# Board of Directors
# August 3, 2016

Business: 8:30 a.m. to 10:50 a.m.
Work Sessions: 11:00 a.m. to 1:30 p.m.

**Location:** Jamestown S'Klallam Red Cedar Hall
1033 Old Blyn Hwy, Sequim, WA
**Web:** https://global.gotomeeting.com/join/530369813
**Dial-In:** +1 (312) 757-3121
Access Code: 530-369-813

**KEY OBJECTIVES**

1. Agree on path forward for OCH Articles of Incorporation
2. Agree on path forward for OCH Bylaws

**AGENDA** (Action items are in red)

| Item | | Topic | Lead | Attachments |
|---|---|---|---|---|
| 1 | 8:30 | Welcome | Roy | |
| 2 | 8:35 | Consent agenda | Elya | 1. Director's Report<br>2. Cover Letter: July Deliverable to the Health Care Authority<br>3. What IS the OCH? |
| | | | Roy | 4. Minutes Board of Directors Meeting 7/6/2016 |
| 3 | 8:40 | Budget | Hilary | 5. 2016-2017 Budget: Approved versus Projected |
| 4 | 8:55 | Coordinated Opioid Response Project | Katie | 6. Submitted "Coordinated Opioid Response Project" proposal to the HCA |
| 5 | 9:10 | Articles of Incorporation | Roy | 7. DRAFT Articles of Incorporation<br>8. Articles of Incorporation Recommendation |
| **BREAK – 9:40 to 9:50** | | | | |
| 6 | 9:50 | Bylaws | Jennifer | 9. DRAFT Bylaws<br>10. Bylaws Recommendation |
| 7 | 10:40 | Public Comment | Roy | |
| 8 | 10:50 | Adjourn Board Business | Roy | |
| **BREAK – 10:50 to 11:00** | | | | |
| | 11:00 | Work Session I | MCOs | Understanding the MCO experience of health care purchasing |
| **BREAK – 12:00 to 12:15 GRAB LUNCH** | | | | |
| | 12:15 | Work Session II | Roy | Connecting the MCO experience with opportunities to align with OCH goals and priorities |
| | 1:15 | Summary and Next Steps | Roy | |
| | 1:30 | Adjourn | Roy | |

**Olympic Community of Health**
**Director's Report**
Board of Directors
August 3, 2016

**A message from your director**
I have focused this past month on hoisting up the scaffolding so we can build a house together. Our two priorities for the August 3rd Board of Directors meeting are to work towards finalizing our articles of incorporation and bylaws. While it may seem like a tedious task, it will prove vital to take advantage of the opportunities ahead.

I am feeling energized after three days in Chelan in June with the eight other ACHs, three state agencies, and a cadre of OCH staff, board members, and friends. It made me realize that the caliber and commitment of the people around our OCH tables is impressive. Looking back, we have already accomplished so much over the past three months together. As always, thank you for the honor of allowing me to serve the OCH. Onwards…

**Regional Health Needs Assessment (RHNA) | Regional Health Improvement Plan (RHIP)**
*Siri Kushner, OCH RHNA/RHNI Lead*
The Regional Health Assessment and Planning (RHAP) Committee met July 25th to finalize the Project Action Plan deliverable to the Health Care Authority (HCA), Three-County Opioid Response Plan. In addition, the committee reviewed the process that was used to arrive at our current RHNA and Regional Priorities, and discussed next steps for and the committee role in continuing to develop the RHNA and RHIP. Materials for the RHAP Committee meeting can be found on our website.

**Executive Committee**
The Executive Committee had its inaugural meeting on Friday July 22nd. The bulk of the meeting was devoted to reviewing the first draft of the bylaws and articles of incorporation. Materials for the Executive Committee meeting can be found on our website.

**OCH Outreach & Engagement**
- The new website is coming along. All meeting materials will be posted on the website as soon as they are available. We are hoping for a September 2016 launch. Watch our progress: www.olympicch.org. We will embed an e-newsletter within the website.
- We have new email addresses specific to the OCH: elya@olympicch.org; angie@olympicch.org; and siri@olympicch.org. We will transition to these addresses when we launch the new website. Note that our Kitsap Public Health District (KPHD) email addresses will continue to work.
- Since the last Director's Report, we have established new connections with First Step Family Resource Center, Kitsap EMS, American Indian Health Commission of Washington, Qualis Health, Worksource, Washington State Hospital Association, Washington Rural Health Collaborative, Department of Health Practice Transformation Hub, and Kitsap County Aging and Long Term Care.
- Key meetings and presentations:
    - Invited panelist, Health Innovation Leadership Network (HILN) *Spotlight On Physical-Behavioral Health Integration | Community Linkages*, July 29th
    - Olympic Community of Health hospital meeting, including Olympic Medical Center, Jefferson Health Care, and CHI Harrison Medical Center, August 1st
    - Invited panelist, Inland NW State of Reform Health Policy Conference: *A Survey of the Accountable Communities of Health,* September 14th
    - Invited panelist, WA State Public Health Association 2016 Annual Conference: *Accountable Communities of Health: The Role of Public Health Leadership - 2016 Update,* October 4th

**Medicaid Waiver link**

*Financial management* is a necessary function in the administration and oversight of transformation projects under the Medicaid Transformation waiver. On July 18th the HCA circulated a document summarizing its decision and intent to contract with a single statewide Financial Executor (Executor) for the disbursement and recording of funds under Initiative 1 of the Medicaid Transformation waiver demonstration. The document lays out four components of financial management in the context of the Waiver:

- *Budget Plan* and related financial decisions to determine the allocation of funds to projects and participating providers
- *Invoice submission*, review and processing for incentive payments (based on milestone achievement)
- *Disbursement of DSRIP payments* (full or partial, depending on agreements)
- *Accounting and reporting* for all project revenues and expenses

The ACHs will need financial and administrative capacity to fulfill the responsibilities listed below. Other functions not listed below will be contracted out to the Executor.

- Develop and oversee an operating budget for ACH administrative support functions related to functions under initiative 1, including appropriate accounting practices and reports.
- Develop a budget and funds flow plan for distribution of incentive payments.
- Meet reporting requirements and timelines.
- Execute operating agreements with providers participating in transformation projects.
- Maintain regular and appropriate communication with partners and stakeholders to ensure each understands the relationship of their role and function to the financial elements of the waiver and the dependencies on each.

The ACHs have requested to be involved in the State's process of Executor selection.

The next Medicaid Transformation webinar will cover negotiations between CMS and the State on the Waiver. Thursday, Aug. 4, from 11 a.m. to 12:30 p.m. Register here.

**Value-Based Payment (VBP) Road Map**

There continues to be a lot of buzz about value-based payment, with various groups weighing in. I have been listening to the wire feed and have started to form my own reflection on the document:

- Overall, the document does a reasonable job of laying out an ambitious path towards value-based payment. Incenting MCOs to revise provider contracts to include value-based payment types is likely to move us closer to the Triple Aim. The key to all of this, however, is only partly the MCOs – the big lever is the providers taking care of patients.
- Many of our local providers are already engaged in some value-based contracting as many payers and providers move away from fee-for-service only. Now our state's big Medicaid structure intends to support clinical improvements and cost savings through their efforts; including a role for local ACH priorities.
- The ACHs are written into the road map as a key player in moving the dial on VBP contracting, which begs the question: how? Below are some considerations to share and spur dialogue:
  - *How are ACHs going to help move the dial on VBP contracting?* Our "reward" rests on performance over clinical quality metrics (see initial seven measures in table below) and the uptake of VBP contracting by providers. Arguably, the OCH as it currently exists has little control over either of these. Further, the existence of the reinvestment pool is based on "left over" funds from the challenge pools; therefore, our incentive is actually contrary to that of the providers and MCOs.
  - *ACHS may not receive any incentive payments through the VBP roadmap mechanism as it is currently designed.* The structure of the various gates and thresholds in the road map greatly reduces the chance that the OCH will receive any real money through this incentive framework. Paradoxically, we *may* only receive funding if other ACHs fall short, creating a "winners" and "losers" scenario.

- *How do the ACHs promote VBP at the MCO and provider levels?* Could this be a waiver activity? A convening activity, especially for independent, rural providers? A behavioral health integration activity? Workforce development? Could the ACHs help providers get ready for VBP? How? So many questions…
- *How do the ACHs navigate the between the role of delivery system transformation and the role of community health improvement?* The waiver and VBP are delivery system transformation initiatives, not necessarily community health improvement. Does the OCH want to play a central role in system transformation? Without a real role in system transformation and deep commitments to that role, the OCH is unlikely to hit benchmarks outlined in the VBP road map.
- *When should the OCH find our own voice, either as an independent ACH or through an association?* Finding our own voice in this whirlwind gives us the advantage of a proactive stance rather than a reactive stance. If not our voice, should the OCH help other sectors or associations find their voice?

**Upcoming: OCH Partner Convening**, September 13th, Jamestown S'Klallam Red Cedar Hall, 9 am to 12 pm
We are optimistic on securing guest speaker Dr. Bruce Goldberg, MD for our next OCH Partner Meeting. He was a speaker at the June Quarterly Convening and gave an exceptional presentation comparing the ACH model in Washington State with models in other states. He reviewed successes, challenges, and lessons learned, with a focus on investing in social determinants of health through a health care lens. More details will follow.

**Summary: ACH Convening**, Chelan June 28th-June 30th
Six Board Members (Roy Walker, Eric Lewis, Hilary Whittington, and Jennifer Kreidler-Moss; MCOs: Caitlin Safford and Andrea Tull) joined Siri and I and eight other ACHs at the July ACH Quarterly Convening. Along with Bruce Goldberg's presentation we heard from the Georgia Health Policy Institute on health care financing, and from Dr. Robert Mauer on how successful people succeed. The event was a great opportunity to talk to other ACH leads and board members and share pointers for how to build a strong ACH.

**Financials**
We are on track to finish the year within budget. I am working with KPHD Directors to make some mid-course corrections to keep FTE at or below budgeted amounts. The Executive Committee will work with staff under the guidance of the Treasurer, Hilary Whittington, to bring a revised 2017 budget to the board by November 2016, if not sooner depending on the Waiver. Kitsap Public Health District continues to offer the OCH a discounted indirect rate. In June this translated to roughly $3,500 dollars of in-kind support.

**APPROVED 2016 BUDGET**

| PERSONNEL | TOTAL | SPEND JAN-JUN '16 | % SPENT (Target 50%) |
|---|---|---|---|
| Director: 1.0 FTE for 9 months | 103,171 | 38,780 | 38% |
| Program Coordinator: 0.5 FTE for 4 months | 19,399 | 0 | 0% |
| Epidemiologist: 0.5 FTE for 11 months | 48,463 | 12,624 | 26% |
| Assistant 0.4 FTE for 10 months | 20,186 | 12,681 | 63% |
| **Subtotal Personnel Costs** | **191,219** | **64,085** | **34%** |
| **NON-PERSONNEL** | **TOTAL** | | |
| Professional Services: | | | |
| Interim Project Manager (Jan. - March 2016) | 23,605 | 19,690 | 83% |
| Communications Support (website) | 3,500 | 0 | 0% |
| Legal or other consultant[2] | 5,000 | 0 | 0% |
| | | | |
| Travel | 4,000 | 794.64 | 20% |
| Supplies | 3,000 | 702.59 | 23% |
| Event/Meeting Expenses | 5,000 | 1,998 | 40% |
| | | | |
| Other | 0 | | |
| **Subtotal Non-Personnel Costs** | **44,105** | 23,185 | 53% |
| Indirect Costs (25% of salaries & benefits)[1] | 47,805 | 16021.13 | 34% |
| **TOTAL EXPENDITURES[3]** | **283,129** | **103,291** | **36%** |
| **DESIGNATED RESERVES[4]** | **206,871** | | |

**OCH-HCA Contract**
On July 29th, staff submitted the next round of deliverables to the HCA, including the Project Action Plan for the Three-County Opioid Response Project. The entire deliverable will be posted online; however, the cover letter is included in the consent agenda in the Board Packet for the August 3rd Board Meeting. On July 7th we received verification that each ACH would receive $50,000 in project funding. On July 18th we were notified that we would have until January 31, 2017 to expend this entire amount. The Board and KPHD will be reviewing a contract and budget amendment as soon as templates are made available to facilitate release of the funds from the HCA to the OCH. The earliest we would receive funding is mid-August.

**Analytics, Interoperability, and Measurement (AIM)**

The HCA has identified the seven measures (from the common measure set) that will be tied to incentives via the 1% withhold for all 2017 Apple Health Medicaid contracts. These measures are referred to in the HCA value-based roadmap.

| **Seven measures for 2017 MCO incentives, July 2016** | |
|---|---|
| **Measure** | **Definition** |
| **Antidepressant Medication Management** | Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported: 12 weeks and 6 months. |
| **Childhood Immunization Status** | Percentage of children that turned 2 years old during the measurement year and had specific vaccines by their second birthday |
| **Comprehensive Diabetes Care: Blood Pressure Control** | Percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure reading is |
| **Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (CDC)** | Percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c > 9.0% during the measurement year. |
| **Controlling High Blood Pressure** | The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled |
| **Use of Appropriate Medications for Asthma (ASM)** | The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year. |
| **Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life** | Percentage of children ages 3 to 6 that had one or more well-child visits with a PCP during the measurement year |

**Opportunities: OCH upcoming meetings and events**

- 8/26/2016, **OCH Executive Committee,** 8:00 a.m. – 10:00 a.m.
- 9/7/2016, **OCH Board of Directors**, 8:30 a.m. – 11:00 a.m.
- 9/12/2016, **Regional Health Assessment and Planning Committee**, 1:00 p.m. – 3:00 p.m.
- 9/13/2016, **OCH Partner Convening**, 9:00 a.m. – 12:00 p.m., Jamestown S'Klallam Red Cedar Hall

**Opportunities: Healthier Washington upcoming meetings and events**

- 8/4/2016, **Medicaid Transformation Waiver Update**, 11:00 a.m. – 12:30 p.m., register here
- 8/8/2016, **Paying for Value Webinar Series**, 1:00 p.pm – 2:00 p.m., register here
- 9/15/2016-9/16/2016, **ACH Quarterly Convening,** Spokane, Washington
- 10/24/2016, **Stakeholder Symposium,** SeaTac, details to come

**Opportunities: Other upcoming meetings and events**

- 7/30/2016, **Port of Olympia Landing**, Paddle to Nisqually Canoe Journey, learn more here
- 8/11/2016, **Different Regions, Different Care** (focus on opioids), All-Alliance Meeting, Washington Health Alliance, 2:00 p.m.-4:00 p.m. Cambia Grove, 1800 9th Avenue, Suite 250, in Seattle, register here
- 9/14/2016, **State of Reform,** Spokane, Washington, learn more here

**Recommended Reading, Viewing, or Participation**

1. Check out this two-minute video that explains value-based purchasing.
2. The technical assistance contractor, the Health Philanthropy Partnership, has released a new website full of great resources for ACHs, from governance to operations to sustainability.
3. There is a shared resource of communications materials for Healthier Washington. It has key messaging, videos (featuring our very own superstar, **Joe Roszak**!) and even business cards (available upon request).
4. The Alcohol and Drug Abuse Institute published a brief report in April 2015 showing rates of crime, death, and treatment for opioids in each county in Washington State.

Olympic COMMUNITY of HEALTH

345 6th Street, Suite 300
Bremerton, WA 98337

CLALLAM • JEFFERSON • KITSAP

July 29, 2016

Mr. Chase Napier
Community Transformation Manager
Office of Health Innovation and Reform
Washington State Health Care Authority
P.O. Box 42710
Olympia, WA 98504-5502

Dear Mr. Napier:

On behalf of the Olympic Community of Health (OCH), it is our pleasure to submit the enclosed deliverables for contract K1434, amendment 2. We included all pertinent OCH developments since our submission of the April 29, 2016 deliverables. Included with this letter is an update within five areas:

1. Three-County Coordinated Opioid Response Project
    a. Project Action Plan
    b. Preliminary data assessments: 1) hospitalizations and death outcomes and 2) birth and maternal diagnosis outcomes
2. Governance
    a. Executive Committee charter
    b. Governance Subcommittee charter
    c. Board of Directors roster and committee membership
3. Communications and engagement
    a. Website and newsletter update
4. Regional Health Needs Assessment and Improvement Plan
    a. Regional Health Assessment and Planning Committee Charter
    b. Revised Regional Health Priorities
    c. Project template
    d. Project scoring criteria

If you require any additional information, please do not hesitate to contact us. As always, thank you for your flexibility, partnership, and continued investment in the OCH.

Sincerely,

Elya Moore, PhD
Director, Olympic Community of Health
*Supported by Kitsap Public Health District*

Keith Grellner
Administrator, Kitsap Public Health District
*Backbone agency to the Olympic Community of Health*

Jennifer Kreidler-Moss, PharmD
Vice President, Olympic Community of Health Board of Directors
Chief Executive Officer, Peninsula Community Health Services

# What IS the Olympic Community of Health?

Olympic Community of Health (OCH) is an accountable community of health, one of nine in the state, designed to be able to address the major health priorities in our region, focusing on health equity and social determinants of health. We do this through three main objectives: improving the health of the population while also improving the patient experience of care and reducing health care costs. Our region includes Clallam, Jefferson and Kitsap Counties as well at the Sovereign Nations of the Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Port Gamble S'Klallam, Quileute and Suquamish Tribes. The OCH Board of Directors (see below) consists of leaders from tribal nations and health sectors. Together they strive to steward a participatory process to identify the greatest areas of need and sustainably align resources and services to achieve the highest attainable level of health and wellbeing for all members of our communities.

We currently are focusing our efforts on five regional health priority areas: Access, Aging, Behavioral Health, Chronic Disease and Early Childhood. Our first regional health improvement project is a tri-county opioid response coordination project.

Our Board of Directors meets once a month. Please visit our website: www.olympicch.org for meeting dates and materials. Email support@olympicch.org to receive updates from the OCH.

Olympic Community of Health
Board of Directors

Updated June 8, 2016

| # | Name and Affiliation of VOTING member | County | Service Area | Sector (primary sector(s) listed) |
|---|---|---|---|---|
| 1 | **Doug Washburn**<br>Director<br>Kitsap County Human Services | Kitsap | Clallam<br>Jefferson<br>Kitsap | **Behavioral Health Organization**<br>**Workforce Development**<br>**Housing/Homelessness**<br>**Long Term Care** |
| 2 | **Joe Roszak**<br>Executive Director<br>Kitsap Mental Health Services | Kitsap | Kitsap | **Mental Health**<br>(Medicaid Provider) |
| 3 | **Gill Orr**<br>Administrator and Provider<br>Cedar Grove Counseling | Clallam | Clallam | **Chemical Dependency**<br>(Medicaid Provider) |
| 4 | **David Schultz**<br>Market President<br>CHI Franciscan Harrison Medical Center | Kitsap | Kitsap | **Private/Not for Profit Hospital** |
| 5 | **Eric Lewis**<br>Chief Executive Officer<br>Olympic Medical Center | Clallam | Clallam | **Public Hospital** |
| 6 | **Hilary Whittington**<br>Chief Financial Officer<br>Jefferson Healthcare | Jefferson | Jefferson | **Rural Health** |
| 7 | **Jennifer Kreidler-Moss, PharmD**<br>Chief Executive Officer<br>Peninsula Community Health Services | Kitsap | Kitsap | **Federally Qualified Health Clinic**<br>**Primary Care**<br>**Oral Health**<br>**Mental Health** |
| 8 | **Justin Sivill**<br>Director, Operations<br>Harrison Health Partners | Kitsap | Kitsap,<br>Jefferson<br>Clallam | **Primary Care** |
| 9 | **Kat Latet** [1]<br>New Programs Integration Manager | Statewide | Statewide | **Medicaid Managed Care** |

| | | | | |
|---|---|---|---|---|
| | Community Health Plan of Washington | | | |
| **10** | **Thomas Locke, MD**<br>County Health Officer, Jefferson<br>CEO, Jamestown Family Health Clinic<br>Board President, Washington Dental Service Foundation | Jefferson | Statewide | **Oral Health**<br>**Public Health**<br>**Philanthropy** |
| **11** | **Katie Eilers**<br>Assistant Director, Community Health<br>Kitsap Public Health District | Kitsap | Clallam<br>Jefferson<br>Kitsap | **Chronic Disease Prevention Across the Lifespan** |
| **12** | **Chris Frank, MD**<br>Health Officer<br>Clallam County Public Health | Clallam | Clallam | **Public Health** |
| **13** | **Roy Walker**<br>Executive Director<br>Olympic Area on Aging | Clallam<br>Jefferson | Clallam<br>Jefferson | **Long Term Care/Area Agency on Aging/ Home Health** |
| **14** | **Larry Eyer**<br>Executive Director<br>Kitsap Community Resources | Kitsap | Kitsap | **Community Action Program/ Social Service Agency**<br>**Housing/Homeless** |
| **15** | **Kurt Wiest**<br>Executive Director<br>Bremerton Housing Authority | Kitsap | Kitsap | **Housing/Homelessness** |
| **16** | **Maria Lopez** [2]<br>Tribal Chairwoman | | | **Hoh Tribe** |
| **17** | **Andrew Shogren** [2]<br>Health Director | | | **Quileute Tribe** |
| **18** | **Elizabeth Buckingham** [2]<br>Health Director<br>**Tracey Rascon** [2]<br>Administrative Officer<br>Sophie Trettevick Indian Health Center | | | **Makah Tribe** |
| **19** | **Dylan Dressler** [2]<br>Health Services Director | | | **Lower Elwha Klallam Tribe** |
| **20** | **Brent Simcosky** [2]<br>Health Clinic Director | | | **Jamestown S'Klallam Tribe** |
| **21** | **Kelly Sullivan** [2]<br>Executive Director, Tribal Services<br>**Kerstin Powell** [2]<br>Health Center Business Office Manager<br>**Jolene George** [2]<br>Director Behavioral Health Division | | | **Port Gamble S'Klallam Tribe** |
| **22** | **Leonard Forsman** [2]<br>Tribal Chair<br>Suquamish Tribe<br>**Leslie Wosnig** [2]<br>Administrator of Health and Policy<br>Suquamish Tribe<br>**Lisa Rey Thomas, PhD** [2]<br>Wellness Center Director | | | **Suquamish Tribe** |

1. *Kat Latet from the Community Health Plan of Washington is the selected representative from among her peers to have a voting seat on the OCH Board of Directors for a one year term starting June 1, 2016.*
2. *Tribes are governments, not sectors, therefore each Tribe is allotted one vote may appoint alternates as desired.*

Olympic Community of Health

Meeting Minutes

Board of Directors

July 6, 2016

| **Date:** 07-06-2016 | **Time: 8:30 a.m.-11:00 a.m.** | **Location:** Olympic Room, Port Ludlow Resort, Port Ludlow WA |
|---|---|---|

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

**Members Attended:** Katie Eilers, *Kitsap Public Health District;* Larry Eyer, *Kitsap Community Resources;* Leonard Forsman; *Suquamish Tribe;* Naomi Jacobson, *Quileute Tribe;* Vicki Kirkpatrick, *Public Health;* Jennifer Kreidler-Moss*, Peninsula Community Health Services;* Kat Latet; *Community Health Plan of Washington;* Eric Lewis, *Olympic Medical Center;* Elya Moore, *Olympic Community of Health*; Gill Orr, *Cedar Grove Counseling*; Joe Roszak, *Kitsap Mental Health;* Brent Simcosky, *Jamestown S'Klallam Tribe;* Justin Sivill, *Harrison HealthPartners;* Doug Washburn, *Salish Behavioral Health Organization;* Hilary Whittington, *Jefferson Healthcare.*

**Non-Voting Members Attended**: Allan Fisher, *United Healthcare;* Laurel Lee, *Molina Healthcare;* Caitlin Safford, *Amerigroup;* Andrea Tull, *Coordinated Care*

**Other:** Kayla Down, *Health Care Authority;* Keith Grellner, *Kitsap Public Health District;* Siri Kushner, *Kitsap Public Health District;* Angie Larrabee*, Olympic Community of Health;* Jeanne McMinds*, Molina Healthcare*

| Person Responsible for Topic | Topic | Discussion/Outcome | Action/Results |
|---|---|---|---|
| | **July Objectives** | 1. Elect an Executive Committee<br>2. Select a regional health improvement project<br>3. Agree on a direction for next phase of governance and structure | |
| Roy Walker | **Welcome and Introductions** | Roy called the meeting to order at 8:40 am.<br><br>Roy welcomed newcomers and asked them to introduce themselves:<br>1. Gill Orr (Cedar Grove Counseling)<br>2. Naomi Jacobson (Quileute Tribe) | |
| Board | **June 1 Minutes** | Approval of minutes | June 1 Board Minutes **APPROVED** unanimously. |
| Board | **Consent Agenda** | Approval of Consent Agenda | Consent Agenda **APPROVED** unanimously. |
| Eric Lewis | **Executive Committee Nominations and Ballot** | Executive Committee Nominee bios were included in the Board Packet.<br><br>Elya handed out ballots to Board members. Each sector received one ballot.<br><br>Siri tallied the votes. | **Results:**<br>President: Roy Walker<br>Vice-President: Jennifer Kreidler-Moss<br>Secretary: Leonard Forsman<br>Treasurer: Hilary Whittington<br>At-Large: Joe Roszak |

| | | | |
|---|---|---|---|
| Roy Walker | **Recognized Kayla Down** | Kayla accepted a position with Coordinated Care, but will continue to be involved with ACH work. | |
| Katie Eilers / Siri Kushner | **Project Selection:**<br><br>**RHAP Committee Recommendation** | The Board approved proposal application forms at the June Board meeting and a Request for proposals (RFP) was sent out to the OCH Partner group immediately following the meeting.<br><br>The RHAP committee reviewed and scored projects before meeting on June 27 to discuss scores and select two final projects for recommendation to the Board.<br><br>The Board reviewed the two final projects and the RHAP committee recommendation.<br><br>Project Selection 1: Opioid Coordination<br>Project Selection 2: Investing in the Health of Future Generations<br><br>Once the Board makes a decision regarding projects, OCH staff will submit a project proposal by July 29 HCA deadline.<br><br>Siri reviewed RHAP Committee's guiding principles of project selection.<br><br>Top 3 Projects by score:<br>1. Olympic Peninsula Coordinated Opioid Response<br>2. Investing in the Health of Future Generations<br>3. Improving Health Through Connections<br><br>Projects and project selections were posted on the website and the public was given the opportunity to provide feedback. | |
| Katie Eilers / Siri Kushner | **Project Selection:**<br><br>**Discussion** | **Discussion:**<br>Concern for both projects: little information on budget requirements<br><br>It is likely that HCA will fund $50k to ACHs for projects. There may be additional funding.<br><br>OCH also has ~$19.5k of funding for Coordinator position that could be re-allocated.<br><br>The timelines for these projects are unclear, but staff asked applicants to use a 2 year timeline for actualization.<br><br>Both projects establish a framework for expansion. It was noted that the Medicaid Waiver is meant to do systems transformations, while the SIM Grant is for more of health collaborative. | |

| | | | |
|---|---|---|---|
| | | The RHAP Committee recommended going back to one or both of applicants with questions regarding missing information.<br><br>The Center for Community Health and Evaluation (CCHE) will provide monitoring and evaluation support to the OCH through project development.<br><br>A Board member commented that opioid addiction has been an ongoing issue and it will take a lot of effort to accomplish the goal of solving this issue, and another member noted it may be difficult to get providers to transition to Suboxone treatment.<br><br>One member suggested that it would be better to put all the money in one project rather than divide it up, and another member recommended putting money into the coordinator position because providers likely won't fund their own coordinator(s).<br><br>Staff noted that only one project needs to go back to HCA for SIM grant.<br><br>The Board voted to approve funding of one project (instead of splitting funding between two projects.)<br><br>Katie asked the Board if the amount of funding influences this decision. Others noted that some health care organizations may be interested in investing if the project supports their work.<br><br>The state Practice Transformation HUB should provide each region with a practice facilitator to improve delivery system in primary care. This will ideally begin in September 2016.<br><br>One Board member asked staff if OCH has a plan to encourage applicants whose projects don't get selected.<br><br>Katie noted that some of the projects are excellent Medicaid transformation projects. After the Board has made a decision for one selection, the Board can discuss how to encourage the other applicants.<br><br>Discussion to select a top project:<br><br>Doug Washburn noted he felt he should recuse himself of discussion on the BHO project because he has a role in the application.<br><br>Roy recommended the Board reserve the $19.5k for now for OCH administrative needs. | Motion to fund only one project: **APPROVED** unanimously. |

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|---|---|---|---|
| | | **Summary:**<br>OCH staff will follow through with proposal selection and submission to HCA. The Board will not see these projects again until August Board Meeting.<br><br>The RHAP committee will review and finalize the project application and make recommendations to the Board.<br><br>The Board can submit additional questions regarding this project to OCH staff. | Motion to select Opioid Coordination project as project to submit to the HCA:<br>**APPROVED** unanimously<br><br>Doug abstained. |
| Roy Walker / Elya Moore | **Why and How to Move the OCH Forward** | The Board reviewed the document "Pathway toward incorporation and next phase of governance"<br><br>**Proposed Motion 1:** The OCH Board authorizes the Executive Director to draft bylaws for presentation and review by the Executive Committee, prior to presenting to the full Board at the August 3, 2016 OCH Board meeting.<br><br>**Proposed Motion 2:** The OCH Board authorizes the Executive Director to draft Articles of Incorporation for presentation and review by the Executive Committee, prior to presenting to the full Board at the August 3, 2016 OCH Board meeting.<br><br>**Proposed Motion 3:** The OCH Board authorizes the Executive Director to draft a Fiscal Sponsorship Agreement for presentation and review by the Executive Committee, prior to presenting to the full Board at September 7, 2016 OCH Board meeting.<br><br>**Proposed Motion 4:** The OCH Board authorizes the Executive Director to research and present recommendations on a process to become a legal entity to the Executive Committee, prior to presenting to the full Board at the September 7, 2016 OCH Board meeting.<br><br>Elya reviewed current 501(c)(3) status of all other multi-county ACHs. Most ACHs have applied or plan to apply for 501(c)(3) status.<br><br>OCH can file articles of Incorporation without knowing legal status. In order to be released funding from state for the Medicaid Waiver, there needs to be some sort of line between OCH and a fiscal representative.<br><br>Kitsap Public Health District (KPHD) would need to discuss with Board as to whether or not OCH could remain under KPHD as backbone. Original plan was for OCH to become separate entity from KPHD. | Motion to accept all 4 motions: **APPROVED** unanimously.<br><br>Eric Lewis noted that he was in favor of all 4 proposed motions, but left before the Board took a formal vote.<br><br>The timing to complete motions 3 and 4 were deemed as targets to aspire to. |

| | | | |
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| | | One Board member commented that the Board should not put Elya in a position where she needs to be negotiating her position in OCH with KPHD. Board should be making effort to support the future of OCH.<br><br>It was noted that Tribes are not obligated to partake in every aspect of OCH and can opt out at any time.<br><br>OCH staff is working to develop processes in writing so the next generation can understand any changes, processes, etc… especially as it affects Tribes.<br><br>There was a concern about OCHs ability to advocate for policy if it became a 501(c)(3); additionally, it was noted that there's a possibility that a statewide 501(c)(4) would be formed as an association of ACH's.<br><br>Roy proposed the Board to approve all 4 motions, one action.<br><br>One Board member commented that OCH should work with other non-profits to raise money for specific projects and goals. | |
| Leonard Forsman / Elya Moore | **Summary of Early Adopter Panel** | **Discussion:**<br>Leonard noted some of comments from HCA were very helpful, including how to get more Medicaid providers.<br><br>Elya asked the Board to make recommendations for next Partner Group convening in September.<br><br>There were some concerns about tone/perspectives but overall attendees thought it was a good presentation.<br><br>One Board member commented that the Early Adopter is still in its early stages.<br><br>Another main concern was how crisis, mental health and chemical dependency is handled. It felt like substitution of services instead of finding a way to use the BHOs who have already been involved.<br><br>Additionally, one attendee didn't see the advantage to having one contract statewide– and their comfort level dropped after the panel.<br><br>An attendee also commented, "How effectively can an out-of-town entity know our community's' needs and issues and take over our current crisis system?"<br><br>A Board member posed the question, "Is there an opportunity to do this differently?" | There was a general consensus to lengthen a future Board meeting to discuss complex issues such as integration, value based payment and the MCO/ACH relationship. |

| | | | |
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| | | Recognizing these concerns, the MCO's offered the Board an "MCO 101" presentation so the Board can better understand the relationship between MCOs and ACHs.<br><br>The Board noted that it may be too early to have data, but would like to hear SW WA results anecdotally.<br><br>There was a recommendation to lengthen the next few meetings to discuss integration, value based payment and the MCO/ACH relationship. | |
| Roy Walker | **Adjourn** | The meeting adjourned at 11:16 am. | |
| Elya Moore | **Value Base Payment Work Session** | The Value Based Payment Work session began at 11:16 am. Due to lack of time, the Work Session was brief and will be continued at the August 3 meeting.<br><br>**Why we're talking about value based purchasing:**<br><br>Paying for more > Paying for better<br><br>Elya asked the Board for ideas on the role of the OCH in Value Based Payment.<br><br>There is trust that savings will be re-invested.<br><br>There were multiple recommendations for work session on VBP with MCO and Board.<br><br>A Board member commented that if the Board can agree together on tools and changes for the region, we can make a difference together.<br><br>Work Session ended at 11:37 am. | |

OLYMPIC COMMUNITY OF HEALTH

**2016-2017 BUDGET: Actual versus projected and year-to-date spend**

Board of Directors

July 27, 2016

Presented below is the approved 2016 OCH Budget compared to the project 2016 OCH Budget and a revised the 2017 OCH Budget based on 2016 projections. As before, we assume the OCH incorporates by 2017 and/or bids for a new backbone organization. Please note that the financial future is extremely uncertain, especially with regard to the Waiver; therefore the details provided in this budget may change. Also, please note that it is unclear how we will operationalize the Opioid Response Project at this stage.

## APPROVED REVENUES 2016

| Description | Total |
|---|---|
| HCA ACH Phase 1 Grant | 330,000 |
| HCA Design Grant | 150,000 |
| | |
| | |
| Clallam County *(not yet received)* | 10,000 |
| **TOTAL REVENUES** | **490,000** |

*Note : Unexpended balance of HCA state funding from 2016 ($480,000) is reserved for 2017 and 2018.*

## PROJECTED REVENUES 2016

| Description | Total |
|---|---|
| HCA ACH Phase 2 Grant | 231,000 |
| Designated reserve | 206,871 |
| Technical Assistance Allotment | 50,000 |
| SIM Grant Funding | 4,950 |
| Partner contributions (TBD) | 80,000 |
| **TOTAL REVENUES** | **572,821** |

*Note : This is a conservative revenue projection. It assumes no new revenue through the waiver, new contracts, or philanthropy.*

## REVENUES 2017

| Description | Total |
|---|---|
| HCA ACH Phase 3 Grant | 99,000 |
| Designated reserve | 302,603 |
| | |
| | |
| Partner contributions (TBD) | 160,000 |
| **TOTAL REVENUES** | **561,603** |

*Note : This is a conservative revenue projection. It assumes no new revenue through the waiver, new contracts, or philanthropy.*

**2016**

**January 1, 2016-December 31, 2016**

## APPROVED EXPENDITURES

YEAR TO DATE: JAN THRU JUNE 2016

| Personnel | Salaries | Benefits[1] | Total | BALANCE REMAINING | YEAR TO DATE | % SPENT (Target 50%) |
|---|---|---|---|---|---|---|
| Director: 1.0 FTE for 9 months | 79,362 | 23,809 | 103,171 | 64,391 | 38,780 | 38% |
| Program Coordinator: 0.5 FTE for 4 months | 14,923 | 4,477 | 19,399 | 19,399 | 0 | 0% |
| Epidemiologist: 0.5 FTE for 11 months | 37,279 | 11,184 | 48,463 | 35,839 | 12,624 | 26% |
| Assistant 0.4 FTE for 10 months | 15,528 | 4,658 | 20,186 | 7,506 | 12,681 | 63% |
| **Subtotal Personnel Costs** | **147,092** | **44,127** | **191,219** | **127,134** | **64,085** | **34%** |
| **Non-Personnel** | | | **Total** | | | |
| Professional Services: | | | | | | |
| Interim Project Manager (Jan. - March 2016) | | | 23,605 | 3,915 | 19,690 | 83% |
| Communications Support (website) | | | 3,500 | 3,500 | 0 | 0% |
| Legal or other consultant[2] | | | 5,000 | 5,000 | 0 | 0% |
| | | | | | | |
| Travel | | | 4,000 | 3,205 | 794.64 | 20% |
| Supplies | | | 3,000 | 2,297 | 702.59 | 23% |
| Event/Meeting Expenses | | | 5,000 | 3,002 | 1,998 | 40% |
| | | | | | | |
| Other | | | 0 | | | |
| **Subtotal Non-Personnel Costs** | | | **44,105** | 20,920 | 23,185 | 53% |
| Indirect Costs (25% of salaries & benefits)[1] | | | 47,805 | 31,784 | 16021.13 | 34% |
| **TOTAL EXPENDITURES[3]** | | | **283,129** | **179,838** | **103,291** | **36%** |
| **DESIGNATED RESERVES[4]** | | | **206,871** | | | |

**2016**

**January 1, 2016-December 31, 2016**

## PROJECTED EXPENDITURES

| Personnel | Salaries | Benefits[1] | Total |
|---|---|---|---|
| Director: 1.0 FTE for 9 months | 79,362 | 23,809 | 103,171 |
| Epidemiologist: 0.3 FTE for 11 months | 22,367 | 6,710 | 29,078 |
| Assistant 0.6 FTE for 10 months | 23,292 | 6,988 | 30,280 |
| | | | |
| **Subtotal Personnel Costs** | **125,021** | **37,506** | **162,528** |
| **Non-Personnel** | | | **Total** |
| Professional Services: | | | |
| Interim Project Manager (Jan. - March 2016) | | | 23,605 |
| Communications Support (website) | | | 3,500 |
| Legal or other consultant[2] | | | 5,000 |
| Program Coordinator: 75 hrs/month for 4 months | | | 22,254 |
| Travel | | | 4,000 |
| Supplies | | | 3,000 |
| Event/Meeting Expenses | | | 5,000 |
| Directors and Officers Liability Insurance | | | 700 |
| Other | | | 0 |
| **Subtotal Non-Personnel Costs** | | | **67,059** |
| Indirect Costs (25% of salaries & benefits)[1] | | | 40,632 |
| **TOTAL EXPENDITURES[3]** | | | **270,219** |
| **DESIGNATED RESERVES[4]** | | | **302,603** |

**2017**

**January 1, 2017-December 31, 2017**

## EXPENDITURES

| Personnel | Salaries | Benefits[1] | Total |
|---|---|---|---|
| Executive Director: 1.0 FTE for 12 months | 107,932 | 26,983 | 134,915 |
| Program Coordinator: 1.0 FTE for 12 months | 72,400 | 18,100 | 90,500 |
| | | | |
| | | | |
| **Subtotal Personnel Costs** | **180,332** | **45,083** | **225,415** |
| **Non-Personnel** | | | **Total** |
| Professional Services: | | | |
| Legal or other consultant[2] | | | 5,000 |
| Epidemiologist: 43 hrs/month for 12 months | | | 45,872 |
| Assistant: 86 hrs/month for 12 months | | | 38,143 |
| Professional Development | | | 2,600 |
| Travel | | | 4,500 |
| Supplies | | | 1,500 |
| Event/Meeting Expenses | | | 6,000 |
| Directors and Officers Liability Insurance | | | 2,000 |
| Other | | | 0 |
| **Subtotal Non-Personnel Costs** | | | **105,615** |
| Indirect Costs (15% of salaries & benefits)[1] | | | 33,812 |
| **TOTAL EXPENDITURES[3]** | | | **364,842** |
| **DESIGNATED RESERVES[4]** | | | **196,760** |

**NOTES**

1. Assumes benefits and indirects reduce from 30% to 25% and 25% to 15% respectively from 2016 to 2017 under new organizational structure with back office service contract
2. Planning to use technical assistance offered by the State; otherwise hopeful for in-kind donation from members
3. The approved Feb 2016 budget was $360,000. This savings has been moved into the designated reserve.
4. Designated reserves move with the ACH, should it incorporate or change backbone agencies

*Items in red in 2016 budget are revisions from the approved May 2016 budget*

*Assumes a 2% cost of living wage increase*

# Accountable Communities of Health – Regional Health Improvement Project – Action Plan Template

**PURPOSE**:

This template is a tool for Accountable Communities of Health (ACHs) while selecting, planning, and implementing the regional health improvement project. Completing the template is required for the one project mandated under the SIM grant.

It is a working document that should be revised and updated as your project develops, so it can be used for communication within your ACH and with the Health Care Authority (HCA), Center for Community Health and Evaluation (CCHE), and technical assistance team (TA).

It is meant to facilitate project development and support alignment with state guidelines, but not undermine local project selection and implementation activities.

**GUIDELINES**:

The HCA has defined an ACH regional health improvement project as having:

- A set of coordinated, multi-sector activities
- A focus on one (or more) regional health priorities
- A design to produce measureable progress toward a health improvement goal

*For additional HCA guidance, please see the ACH Health Improvement Project Requirements and Definitions document (see appendix).*

**SUBMISSION**:

The HCA's deadline for ACH project submission is **no later than July 29, 2016, but** ACHs are expected to submit a **draft** version of the action plan template to HCA as soon as a project is identified before the July 29 deadline. This is because ACHs are encouraged to communicate early and often to help staff from HCA, CCHE, and TA provide feedback and resources in a timely manner to support project work.

Please complete the form below with as much information as you have available, while adhering to the instructions about content and length. Refer to the "ACH Action Plan example" document for additional information about how to fill out the form. Questions about completing and submitting the form below can be sent to the Community Empowerment & Accountability Team at HCA: CommunityTransformation@hca.wa.gov

## BASIC INFORMATION

*This section must be filled out and submitted to HCA before July 29, 2016 for project review and approval.*

**ACH**:

Olympic Community of Health (OCH)

**Backbone staff contact (email, phone):**

**Elya Moore**, Director
Office: (360) 337-5289
Mobile: (360) 633-9241
Email: elya.moore@kitsappulichealth.org

**Angie Larrabee**, Assistant
Office: (360) 337-5216
Email: angie.larrabee@kitsappublichealth.org

**Siri Kushner**, Epidemiologist
Office: (360) 337-5233
Email: siri.kushner@kitsappublichealth.org

**Partner Organization:**

Salish Behavioral Health Organization

**Partner Organization staff contact (email, phone):**

**Anders Edgerton**, Administrator
Office: (360) 337-4886
Email: aedgerton@co.kitsap.wa.us

**Key contact for project-related issues, if different than above (email, phone)**:

**Elya Moore**, OCH Director (see above)

**Date work plan was last updated**:

July 29, 2016

## 1 – OVERVIEW

*This section must be filled out and submitted to HCA before July 29, 2016 for project review and approval.*

**Project Title**:

Olympic Peninsula Coordinated Opioid Response

**County or Counties directly served by project**:

Kitsap, Clallam and Jefferson counties

**Brief description** (*3-4 sentences*):

This project is the first phase of a comprehensive initiative to coordinate and implement a community response to the opioid crisis in Kitsap, Jefferson, and Clallam Counties, including the tribal nations within those boundaries. Project personnel, either staffed or through a subcontract, will work under the direction of the Executive Director of the Olympic Community of Health, in close partnership with the Administrator of the Salish Behavioral Health Organization (SBHO). Staff will convene community advisors from multiple sectors across the three counties and tribal nations to address this significant opioid crisis. The project will have multiple phases, beginning with a six-month planning and assessment phase, which is the focus of this proposal.

**Goal statement** (*1-2 sentences*):

For the purposes of this proposal, the six-month goals are to:

1. Perform a three-county assessment into the scope of the opioid problem including an inventory of the solutions already underway
2. Identify and engage with key stakeholders including payers (SBHO and Medicaid managed care plans (MCO)), mental health providers, substance use treatment providers, public health officers, local health jurisdictions, primary care providers, hospitals, emergency departments, dental providers, FQHCs, first responders (defined as law enforcement, EMTs, paramedics, fire, and others), consumers, and Courts. Staff will also engage with each of the tribal nations.
3. Form a project steering committee
4. Select 3-5 measures to gauge success
5. Hold a three-county Opioid Summit

The long term goals are to:

1. Prevent opioid misuse and abuse through improving prescribing practices
2. Treat opioid dependence through expanding access to treatment
3. Prevent deaths from opioids through distributing naloxone to people who use heroin
4. Use data to monitor and evaluate the first three goals through optimizing and expanding data sources into a shared three-county evaluation hub

**Project scope,** 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) (*1-2 sentences*):

This project is the first phase of a comprehensive initiative to coordinate and implement a community response to the opioid crisis in Kitsap, Jefferson, and Clallam Counties, including the tribal nations. For the purposes of this proposal, we describe the project scope for the first six months, from August 2016 through January 2017, which we call *the planning phase*. We will use information and community input from the planning phase to inform the implementation phase.

## 2 – STRATEGIC PLANNING & ALIGNMENT

*This section must be filled out and submitted to HCA before July 29, 2016 for project review and approval.*

**This project is** (*check one*): ☒ New ☐ Enhancing an existing project or set of projects

**The ACH's "value add" for this project** (e.g., What difference does ACH involvement make to the project?) (*2-3 sentences*):

This is a multi-pronged approach to a very intractable and urgent problem which demands a high level of coordination between behavioral health and primary care, other health-related entities as well as law enforcement and local courts. The OCH is uniquely positioned to provide this level of coordination.

**Rationale for this project** (*up to half a page*), including:

- The regional health need or priority the project addresses, including how the need/priority was identified
- The significance for the region (i.e. how the project contributes to the community in a different way than other, existing programs or resources)
- Any evidence-based interventions, innovative practices, or models that informed the project idea

**Regional Health Priority**

This project addresses a major public health issue facing our three counties that cuts across all demographic groups: gender, age, ethnicity, and zip code. Within this framework, this project addresses two of the five regional health priorities:

1. Access: A continuum of physical, behavioral, and oral health care services is accessible to people of all ages and care is coordinated across providers.
    a. This priority was identified from a review of local agency assessment and planning documents and input from stakeholder small group discussions where lack of access to providers and health care services as well as a need for better coordination of care across health care, social services, and other service providers were key findings. Across our region we have numerous federally designated health professional shortage areas.
2. Behavioral Health: Individuals with behavioral health conditions receive integrated care in the best setting for recovery.
    a. This priority was most clearly identified in stakeholder small group discussions – not only do our communities need better access to behavioral health care but additionally, we lack settings with integrated care to address the needs of the whole person.

**Significance for the region**

The data presented below represent a snapshot from two-four years ago. Given the rapid change in opioid use over the past few years, these estimates are likely underestimates. Current syringe exchange data indicate substantial increases in needle exchange. The data presented below represent the most acute presentations of opioid abuse. Data are not currently available to quantify the true public health scale of the problem.

**Data from Comprehensive Hospital Abstract Reporting System (CHARS) 2012-2014 on Maternal and Newborn Inpatient Stays with a Substance Use or Use-Related Diagnosis**

Birth and Maternal Outcomes

Of multi-county regions in WA State, the Olympic Peninsula (Clallam, Greys Harbor, Jefferson, and Mason Counties) has among the highest rates of maternal stays with opiate-related diagnoses, newborn discharges with drug withdrawal syndrome, maternal stays with amphetamine-related diagnoses, and newborn

discharges with narcotics affecting newborn. The Olympic Community of Health (OCH) region including Clallam, Jefferson and Kitsap Counties has rates statistically higher than the rest of WA State for maternal stays with opiate-related diagnoses and amphetamine-related diagnoses.

Report prepared May 2016

**Data from CHARS and Death Certificate Database 2012-2014 on opioid-related hospitalizations and deaths (accidental and intentional)**

Clallam County age-adjusted rates are statistically higher for accidental opiate-related hospitalizations and deaths; the crude death rate is statistically the same; Kitsap County age-adjusted rates are statistically lower for opiate-related hospitalizations and deaths while the crude death rate is statistically the same; Jefferson County age-adjusted rates and the crude death rate are statistically the same. Compared to Washington State: age-adjusted accidental opiate-related hospitalization rates were statistically higher in Port Angeles and the West End of Clallam County; and for all sub-county areas, age-adjusted accidental death and crude death rates were statistically the same. While 20% of the OCH region population is in Clallam County, Clallam's share of inpatient hospitalizations and deaths ranged from 30% to 38% of the OCH region events.

Hospitalization and Death Outcomes

Report prepared May 2016

No single sector or county can solve this problem alone. County government has asked the SBHO pursue a coordinated, three-county, multi-sector response. The OCH is well positioned to collaborate with the SBHO to address this complex problem: the OCH board consists of 15 sectors and 4 tribal nations (work is underway to engage all 7 Tribes). We have started a community engagement strategy and each quarter we convene 60-100 community partner around topics relevant to the regional health priorities.

**Evidence Base**

Attempts to address the opioid crisis have been made by 100 Million Healthier Lives from the Institute for Healthcare Improvement and multiple Washington State Agencies. The Washington State Hospital Association (WSHA) and the Washington State Medical Association (WSMA) have formed a Task Force around this issue. Our regional approach will draw from these efforts to create a road map to guide our own local response, starting with the importance of partner (stakeholder) engagement. The Alcohol and Drug Abuse Institute (ADAI) published a report showing startling increases in opioids in our region. Two of the four long term goals of this project are supported by evidence-based practice: 1) to enhance the availability of Suboxone and 2) Naloxone (ADAI, Info Brief, June 2015; Pierce et. al, *Addiction*, 111, 298-308. 2015).

☒ Check box for TA help identifying resources to inform project strategy/design from the evidence-base/ pool of existing innovative practices.

**Sectors and stakeholders engaged**, please explain how your project meets the criteria of "a set of coordinated, multi-sector activities" (*2-4 sentences)*:

This crisis cuts across multiple sectors, payers (SBHO and MCOs), mental health, substance use treatment, public health, primary care, hospitals, emergency departments, oral health, FQHCs, first responders, consumers, and criminal justice. It also affects each of the tribal nations. In the *planning phase* we will assess which sectors and Tribes have already started to address this issue and how they have begun to organize themselves around the problem. We do not want to duplicate any existing initiatives. We aim to build from existing momentum and connect efforts into a multi-county, cross-sector approach that also aligns with broader goals to integrate behavioral health and primary care in Washington State.

## 3 – KEY ACTIVITIES & TIMELINE

| Activity | Contributing stakeholders*, their roles & responsibilities | Timeline | TA help? |
|---|---|---|---|
| **PLANNING PHASE ACTIVITIES** | | | |
| Perform a three-county assessment into the scope of the problem and the current solutions already underway | *The OCH will either hire a program coordinator or contract with a coordinator to staff the work of all activities listed in the 'activity' column. The three-county assessment will be overseen by an Epidemiologist employed by Kitsap Public Health District who is also part of the OCH backbone staff team. The OCH Executive Director will oversee all activities in close partnership with the Administrator of the Salish Behavioral Health Organization.*<br><br>*Partners (stakeholders) will include, at a minimum, representatives from EMS, police, the SBHO, MCOs, substance use treatment, mental health treatment, primary care, hospitals, emergency departments, public health, and possibly other sectors, and also leadership from the tribal nations. Partners (stakeholders) will advise on the selection of measures and phase II of the project.* | Aug to Nov 2016 | ☒ |
| Identify and engage with key partners (stakeholders) | | Aug 2016 onwards | ☐ |
| Form a multi-county, cross sector leadership committee to advise the overall project that includes tribal participation | | October 2016 | ☐ |
| Hold a three-county Opioid Summit (NOTE: Timing may change depending on other regional health summits currently being planned) | | January 2017 | ☐ |
| Select 3-5 measures to gauge success | | January 2017 | ☒ |
| Begin work on project implementation plan as consensus builds during the planning phase; develop a visual tool to represent implementation plan. | | February 2017 | ☒ |
| ***POSSIBLE**** **IMPLEMENTATION PHASE ACTIVITIES** | | | |
| Formation of task forces around each identified priority | There may be three task forces: 1) Medication-Assisted Treatment Task Force, 2) Naloxone Task Force, 3) Prevention and Education Task Force | March 2017 | |
| Primary care provider qualitative interviews | Identify barriers to Suboxone prescribing; identify what primary care providers need from SU providers to change prescribing practices | March to May 2017 | |
| Substance use provider training | Train SU providers in how to work with primary care providers to treat patients on Suboxone | July to Aug 2017 | |
| First responder* training<br>** NOTE: "First responder" is defined as the first personnel on the scene, including police, EMTs, paramedics, fire, street outreach, emergency shelters, family caregivers, schools, and possibly others* | Train first responders in how to safely and effectively administer Naloxone | April-June 2017 | |
| Community education | Identify venues to deliver education about harm reduction | Aug to Dec 2017 | |

****** While we do not yet know the specific priorities, measures, and early tactics that will be identified during the planning phase, we offer several examples of implementation activities.*

## 4 – MEASURING SUCCESS: PROJECT OUTCOMES & DATA

At this time, we do not know which of the measures will be selected by the community to gauge success during the implementation phase. Some of the indicators listed below may already be available. Researching the available data sources will be part of the three-county assessment during the planning phase. For data pertaining to American Indian/Alaska Natives (AI/AN), the best practice is to obtain approval directly from Tribal leadership, such as a Tribal Council or Health Board, prior to collecting or sharing any data. We will work with Tribes to determine which data should be shared, why, how it will be used, how it will be protected, and other safe guards. Given its sensitive nature, this will be an area of early exploration and will be directed by each Tribe. Also of note, Tribes are carved out of SBHO and operate under a fee-for-service model directly with the HCA.

| **Outcome** (Desired result) | **Outcome indicator** (How success is measured) | **Data source** | **Stakeholder(s) helping w/ data collection or analysis** | **Timeline** | **Need CCHE help?** |
|---|---|---|---|---|---|
| **POSSIBLE IMPLEMENTATION PHASE OUTCOME MEASURES** | | | | | |
| Improved health outcomes* | Decrease in opioid-related emergency department visits | EDIE | Hospitals | | ☒ |
| Improved health outcomes* | Decrease in opioid-related hospitalizations | Comprehensive Hospital Abstract Reporting System (CHARS) | Kitsap Public Health District | | ☐ |
| Improved health outcomes* | Decrease in births with an opiate-diagnosis | CHARS | Kitsap Public Health District | | ☐ |
| Improved health outcomes | Increase in post-partum women engaged in Parent-Child Assistance Program or other related programs | Organizations offering these programs | First Step Family Resource Center and other organizations offering these programs | | ☐ |
| Improved health outcomes | Decrease in opioid-related deaths (accidental or intentional) | Death Certificate | Kitsap Public Health District | | ☐ |
| Improved health outcomes | Increase in opioid overdose reversals with use of Naloxone | Organizations using Naloxone | Olympic Community of Health | | |
| Increase in access to services | Increase in number of providers with a Suboxone certification | Primary care providers, medical groups, and FQHCs | Olympic Community of Health | | ☐ |
| Increase in access to services | Increase in number of outpatient substance use disorder providers trained to support Suboxone treatment | Salish Behavioral Health Organization | Behavioral Health Organization | | ☐ |
| Increase in access to treatment/ Change in behavior | Increase in number of prescriptions of Suboxone filled | Health Care Authority | Olympic Community of Health | | ☒ |
| Increase in access to treatment/ Change in behavior | Decrease number of opioid prescriptions filled (split out by new vs. refills) | Health Care Authority | Olympic Community of Health | | ☒ |
| Increase in access to treatment/ Change in behavior | Increase in substance use disorder treatment completion for opioid addiction | Salish Behavioral Health Organization | Behavioral Health Organization | | ☐ |
| Increase in access to treatment/ Change in behavior | Increase in number of first responders carrying Naloxone | EMS and law enforcement | Olympic Community of Health | | ☐ |
| **PLANNING PHASE PROCESS AND DELIVERABLE MEASURES** | | | | | |

| | | | | |
|---|---|---|---|---|
| Process | Number of people attending meetings; number of people attending Summit; list of sector and Tribe representation; meeting minutes; committee discussion papers and products; communications collateral | Olympic Community of Health | Aug to Jan 2017 | |
| Deliverable | Opioid Summit | Olympic Community of Health | Jan 2017 | |
| Deliverable | Opioid Response Implementation Plan, including tools and measures | Olympic Community of Health | Jan 2017 | |
| Deliverable | Opioid Three-County Assessment | Olympic Community of Health | Jan 2017 | |

** These measures are categorized as "improved health outcomes"; however, they can also be categorized as "reduced cost". This would require data from the plans, the Health Care Authority, or possibly the Washington Health Alliance. For now, we focus on utilization rates, rather than associated costs.*

**Connection to the statewide Common Measure Set**, please explain how the project measures and overall goal will help improve one or more of the metrics from the Common Measure Set (*up to 3 sentences*):

This project connects with several measures from the Common Measure Set:

- Adult Access to Primary Care Providers *through increasing the number of Suboxone prescribers*
- Substance Use Disorder Treatment Penetration *through increasing the number of outpatient substance use disorder providers trained to support Suboxone treatment*
- Potentially Avoidable ER Use *through appropriate treatment for people with opioid addiction*

☒ Check box for additional help from CCHE on connecting the project to the Common Measure Set.

**Advancing the Triple Aim**, please describe how successful implementation of the project would contribute to one or more component of the Triple Aim in your community – i.e. (1) improving services (quality of care, patient experience); (2) reducing health-related costs, and (3) improving health and wellbeing in your region (*up to 4 sentences*):

Well-coordinated response to opioid addiction will result in:
Lower costs:

- fewer avoidable hospitalizations
- fewer avoidable EMS transports
- fewer avoidable emergency department visits
- fewer complicated births to mothers with an opiate-use diagnosis

Improve health:

- fewer opioid-related emergency department visits, hospitalizations and deaths
- decrease negative health impacts of chronic opioid use

Improve services:

- enhance the availability of Suboxone and Naloxone
- increase the number of opioid-addicted community members who engage in treatment for their addiction
- enhance coordination between medical and behavioral healthcare providers to maximize treatment efforts and patient success in recovery

## 5- WRAP-UP QUESTIONS

*This section must be filled out and submitted to HCA before July 29, 2016 for project review and approval.*

**What top two challenges are you currently concerned about the project?** (*2-3 sentences*):

This is a BIG problem; a crisis, really. Getting to our long term goals will take trust, which will take time. We are concerned about losing buy-in as we go, and getting distracted by Waiver activity.

**What top two strengths in your region make you feel confident about making progress?** (*2- 3 sentences*):

There was unanimous support for this project from the Regional Health Assessment and Planning Committee, the Board of Directors, and the broader OCH Partner Group. One thing is clear: the opioid problem unites us. If successful, this project will take our local communities beyond the Triple Aim, positively affecting overall community wellbeing and safety.

**Do you have any questions or need clarification from HCA?** (*2-3 sentences*):

It would be helpful to know as soon as possible if additional funding were available starting February 1, 2017.

## APPENDIX – Health Care Authority guidance on selection and requirements for official SIM project:

Copy guidance language here when ready.

**ARTICLES OF INCORPORATION**
**OF THE**
**OLYMPIC COMMUNITY OF HEALTH**

**Article I**
NAME OF CORPORATION

Olympic Community of Health

**Article II**
EFFECTIVE DATE OF CORPORATION

Upon filing by the Secretary of State

**Article III**
TENURE

Perpetual existence

**Article IV**
PURPOSE FOR WHICH THE ORGANIZATION IS ORGANIZED

To operate exclusively for charitable and educational purposes under 501(c)(3) of the Internal Revenue Code, or corresponding section of any future federal tax code.

**Article V**
DISSOLUTION OF ASSETS

Upon dissolution of the OCH, assets (including monies and equipment) and property (including records) shall be distributed among other charitable, educational, religious or scientific organizations that qualify as an exempt organization or organizations under section 501 (c) (3) of the Internal Revenue Code. Decisions regarding dissolution will be made by the Board, however, no transfer will be made that will adversely affect the OCH's tax status at time of dissolution or retroactively.

**Article VI**
NAME AND ADDRESS OF EACH INITIAL DIRECTOR

| Name | Address | City | State | Zip Code |
|---|---|---|---|---|
| Joe Roszak | 5455 Almira Drive NE | Bremerton | WA | 98311 |
| Hilary Whittington | 834 Sheridan Street | Port Townsend | WA | 98368 |
| Jennifer Kreidler-Moss | 400 Warren Avenue, Suite 200 | Bremerton | WA | 98337 |
| Roy Walker | 11700 Rhody Drive | Port Hadlock | WA | 98339 |
| Leonard Forsman | 18490 Suquamish Way | Suquamish | WA | 98392 |

**Article VII**
NAME AND ADDRESS OF THE WASHINGTON STATE REGISTERED AGENT

| Name | Address | City | State | Zip Code |
|---|---|---|---|---|
| Elya Moore | 345 6th Street, Suite 300 | Bremerton | WA | 98337 |

Consent to serve as registered agent

*I consent to serve as Registered Agent in the State of Washington for the above named corporation. I understand it will be my responsibility to accept Service of Process on behalf of the corporation; to forward mail*

*to the corporation; and to immediately notify the Office of the Secretary of State if I resign or change the Registered Office Address.*

SIGNATURE OF REGISTERED AGENT PRINTED NAME DATE

**Article VIII**

NAME AND ADDRESS OF INCORPORATOR

| Name | Address | City | State | Zip Code |
|---|---|---|---|---|
| Joe Roszak | 5455 Almira Drive NE | Bremerton | WA | 98311 |
| Hilary Whittington | 834 Sheridan Street | Port Townsend | WA | 98368 |
| Jennifer Kreidler-Moss | PO Box 960, 400 Warren Avenue, Suite 200 | Bremerton | WA | 98337 |
| Roy Walker | 11700 Rhody Drive | Port Hadlock | WA | 98339 |
| Leonard Forsman | PO Box 498, 18490 Suquamish Way | Suquamish | WA | 98392 |

SIGNATURE OF INCORPORATOR PRINTED NAME DATE

SIGNATURE OF INCORPORATOR PRINTED NAME DATE

SIGNATURE OF INCORPORATOR PRINTED NAME DATE

SIGNATURE OF INCORPORATOR PRINTED NAME DATE

SIGNATURE OF INCORPORATOR PRINTED NAME DATE

## Olympic Community of Health

Articles of Incorporation

Situation | Background | Action | Recommendation

Presented to the Board of Directors August 3, 2016

Input from Executive Committee July 22, 2016

Prepared July 26, 2016

**Situation**

On July 6th the OCH Board authorized the Director to draft Articles of Incorporation for presentation and review by the Executive Committee, prior to presenting to the full Board at the August 3rd OCH Board meeting.

**Background**

Staff reviewed Articles of Incorporation from two ACHs: Greater Columbia and North Sound. Both are multi-county ACHs that recently undertook the process of incorporation. Both had legal review. Staff drafted Articles of Incorporation for the OCH and created a crosswalk to examples from the two other ACHs, highlighted four topical areas for discussion.

| **Action**<br>Executive Committee discussed the following issues: | **Recommendation**<br>Executive Committee offered recommendations based on each issue: |
|---|---|
| **501c3**: All other versions selected nonprofit status to file Articles of Incorporation. | For the time being, identify nonprofit 501(c)3 as the OCH legal status in the Articles of Incorporation until the Board can have a full discussion to elect a legal entity, either at this meeting, or the September Board meeting. |
| **Simplicity**: North Sound ACH went beyond the articles required to incorporate while Greater Columbia ACH restricted their articles to the basic requirement. | Keep the Articles of Incorporation short and simple. Details and additional structure can go in the bylaws, which are much easier to amend. |
| **Directors**: How should we list Directors? | In the spirit of simplicity, list only the five officers as Directors. |
| **Incorporators**: How should we determine the Incorporators? | In the spirit of simplicity, list only the five officers as Incorporators. |

**Motion**

The OCH Board of Directors authorizes the Executive Director to electronically submit the Articles of Incorporation as presented with the Washington Secretary of State pending legal review from interested parties and an approved motion from the Board to move forward and select 501(c)3 as the legal entity.

BYLAWS
OF
Olympic Community of Health

**ARTICLE I.**
**NAME**

The name of the corporation shall be The Olympic Community of Health, and it is referred to in these Bylaws as the "OCH."

**ARTICLE II.**
**PURPOSES**

Section 1. Purposes. The purposes for which the OCH is formed, and the business and objectives to be carried on and promoted by it, are as follows:

To operate exclusively for charitable, scientific, and educational purposes, and to advance the goal of the OCH to improve the overall health and wellbeing of our communities and Tribes through a collaborative approach focused on sustainable and equitable solutions.

Section 2. Dedication of Assets. The property of the OCH is irrevocably dedicated to charitable purposes. No part of the net earnings, properties or other assets of the OCH shall inure to the benefit of any private person or individual, or to any member, Director or officer of the OCH. Notwithstanding the foregoing, this Section shall not prevent payment to any such person of reasonable compensation for services performed for the OCH in effecting any of its public or charitable purposes, provided that (i) compensation is permitted by these Bylaws and approved by resolution of the Board, and (ii) no such person or persons shall be entitled to share in the distribution of, and shall not receive, any of the corporate assets on dissolution of the OCH.

**ARTICLE III.**
**DEFINITIONS**

The following terms used in these bylaws are defined as follows:

"Administrative Service Organization" means the organization that supports and facilitates the business and activities of the OCH. Such activities may include: payroll services, benefits administration, human resources, information technology, data analytics and evaluation, and communications.

"Board" means the Board of Directors of the OCH.

"Committee" means two or more individuals who are assigned to work on a specific issue, and are interdependent in the achievement of a common goal.

"Community Member" means a representative of the community that represents a priority health issue or a local health coalition of community members.

"Conflict of Interest" means a situation in which a Director has the potential to vote on a matter that would provide direct or indirect financial benefit to that Director or their immediate family or to any agency with which that member is affiliated.

"Director" means an individual appointed as a member of the Board of Directors.

"Executive Committee" means the Board of Directors President, Vice-President, Secretary, Treasurer, and At-Large.

"Executive Director" means the senior operating officer of the OCH.

"Financial Interest" means a person having directly or indirectly, through business, investment, or family:

- An ownership or investment interest in any entity with which the Organization has a transaction or arrangement,
- A compensation arrangement with the Organization or with any entity or individual with which the Organization has a transaction or arrangement, or
- A potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which the Organization is negotiating a transaction or arrangement.

"Health" means the state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity. These include the conditions in which people work, live, play and contribute.

"Member" means a person admitted to the OCH Partner Group as provided in Article VII.

"Organization" means any group of people who have joined together for a particular purpose, ranging from social to business, and usually meant to be a continuing organization. It can be formal, with rules and/or bylaws, membership requirements and other trappings of an organization, or it can be a collection of people without structure.

"Regional Health Improvement Plan" means a mechanism through which key health stakeholders in a community representing whole-person health plan, facilitate and coordinate activities required for transformation of the community's health system.

"Regional Service Area" means the Accountable Community of Health region as defined by the Health Care Authority.

"Sector" means a category of organizations, governments, businesses and/or individuals who share the same or related mission, product or service within the Regional Service Area. (For example, Social Services, Hospitals, Transportation, Federally Qualified Health Centers, Philanthropy, Housing, Community Based Organizations, Consumer Representative, Public Health, Managed Care Organizations)

"Tribe" means an American Indian or Alaska Native tribal entity that is recognized as having a government-to-government relationship with the United States, with the responsibilities, powers, limitations, and obligations attached to that designation, and is eligible for funding and services from the Bureau of Indian Affairs.

**ARTICLE IV.**
**BOARD OF DIRECTORS – DUTIES AND PRINCIPLES**

Section 1. Power and Duties.

1.1 Powers. Prudent management of all the affairs, assets, property and goodwill of the OCH shall be vested in a Board of Directors. The Board may delegate the management of the day-to-day operation of the business of the corporation to a management company, committee (however composed), or other person, provided that the activities and affairs of the corporation shall be managed and all corporate powers shall be exercised under the ultimate direction of the Board of Directors. Directors shall not delegate or proxy their respective responsibilities and rights as members of the Board pursuant to these Bylaws and required under federal and state law.

1.2 General Duties. The Board will provide strategic direction and work in partnership with the Partner Group and workgroups on approved projects. They shall act as liaison for the OCH to Washington State Health Care Authority on funding, governance, alignment of state initiatives with regional preferences and other topics that may arise. They shall serve as voice for the OCH to other, relevant offices in Olympia and to local, elected officials. The Board secures funding for core collaborative activities of the OCH partners that benefit the shared aims of the organization, and overseas and develops the sustainability plan for the corporation. They ensure that the corporation obeys applicable laws and acts in accordance with ethical practices, that it adheres to its stated corporate purposes, and that its activities advance its mission.

Section 2. Number. The number of Directors shall be determined from time-to-time by a vote of the Board but shall consist of not less than fifteen (15) and not more than twenty-five (25). Other than as to the initial Board, the number of Directors may at any time be increased or decreased by the Board who shall have the power to elect additional Directors at any regular or special meeting of the Board. The change in number of Directors shall not however, diminish the term of any incumbent director, whose term may be diminished only as provided by law and these Bylaws.

Section 3. Board Representation by Sector and Tribe. Each Board member shall either represent a Tribe or a designated Sector established by the Board. Board membership may include representation up to the maximum number of directors pursuant to Section 2 hereof. No Sector shall have more than one designated member on the Board of Directors. The Board may add or modify Sectors that should be represented by a vote of the Board. Tribes may alternate designated members on the Board of Directors, with each Tribe represented by one vote on the Board of Directors. The Administrative Service Organization shall maintain a list of the Sectors and Tribes for representation on the Board.

Section 4. Nomination and Election of Directors.

4.1 Board Sector Representative Nomination Process. Candidates for Board members shall be nominated by each Sector. The nominations will be referred directly to the Board for approval. In the event a Sector cannot nominate a representative within thirty (30) days, the Board, either directly or through Committee, will solicit, receive and vet nominations, and recommend a sector representative to the Board.

4.2 Tribe Representative Nomination Process. Tribes may appoint alternate representatives as desired on the Board of Directors. Tribal representation on the Board of Directors is voluntary.

4.3 Election. The Board approves Sector membership to the Board and elects its Board Sector Directors. Directors shall be elected at the annual meeting, or at any regular or special meeting of the Board. The Board does not have authority to confirm or deny Tribal appointments.

Section 5. Term of Office. During the first year after adoption of these Bylaws, Directors shall be elected to an initial one-year (1) term. For the purpose of staggering the terms, following the initial one-year term, thirty (30%) of the Board of Directors shall serve a one (1) year term and the remaining Directors shall serve a two (2) year term. The initial groups shall be determined by a lottery. Thereafter, each Director's term of office shall be for two (2) years, which shall end on the latter of the date of the annual meeting or succession of a new director. At the end of three (3) consecutive terms, each sector has the option to nominate the same Candidate or to nominate a new Candidate to represent the sector on the Board. Term of Office does not apply to Tribes.

Section 6. Compensation. The Directors shall receive no compensation for services for and on behalf of the OCH.

Section 7. Meetings.

7.1 Annual Meeting. An annual meeting of the Board shall be held each year in the autumn (between September and November), prior to December 31. At this meeting the Board shall approve a budget for the activities of the OCH for the following year, and elect new Board members.

7.2 Regular Meetings. Regular Board meetings shall be scheduled at the discretion of the Board, but are required not less than four (4) times per year. By resolution, the Board may specify the date, time and place for the holding of regular meetings without other notice than such resolution.

7.3 Special Meetings. Special meetings of the Board may be called at any time by the President or any five (5) members of the Board, whereupon the Secretary shall give notice as specified by the Board to each Board member.

7.4 Meetings by Telephone. Members of the Board or any committee designated by the Board may participate in a meeting of such Board or committee by means of a conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other at the same time. Participation by such means shall constitute presence in person at a meeting.

7.5 Place of Meetings. All meetings shall be held at the principal office of the corporation or at such other place within or without the State of Washington designated by the Board, by any persons entitled to call a meeting or by a waiver of notice signed by all Directors.

7.6 Notice of Special Meetings. Notice of special Board or committee meetings shall be given to a Director in writing or by personal communication with the Director not less than ten days before the meeting. Notices in writing may be delivered or mailed to the Director at his or her address shown on the records of the corporation or given by facsimile or electronic transmission. Neither the business to be transacted at, nor the purpose of any special meeting need be specified in the notice of such meeting. If notice is delivered by mail, the notice shall be deemed effective when deposited in the official government mail properly addressed with postage thereon prepaid.

7.7 Waiver of Notice.

A. In Writing. Whenever any notice is required to be given to any Director under the provisions of these Bylaws, the Articles of Incorporation or applicable Washington law, a waiver thereof in writing, signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the Board need be specified in the waiver of notice of such meeting.

B. By Attendance. The attendance of a Director at a meeting shall constitute a waiver of notice of such meeting, except where a Director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened.

7.8 Quorum. A simple majority of the Directors then in office at the beginning of each meeting shall constitute a quorum for the transaction of business. Each of the Tribes in the Regional Service Area shall be eligible to vote at each meeting but are not subject to the attendance requirements of section 10. Therefore, the Tribes shall not be included in determining a quorum.

7.9 Alternative Representation. In the event a Director is unable to attend a board meeting, the Director may authorize a representative to attend as a guest at a board meeting, provided that such Director provides reasonable notice to the Board. Only attendance by Directors will constitute a quorum and for the purposes of voting on business items.

Section 8. Voting and Manner of Acting.

8.1 Board Actions. Each Director and each Tribe will have one (1) vote. The act of the majority of the Directors present at a meeting at which there is a quorum shall be the act of the Board, unless the vote of a greater number is required by these Bylaws, the Articles of Incorporation or applicable Washington law.

8.2 Presumption of Assent. A Director at a Board meeting at which action on any corporate matter is taken shall be presumed to have assented to the action taken unless his or her dissent or abstention is entered in the minutes of the meeting, or unless such Director files a written dissent or abstention to such action with the person acting as secretary of the meeting before the adjournment thereof, or forwards such dissent or abstention by registered mail to the Secretary of the corporation immediately after the adjournment of the meeting. Such right to dissent or abstain shall not apply to a Director who voted in favor of such action.

8.3 Action by Board Without a Meeting. Any action which could be taken at a meeting of the Board may be taken without a meeting if a written consent setting forth the action so taken is signed by each of the Directors. Such written consents may be signed in two or more counterparts, each of which shall be deemed an original and all of which, taken together, shall constitute one and the same document. Any such written consent shall be inserted in the minute book as if it were the minutes of a Board meeting.

Section 9. Resignation. Any Director may resign at any time by delivering written notice to the President or the Secretary at the registered office of the corporation, or by giving oral or written notice at any meeting of the Directors. Any such resignation shall take effect at the time specified therein, or if the time is

not specified, upon delivery thereof and, unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

Section 10. Removal from Office. Directors are expected to regularly attend Board meetings; however, they shall notify the President or Executive Director with appropriate notice if they are not able to attend such meeting. Absences from more than one-third (1/3) of the regularly scheduled meetings in any given calendar year may be grounds for removal. Any Director, unless they have been appointed by a Tribe, may be removed by a sixty percent (60%) vote of the Board, such vote being held at an annual, regular or special meeting of the Board.

Section 11. Vacancies on Board of Directors. Sector representatives are responsible for identifying and forwarding candidates to the Board to fill vacant positions. Vacancies occurring on the Board may be voted on and ratified at any regular or special Board meeting by the remaining Directors. Newly elected Directors shall serve the remaining term of the vacant position.

Section 12. Duty of Loyalty. Directors shall put the OCH interests ahead of their own when making all decisions in their capacities as corporate fiduciaries. They must act without personal economic conflict, and are required to sign a conflict of interest policy upon election to the Board.

## ARTICLE V.
## OFFICERS

Section 1. Election and Term of Office. The officers of the OCH Board shall be President, Vice President, Secretary a 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. Any two or more offices may be held by the same person, except the offices of President and Secretary. 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.

Section 2. Removal. Any officer or agent may be removed by the Board with or without cause by a sixty percent (60%) vote of the Board, if deemed in the best interests of the OCH.

Section 3. Compensation. The officers shall receive no compensation for services rendered on behalf of the OCH.

Section 4. President. The President shall preside at all meetings of the Board, shall have general supervision of the affairs of the corporation, and shall perform such other duties as are incident to the office or are properly required of the President by the Board.

Section 5. Vice-President. The Vice-President shall preside at all meetings in the absence of the President and perform such other duties as are incident to the office or are properly required of the Vice-President by the Board.

Section 6. Secretary. It shall be the duty of the Secretary of the Board to keep all records of the Board and of the OCH, to give notice of meetings, and to perform such other acts as the President or Board may direct.

Section. 7. Treasurer. The Treasurer is accountable for all funds belonging to the OCH, and shall assure that policies and procedures regarding the disposition of assets and all related financial transactions are followed as prescribed by the Board or these Bylaws.

Section 8. Past-President. The Past-President shall advise the incoming President of position responsibilities and provides advice, support and information as needed to the new President and board.

Section 9. At-Large. The At-Large may be assigned to serve on committees or undertake special projects. This office will be replaced by the Past-President office after the first term.

**ARTICLE VI.**
**COMMITTEES**

Section 1. Committees. The Board may appoint, from time to time, from its own members and/or the public, standing or temporary committees consisting each of no fewer than two (2) Directors. Such committees may be vested with such powers as the Board may determine by resolution passed by a majority of the Board. No such committee shall have the authority of the Board in reference to amending, altering, or repealing these Bylaws; electing, appointing, or removing any member of any such committee or any Director or officer of the corporation; amending the Articles of Incorporation, adopting a plan of merger or adopting a plan of consolidation with another corporation; authorizing the sale, lease, or exchange of all or substantially all of the property and assets of the corporation other than in the ordinary course of business; authorizing the voluntary dissolution of the corporation or adopting a plan for the distribution of the assets of the corporation; or amending, altering, or repealing any resolution of the Board which by its terms provides that it shall not be amended, altered, or repealed by such committee. All committees so appointed shall keep regular minutes of the transactions of their meetings and shall cause them to be recorded in books kept for that purpose in the office of the corporation. The designation of any such committee and the delegation of authority thereto shall not relieve the Board or any member thereof of any responsibility imposed by law.

Section 2. Standing Committees. The following committees are authorized and ongoing Committees of the Board:

A. Executive Committee. Membership of the Executive Committee shall consist of the officers of the Board which are President, Vice-President, Secretary, Treasurer, and At-Large. At the end of the President's term, the At-Large office will be replaced by Past-President. A majority of the Executive Committee shall be necessary and sufficient at all meetings to constitute a quorum for the transaction of business. 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. The Executive Committee will review and recommend changes, if charged by the Board, to the Bylaws.

B. Finance Committee. The Treasurer of the Board shall chair a committee comprised of at least three (3) Directors to provide financial oversight for the organization. In addition to developing an annual

budget, the committee will establish long-term financial goals that will provide for the sustainability of the corporation.

C. Regional Health Assessment and Planning Committee. A Director of the Board shall chair the RHAP Committee, which will be comprised of at least two (2) Directors and no fewer than eleven (11) general members, including at least one representative from a Tribe and one representative from each of the three counties in the RSA. Thirty-three percent (33%) of RHAP Committee members shall be necessary and sufficient at all meetings to constitute a quorum for the transaction of business, with at least one representative present from each county and ideally at least one representative from a Tribe. RHAP Committee membership will be open to each Tribal Nation and multiple sectors; the roster will be updated on a regular basis. RHAP Committee regularly reviews health assessments and advises the Board on regional health priorities and how to address them.

## ARTICLE VII.
## ADMINISTRATIVE SERVICE ORGANIZATION

The Board shall select and contract with an Administrative Service Organization that shall be the general manager of this corporation. The Administrative Service Organization shall have such qualifications as determined by the Board from time to time, including experience and education suitable to fulfill the duties of managing the corporation. The Administrative Service Organization shall have the necessary authority and be held responsible for the administration of all corporate activities and departments subject only to the policies adopted by and the orders issued by the Board or by any of its committees to which it has delegated powers for such action The Administrative Service Organization shall act as the duly authorized representative of the Board in all matters in which the Board has not formally designated some other person for that specific purpose. At least annually, the Board shall evaluate the performance of the Administrative Service Organization against measurable goals developed by the Board in consultation with the Administrative Service Organization. The Board may elect to terminate any and all contracts with the Administrative Service Organization, with notice and with or without cause. The Board shall provide notification of contract termination in writing to the executive representative of the Administrative Service Organization.

## ARTICLE VIII.
## FINANCE

Section 1. Finance. The annual budget shall be prepared and approved by the Board at the annual meeting of the Board. The OCH shall operate on a fiscal year, which runs from January 1 to December 31.

There shall be created by the Board a general fund of the OCH. Said funds shall be administered by the Board or their designee. This fund shall be utilized for the payment of general operating expenses. Any non-budgeted expenditure in excess of $2,500.00 shall require approval by the Directors.

Section 3. Contracts. The Board may authorize any officer or officers, agent or agents, to enter into any contract or execute and deliver any instrument on behalf of the OCH, and that authority may be general or confined to specific instances.

Section 4. Checks, Drafts, Etc. All checks, drafts or other orders for the payment of money, notes or other evidences of indebtedness issued in the name of the OCH shall be signed by the officer or officers, agent

or agents of the OCH and in the manner as shall from time to time be determined by resolution of the Board of Directors.

Section 5. Deposits. All funds of the OCH shall be deposited in a timely manner to the credit of the OCH in the banks, trust companies or other depositories as the Board of Directors may select.

Section 6. Remuneration. No salary shall be paid to members of the Board or Committee. Members may be reimbursed for reasonable and necessary expenses incurred for the purposes of doing business, and attending meetings on behalf of the OCH. Such expenses incurred may be reimbursed provided appropriate documentation and timely submission of expense receipts are provided within sixty (60) days of such occurrence.

**ARTICLE IX.**
**CONFLICTS OF INTEREST AND PROHIBITED TRANSACTIONS**

Section 1. Conflicts of Interest Policy. The Board of Directors shall adopt policies and procedures to comply with the requirements of this Article X and to address any conflicts of interest between the OCH and the Board and its officers, employees and/or agents of this corporation ("Conflicts of Interest Policy"). To ensure the OCH operates in a manner consistent with its charitable purposes and does not engage in activities that could jeopardize its tax-exempt status, the Board shall conduct periodic reviews of these Bylaws and the Conflicts of Interest Policy. The periodic reviews shall, at a minimum, include the following subjects:

(i) whether compensation arrangements and benefits are reasonable, based on competent survey information, and the result of arm's length bargaining; and

(ii) whether partnerships, joint ventures, and arrangements with management organizations conform to the Corporation's written policies, are properly recorded, reflect reasonable investment or payments for goods and services, further charitable purposes and do not result in inurement, impermissible private benefit or in an excess benefit transaction.

Section 2. Annual Disclosure. Each member of the Board and principal officer shall annually sign a disclosure statement which affirms such person: (i) has received a copy of the conflicts of interest policy; (ii) has read and understands the conflicts of interest policy; (iii) has agreed to comply with the conflicts of interest policy, and (iv) understands the OCH is charitable and in order to maintain its federal tax exemption it must be organized and operated for one or more tax-exempt purposes set forth in Section 501(c)(3) of the Internal Revenue Code. In addition, such disclosure state shall include each director's affiliations (as trustee, board member, officer, employee, advisory committee member, development committee member, volunteer, etc.) with any actual or potential grantee or borrower of the OCH or any other organization with which the OCH may have a financial relationship, and the affiliations of persons with whom a director has a close relationship (a family member or close companion) with any actual or potential grantee or borrower of the OCH or any other organization with which the OCH may have a financial relationship. The form of such annual disclosure statement shall be prescribed and adopted by the Board of Directors and reviewed on an annual basis.

Section 3. Self-Dealing Transactions.

3.1 Prohibition and Standard for Approval. Except as provided by this Section, the Board of Directors shall not approve or permit the OCH to engage in any self-dealing transaction. A self-dealing

transaction is a transaction to which this corporation is a party and in which one or more of its directors has a financial interest. Notwithstanding the foregoing, the OCH may engage in a self-dealing transaction only as follows:

(i) if the transaction is approved by a court or by the Attorney General, or

(ii) if the Board determines, before the transaction, that (1) this corporation is entering into the transaction for its own benefit; (2) the transaction is fair and reasonable to this corporation at the time; and (3) after reasonable investigation, the Board determines that it could not have obtained a more advantageous arrangement with reasonable effort under the circumstances. Such determinations must be made by the Board in good faith, with knowledge of the material facts concerning the transaction and the interest of the director or directors in the transaction, and by a vote of a majority of the directors then in office, without counting the vote of the interested director or directors.

3.2 Notification and Process. Whenever a Director or Officer has a financial or personal interest in any matter coming before the Board, the affected person shall a) fully disclose the nature of the interest and b) withdraw from discussion, lobbying, and voting on the matter. Any transaction or vote involving a potential conflict of interest shall be approved only when a majority of disinterested Directors determine that it is in the best interest of the corporation to do so. The minutes of meetings at which such votes are taken shall record such disclosure, abstention and rationale for approval.

The Board may also vote to exclude a Director against whom a claim of conflict of interest or violation of appearance of fairness is made from Board votes or from executive sessions until the claim against the member is resolved. Additionally, the Board may by majority vote exclude a member from a portion of any executive session where a matter of potential legal conflict between OCH and the member is to be discussed.

Section 4. No Loans. No loans shall be contracted on behalf of the OCH and no evidences of indebtedness shall be issued in its name unless authorized by a resolution of the Board. That authority may be general or confined to specific instances. No loans shall be made by the OCH to a Director nor shall the OCH guarantee the obligation of a Director unless either: (a) the particular loan or guarantee is approved by the vote of a majority of the votes represented by members in attendance at the meeting upon which the matter is considered, except the votes of the benefited Director, or (b) the Board determines that the loan or guarantee benefits the OCH and either approves the specific loan or guarantee or a general plan authorizing loans and guarantees.

## ARTICLE X.
## INDEMNIFICATION AND INSURANCE

Section 1. Indemnification. The OCH shall indemnify any present or former volunteer of the corporation including Directors, officers, Committee officers and Committee members as well as any present or former employees or agents of the corporation, to the fullest extent possible against expenses, including attorneys' fees, judgments, fines, settlements and reasonable expenses, actually incurred by such person relating to his or her conduct as a Director, officer, Committee officer, Committee member, volunteer, employee or agent of the corporation, except that the mandatory indemnification required by this sentence shall not apply (i) to a breach of the duty of loyalty to the organization; (ii) for acts or omissions not in good faith or which involve intentional misconduct or knowing violation of the law; (iii) for a transaction from which such person derived an improper

personal benefit; (iv) against judgments, penalties, fines and settlements arising from any proceeding by or in the right of the organization, or against expenses in any such case, where such person shall be adjudged liable to the corporation, or (v) when otherwise prohibited by law.

Service on the Board of Directors of the corporation, or as an officer, Committee officer, Committee member, volunteer, employee or agent thereof, is deemed by the corporation to have been undertaken and carried on in reliance by such persons on the full exercise by the corporation of all powers of indemnification which are granted to it under these bylaws and as amended from time to time. Accordingly, the corporation shall exercise all of its powers whenever, as often as necessary and to the fullest extent possible, to indemnify such persons. Such indemnification shall be limited or denied only when and to the extent provided above unless legal principles limit or deny the corporation's authority to so act.

Section 2. Insurance. Upon and in the event of a determination by the Board of Directors to purchase indemnity insurance, the OCH shall purchase and maintain insurance on behalf of any agent of the OCH against any liability asserted against or incurred by the agent in such capacity or arising out of the agent's status as such, provided that the OCH has the power to indemnify the agent against such liability under the provisions of this Article.

## ARTICLE XI.
## DISSOLUTION

Upon dissolution of the OCH, assets (including monies and equipment) and property (including records) shall be distributed among other charitable, educational, religious or scientific organizations that qualify as an exempt organization or organizations under section 501 (c) (3) of the Internal Revenue Code. Decisions regarding dissolution will be made by the Board, however, no transfer will be made that will adversely affect the OCH's tax status at time of dissolution or retroactively.

## ARTICLE XII.
## AMENDMENTS

The Board shall have power to make, alter, amend and repeal the Bylaws of the OCH, provided the Board will not approve any such alteration, amendment or repeal on which such action shall first have received approval of two-thirds of the Board. The Board shall receive 10 business days' notice of any proposed action to alter or amend the Bylaws of the OCH. These Bylaws may be amended by sixty percent (60%) vote of the votes cast by the Directors. This may be accomplished at either a regular or special meeting with notice given as specified in Article IV.

*I certify that the foregoing Bylaws of the Olympic Community of Health were adopted by the Board of Directors this _____ day of _____, 2016, and that they are currently in effect.*

_____

Roy Walker, Executive Director, Olympic Area Agency on Aging
President of the Olympic Community of Health Board of Directors

*I certify that the foregoing Bylaws of the Olympic Community of Health were adopted by the Board of Directors this _____ day of _____, 2016, and that they are currently in effect.*

_____

Leonard Forsman, Suquamish Tribal Chairman
Secretary of the Olympic Community of Health Board of Directors

## Olympic Community of Health

Bylaws Recommendation

Situation | Background | Action | Recommendation

Presented to the Board of Directors August 3, 2016

Input from Executive Committee July 22, 2016

Prepared July 27, 2016

**Situation**

On July 6th the OCH Board authorized the Director to draft bylaws for presentation and review by the Executive Committee, prior to presenting to the full Board at the August 3rd OCH Board meeting.

**Background**

In 2015 ACH technical assistance funding was used to hire legal counsel to co-create a set of ACH bylaws. These bylaws are now in use by Greater Columbia and have been touted as "best practice" in the ACH sphere. Staff drafted OCH bylaws off of this template, but also reviewed bylaws from North Sound ACH and other non-profit entities. Staff created a crosswalk comparing the OCH bylaws with the bylaws from the other two ACHs and presented this to the Executive Committee for discussion. [NOTE: In the bylaws draft, red font indicates additions or diversions from the ACH bylaws template.]

| **Action**<br>Executive Committee discussed the following issues: | **Recommendation**<br>Executive Committee offered recommendations based on each issue: |
|---|---|
| **501c3**: All other versions articulated a nonprofit status. | For the time being, identify nonprofit 501(c)3 as the OCH legal status in bylaws until the Board can have a full discussion to elect a legal entity, either at this meeting, or the September Board meeting. |
| **Purpose**: We have not yet gone through the process of creating a mission, purpose, or vision yet. | Keep the purpose concise and vague enough to allow the OCH to evolve, but specific enough so we can all agree to it. We can revise the bylaws when we finalize the OCH specific purpose. (Article II) |
| **Tribes**: Does the language in the bylaws about Tribes represent the will of the Board? | Yes, however, each Tribe may wish to take the bylaws to their leadership and seek their own legal counsel to ensure no interference with the Tribe's government-to-government relationship. |
| **Committees**: Are the committees listed in the bylaws the right committees? They differ slightly from other ACH structures, in both number and type. | Yes. The number and type of committees should meet the need of the OCH. Start the process of forming a Finance Committee – this will require a relatively low effort on the part of staff and members, and is an important board function. We should present the idea of a community advisory council at a future board meeting, but for now the OCH Partner Group is working well. (Article VI) |
| **Nominations:** Other bylaws describe a Nominating Committee to solicit and vet nominations. Should we stick with our previously approved new member policy? | Yes, we should stick with our process: "Candidates for Board members shall be nominated by each Sector. The nominations will be referred directly to |

| | |
|---|---|
| | the Board for approval." (Article IV section 4.1) Note, however, that this process does not apply to Tribes. |
| **Term Limits:** How do we want to handle term limits? There is a limited number of people with the skills and experience to represent their sector. | The bylaws should not limit the number of terms a board member can serve. At the end of three consecutive terms, a sector can opt to select a new representative. Terms should be described as two years. These parameters will make it easier to recruit new board members. Membership should be staggered with the goal of revisiting 1/3 of the board membership each year. (Article IV section 5) |
| **Insurance:** Should we purchase Directors and Officers (D&O) insurance at the same time as filing the articles of incorporation? Indemnity insurance is mentioned in Article X of the bylaws. | Hilary offered to seek legal counsel within Jefferson Health Care who provided the following: *The entity would not be liable until formation, when the Articles of Incorporation have been accepted by the Secretary of State's office and the organization is issued its certificate of formation. However, with that said, any director or officer of the ACH could still be liable for any pre-formation actions (e.g. breach of contract, tort, etc.) undertaken in their official capacity as an agent of the ACH. But the ACH, as a non-profit corporation, would generally not be liable for any actions taken by any director or officer until the certificate of formation has been issued and the non-profit corporation has been officially formed under WA law.* |

**Motion 1.** The OCH Board authorizes the Executive Director to revise the bylaws as per the discussion at the August 3rd Board meeting and circulate the revised version to Board Members as soon as possible to facilitate independent legal review. The Executive Committee will review a revised version of the bylaws at their August 26th meeting and make a recommendation to the Board at the September 7, 2016 meeting.

**Motion 2.** The OCH Board authorizes the Executive Director to investigate **Directors and Officers Liability Insuranc**e and select and purchase a plan prior to the Articles of Incorporation being accepted by the Secretary of State's office.

**Motion 3.** The OCH Board authorizes the Executive Director to draft a **Fiscal Sponsorship Agreement** for review and recommendation by the Executive Committee for the full Board at the September 7, 2016 OCH Board meeting.

**Motion 4.** The OCH Board authorizes the Executive Director to draft a **Conflict of Interest Policy** as described in the bylaws for review and recommendation by the Executive Committee for the full Board at the October 5, 2016 OCH Board meeting.