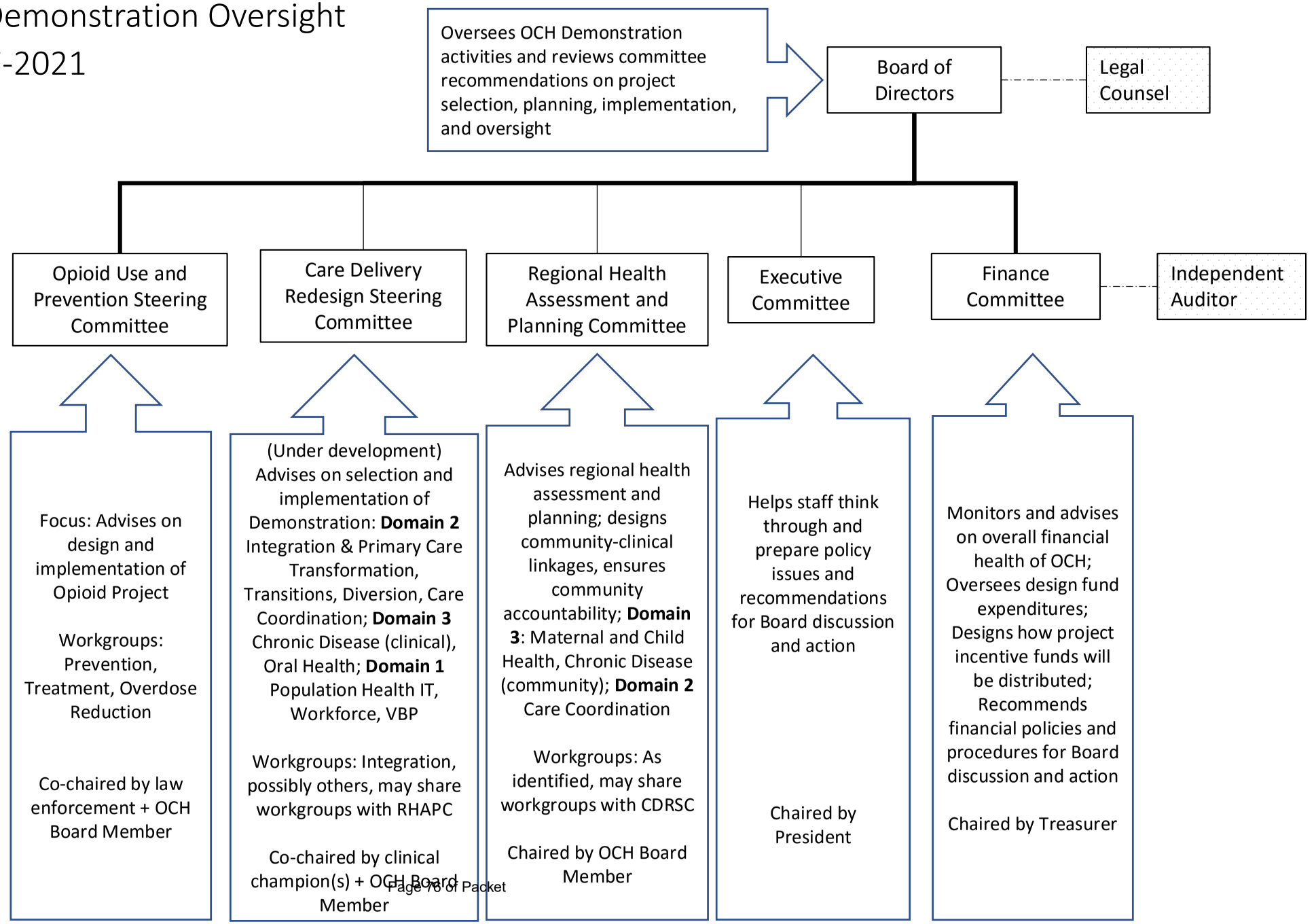
OCH Longitudinal Organizational Chart
Demonstration Years 2017-2021
Revised June 5, 2017



OCH Governance Chart: Demonstration Oversight

Demonstration Years 2017-2021

Revised June 7, 2017



Organizations represented on Health Systems Redesign Steering Committee (N=30)

Hospitals and Rural Health Clinics	Federally Qualified Healthcare Clinics	Independent Clinics	Tribal Clinics	Behavioral Health Clinics	Plans
CHI Harrison	North Olympic Health Network	Bogachiel Medical Clinic	Jamestown Family Health Center	Discovery Behavioral Health	Amerigroup
Forks Community Hospital	Peninsula Community Health Services	Harrison Health Partners/Doctor's Clinic	Lower Elwha Health Clinic	Kitsap Mental Health Services	Coordinated Care
Jefferson Healthcare		Jamestown Family Health Center	Makah Health Center	Peninsula Behavioral Health	Community Health Plan of Washington
Olympic Medical Center		Jefferson Healthcare Adult and Pediatric Clinics	Port Gamble S'Klallam Health Clinic and Wellness Center	Safe Harbor Recovery	Molina
		North Kitsap Family Practice and Urgent Care	Quileute Health Center	West Sound Treatment Center	Salish Behavioral Health Organization
		Olympic Medical Physicians	Suquamish Wellness Center	West End Outreach Services	United Health Care

Olympic Community of Health

Phase II Certification Requirements

Presented to the Board of Directors June 12, 2017

The following attachments are required for Phase II Certification, due August 14th. ACHs will be scored and can be awarded $3.5 to 5 million dollars in Phase II Design Funds depending on completeness and quality. Incomplete applications will receive a lower score and hence, fewer dollars.

Governance and Organizational Structure	**Complete**	**Well Underway**	**Needs Attention**
A. Copies of charters for committees and workgroups that outline purpose, members, responsibilities, and scope.	x		
B. Conflict of interest policy.	x		
C. Draft or final job descriptions for all identified positions.		x	
D. Short bios for all staff hired.	x		
Tribal Engagement and Collaboration	**Complete**	**Well Underway**	**Needs Attention**
A. Demonstration of adoption of the Model ACH Tribal Collaboration and Communication Policy, either through bylaws, meeting minutes, or other evidence. Highlight any modifications that were agreed to by all required parties.		x	
B. Bio(s) for the representative(s) of ITUs seated on the ACH governing board.		x	
Community and Stakeholder Engagement	**Complete**	**Well Underway**	**Needs Attention**
D. Meeting minutes or meeting summaries for the last three decision-making body meetings and screenshot capturing distribution of meeting minutes/summaries (e.g., email distribution, website post).	x		
A. List of all public ACH-related engagements or forums for the last three months.	x		
B. List of all public ACH-related engagements or forums scheduled for the next three months.		x	
C. Evidence of meaningful participation by community members. Examples include: attestation of meaningful participation by at least one Medicaid beneficiary, meeting minutes that memorialize community member attendance and comments, and solicitation for public comment and ACH response to public comments.		x	
D. Attestation of meaningful participation from at least three partners from multiple sectors (e.g., managed care organizations, Federally Qualified Health centers, the public health community, hospitals, primary care, and behavioral health) not participating directly on the decision-making body.		x	
E. A list of communication tools/resources with corresponding target audiences and estimated number reached.			
Budget and Funds Flow *	**Complete**	**Well Underway**	**Needs Attention**
A. Bio or resume for the treasurer and/or Chief Financial Officer (CFO) or equivalent.	x		

B. Financial Statements for the previous four quarters. Audited statements are preferred. If an ACH does not have four quarters of financial statements available, provide as many as possible.		x	
C. Completed Phase II Project Design Funds Budget Template, which includes Projected Project Design fund budget over the course of the demonstration, percent allotments by organization type, additional funding sources, and in-kind resources that the ACH expects to leverage to prepare their Project Plans and build the capacity and tools required to implement the Medicaid Transformation Project demonstration.			x
Clinical Capacity	**Complete**	**Well Underway**	**Needs Attention**
A. Additional and/or current bios or resumes for identified clinical and workforce subject matter experts or provider champions not provided in Phase I.			x
Data and Analytic Capacity	**Complete**	**Well Underway**	**Needs Attention**
A. The latest draft of the ACH's Regional Health Needs Inventory (RHNI).		x	
B. Data-sharing Memoranda of Understanding, Data Sharing Applications, or other data requests from partner organizations			x
C. Any data or analytic support procurements, and if applicable, winning vendor profile with expected scope of services and duration of contract.	x		
D. Meeting minutes or materials that highlight data-driven decision-making for the demonstration (i.e., project selection, target populations, and partnering providers).	x		
A. Initial list of partnering providers or categories of partnering organizations interested in or committed to implementing projects.	x		

*** Must answer these questions pertaining to budget and funds flow:**

1. Attest that OCH has secured the primary Board's approval of detailed budget plan for Project Design funds awarded under Phase I Certification
2. Attest that OCH has secured the Board's approval of approach for projecting and budgeting for the Project Design funds anticipated to be awarded under Phase II Certification
3. Discuss how the OCH has used Phase I Project Design funds. Provide percent allotments in the following categories: ACH Project Plan Development, Engagement, ACH Administration/Project Management, Information Technology, Health Systems and Community Capacity Building, and Other.
4. Describe how the OCH plans to use Phase II Project Design funds to support successful Project Plan development.
5. Describe what investments have been made or will be made through Project Design funds in the following capacities: data, clinical, financial, community and program management, and strategic development.
6. Describe the process for managing and overseeing Project Design fund expenditures.
7. In the Project Plan, the OCH will be required to describe how Project Incentive funds will be distributed to providers. Describe the OCH's Project Incentive fund planning process to-date, including any preliminary decisions, and how it will meet the Project Plan requirement.