Leadership Council
June 1, 2016

8:30 a.m. to 11:00 a.m.
Olympic Room – Inn at Port Ludlow
1 Heron Road, Port Ludlow

Chair: Roy Walker

Objectives

- Agree on evolving governance structure and supporting policy
- Agree on plan to select a regional health improvement project
- Gain a better understanding of the Medicaid Waiver and how it relates to the OCH

AGENDA (Action items are in red)

Item		Topic	Lead	Attachments
1	8:30	Welcome & Introductions	Roy Walker	
2	8:40	Consent agenda	Elya Moore	1. Director's Report a. ACH milestones for the waiver b. Strawman recommendation for financial management under the waiver 2. DRAFT Minutes Leadership Council Meeting (5/4/2016) 3. OCH Partner Meeting DRAFT Agenda (6/14/16) 4. Tribal Consultation Letter and Policy 5. OCH-Tribal Workshop Agenda (6/7/16) 6. MCO Sector Representation Recommendation
3	9:00	Governance Subcommittee Recommendations	Eric Lewis	7. Leadership Crosswalk 8. Governance Subcommittee Charter 9. Governance Subcommittee Recommendations 10. Policy for New Members 11. Executive Committee Charter
4	9:30	Regional Health Assessment and Planning Subcommittee Recommendations	Katie Eilers	12. Regional Health Assessment and Planning Committee Charter (*work in progress)* 13. Shared Regional Health Priorities 14. Project Selection Timeline and Process 15. OCH Project Proposal Template 16. OCH Project Proposal Scoring Guide
5	10:00	Public comment period	Roy Walker	
6	10:10	Adjourn	Roy Walker	
BREAK – FIVE MINUTES				
10:15 to 11:00		Waiver Presentation from the Medicaid Transformation Team at the Health Care Authority	Marc Provence Kali Morris	Handouts provided All attendees are invited to participate including members of the public

Upcoming meetings

- **OCH-Tribal Workshop** June 7, 2016, 12:00 p.m. – 4:00 p.m., Jamestown S'Klallam Red Cedar Hall
- **OCH Stakeholder Group** June 14, 2016, 9:00 a.m. – 12:00 p.m., House of the Awakened Culture, Suquamish

A message from your director

In the blink of an eye, I am now nearly two months into my new position. In that time, I have met with many of you and have been learning about locally-driven health innovation projects in various organizations across the region. I look forward to meeting with the rest of you, as well as key community leaders outside of the Leadership Council, to complete my asset map of our Olympic Community of Health.

In the meantime, Siri Kushner, our Kitsap Public Health District epidemiologist, and I have launched the Regional Health Assessment and Planning (RHAP) Committee to guide our work moving forward. Angie Larrabee, our Health District staff assistant, is building on our OCH brand and message so that it is more accessible to the public. I continue to collaborate with State partners on the Medicaid Waiver, Practice Transformation, Tribal engagement, and Analytics, Interoperability, and Measurement. In summary, we are on target to meet our contractual deadlines with the Health Care Authority (HCA), moving us closer to a high-functioning, thriving ACH every day.

Communications

Website development is underway, including new OCH email addresses. We also now have a Facebook, Instagram, and Twitter account. Please follow/tweet us! We are asking for local photos to include in our collection for social media outreach. Please send your photos to: angie.larrabee@kitsappublichealth.org.

Medicaid Waiver

Please refer to the two additional discussion papers after the Director's Report: 1) ACH milestones for the waiver, and 2) Strawman recommendation for financial management under the waiver, and the summary points below. Note that we will be having an interactive discussion with the HCA waiver team at 10:00 am today.

- ✓ HCA continues negotiations with the Centers for Medicare and Medicaid Services (CMS) regarding budget neutrality and the total state award. The timeline for decision is not settled.
- ✓ CMS and the HCA want assurances that conflict of interest policies are in place.
- ✓ Reminder: the waiver is primarily about clinical delivery system transformation.
- ✓ There may be one committee per waiver project per ACH; this has logistical implications.
- ✓ ACHs are hindered from making structure/staffing changes not knowing 1) how much funding might be coming to the ACHs, and not knowing what functions the ACHs must perform. HCA is working to provide this information.
- ✓ There is general support for the Financial Executor model, a single financial management firm providing financial management services, for all ACH regions. The firm must be experienced as a financial management firm, with core competencies and a proven track record, with services limited solely to the "mechanics of money management" without policy making authority or contract management services. ACHs should be involved in the selection and evaluation of the vendor.
- ✓ Administrative resources are needed for ACHs to take on responsibility for waiver projects.

Tribal Consultation

On May 11th all nine ACHs participated in a Tribal Consultation between the Washington State Tribes and HCA on the ACH Program, as requested by the American Indian Health Commission (AIHC). The purpose of this consultation was to ensure that the ACHs met the needs of tribal communities and urban Indians, particularly around tribal engagement and consultation. A topic of conversation was the government-to-government relationship that the Tribes hold with the State, and whether or not this extends to ACHs. Another discussion

topic was the inconsistency in how each ACH has engaged with Tribal Nations. For example, although it was only as recently as February 2016 that the OCH invited all seven Tribes onto the Council, we remain one of the first ACHs to do this.

It became clear that the ACHs are not conversant in government-to-government relationships. There is an opportunity for education to ACHs about Tribes as sovereign nations and to Tribes about the role and functions of an ACH. This conversation begins in our region on June 7th with an OCH-Tribal Workshop. However, I see this as an ongoing conversation and look forward to personally visiting each Tribal Nation within our region to understand how best to involve or engage that nation. Please refer to attachment 4 for the Tribal Letter and Consultation Policy.

Financials

The Council approved a 2016 operating budget on May 4th, 2016. Below you will find a year-to-date financial tracking report against budgeted amounts. Based on this report, the OCH is currently well below budget; however, we are slightly over budget for events and meetings. The professional services expenses were for project management in the first quarter of 2016 before the Director was hired.

Olympic Community of Health Budget January thru April 2016
Prepared May 17, 2016 for June 1, 2016 OCH Leadership Council Meeting

	2016 BUDGET	BALANCE REMAINING	YEAR TO DATE	% SPENT (Target 33.3%)
LABOR (SALARY & BENEFIT)				
Epidemiologist	$ 48,463.00	**$ 43,213.85**	5,249.15	11%
Assistant	$ 20,186.00	**$ 16,683.00**	6,335.14	31%
Director	$ 103,171.00	**$ 90,030.80**	13,140.20	13%
Program Coordinator	$ 19,399.00	**$ 19,399.00**	-	0%
			-	
SUBTOTAL	$ 191,219.00	**$ 166,494.51**	24,724.49	13%
Indirect (Billable)	$ 47,804.75	**$ 41,623.63**	6,181.12	13%
LABOR TOTAL	$ 239,023.75	**$ 208,118.14**	30,905.61	13%
NON-LABOR EXPENSES				
Supplies	$ 3,000.00	**$ 2,576.79**	423.21	14%
Professional Services	$ 32,105.00	**$ 12,415.00**	19,690.00	61%
Travel & Mileage	$ 4,000.00	**$ 3,933.74**	66.26	2%
Event/Meeting	$ 5,000.00	**$ 3,001.83**	1,998.17	40%
NON-LABOR EXPENSES	$ 44,105.00	**$ 21,927.36**	22,177.64	50%
TOTAL MONTHLY EXPENSES	$ 283,128.75	**$ 230,045.50**	53,083.25	19%

Health Innovation Leadership Network (HILN)

OCH Council Member Representative on this committee: Joe Roszak and Mike Glenn

The Health Innovation Leadership Network (HILN) is comprised of providers, business, health plans, consumers, community entities, governments, tribal entities and other key partners, who are helping to accelerate the efforts of Healthier Washington. Our region is represented on the HILN (view roster) by Mike Glenn (CEO Jefferson Health Care) and Joe Roszak (CEO Kitsap Mental Health Services) as members. The next meeting is July 29, 9:00 am to 12:00 pm if anyone cares to join me in the public seating area.

Plan for Improving Population Health (P4IPH)

OCH Council Member representative on this committee: Katie Eilers (Kitsap Public Health District)

CMMI representatives recently expressed some concerns about the Plan for Improving Population Health's proposed scope and direction--specifically that it was not focused enough on the health delivery system and linkage interventions, and that it might not be far enough along to meet deadlines. Given this new development, the Department of Health team has been doing some strategic planning. A few key points:

- To be effective, the Plan cannot be a static resource that is printed out and stored on a shelf.
- What is needed is a flexible set of strategies and best practices that may be applied to specific practice, community or regional goals.
- The Plan must focus on alignment with the Prevention Framework, promoting clinical-community linkages and supporting value-based payments.
- The Plan must support--but not conflict with--other transformation efforts in the state, including ACH projects.

The team is developing an interactive website to house the elements and resources of the Plan. The P4IPH Advisory Group will be temporarily suspended while the WA Department of Health works on the website.

Analytics, Interoperability, and Measurement (AIM)

HCA is contracting with CORE as an interim solution during the implementation year of Analytics, Interoperability, and Measurement (AIM) to provide data and analytics about the Common Measure Set's 55 measures to all ACHs and to state agencies involved with AIM work. The first release is now scheduled for June 2, 2016 (originally scheduled for late May 2016).

Follow-up on the letter of support to CHI/MultiCare

CHI/MultiCare successfully submitted their application to CMMI to become an Accountable Health Community. Their application was ultimately supported by all three ACHs in their region: King, Pierce, and the OCH. Larry Eyer and Jennifer Kreidler-Moss signed non-binding MOUs between their organizations and the Alliance for South Sound Health. We should hear back in fall of 2016 for funding that would start in April 2017.

OCH upcoming meetings and events

- 06/07/2016, **Olympic ACH- Tribal Workshop**, 12:00 p.m. – 4:00 p.m., Jamestown S'Klallam Red Cedar Hall, 1033 Old Blyn Hwy, Sequim, WA. Lunch will be provided.
- 06/14/2016 **OCH Partner Convening** (Formerly OCH Stakeholder Meeting), 9:00 a.m. – 12:00 p.m., House of Awakened Culture, 7235 NE Park Way, Suquamish, WA 98392. Breakfast and logistical support provided by Federal Reserve Bank of San Francisco.
- 7/6/2016, **OCH Leadership Council Meeting**, 8:30 a.m. – 11:00 a.m., location TBD

Healthier Washington upcoming meetings and events

- 06/13/2016, **Value-Based Benefit Design Webinar**, Register here
- 07/14/2016, **Healthier Washington Quarterly Webinar**, Register here
- 7/29/2016, **Health Innovation Leadership Network (HILN)**, 9:00 am – 12:00 pm, Cambia Grove, Seattle

Recommended Reading

- **New York Waiver Experience:** CMS officials have been clear that New York's waiver is the new baseline for how State's should pursue transformational projects under the waiver. New York used "lead entities" to lead transformation activities in the same way Washington State proposed ACHs as "coordinating entities". The Commonwealth Fund just released a report about New York's model and lessons learned.
- **Role of spending on social services***:* Variation in health outcomes: the role of spending on social services, public health, and health care, 2000-09. *Health Affairs.* May 2016. If you do not have a subscription to *Health Affairs*, email Angie and we will send you the pdf.

ACH Milestones for the Waiver: First Six Months

NOTE from the Director: This document was prepared by the HCA for **discussion only** for the waiver workgroup meeting on April 14th. It was circulated to all ACHs on May 5th. I am not part of the waiver workgroup, but will be attending the May 26th meeting and will keep the Council informed of all key dates and opportunities to inform decisions.

Assumptions: While the exact timeline has not yet been confirmed, this assumed timeline will provide context for possible milestones in the first six months after waiver approval. The assumption, **for purposes of this document only**, is finalized Special Terms and Conditions by July 1, 2016 and transformational projects soft-launch on January 1, 2017.

How to read this chart: This document provides an initial approach that builds certain ACH capacity while simultaneously moving towards implementation of the Medicaid Transformation Waiver. In support of this approach, we identified the major anticipated milestones ACHs would meet in the first six months of the Waiver. Below each milestone is the function necessary to achieve the milestone and ideas around the minimum form required to achieve the function. Additionally, we have broken out what would be necessary at the state level and the regional level.

Milestones Milestones are significant events to support the role of ACHs in Medicaid Transformation.	ACHs receive planning dollars and technical assistance (July 2016)		Demonstration of ACH capacity for fulfilling certification[1] requirements (August/September 2016)		Certification by Independent Assessor[2] of ACH organizational capacity to fulfill role in Medicaid Transformation (November/December 2016)		Approval by State/Independent Assessor of ACH application for regional transformation (November/December 2016)	
Necessary Functions Necessary Functions are the operational activities of ACHs and the state to achieve milestones.	Regional	State	Regional	State	Regional	State	Regional	State
	- ACHs, in collaboration with back bone organizations,[3] submit work plan to the State for planning dollars - The work plan will specify how the ACH/backbone will spend planning funds	- Provide clear guidance on how planning dollars are received and how they must be used - Mechanism in place for regional work plans to be	- Fulfillment of initial State governance and functional requirements - Submission of organizational application; including planned organizational structure, governing processes and	- Provide guidance and template materials for organizational application.	- Completion of the organizational application - Develop plan to contract out functions the ACH cannot/will	- State development of scoring guide for fulfillment of certification requirements - Organizational applications scored by Independent Assessor with recommendations to the	- Decision on regional work/projects from the toolkit - Completion of the regional transformation application[4]	- Provide Transformation Project Toolkit - Provide regional transformation application and guidance (as well as scoring guide approved by CMS) - Provide support/technical

[1] In the waiver application (page 51), it was referenced that ACHs would need to demonstrate readiness to serve an important coordinating role in Medicaid Transformation. The process to satisfy certification requirements reflects that readiness assessment.

[2] In other state demonstrations, CMS has required that an Independent Assessor be contracted with for the purposes of scoring and recommending approval of regional project applications (e.g. http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/independent_assessor.htm)

[3] Assumption for July 2016: ACHs without legal status would require support of a backbone organization to receive funds on behalf of the ACH.

[4] It is important to understand the New York approach is very different than what Washington is proposing for Medicaid Transformation. However, the project plan applications required in New York can be referenced as an example of what the process could look like: http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/.

	and how dollars support ramp-up activities - Planning dollars are distributed by the state and work plans executed by the regions	submitted and approved to receive dollars	functional development activities		not perform	state on next steps	- Identify and engage participating providers for projects	assistance for regions to complete application - Make decision regarding application approval based on CMS' and Independent Assessor recommendations
Minimum Form Minimum form is the ACH organizational capacity or structure necessary to perform the functions.	Regional	State	Regional	State	Regional	State	Regional	State
	-If backbone or a separate contracted entity receives planning funds on behalf of the ACH, an agreement must be in place between backbone and ACH regarding fiscal accountability - Effective Decision making processes in place for ACHs and agreement on who is authorized to sign on behalf of the ACH	-Contracting ability in place -Process for reviewing how ACHs/backbones receive planning dollars	- ACH board reflects composition requirements set by state and CMS - Functional and governance development plan submitted by ACH or backbone w/ ACH endorsement	- Team in place to develop the demonstration materials - CMS and Leadership approval on what will be included - Timeline set and review/approval process in place	- Necessary capacity to fulfill functions	- Contract with Independent Assessor in place - Formal decision-making procedure in place for approval of certification/project application, based on independent assessor recommendations	- Necessary capacity to fulfill functions - Identification of contracted entities to perform functions ACH cannot/will not perform[5]	- Contract with Independent Assessor in place - Contract with statewide vendors for project support, if applicable - Formal decision-making procedure in place for approval of certification/project application, based on independent assessor recommendations

[5] It has also been discussed that the state may have a role in selecting statewide vendors to perform certain necessary functions.

Strawman: Recommendation for financial management under the waiver

NOTE from the Director: This document was prepared by the HCA for **discussion only** on April 28th. It was circulated to all ACHs on May 5th and was discussed by all ACHs on May 16th. No final decision has been made to-date.

Key among the functional expectations of ACHs (as recommended by HMA) under the proposed Medicaid Transformation Waiver is financial management. ACHs have expressed concern regarding readiness to take on this activity; and HCA is very aware of the requirements for overseeing the management of funds under the waiver. This analysis summarizes points raised during discussions to date and offers a recommendation for consideration.

Background

Financial management is a necessary function in the administration and oversight of transformation projects under the Medicaid 1115 waiver. For purposes of this discussion, the components of financial management can be characterized as follows:

- Invoicing for incentive payments (based on milestone achievement)
- Disbursement of DSRIP payments (full or partial, depending on agreements)
- Accounting for all project revenues and expenses
- Auditing
- Reporting

It is important to distinguish these core financial management competencies from the kind of financial decision-making that ACHs are expected to perform when, for example, recommending the allocation of funds to the projects under their purview.

Options

HMA, as a consultant to HCA, has identified financial management as an "essential component" of ACH functional requirements under Initiative 1 of the waiver. ACHs have, however, expressed concern regarding acceptance of financial management responsibilities. Principal concerns relate to the necessary capabilities, capacity build, potential duplication, and shift of ACH focus. This suggests the following options for fulfillment of the financial management requirements as defined above:

1. HCA contracts for these functions with a single "executor" on behalf of all ACHs
2. HCA performs these functions centrally within its existing organization
3. Each ACH is required individually to arrange for financial management by:
    a. Hiring appropriate staff or
    b. Selecting and contracting with an appropriate vendor

Analysis

Each of the options can be evaluated across the following criteria:

- Accountability
- Consistency/standardization
- Ease of administration
- Alignment with the envisioned role of ACHs
- Acceptance by CMS
- Sustainability
- Duplication

The following table illustrates the advantages and challenges of the various options.

	ACH Hires	**ACH Contracts**	**HCA Performs**	**HCA Contracts, Single Executor**
Accountability	Directly accountable to ACH.	Directly accountable to ACH. Could be indirectly accountable to HCA depending on contract terms.	Directly accountable to HCA.	Directly accountable to HCA.
Consistency/ Standardization	Hard to assure consistency. Financial capabilities and performance can vary across ACHs. Consistent reporting may be a challenge.	Hard to assure consistency unless HCA specifies standard contract terms. Consistent reporting may be a challenge.	Consistency and standardization assured through single point of performance. Processes and reporting will be consistent.	Consistency and standardization assured through single point of performance. Processes and reporting will be consistent.
Administrative Ease	Can vary by ACH depending on core competencies and readiness to hire and manage staff. Requires HCA review across ACHs and potential burden if performance varies.	May vary depending on the contract terms and expertise of the contractor. Risk of vendor non-performance. Requires HCA review across ACHs and potential burden if performance varies.	Requires additional recruitment and staffing by HCA. Training will also likely be required. Inconsistent with efforts to realign HCA business functions to health care purchaser role.	Requires solicitation of and contract with a vendor. Requires contract management resources. Can focus on specific expertise.
Alignment with the envisioned	Variable. Some believe it is	Variable. Some feel more ready to	General acceptance more	General acceptance more

role of ACHs	complementary while others see it as a distraction from mission and purpose.	manage a contract of this nature. Funds flow and fiduciary responsibility would still remain with the ACH and some are nervous about the additional responsibility.	likely, given removal of concerns around financial management requirements.	likely, given removal of concerns around financial management requirements.
CMS Acceptance	Potential variability in ACH readiness/ acceptance may cause CMS to question this approach (although CMS has authorized similar approaches in other states).	CMS acceptance may depend on the degree of standardization directed by HCA.	Seemingly acceptable due to direct accountability of HCA to CMS.	Seemingly acceptable due to direct accountability of HCA to CMS.
Sustainability	ACHs would need to decide whether these significant financial management responsibilities would be necessary post-waiver. Tendency would be to attempt to find future functions that would help sustain newly built capacity.	Contracting out function ensures that in-house capacity does not become a permanent fixture, and sustainability issues are apparently addressed.	HCA would have concerns around hiring significant staff to maintain this function, as time-limited, project positions with this level of specialty are often hard to fill. Sustainability post-waiver may not be an issue if all positions were project-based, but perception of needing to sustain additional state staff in perpetuity would be hard to address.	Contracting function to single source alleviates concern of how staff level and business function would be sustained post waiver.
Duplication	Some would suggest that ACHs would be duplicating	Contracting out by ACH would alleviate some duplication	HCA would be performing a task that duplicates existing	A single contract would minimize duplication risk.

	existing marketplace functions capable of most or all of the financial management responsibilities.	concerns, but multiple vendors would likely be establishing systems with similar functions across the state.	marketplace capabilities	

Recommendation

Given the criteria applied, the option with the greatest likelihood of success appears to be a contract by HCA with a single vendor as a "financial executor". This approach offers direct accountability to ACHs and HCA (and, through HCA, to CMS), assures consistency, is least burdensome administratively, can be implemented on a reasonable timetable and is expected to find acceptance among ACHs.

Olympic Community of Health
DRAFT Meeting Minutes – Attachment 2
Leadership Council
May 4, 2016

Date: 05-04-2016	**Time:** 9:00 am – 11:00 am	**Location:** JH Conference Room, 2500 W. Sims Way, Port Townsend, WA

Chair: Roy Walker, *Olympic Area Agency on Aging*.

Members Attended: Peter O. Casey, *Peninsula Behavioral Health*; Larry Eyer, *Kitsap Community Resources*; Leonard Forsman, *Suquamish Tribe*; Vicki Kirkpatrick, *Jefferson County Public Health*; Jennifer Kreidler-Moss, *Peninsula Community Health Services*; Kat Latet, *Community Health Plan of WA*; Eric Lewis, *Olympic Medical Center*; Elya Moore, *Olympic Community of Health*; Kerstin Powell, *Port Gamble S'Klallam Tribe*; Andrew Shogren, *Quileute Tribe*; Brent Simcosky, *Jamestown S'Klallam Tribe*; Doug Washburn, *Kitsap County Human Services*; Hilary Whittington, *Jefferson Healthcare*.

Other: Scott Daniels, *Kitsap Public Health District;* Kayla Down, *Washington State Health Care Authority*; Allan Fisher, *United Healthcare*; Keith Grellner, *Kitsap Public Health District;* Siri Kushner, *Kitsap Public Health District;* Angie Larrabee, *Olympic Community of Health;* Jorge Rivera, *Molina Healthcare;* Caitlin Safford, *Amerigroup;* Andrea Tull, *Coordinated Care.*

Person Responsible for Topic	Topic	Discussion/Outcome	Action/Results
	Objectives:	1. Approve HCA Contract Deliverables 2. Agree on next phase of governance structure 3. Agree on next steps for regional health project planning and implementation	
Roy Walker	**Call to Order**	Roy called the meeting to order at 9:08 am.	
Roy Walker	**Audio Recording**	Roy informed the Council that this and future meetings would be recorded for the public and asked for objections.	There were no objections.
Council	**Agenda**	Approval of Agenda.	Agenda approved unanimously.
Council	**Consent Agenda**	Approval of Consent Agenda.	Consent Agenda approved unanimously.
Eric Lewis	**Three-year OCH Budget**	Discuss Budget through December 31, 2018:	Budget approved unanimously.

		• Budget assumes OCH will be incorporated by 2017 and/or bids for new backbone organization. • May change depending on legal structure in the future. • Lowered indirect costs to 15% • Larger donors will have equal stake in governance structure as rest of governance members. • Surplus in the budget will be kept in reserve. • Grant money will rollover year to year, but needs to be spent down by the end of 2018. • Program Coordinator position moved from Personnel to Non-Personnel, as it may be contracted out. • Roles of Program Coordinator to be decided by Council at a later date, and to include health improvement project coordination.	
Elya Moore	**OCH Readiness Proposal Comments**	Summary of the strengths and weakness of OCH Readiness Proposal: • Web/Media/Public presence • Sector engagement. • OCH/Tribal representation is best of ACHs in state, but has room for improvement. • Need for executive council	No action required Request to develop an OCH elevator pitch – describe OCH in 3 sentences.
Doug Washburn & Council	**Moving Governance Forward**	**Recommendation 1:** Establish a 19-member Council (currently 22). Several members of Council were not comfortable eliminating members who were not present at this meeting. Sectors were originally voted on by entire group and were not broken down by county. Discussion established that the Council was not ready to make a decision on this recommendation. There needs to be a representative for each tribe on the Council. MCO's and Tribes asked to participate on governance subcommittee. **Recommendation 2:** Create an Executive Committee.	**Recommendation 1 & 2: TABLED.** Council did not take action. Governance Committee will meet to discuss sector representation and formation of an Executive Committee.

		Recommendation 3: Convert current Assessment and Planning subcommittee into an ongoing Regional Health Assessment and Planning (RHAP) Committee. RHIP committee is needed to choose a project for the waiver. MCO's asked to participate on RHAP Committee. **Recommendation 4:** Elya proposed that the Governance Committee meet one final time for full recommendations of final policies and bylaws. **Recommendation 5:** The work of the Sustainability Committee will become the responsibility of the director, with support of the executive committee, as needed. **Recommendation 6:** Each committee will use the same (or similar) charter that clearly defines membership, objectives, responsibilities and timeline. **Recommendation 7:** When a board member retires or changes employment into a new sector, the member must caucus with his or her sector to declare a replacement on the board.	**Recommendation 3: APPROVED.** Regional Health Assessment and Planning Committee Approved unanimously. **Recommendation 4: APPROVED.** Final Governance Meeting approved unanimously. **Recommendation 5: APPROVED.** Director taking over work of Sustainability Committee approved unanimously. **Recommendation 6: APPROVED.** Use of same charter by all committees approved unanimously. **Recommendation 7: APPROVED.** Method for replacing seats on board approved unanimously.
Elya Moore & Siri Kushner	**Project Planning and Implementation**	Overview of goals and representation. At March 22, 2016 meeting, approval of board priority categories: • Access • Aging • Behavioral Health • Chronic Disease • Early Childhood HCA Framework for the Project Toolkit contains guidance on the transformation projects that will be included in the toolkit for the Medicaid Waiver. OCH needs to select a project by July 31, 2016. Full development of the RHIP Plan due January 31, 2017. Elya suggests finding projects that meet waiver requirements *and* are best for the community.	RHAP Committee representation approved unanimously with revisions to add MCO's, education, workforce council, EMS, and housing.

Jennifer Kreidler-Moss	**Accountable Health Communities CMMI funding opportunity**	Should OCH provide a Letter of Support (LoS) to the HCA for an application from the Alliance for South Sound (a Partnership between CHI Franciscan and Multi-Care hospital systems) to CMS for the ACH funding opportunity? Several members expressed approval, while others expressed caution. It was noted that King and Pierce counties had not yet committed Letters of Support to this application. The letter is nonbinding; if OCH opts in now, it can opt out later. However, if it does not provide a LoS now, OCH cannot opt in later. Council asked to see a draft letter and hold revote via email (and recommended bringing Draft Letters for a future votes).	Motioned and seconded; 4 in favor, 7 opposed. Motion Failed. Motion to hold electronic revote based on draft letter to be sent via email approved unanimously.
Elya Moore	**Next Steps**	Set schedule for future monthly Council meetings: 9:00 am – 11:00 am first Wednesday of each month. ACH Quarterly Convening June 29-July 1 – room for one additional attendee. • Hilary volunteered. Elya suggested OCH reconvene Stakeholder Meetings quarterly. Asked for informal vote. Roy invited all members to participate in the Tribal Consultation on May 11, 2016.	Unanimous agreement.
Roy Walker	**Adjourn**	There was no additional business. The meeting was adjourned at 11:35am	

OCH Partner Convening
June 14, 2016

9:00 a.m. to 12:00 p.m.
Suquamish House of the Awakened Culture
7235 NE Park Way, Suquamish, WA 98392

We would like to express our gratitude to the Suquamish People for hosting us in the House of Awakened Culture. To learn more about this magnificent space, please visit the Suquamish Foundation website.

Objectives

- Shared understanding of and willingness to participate in process to select a regional health improvement project
- Initiate conversation of what integration might mean for our communities

AGENDA

	Topic	Facilitator	Materials
9:00	Welcome and Host Introductions	Leslie Wosnig and Craig Nolte	
9:05	Participant Introductions & Name Change	Roy Walker	
9:15	Evolving OCH Governance	TBC	• OCH Rosters
9:25	Regional Health Assessment and Planning (RHAP) *****Call for proposals*****	Katie Eilers & Siri Kushner	• Project Application Form • Project Scoring Sheet • Regional Health Assessment 1-pager
10:25	**BREAK** Help yourself to continental breakfast, courtesy of the Federal Reserve Bank of San Francisco		
10:35	**Presentation:** The first six months into integration: lessons from *Southwest Washington Early Adopter Region* **Guest Speaker**: Tabitha Jensen, Early Adopter Project Manager, Southwest Washington and one other speaker TBD Followed by a discussion with OCH Partners	Rochelle Doan	• Materials to be handed out at the meeting and posted online
11:35	Information and Q&A	Elya Moore	• Director's Report with waiver update • Notes from last convening
11:50	Meeting wrap-up	Roy Walker	• Survey – please tell us how to improve and who else to invite!
12:00	Adjourn	Roy Walker	

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

April 13, 2016

Dear Tribal Leader:

SUBJECT: Tribal Consultation on Accountable Communities of Health Program

In accordance with the Health Care Authority (HCA) Consultation and Communication Policy and in response to a request for consultation received from the American Indian Health Commission for Washington State (the Commission), I am requesting a meeting with representatives from the Washington State Tribes (the Tribes) and the Indian Health Service and Urban Indian Organization clinics to solicit your advice and counsel.

Based on feedback from the Commission, we have scheduled the requested consultation for the following date and time:

What:	Tribal Consultation with HCA on ACH Engagement
Date:	May 11, 2016
Time:	2:00 p.m. to 4:00 p.m.
Location:	Suquamish House of the Awakened Culture 7235 NE Park Way Suquamish, WA 98392

For those who cannot attend the consultation person, the Commission is offering webinar access. To participate via webinar, please register at: https://attendee.gotowebinar.com/register/4700982129649253892.

Topic: Tribal Consultation with HCA on ACH Engagement

Accountable Communities of Health (ACHs) are intended to bring together a group of leaders from a variety of sectors in a given geographic area with a common interest in improving health and health equity. By increasing community-based, cross-sector collaboration, ACHs better align resources and activities, which will improve whole person health and wellness. ACH participants promote health equity across the state and address the broader issues that affect health through regional health improvement plans. As Healthier Washington continues to expand, ACHs will serve a key role in supporting regional and statewide initiatives, such as practice transformation, value-based purchasing and the alignment of performance measures.

On March 1, 2016, HCA received a letter from the Commission (enclosure) requesting immediate Consultation between HCA and the Tribes and Urban Indian Health Organizations (UIHOs) to discuss the minimum requirements to be placed on the ACHs for the ACH program as a federally-funded and state-designed program.

As the Commission has requested, the agenda of the Consultation will be:

1. Adoption of a model ACH Consultation Policy
2. Requiring all nine ACHs to adopt the model ACH Consultation Policy
3. Tribal and UIHO representation on ACH governing boards

HCA would like to note that ACHs are regionally governed, voluntary collaboratives, supported by a variety of fund sources, including the Washington State Innovation Models grant from the Center for Medicare and Medicaid Innovation. HCA supports further dialogue on these important topics and is happy to play a role of facilitation and partnership.

HCA will also invite leads from each ACH to attend this Consultation. Please forward this information to any interested party.

Please RSVP by May 6, 2016, with Jessie Dean, Administrator, Tribal Affairs & Analysis, by telephone at 360-725-1649 or via email at jessie.dean@hca.wa.gov. He will also be available to answer any questions or address any concerns you may have.

Sincerely,

Dorothy F. Teeter, MHA
Director

Enclosure

By mail, email

cc: Nathan Johnson, Chief Policy Officer, PPP, HCA
Laura Zaichkin, Deputy Policy Officer, PPP, HCA
Chase Napier, ACH Program Manager, PPP, HCA
Jessie Dean, Administrator, Tribal Affairs & Analysis, PPP, HCA
Steven Kutz, Chair, AIHC
Tribal Leaders
Tribal Health Directors
UIHO CEOs
NPAIHB CEO
AIHC Delegates
ACH Leads

Attachment A

American Indian Health Commission for Washington State

"Improving Indian Health through Tribal-State Collaboration"

Chair
Stephen Kutz
Cowlitz Tribe

Vice-Chair
Dylan Dressler
Lower Elwha Klallam Tribe

Treasurer
Andrew Shogren
Quileute Tribe

Secretary
Charlene Nelson
Shoalwater Bay Tribe

Member-at-Large
Aren Sparck

Executive Director
Vicki Lowe

Member tribes:
Chehalis
Colville
Cowlitz
Jamestown S'Klallam
Kalispel
Lower Elwha Klallam
Lummi
Makah
Muckleshoot
Nisqually
Nooksack
Port Gamble S'Klallam
Puyallup
Quileute
Quinault
Samish
Sauk-Suiattle
Shoalwater Bay
Skokomish
Snoqualmie
Spokane
Squaxin Island
Stillaguamish
Suquamish
Swinomish
Tulalip
Upper Skagit
Yakama

Member Organizations:
Seattle Indian Health Board
NATIVE Project of Spokane

February 19, 2016

RECEIVED

MAR 01 2016

Health Care Authority

Dorothy Teeter, Director
Washington State Health Care Authority
626 8th Avenue SE
P.O. Box 45502
Olympia, Washington 98504-5502

RE: ACH Tribal and UIHO Engagement and Consultation

Dear Director Teeter:

The American Indian Health Commission for Washington State (Commission) appreciates the opportunity to provide technical assistance through January 2017 to the twenty-nine tribes, the two urban Indian health organizations (UIHOs) and the State of Washington in ensuring that the nine regional Accountable Communities of Health (ACHs) meet the needs of tribal communities and urban Indians. We look forward to helping the tribes and UIHOs better understand the regional ACHs and helping the ACH organizations better understand the Indian health delivery system and the nature and importance of the government-to-government relationship that the State maintains with the tribes under chapter 43.376 RCW and the Centennial Accord and Millennium Agreement. We also look forward to working with each tribe and UIHO to understand how their regional ACHs and/or a tribal coordinating entity (as an alternative to the regional ACHs) can best help them address the severe health disparities among AI/AN throughout the State of Washington.

The AIHC-ACH Project includes "Developing and creating written recommendations including standard consultation/engagement protocols and best approaches for ACH's to interact with Tribes and HCA's responsibility to facilitate the government-to-government relations." Over the next several months, the AIHC will be gathering more detailed information and feedback from the tribes and UIHO regarding consultation and ACH implementation recommendations. However, the need for consultation, engagement and tribal and UIHO representation is already very apparent. During the past year, tribes and UIHOs have communicated their increasing alarm at both state meetings and Commission meetings that the ACH design and development efforts are progressing without consultation and engagement of tribes or UIHOs at the state or regional levels. Several tribal and UIHO representatives, including those of the Suquamish, Kalispel, and the Native Project, have reported they have made significant efforts to engage in the ACH process, only to be added to the ACH equivalents of stakeholder advisory groups. If one of the ACH constituent county governments received this treatment, they would report similar lack of engagement and consultation. These ACHs clearly do not understand the nature of a government-to-government relationship, and, with the exception of a few ACHs, their attempts to engage the tribes and UIHOs have failed as a result.

Meanwhile, the State's stated vision for these ACHs has grown since the State submitted its

*E-mail AIHC.General.Delivery@outlook.com ** Website: www.aihc-wa.com*
**Phone: 360-477-4522*

application to the Center for Medicare and Medicaid Innovation (CMMI). The State's vision was
already transformational, with regional partnerships to improve the health status of every Washington resident and redesign the manner in which providers operate. More recently, the State is proposing to offer ACHs responsibilities in connection with the Medicaid Transformation Waiver, the largest federal investment of 1115 waiver dollars ever pursued by the State. While this proposal may fit within the intent of the ACHs, the result is to raise the stakes for the tribes and UIHOs. Without the involvement and expertise of tribes and UIHOs in ACH design and development, any effort by ACHs to address AI/AN health needs, including the severe health disparities, is likely to fail.

With these concerns in mind, the Commission has determined that time is of the essence. In accordance with Section 1902(a)(73) of the Social Security Act, the Washington State Medicaid State Plan, and the HCA Tribal Consultation Policy, the Commission requests immediate consultation between HCA and the tribes and UIHOs to discuss the minimum requirements to be placed on the ACHs for the ACH program as a federally-funded and state-designed program. For the agenda of the consultation, the Commission recommends the following:

1. Adoption of a Model ACH Consultation Policy that contains the same requirements as the Washington Health Benefit Exchange (WAHBE) and the Washington Department of Health (DOH);
2. Requirement for each ACH to adopt and comply with an ACH Consultation and Engagement Policy as a condition for each ACH to receive continued funding from CMMI; and
3. Representation of tribes and UIHOs within ACH Governing Bodies.

While the Commission understands HCA's perceived challenges in imposing requirements on non-state entities such as the ACHs to consult with tribes and UIHOs, the Commission calls on HCA to meet the government-to-government requirement under RCW 43.376.020(1), to "collaborate with Indian tribes in the development of policies, agreements, and program implementation that directly affect Indian tribes." Two decades ago, the Regional Support Network was designed and maintained without the involvement of tribes (or UIHOs), and, as a result, countless AI/AN suffered from lack of access to RSN-care they were entitled to by law and tribes were given no recourse – ostensibly because the RSNs were not state-entities. In contrast, the Commission faced a similar situation with the WAHBE, an entity that is not a state agency, but rather a public-private partnership. Nonetheless, early in the formation of the WAHBE, WAHBE approved a consultation policy that was drafted by tribes and UIHOs after months of input and engagement. This same model policy was adopted by the DOH and will likely be adopted by Office of the Insurance Commissioner as well. Chehalis Tribe, Confederate Tribes of Colville, Cowlitz Tribe, Jamestown S'Klallam Tribes, Kalispel Tribe, Lummi Nation, Port Gamble S'Klallam Tribe, Puyallup Tribe, Quinault Nation, Samish Tribe, Suquamish Tribe, Shoalwater Bay Tribe, Snoqualmie Tribe, Stillaguamish Tribe, Swinomish Tribe and Seattle Indian Health Board and the NATIVE Project UIHOs request that ACHs be required to adopt and implement the same model consultation policy.

Even though the ACH program was not initially designed with minimum tribal and UIHO engagement requirements in mind, the Commission urges HCA to collaborate with the tribes and UIHOs in the development of minimum ACH requirements going forward – before yet another state-designed program fails to include tribes and UIHOs and results in poor health outcomes for AI/AN.

Should you have any questions, please do not hesitate to contact our Executive Director, Vicki Lowe, at 360-477-4522.

Sincerely,

Steve Kutz, BSN, MPH
Chair, AIHC

cc:

Kitty Marx, Director CMS Division of Tribal Affairs
Priya Helwig, CMS Region 10, NAC
Cecile Greenway, CMS Medicaid Region 10 Program Branch Manager
Alice Lind, Section Manager, HCS, HCA
Alison Robbins, Program Manager, HCS, HCA
Kathy Pickens-Rucker, Project Manager, MCS, HCA
Ann Myers, State Plan Coordinator, LAS, HCA
Tribal Leaders
Tribal Health Directors
Urban Indian Health Organization Directors
AIHC Delegates
Indian Policy Advisory Committee Delegates
Nathan Johnson, HCA Policy Director
MaryAnn Lindeblad, HCA Medicaid Director
Jessie Dean, HCA Tribal Liaison
Joe Finkbonner, NPAIHB Executive Director
Laura Bird, NPAIHB Governmental Affairs/Policy Director
Vicki Lowe, AIHC Executive Director
Heather Erb, AIHC Legal Consultant

Model ACH Engagement and Consultation Policy and Procedure

I. Purposes

To establish a clear and concise consultation and engagement policy and procedure between the Accountable Community of Health and tribal governments and Urban Indian Health Organizations (UIHOs) in the development of ACH policies or actions that have tribal or urban Indian implications.

To ensure the ACH respects the government-to-government relationship between the tribes and the State of Washington established in RCW 43.376, RCW 43.88.230, and the Washington Centennial Accord of 1989.

II. General Requirements

Consistent with these laws, the ACH will consult and engage with tribal governments and UIHOs in a manner that is separate and distinct from ACH relationships with stakeholders, municipalities or counties or local health jurisdictions. Unlike these entities, tribal governments are sovereign nations and are not subject to the authority of Washington State. This means that ACH will consult with and engage tribes and UIHOs from the beginning and throughout any time in the planning and development process, rather than solicit feedback from tribes after key decisions have been made. If a tribe or UIHO declines an invitation to engage, the door should always remain open.

III. Engagement and Inclusion Process

1. The ACH will collaborate with tribes and UIHOs prior to the development of policies, agreements and program implementation that directly affect Indian tribes and UIHOs.
2. Engagement with tribal and UIHO representatives (including clinical health directors and behavioral health directors) shall consist of inclusive decision-making where the ACH policies, processes, and actions are developed and implemented in ways that reflect the contributions of the tribes and UIHOs.
3. In order to maximize tribal and UIHO representation, the ACH will send notification and materials to tribal and urban representatives as identified in Section IV.2 of all ACH Meetings.

IV. Consultation Process

To the extent permitted by law, ACH shall not proceed on any policy or action that has tribal implications unless and until the ACH, prior to proceeding on the policy or action, has adhered to the process described below.

1. **Identification of Issues Requiring Tribal Engagement/Consultation.** Consultation and engagement with tribes and UIHOs must occur prior to implementation of all ACH policies and actions that have "tribal implications." Tribal implications refer to policies or actions that have a substantial direct effect on one or more of the tribes or UIHOs or the relationship between the ACH and Tribes. The determination of whether a policy or action has tribal implications will be made by the ACH or by any other party referenced in Section IV.2. Tribal and UIHO representatives should be included in the development of all ACH policies, processes, and actions in order to identify issues for tribal consultation/engagement.
2. **Prior Written Notification of Consultation.** The ACH, Tribes or UIHOs may initiate consultation at any time. The ACH shall send a written notification requesting consultation at least 21 days prior to the scheduled consultation. See Appendix A. The written request must identify the proposed policy or action and provide an estimate of its impact on AI/AN people, their providers, and/or the Tribes. All ACH requests for consultation will also be posted on the ACH website and emailed to the following parties to consultation:

i. Federally-Recognized Indian Tribes represented by the Tribal President, Tribal Chair, or Tribal Governor, or an elected or appointed Tribal Leader, or their authorized representative(s). All tribes who are parties to this policy are listed in Appendix A;

ii. UIHO Directors or their authorized representative. **NOTE:** UIHOs are not tribal governments. However, UIHOs are Indian health providers who receive funding from Indian Health Services pursuant to Title V of the IHCIA (Pub. L. 94-437) and are parties to consultation for both the Washington Department of Health and the Health Care Authority. **While consultation with these parties is required, it will not serve as a substitute for the requirement under this policy to consult with the individual tribal governments directly;**

iii. The Health Care Authority Director or authorized representative; and

iv. The highest level of the ACH Executive Leadership acting under the delegated authority of the ACH governing body.

The ACH will work with each of the individual tribes and UIHOs to ensure that all contact information is up-to-date and the correct consultation representatives are notified and regularly receive information.

3. **Consultation Meeting.** In order for consultation to be meaningful as required in Section II of this policy, the following actions shall occur at all tribal consultations:
   i. meeting held in a mutually agreeable public forum;
   ii. parties identified in Section IV.2 of this policy shall be present (It is not required that all Tribes be represented for a formal consultation to occur.);
   iii. identification and full explanation of the issue, proposed action or policy that is basis of the consultation request;
   iv. opportunity for all parties to further collaborate, ask questions, provide feedback, criticisms, etc.;
   v. proposal of ACH action in specific response to other party's questions, feedback, criticisms, etc.; AND
   vi. recording of meeting in the form of taking minutes.
4. **Action Required After Consultation**
   i. ACH will communicate to all parties listed in Section IV.2 within three business days of the time the decision is made to implement a proposed policy or action , or an agreed upon time frame. Such communication shall be made via the ACH website, post office mail, and electronic mail.
   ii. ACH will maintain records of its tribal consultation activities including minutes and reports on outcomes and decisions from Consultation meetings. Such records shall be made available to all parties in Section IV.2 on the ACH website.

V. State as Party to the Relationship

Because of the government-to-government relationship, the ACH shall send copies of any written communication from the ACH to a Tribe or UIHO to the Health Care Authority. At a Tribe's or UIHOs request, the HCA will participate in any ACH meetings involving a Tribe or a Tribal representative.

VI. Tribal and UIHO Representation on Oversight Body

ACH will consult independently with each Tribe and UIHO in their region and allow each Tribe and UIHO to decide whether or not they will participate and how they will coordinate their participation. The oversight body of the ACH shall include representation from each of the tribes and UIHO within the region. The purpose of tribal and UIHO representation is to identify key implications of the intersection and interaction

of the Indian health care delivery system with ACHs during the design and development ACH policy, processes, and actions.

VII. Sovereignty and Disclaimer

ACH respects the sovereignty of each tribe located in the State of Washington. In executing this policy, no party waives any rights, including treaty rights; immunities, including sovereign immunities or jurisdiction. This policy does not diminish any rights or protections afforded other Indian persons or entities under state or federal law including the right of each of the parties to elevate an issue of importance to any decision-making authority of another party, including, where appropriate, to the Health Care Authority, Governor of the State of Washington or Region X Administrator of HHS.

X. Effective Date

This policy will be effective on _____ , and will be reviewed and evaluated annually at the request of any of the parties referenced in Section IV.2.

APPROVED BY:

_____

ACH Chair

Olympic ACH-Tribal Workshop

June 7, 2016 9:00 a.m. – 4:00 p.m.

Jamestown S'Klallam Red Cedar Hall, 1033 Old Blyn Hwy, Sequim, WA

Sponsored by

American Indian Health Commission for Washington State

Healthier WASHINGTON

Agenda

Morning - Tribes Only Workshop

HANDOUT: *Model ACH Tribal Consultation Policy*

9:00am-9:15am Part I - Introduction

1. About the AIHC and AIHC-ACH Project
2. Today's Goals, Objectives, Desired Outcomes
3. Potential Benefits of ACH-Tribal Partnerships

9:15am-10:30am Part II –Health System Transformation & Accountable Communities of Health

1. Federal Framework for Health System Transformation
2. Washington Health System Transformation
3. ACH Overview
4. Transformation Projects
5. Olympic ACH
6. ACH Implications for AI/AN, Indian Health Care and Social Service Providers, and Tribal Governments
7. Federal & State Consultation Requirements

10:30am-10:45am BREAK

10:45am-12:00pm Part III – Gathering Feedback – White Board

1. Discussion
2. Tribal Profiles
3. Questions and Concerns

Afternoon – Roundtable with ACH and Tribes

HANDOUTS: *Note Cards for Questions/Comments*
Model ACH Consultation Policy
Evaluations

12:00pm-12:30pm WELCOME & LUNCH

12:30pm-12:45pm Part I - Introduction

1. About the AIHC and AIHC-ACH Project
2. Today's Goals and Objectives
3. Potential Benefits of ACH-Tribal Partnership to ACH and Tribes

12:45pm-1:45pm Part II - WA Indian Health System Overview

1. Indian Health in a Nutshell
2. Introduction to Government-to-Government
3. ACH Governance & Model ACH Tribal Consultation Policy
4. Federal Trust Responsibility to Provide Health Care to AI/AN
5. Insufficient Federal Funding for Indian Health Care
6. AI/AN Health Disparities
7. Indian Health Care Providers, Social Services, Public Health

1:45pm-2:15pm Part III - Local Tribal Overview for the ACH & Tribal Concerns

2:15pm-2:30pm BREAK

2:30pm-2:45pm Olympic ACH Feedback

2:45pm-3:45pm Part IV – Creating Next Steps - White Board

1. ACH-Tribal Partnership
2. Regional Health Needs Inventory & Regional Health Improvement Plan
3. ACH-Tribal Key Players & Contacts
4. Engagement & Representation
5. Consultation
6. Coordination

3:45pm-4:00pm Part V – Conclusion

Workshop Evaluation

Medicaid Managed Care Organization (MCO) Sector Representation – Recommendation from the MCOs:

- We propose one board seat be provided to the MCOs with one vote. We will rotate on an annual basis using the calendar year.
- Kat Latet will finish out the term for Community Health Plan of Washington (CHPW) for 2016. We will propose a rotation schedule in the near term to give the OCH Leadership Council an understanding of which plan will rotate on next.
- While we have a rotating seat, we encourage ACHs to maintain meetings so MCO sector peers can be present. We will strive to be prepared for votes, by reviewing agendas ahead of time with our sector team to ensure we can make an educated vote that represents our sector view. This is assisted when specific items that will be voted on are shared in advance of the meeting.
- In the last meeting, we provided an example of ceding the "floor" to other MCO colleagues to express their opinion. In other ACH governance tables, MCOs are able to engage in the discussion, but ultimately there is one MCO vote. We would recommend this model.
- We want to make sure ACHs across the state maintain the notion and intent of sector representation, even as we move toward "legal entity" status. We believe the MCOs have actually created a model that could be replicated across other sectors as we start to whittle down the board due to numbers.
- If the Leadership Council decides to create an Executive Committee, we have agreed the individual who is the MCO sector representative should be on that committee if elected for their term and then rotate off when their term is complete.

SECTOR BALANCE: Primary representation is denoted in green; secondary representation is denoted in red for consideration

Reviewed and revised by the Governance Subcommittee 5/19/2016

		Health Care System						Behavioral Health System						Social determinants of health									County break down *(not including Tribal Nations)*		
	OCH Member	Primary Care	Public Hospital	Public Rural Hospital	Private/ Nonprofit Hospital	FQHC	MCO	BHO	MH	CD	LHJ	LTC	Oral Health	Comm'y Action / Social Services	Housing	Chronic dz prev'n across the lifespan	* Economic or workforce Dev't	* Educ-action	* Law & Justice	* Philanthropy	* Transportation	* Nurtrition/active living	Kitsap	Jefferson	Clallam
1	Justin Sivill	1																					1		
2	Eric Lewis		1																						1
3	Hilary Whittington			1																				1	
4	David Schultz (replacing Michael Anderson)				1																		1		
5	Kat Latet						1																		
6	Jennifer Kreidler Moss	1				1			1				1										1		
7	Joe Roszak (replacing Peter Casey)								1	1				1	1	1		1			1	1	1		
8	Chemical Dependency									1															
9	Doug Washburn							1		1		1			1		1						1		
10	Chris Frank										1														1
11	Roy Walker											1		1										1	1
12	Tom Locke	1									1		1								1			1	1
13	Katie Eilers															1						1	1		
14	Larry Eyers													1	1		1				1		1		
15	Kurt Wiest														1								1		
16	Hoh													1	1	1	1	1	1		1	1			
17	Quileute	1											1	1	1	1	1	1	1		1	1			
18	Makah													1	1	1	1	1	1		1	1			
19	Lower Elwah Klallam	1												1	1	1	1	1	1		1	1			
20	Jamestown S'Klallam	1				1				1			1	1	1	1	1	1	1		1	1			
21	Port Gamble S'Klallam	1												1	1	1	1	1	1		1	1			
22	Suquamish								1	1				1	1	1	1	1	1		1	1			
	Column Totals	**7**	**1**	**1**	**1**	**2**	**1**	**1**	**3**	**5**	**2**	**2**	**4**	**10**	**11**	**9**	**9**	**8**	**7**	**1**	**9**	**9**	**8**	**3**	**4**

* Sectors that were previously identified by the interim council to consider at a later date

GLOSSARY

BHO: Behavioral health organization
CD: Chemical dependency
FQHC: Federally qualified health care center
LHJ: Local health jurisdiction
LTC: Long term care
MCO: Medicaid Managed Care Plan
MH: Mental health

ADDITIONAL SECTORS FOR CONSIDERATION

Economic Development
Workforce Development
Education (early learning through higher education)
Law & Justice
Philanthropy
Transportation
Nutrition and Active Living

Olympic COMMUNITY of HEALTH

Ad Hoc Governance Subcommittee Charter

Subcommittee Members

	Name	Affiliation
1	Adam Marquis	Jefferson Mental Health Services
2	Allan Fisher	United Health Care representing MCOs
3	Doug Washburn	Kitsap Human Services
4	Eric Lewis (Chair)	Olympic Medical Center
5	Joe Roszak	Kitsap Mental Health Services
6	Peter Casey	Peninsula Behavioral Health
7	Andrew Shogren	Quileute Nation
8	Leslie Wosnig	Suquamish Nation
9	*Other members TBC*	

Governance Subcommittee Purpose
To advise on a cross-sector, multi-county governance structure that and identifies a clear decision making process.

OCH Governance Guiding Principles
The governance should be multi-sector, balanced, transparent, and demonstrate effective decision-making. Governance should be supported by bylaws, articles of incorporation and policies. In turn, the governance structure must support:

- Financial capacity to provide strong financial management and transparency, including budget development, the distribution of funds and financial reporting.
- Governance over data and information technology, oversight over transformations projects, and monitoring of performance.
- Binding regional partnerships.

Responsibilities
The governance subcommittee is an *ad hoc* committee of the Leadership Council. On a case-by-case basis, the Leadership Council or the Executive Committee may call on the Governance Subcommittee to develop governance recommendations. Membership of the Governance Subcommittee may adapt to meet the specific charge. No single sector shall dominate the group.

Timeline
The Governance Subcommittee is an *ad hoc* committee that will meet on a case-by-case basis as delegated by the OCH Leadership Council or the Executive Committee.

Olympic Community of Health

Recommendations for consideration by the Governance Subcommittee – Attachment 9

Situation. Background. Assessment. Recommendation.

Approved by the Governance Subcommittee May 19, 2016

Presented to the OCH Leadership Council June 1, 2016

Situation

In the immediate future, our governance structure must accommodate the following functions:

1. Selection and strategic oversight of a regional health improvement project, and
2. Becoming the single point of authority for transformation project implementation and oversight under the Medicaid waiver.

Background

The OCH Charter clearly states that 15 sectors and 7 Tribes will constitute the first iteration of the OCH Leadership Council. Please refer to the table below for the list of current OCH Leadership Council members.

As stated in the OCH Charter: *Representatives are expected to communicate on behalf of and represent the sector as a whole and to ensure a system for regular communication and feedback within their sector and as a responsibility of their Council participation. Each sector will constitute one "vote" in decision making.*

Assessment

The current sector balance is good; however, there is room for additional sectors that directly address the social determinants of health. Careful consideration of county balance is necessary when selecting representatives.

Four Governance Subcommittee Recommendations to the OCH Leadership Council:

1. **Name Change**

   Transition the OCH Leadership Council to the OCH Board of Directors (Board).

   Rationale: Names matter. To prepare for becoming a legal entity and the types of decisions the OCH will need to make in the coming months, the Council should think of itself as a Board with the fiduciary responsibility over an organization. Councils that are *not* councils of government are typically advisory or deliberative bodies of people formally constituted and meeting regularly. In contrast, boards of directors are bodies of elected or appointed members who jointly oversee the activities of a company or organization. Using the term board could help enhance the general perception of value and function.

2. **Additional Board Members from Sectors not Currently Represented**

   Postpone the addition of new Board members until we know more about the function and projects of the OCH. In the meantime, staff engages with leaders from additional sectors through OCH committees and other mechanisms. The Board will revisit the issue of new members in fall of 2016. In the interim, the Governance Subcommittee suggests prioritizing the following sectors for enhanced engagement:

   - first responders/EMS
   - law & justice
   - education (early learning)

Rationale: The size of the OCH Board, 22 members, is already greater than a reasonable size for a high-functioning governing body. The sectors listed above are prioritized because they offer an essential perspective that no other sector can offer, and that is highly relevant to the anticipated work of the OCH.

3. **Policy to fill new seats and refill seats**
   Approve a more formal process to fill new seats or replace existing seats on the Board. Please refer to Attachment 10, "*Policy to Fill New Seats and Refill Seats".*

   Rationale: It is essential to have a robust and transparent policy in place for how new members are added to the Board.

4. **Formation of an Executive Committee**
   Form an Executive Committee of 5 officers all drawn from the OCH Board of Directors (Board). The roles for each officer position are listed below. At the outset, officer term limits are one year, or until bylaws are adopted by the Board that define officer term limits. This allows flexibility during this next iterative phase of governance. Each officer position will be up for re-election at the end of its term limit, except the Past-President position.

   1. **President**
      - Oversees Board and executive committee meetings
      - Works in partnership with the director to make sure Board resolutions are carried out
      - Calls special meetings if necessary
      - With the director, recommends who will chair and serve on committees
      - Assists director in preparing agenda for Board meetings
      - Assists director in conducting new Board member orientation
      - Oversees searches for a new director
      - Coordinates director's annual performance evaluation
      - Acts as an alternate spokesperson for the organization

   2. **Vice-President**
      - Attend all Board meetings
      - Serve on the executive committee
      - Carry out special assignments as requested by the Board president
      - Understand the responsibilities of the Board president and be able to perform these duties in the president's absence
      - Participate as a vital part of the Board leadership

   3. **Secretary**
      - Attend all Board meetings
      - Serve on the executive committee
      - Ensure the safety and accuracy of all Board records
      - Review Board minutes
      - Assume responsibilities of the president in the absence of the Board president and vice-president
      - Provide notice of meetings of the Board and/or of a committee when such notice is required

4. **Treasurer**
    - Attend all Board meetings
    - Maintain knowledge of the organization and personal commitment to its goals and objectives
    - Understand financial accounting for organizations, especially nonprofit organizations
    - Serve as the chair of the finance committee should one exist
    - Manage, with the finance committee, the Board's review of and action related to the Board's financial responsibilities
    - Work with the director and relevant administrative staff to ensure that appropriate financial reports are made available to the Board on a timely basis
    - Present the annual budget to the Board for approval
    - Review the annual audit and answer Board members' questions about the audit

5. **At-Large** (to be replaced by Past-President)
    - Attend all Board meetings
    - May be assigned to serve on committees or undertake special projects

Suggested process

1. Instruct any interested person to self-nominate for a specific officer position via email to the Director. Include a paragraph including skills, experience, qualifications, and statement explaining interest. OCH staff will collate nominations and present to the next Board meeting.
2. At the next Board meeting, the Board will vote for each officer by ballot. All present Board members may vote.
3. In the event of a tie, follow Roberts Rules of Governance. In the event that the Board Chair is on the ballot, the Director will delegate the Chair responsibilities temporarily to another Board member familiar with Robert's Rules of Governance.

Rationale: The OCH needs an Executive Committee. Over the next six months, the OCH must move quickly to maximize opportunities arising from Healthier Washington, the Medicaid Waiver, and health care reform in general. Given the speed of information, the so-called "*drinking from the firehose*" effect, the ability to adeptly assess and synthesize information to allow for thoughtful, strategic discussion at the Board level is in jeopardy. The primary role of the Executive Committee is to tee up policy and discussion issues for the full Board for discussion and decision-making.

Olympic Community of Health

Policy for new members – Attachment 10

Approved by the Governance Subcommittee May 19, 2016

Presented to the OCH Leadership Council June 1, 2016

Policy to fill vacant seats and refill seats in the event a) term limit is reached, b) member retires or c) member no longer can represent his/her sector

Nominations to the Leadership Council (Council) are to be made when a new sector seat is identified, a member's term limit is nearing, a member retires, or a member changes employment into a new sector. Sector nominations will be confirmed at Council meetings.

Nomination to the Council is to be made among and by stakeholders of the sector for whom the individual serves as the representative. Stakeholders are to be inclusive of their peers within the tri-county region in making the selection for representation, and to inform their representative by meeting regularly and independently of the OCH. Representatives are expected to communicate on behalf of and represent the sector as a whole and to ensure a system for regular communication and feedback within their sector and as a responsibility of their Council participation. Each sector will constitute one "vote" in decision making.

In the event a brand new sector is offered a seat on the Council for which there has been little engagement, staff will assist in facilitating the nomination process.

In the event that stakeholders within a sector cannot agree on their sector representative, or are unable to do the due diligence to caucus with other members within their sector to select a representative, an *ad hoc* Nominating Committee of at least three Council members will receive and vet nominations and recommend a sector representative to the Council.

Tribes are governments, not sectors, therefore each Tribe is allotted one vote may appoint alternate representatives as desired. The Council does not have authority to confirm or deny Tribal appointments.

This policy shall be renewed annually from 2016-2018, and then bi-annually thereafter.

_____	_____
OCH Board Chair/President	OCH Director/Executive Director
_____	_____
Date	Date

Executive Committee
Charter
Members

	Name	Role	Agency or Affiliation
1		President	
2		Vice President	
3		Secretary	
4		Treasurer	
5		At-Large	

Executive Committee Purpose

The purpose of the Executive Committee is to discharge the responsibilities of the OCH Board of Directors (Board) relating to the transaction of routine, administrative matters that occur between regularly scheduled meetings of the Board and to tee up policy issues for full Board discussion and decision-making. The Executive Committee will advise the Director regarding emerging issues, problems, and initiatives.

Executive Committee Operating Principles

- Committee membership will comprise of five officer positions: President, Vice-President, Secretary, Treasurer, and At-Large (to be replaced by Past-President after the first term).
- A majority of the Executive Committee shall be necessary and sufficient at all meetings to constitute a quorum for the transaction of business.
- Executive Committee members will be held to term limits outlined in the bylaws.
- The Executive Committee shall be accountable to the OCH Board and shall present all recommendations and actions for review at their next meeting.

Responsibilities

- Work with the President and Director on ongoing issues regarding the business of the organization and to hear and decide on pressing matters of business which may arise between regularly scheduled OCH Board meetings which require a decision before the next meeting.
- To support decision-making by the OCH Board by reviewing material ahead of time to ensure that options are clearly identified and sufficient background information is provided.
- The Executive Committee shall have authority to conduct business on behalf of the OCH between regular Board meetings should authority be expressly given to them by the Board.
- Specific Executive Committee duties include:
  - Preparing for OCH Board meetings
  - Recommending the annual budget to the OCH Board for approval
  - Evaluating the performance and compensation of the director
  - Facilitating development of and implementation of OCH initiatives as needed
  - Monitoring status of internal operations including financial systems, personnel issues, and information systems
  - Appointing authorized subcommittees as needed
  - Assuring that business is conducted in a manner that is consistent with OCH's mission, goals and values

Timeline

The Executive Committee shall meet as needed.

Regional Health Assessment and Planning Committee
Charter

Committee Members *WORK IN PROGRESS*

	Name	Representing	County representation
1	Barbie Rasmussen	AAA Planning Unit Director	Clallam, Jefferson
2	Kirsten Jewell	Kitsap County Human Services/Housing	Kitsap
3	Kurt Wiest	Bremerton Housing Authority	Kitsap (also representing Clallam and Jefferson)
4	Gay Neal	Kitsap County Human Services/ 0.01% for MHCDTC	Kitsap
5	Jennifer Johnson-Joefield	Peninsula Community Health Services	Kitsap
6	TBC	Primary Care (rural provider)	Clallam and/or Jefferson TBC
7	Vicki Kirkpatrick	Jefferson County Public Health	Jefferson
8	Monica Bernhard	Kitsap Community Resources	Kitsap
9	Bobby Beaman	Olympic Medical Center	Clallam
10	TBC	Jefferson Healthcare	Jefferson
11	TBC	CHI Harrison Medical Center	Kitsap
12	Rochelle Doan	Kitsap Mental Health Services	Kitsap
13	TBC	Chemical Dependency	TBC
14	Katie Eilers (chair)	Kitsap Public Health District	Kitsap
15	Alyson Rotter	Olympic Educational Services District	Clallam, Jefferson, Kitsap
16	Molly Staudenraus, RN	Olympic Educational Services District	Clallam, Jefferson, Kitsap
17	TBC	Clallam County Health and Human Services	Clallam
18	Doug Baier	Bremerton EMS	Kitsap
19	TBC	EMS	Clallam and/or Jefferson, TBC
20	Bob Potter	Workforce Council	Clallam, Jefferson, Kitsap
21	TBC	Law enforcement	TBC
22	TBC	Corrections	TBC
23	Allen Fisher, Jorge Rivera, Caitlin Safford, Andrea Tull, Kat Latet	Medicaid Managed Care Organizations (MCOs)	NA
24	Siri Kushner	Kitsap Public Health District	Clallam, Jefferson, Kitsap (contract epidemiologist)
25	TBC	OlyCAP	Clallam, Jefferson
26	TBC	Salish Behavioral Health Organization	Clallam, Jefferson, Kitsap
27	Lisa Rey Thomas, PhD	Suquamish Tribe	NA
28	TBC	Hoh Tribe	NA
29	TBC	Quileute Tribe	NA
30	TBC	Makah Tribe	NA
31	TBC	Lower Elwah Klallam Tribe	NA
32	TBC	Jamestown S'Klallam Tribe	NA
33	TBC	Port Gamble S'Klallam Tribe	NA

Overview
Assessment and planning are core functions of the Olympic Community of Health (OCH): they keep us grounded and focused on addressing the health needs of our communities. The Regional Health Assessment and Planning (RHAP) Committee will be accountable to the OCH Leadership Council to ensure this vital component of the OCH work is high quality and reflective of the communities we all serve.

Objective
The RHAP Committee guides the OCH to meet our contractual obligations of continually developing a Regional Health Needs Assessment (RHNA) and Regional Health Improvement Plan (RHIP).

Responsibilities
- Update the RHNA as new information comes available.
- Develop and update a RHIP.
- Submit the RHNA and RHIP to the Leadership Council for adoption at regular intervals.
- Share developments on the RHNA and RHIP with the OCH Stakeholder Group for feedback.
- Submit project ideas to the Council for discussion and approval.
- Perform RHNA and RHIP-related activities on a case-by-case basis as charged by the Council.

Timeline
The RHNA and RHIP are living documents that will be continually updated as new information comes available. The RHAP Committee will meet as needed to be accountable for the quality and accuracy of these documents. Note that the timeline may vary based on the OCH contract with the State.

OLYMPIC COMMUNITY OF HEALTH

SHARED REGIONAL HEALTH PRIORITIES – Attachment 13

ACCESS	AGING	BEHAVIORAL HEALTH	CHRONIC DISEASE	EARLY CHILDHOOD
A continuum of physical, behavioral, and oral health care services are accessible to people of all ages and care is coordinated across providers.	**Aging adults and their caregivers are safe and supported.**	**Individuals with behavioral health conditions receive integrated care in the best setting for recovery.**	**The burden of chronic diseases is dramatically reduced through prevention and disease management.**	**Children get the best start to lifelong health and their families are supported.**

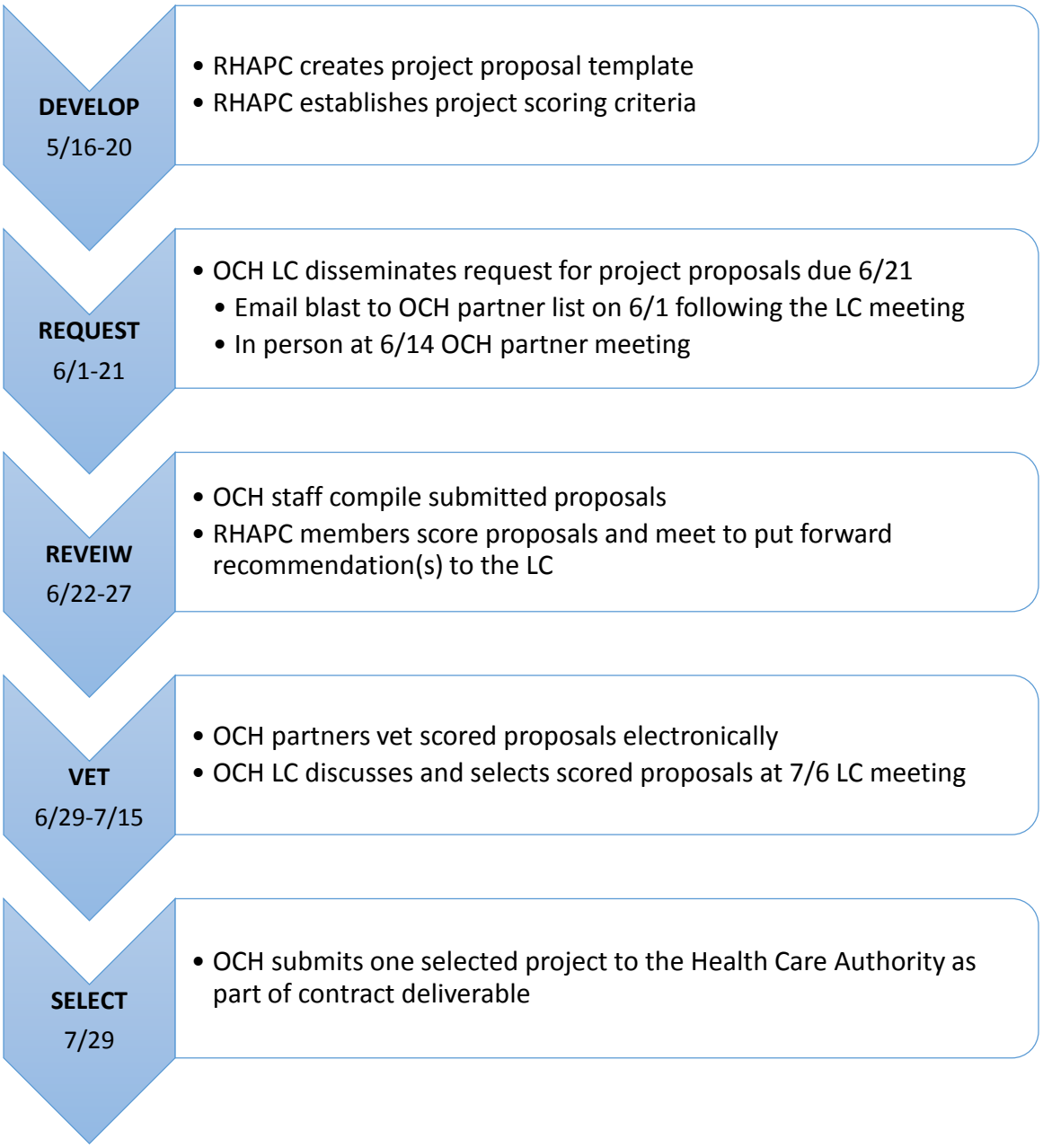
Progress on these priorities depends on improving health equity through SOCIAL DETERMINANTS – housing, education, workforce development, employment, transportation, safety, environmental conditions.

	Alignment of OCH Priority Areas with WA State Medicaid Transformation Waiver Project Categories*	ACCESS	AGING	BEHAVIORAL HEALTH	CHRONIC DISEASE	EARLY CHILDHOOD	SOCIAL DETERMINANTS
DOMAIN 1	**Health Systems Capacity Building**						
	• Primary Care Models	x	x	x	x	x	x
	• Workforce and Non-conventional Service Sites	x	x		x		
	• Data Collection and Analytic Capacity						
DOMAIN 2	**Care delivery redesign**						
	• Bi-directional Integration of Care	x		x			
	• Care Coordination	x	x	x	x		x
	• Care Transitions		x	x	x		x
DOMAIN 3	**Prevention and health promotion**						
	• Chronic Disease Prevention and/or Management	x		x	x		x
	• Maternal and Child Health	x		x		x	x

*overlap based on content in HCA Medicaid Transformation Waiver Toolkit "Objectives and Outcomes" bullets available at: http://www.hca.wa.gov/hw/Pages/medicaid_transformation.aspx

Olympic Community of Health

Regional Project Selection Process and Timeline – Attachment 14



OCH=Olympic Community of Health
RHAPC= Regional Health Assessment and Planning Committee
LC=Leadership Council

DRAFT

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL

Instructions: The categories in this Project Proposal form request information to inform selection of the first OCH project. Ideally projects submitted are already up and running and occur in more than one of the OCH geographies; however new or county-specific projects will also be considered. Priority will be given to projects that address the WA State Common Measure Set. Using standardized evaluation criteria, projects will be scored by the Regional Health Assessment & Planning Committee and the top scoring projects will be voted on by the OCH Leadership Council. The OCH must select a project by 7/31/16. At this time there is no OCH funding for the selected project however performance monitoring and evaluation of the selected project will be supported by OCH staff. Please respond to all categories and limit your proposal submission to 2 double-sided legal pages (equivalent to 4 single-sided), 11 point font.

This form is due via electronic submittal to Angie Larrabee angie.larrabee@kitsappublichealth.org (fax: 360-475-9326) no later than 4pm, Tuesday, June 21, 2016. Please contact Angie if you have questions or have trouble using this form.

PROJECT TITLE:				
HOST ORGANIZATION:				
CONTACT NAME AND TITLE:				
EMAIL:		**PHONE:**		
CONTRIBUTING ORGANIZATIONS:				
COUNTIES SERVED BY THIS PROJECT: ☐ Clallam ☐ Jefferson ☐ Kitsap ☐ Other:				
TRIBES (please name each):				
THIS PROJECT IS (check one): ☐ **New** ☐ **Enhancing an existing project or set of projects**				
SECTORS ENGAGED BY THIS PROJECT (check all that apply)**:**				
☐ Aging	☐ Behavioral Health Org	☐ Chemical Dependency	☐ Chronic Disease	☐ Community Action Pgrm
☐ Early Childhood	☐ Economic Development	☐ Education	☐ Emergency Medical Services	☐ Employment
☐ FQHC	☐ Housing	☐ Justice	☐ Managed Care Organization	☐ Mental Health
☐ Oral Health	☐ Philanthropy	☐ Primary Care	☐ Private not-for-profit hospital	☐ Public Health
☐ Public Hospital	☐ Rural Health	☐ Social Services	☐ Specialty Care	☐ Workforce development
☐ Other (please list):				

BRIEF PROJECT DESCRIPTION (3-4 sentences):	
PROJECT GOAL STATEMENT (1-2 sentences):	
PROJECT SCOPE (1-2 sentences):	*Please describe what part of your regional community the project will serve (e.g. three counties, patients enrolled with two health plans, four primary care clinics, approximate number of individuals served by a social service agency in one city).*

PROJECT ACTIVITIES: (Add rows as needed)	**CONTRIBUTING STAKEHOLDERS/PARTNERS:** (Include their roles & responsibilities)	**ACTIVITY TIMELINE:**

CATEGORY	**DESCRIPTION**	**RESPONSE**					
EVIDENCE BASE	Is project an evidence based, promising or innovative practice or model? Include source.						
ALIGNMENT TO OCH PRIORITY AREAS	Under which one or more of the OCH Priority Areas does this project align?	☐ Access	☐ Aging	☐ Behavioral Health	☐ Chronic Disease	☐ Early Childhood	☐ Social Determinants
VALUE ADD	What difference does OCH involvement make to the project?						

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL

CATEGORY	DESCRIPTION	RESPONSE
TARGET POPULATION/ SCALABILITY	Who are the project participants? How many are currently served and what is the project's potential reach in terms of individuals and communities? Describe potential for scalability.	____ Annual unduplicated number of participants served, Year: _____
IMPACT	How does the project impact/address social determinants of health, health disparities, and/or healthy equity?	
SUSTAINABILITY	How the project is currently funded? What is the sustainability plan for ongoing/future funding?	
ADVANCING THE TRIPLE AIM	Describe how project addresses the Triple Aim of better health, better care, and lower cost?	
MEDICAID WAIVER ALIGNMENT	Is this a potential Medicaid Transformation Waiver project (see table on pages 7-14)? If so, name the Waiver project.	
ALIGNMENT WITH WA COMMON MEASURE SET	List any of the *Common Measures* that this project will track; priority will be given to projects listing at least one.	

EVALUATION: How is the project evaluated? Describe measures and results if any are available. Add rows as needed.

OUTCOME (Desired result)	OUTCOME INDICATOR (How success is measured)	DATA SOURCE (Identify stakeholder/s helping with data collection or analysis)	TIMELINE	RESULTS (Include time frame)

DRAFT

OLYMPIC COMMUNITY OF HEALTH: PROJECT PROPOSAL SCORING FORM

This form is for the OCH RHAP committee to score all submitted Project Proposals by category.
Reviewers will score projects in each category shaded grey using a 3-point scale (0, 1, or 2): 0= does not meet; response is unclear; 1= partially meets; response is not entirely clear or compelling, or 2= fully meets; response is clear and compelling.

Project Title	**List Counties Served**	**Tribes** (Yes or no, not scored)	**Project Description**	**Project Goal**	**Project Activities & Timeline**	**Stakeholders & Partners**	**Evidence Base**	**Alignment to OCH Priorities**	**Value Add**	**Target Population/ Scalability**	**Impact**	**Sustainability**	**Advancing the Triple Aim**	**Medicaid Waiver Alignment**	**Alignment to WA Core Measures**	**Evaluation**	**Additional Information** (not scored)	**TOTAL SCORE**
INSERT PROJECT TITLE HERE	☐ Clallam ☐ Jefferson ☐ Kitsap	☐ Yes ☐ No																
COMMENTS			The columns are not very wide but it might be helpful to have a place to make comments in each category for each project.															
INSERT PROJECT TITLE HERE	☐ Clallam ☐ Jefferson ☐ Kitsap	☐ Yes ☐ No																
COMMENTS																		
INSERT PROJECT TITLE HERE	☐ Clallam ☐ Jefferson ☐ Kitsap	☐ Yes ☐ No																
COMMENTS																		