

Board of Directors Meeting

August 14, 2017

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

Web: <https://global.gotomeeting.com/join/938965461>

Telephone: +1 (872) 240-3412

Access Code: 938-965-461

KEY OBJECTIVE

Agree on next phase of strategy for Demonstration portfolio and approach

AGENDA (Action items are in red)

Item		Topic	Lead	Attachment
1	1:00	Welcome	Roy	
2	1:05	Consent Agenda	Roy	1. DRAFT Minutes 7.10.2017 2. Executive Director Report 3. Director Community and Tribal Partnership Report 4. Revised Fiscal Policies and Procedures 5. Revised Executive Committee Charter
3	1:10	Evolution Projects → Transformation	Elya	6. Phase II Portfolio Recommendation 7. Baseline Assessment 8. S.W.O.T. Analysis: Demonstration Consultant 9. Transformation Illustration: Natural Communities of Care 10. Workplan Illustration: Project Plan Development Process 11. S.B.A.R. Value-Based Payment Technical Assistance
4	1:45	Apple Integrator Pilot: First Use Case	Elya Joe	12. S.B.A.R. Apple Integrator Pilot Recommendation 13. Contractor Portfolio
5	2:00	Incentive Funds Flow	Eric	14. Funds Flow Illustration
6	2:20	Financials	Hilary	15. Balance Sheet, Profit & Loss Budget vs. Actual
7	2:30	VBP Action Team	Joe	
8	2:40	Tribe Demonstration Funding Development	Brent Lisa Rey	
9	3:00	Adjourn	Roy	

Acronym Glossary

SBAR: Situation. Background. Action. Recommendation.

SWOT: Strength. Weakness. Opportunity. Threat.

VBP: Value-based payment

Olympic Community of Health

Meeting Minutes

Board of Directors

July 10th, 2017

Date: 7/10/2017	Time: 1:00pm - 4:00pm	Location: Jefferson Health Care Conference Room	
Chair: Roy Walker			
Members Attended: Eric Lewis, <i>Olympic Medical Center</i> , Hilary Whittington, <i>Jefferson Healthcare</i> , Anders Edgerton, <i>Salish Behavioral Health</i> , Chris Frank, <i>Clallam Public Health</i> , Brent Simcosky, <i>Jamestown Family Health Clinic</i> , Joe Roszak, <i>Kitsap Mental Health</i> , Thomas Lock, <i>Jefferson Public Health</i> , Gill Orr, <i>Cedar Grove Counseling</i> , Karol Dixon, <i>Port Gamble S’Klallam Tribe</i> , Caitlin Safford, <i>Amerigroup</i> , Jennifer Kreidler-Moss <i>Peninsula Community Health Services</i> , (replaced Mike Maxwell, alternate), David Schultz, <i>CHI Harrison Medical Center</i>			
Alternate Members Attended: Gary Kreidburg, <i>Harrison Health Partners</i> , Mike Maxwell, <i>North Olympic Health Network</i> (replaced by Jennifer Kreidler-Moss partway through meeting)			
Non-Voting Members: Kat Latet, <i>Community Health Plan of Washington</i> , Jorge Rivera, <i>Molina</i>			
Phone Members: John Miller, <i>Makah Tribe</i> , Patrick Anderson, <i>Makah Tribe</i> , Andrew Shogren, <i>Quileute Tribe</i>			
Staff and Contractors: Elya Moore, <i>Olympic Community of Health</i> , Lisa Rey Thomas, <i>Olympic Community of Health</i> , Mia Gregg, <i>Olympic Community of Health</i> , Siri Kushner, <i>Kitsap Public Health District</i> , Rochelle Doan, <i>Independent Contractor</i> , Maria Klemesrud, <i>Qualis Health</i>			
Guests: Kali Klein, Katherine Weiss, Vicki Kirkpatrick, Mike Maxwell, Dan Vizzini (phone)			
Person Responsible for Topic	Topic	Discussion/Outcome	Action/Results
	July Objectives	1. Agree on next iteration of the OCH Project Portfolio under the Demonstration Project 2. Take action on requirements for Phase II Certification	
Roy Walker	Welcome and Introductions	Roy called the meeting to order at 1:07 pm.	
Roy Walker	Consent Agenda	Approval of minutes	June Board Minutes APPROVED unanimously
Hilary Whittington	Quarter 2 Financials April 2017 – June 2017	Moved quarterly financial review to August Board meeting	

	Tribal Engagement Policy	• Update-New tribal collaboration and communication policy accepted. • Tribes have voiced their appreciation that the OCH understand and respects tribal sovereignty, the OCH appointing a tribal liaison is much appreciated in helping accomplish regional collaboration. • Tribal Policy will be reviewed annually. • Tribal protocol should be approved within the next 45 days. • Move comma on page 8, section 3, paragraph 2.	MOTION Approve the policy contingent on minor suggested grammatical edits APPROVED
Elya Moore	Executive Committee Officers	• No new candidates stepped forward, voted to reelect same slate to serve for another 1-year term. • Discussed current charter. • Executive Committee continue to align with BoD strategy and act with appropriate designated power • Suggested edits: ○ Change term to two years, staggering positions 3-year term limit; need to be consistent with bylaws. ○ Replaced by immediate past president instead of at large. ○ Delegate some authority to Executive Committee to act in an emergent situation while still maintaining Board's ultimate decision making authority.	(Retroactive) MOTION effective July 1-to elect the slate of current officers for another one-year term APPROVED 4 abstentions: • Jennifer Kreidler-Moss • Roy Walker • Joe Roszak • Hilary Whittington MOTION to extend current Executive Committee charter for another month. Delegate review and proposed edits to OCH staff for approval at next Board meeting. APPROVED
Elya Moore Siri Kushner	Portfolio and Survey Results	• Discussed community input on processes, January partner convening feedback, 6 project categories reviewed. 64 responses regarding • All feedback projects scores were about average. • Second input opportunity was released at partner convening in June. Again, all projects received similar scoring. • Discussed pros and cons of each project.	MOTION- move forward with recommended flagship projects APPROVED MOTION to not submit 2B project plan "Pathways" APPROVED

		- Discussed building a repository of metrics - Discussed state's specific payment metrics, "gap to goal" baseline, all measures are weighted equal. - Discussed Apple Integrator, projects 2A, 3A, 2D, 3C; recommendation made to submit pathways project application or nothing at all. - Discussed 9 potential score/funding scenarios - DSRIP incentives funds discussed to assist in partner/hospital/clinic staffing. - OCH Executive Director will present update at next BoD meeting regarding timeline on project recommendations	
Elya Moore Hilary Whittington	Financial and Organizational Framework	- Discussed budget plan for design funds SIM planned expenditures, total OCH staff FTE. Goal to set budget- Agree on overall approach and framework. - Reviewed and discussed organizational structure chart. - Debated potential CFO needs, suggestions to ramp up finance support and Human Resources. Continue to outsource payroll. - Explore contract with systems modeler - Approach to design funds budget plan-reserve Phase I and Phase II Design Funds for OCH operations through 2021. Use DSRIP funds to fill gap. Each year, intentionally set money aside. Design funds must be spent by 2021. - Discussed data contract with King County Public Health. - Deeper dive on modeling, funds and metrics will be upcoming.	MOTION approve detailed budget plan for Project Design funds awarded under Phase I. APPROVED MOTION approach for projecting and budgeting for the Project Design funds anticipated to be awarded under phase II certification. APPROVED
Elya Moore	Governance, Provider Engagement & Consumer Engagement	- To accommodate governance needs/structuring needs, OCH may need to revise Bylaws. - Reviewed proposed governance chart, Care Delivery Redesign Team concept, organization based teams, potential for Performance Measurement Committee and Consumer Advisory Committee.	MOTION to continue to hold public meetings, continue transparency. APPROVED. OCH staff to research public notification best practices.

		• Discussed potential expectations, qualifications and skills of CDRC as RHAPC will be sunseted. • Suggestion for small project committees. • Brainstormed considerations for consumer engagement.	
Rochelle Doan	Approach to Bi-Directional Integration and Primary Care Transformation Planning	• Discussed concept of weaving bi-directional care through all projects in portfolio • Focus next few months on assessment • Leverage work being done with Transformation Hub (Maria Klemusrud). • PGST tribal council developing plan for integration, working with Maria to implement. • Organization-specific work, provider meeting in September, SUD providers must be included. • Aggregate data for OCH to give an overview of providers baseline. • Question- Will/are collaborative care codes included in the state budget this year?	
Roy Walker	Adjourn	The meeting adjourned at 4:30pm.	

Olympic Community of Health

Executive Director's Report

Prepared for August 14 Board Meeting

Top 3 Things to Track (T3T) #KeepingMeUpAtNight

1. We continue to have trouble filling open staff positions. We are the leanest ACH across the state with 3 FTE. Average is 6 FTE and the largest is 12 FTE.
2. Phase II Certification has posed a significant challenge, especially in our limited capacity. The OCH has maintained a singular focus on this deliverable to put together a competitive application that will earn the maximum \$5 million dollars. The opportunity cost of this on our momentum heading into the project plan due date (November 16) may be substantial.
3. Most ACHs are going out-to-bid to large consulting firms to assist with strategic planning and drafting of the project plan and funds flow modeling.

Upcoming OCH meetings:

- Partner Convening, Sequim, September 21, 9 am-12 pm ***save-the-date***
- Board of Directors, Port Townsend, August 14, 1 pm-3 pm
- Executive Committee, August 22, Suquamish, 12 pm - 3:30 pm (includes MCO meetings)
- Finance Committee, August 21, Virtual, 2 pm – 4 pm
- Regional Health Assessment and Planning Committee, Port Townsend, September 12, 10 am to 12 pm
- Opioid Prevention Workgroup, August 7, 1:30 pm-3:30 pm, Poulsbo
- Opioid Treatment Workgroup, August 15, 1:30 pm – 3:30 pm, Port Townsend
- Six Building Blocks to Safer Opioid Prescribing, [Webinar](#), 11 am – 12 pm

Phase II Certification

This has taken a substantial number of hours to complete and has pulled staff and contractors away from essential activity at a time when engagement and project planning ought to be our primary focus. At the time of this report, all but one section is drafted. We will submit the application before the August 14th Board meeting, as it is due by 3 pm that day.

Term Limits

It has nearly been one year since the Board adopted the bylaws. Time flies! This means that at the September Board meeting, we will be drawing numbers out of a hat to stagger term limits. If you cannot make the September meeting, please let Mia know and/or send your designated Alternate.

Partnership

Due to the incredible demands of the Demonstration, the OCH has teamed up with two other rural, multi-county ACHs that share in the OCH's non-mid-adopter trajectory. The benefit of this partnership is to share ideas, documents, and strategy. These are: Cascade Pacific Action Alliance and Greater Columbia. This partnership may be expanded over the coming months.

Executive Committee – MCO Meetings

The Executive Committee has invited leadership from each of the 5 MCOs to meet to discuss:

1. In the future: Describe your ideal partnership with the Olympic Community of Health, beyond the Demonstration, to support our shared goals?
2. In the long term: Together, how will we identify mutually beneficial value-based purchasing (VBP) goals to sustain Demonstration transformation and develop a shared work plan to get there?

3. In the short term: How can we coordinate Domain 1 work and project plan development to align/support/leverage the MCO's VBP goals?

These meetings are scheduled to take place between August and September. When complete, the Executive Committee will report out a summary of the meetings. TO date we have met with Molina on July 25th.

Conflict of Interest

The Executive Committee reviewed and offered revisions to the Conflict of Interest Policy. We will bring this to the Board when we offer a Conflict-of-Interest Board training. At this time we will also introduce a Dispute Resolution Policy.

Independent Audit Firm Selection Process

The Finance Committee released the bid for independent audit firms. All bids must be received by August 18th. We solicited four firms and have received two bids already. The Finance Committee will recommend a firm at the September Board Meeting.

Health Care Authority Site Visit

As standard procedure under the State Innovation Model Grant with the HCA, and because we are subrecipients of this grant, each year the OCH will receive an HCA Site Visit for audit purposes. This visit is scheduled for September 18th. Staff is meeting to review the audit preparation materials from last year's audit to ensure a smooth audit this year.

501c3 Application Status

The first draft of the 501c3 application is complete and is with the CFO hired service for review.

Outreach & Engagement

- Jefferson County MH/SUD Advisory Committee, Port Townsend, July 11
- Graduate Mason Kitsap, Bremerton, July 18
- Monthly Tribal/HCA/BHA, Olympia, July 24
- Unintentional Poisoning Workgroup, Olympia, July 25
- Monthly OCH/Tribal/AICH/HCA meeting, Sequim, August 3
- Salish Behavioral Health Organization Advisory Meeting, Sequim, August 4
- Olympic Peninsula Health Communities Coalition: Take Action to Help Children, Sequim, August 16
- Salish Behavioral Health Organization Executive Meeting, Sequim, August 18
- NW Washington Family Medicine Residency Conference, Silverdale, August 19
- AIAN Resilience in Action: Policy, Data, and Collaboration, Suquamish, August 22-23
- AIHC Delegates Meeting, Lummi Nation, Whatcom County, August 24
- Team Retreat to the West End: Makah Nation, Forks Community Hospital, Bogachiel Clinic, West End Outreach Services, August 29-30
- Salish Behavioral Health Organization Advisory Meeting, Sequim, September 1
- Community Voice Committee, Poulsbo, 1:30 pm-2:30 pm, September 13

Three County Coordinated Opioid Response Project

- **The 3CCORP Prevention Workgroup** had two presentations at the June 20 meeting. One presentation focused on developing policies and regulations for safe disposal of medicine. The second presentation focused on the Six Building Blocks (6-BBs) for clinic redesign for safer opioid prescribing and transforming the treatment of chronic pain. We are following up with the 6-BB team to bring it to our region. The OCH is co-hosting a webinar for the other ACHs and the HCA; the 6-BB team will present the model so other ACHs can consider bringing the model to their regions. The next Prevention Workgroup meeting is July 31, 2017, 10:30am-12:30pm in the Red Cedar Hall at the Jamestown Tribal Center.
- **The 3CCORP Treatment Workgroup** had a lively and rich discussion about how best to align primary care and substance use disorder (SUD) agencies to ensure that our community has access to and choice of the full spectrum of treatment for Opioid Use Disorder (OUD). The Treatment Workgroup is also crafting a survey for SUD providers to better understand barriers and facilitators to accessing and coordinating care. The next Treatment Workgroup meeting is August 15, 1:30-3:30pm in the third-floor conference room at the Jefferson Healthcare building.
- **The 3CCORP Overdose Prevention Workgroup** is developing an assessment plan to document points of access for naloxone (opioid overdose reversal medication). Chief Mike Lasnier (Suquamish Police Department) recently went live with ODMAP in his jurisdiction. ODMAP is an app for first responders who can enter real time data when responding to an opioid overdose. This is super exciting! Chief Lasnier is working with other first responder agencies and jurisdictions to expand the implementation of ODMAP to the region and state. The next Overdose Prevention Workgroup meeting is August 7, 1:30-3:30 at PCHS in Poulsbo.
- **The 3CCORP Steering Committee** continues to both guide and do the work planned, implemented, and accomplished by the teams. The Steering Committee has representation from primary care, psychiatry, addiction medicine, SUD provider, lived experience, criminal justice, elected officials, ER/ED, schools, SBHO, behavioral health, law enforcement, fire/EMS, public health, tribes, hospitals. Currently there are vacancies for the housing, elected tribal official, and elected law enforcement seats. The next SC meeting is July 31, 1-3:00pm in the Red Cedar Hall.
- The 3CCORP team was one of three ACHs invited to present at the quarterly statewide Unintentional Poisoning Workgroup. Each ACH presented the work they are doing to address the opioid epidemic in their region.
- Congratulations to the region for being awarded one of six hub-and-spoke system grants in the state. **Peninsula Community Health Services** will serve as the hub and the spokes currently are Kitsap Mental Health Services, Kitsap Human Services, Discovery Behavioral Health, Peninsula Behavioral Health, the North Olympic Healthcare Network, Clallam Health and Human Services, and the Port Angeles Police Department. The purpose of this grant is to reduce barriers and increase access to referral and treatment for OUD in our region. More to come!

Tribal Engagement and Partnership

- Look for updates on OCH and Tribal Engagement and Partnership. For now, please note that the seven Tribes in the region and the OCH have initiated monthly meetings (in-person with webinar/conference call available). These meetings are also attended by the Administrator of Tribal Affairs and Analysis and the Tribal Liaison from the HCA and the Executive Director of the American Indian Health Commission. Meetings to date are June 26 and August 3, 2017.



Fiscal Policies and Procedures Manual

Created January 23, 2017

Revised February 6, 2017

Revised July 10, 2017

Adopted February 13, 2017

Adopted July 10, 2017

GENERAL PURPOSE

The purpose of the Fiscal Policies and Procedures Manual is to establish guidelines for the Board of Directors and Olympic Community of Health (OCH) staff about standards and procedures to be applied when developing financial goals and objectives, making financial decisions and reporting the financial status of OCH. In addition, these policies will provide guidelines to allow for an effective management of OCH funds. The OCH is a Washington nonprofit organization.

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ROLES & RESPONSIBILITIES

BOARD OF DIRECTORS

It is the responsibility of the Board of Directors to formulate financial policies, delegate administration of such policies to staff, and review operations and activities on a periodic basis. The Board of Directors adopts the annual budget by board vote. The Board of Directors oversees the general financial administration of Olympic Community of Health and delegates responsibility to the Executive Director for the day-to-day operations and financial decisions.

FINANCE COMMITTEE

The Finance Committee, chaired by the Board Treasurer, shall be responsible for the oversight and coordination of the duties outlined in the approved charter, including: Annual budget presentation for Board approval, presentation of monthly financial statements, management of fund investments, selection of the outside auditors, annual financial report, internal controls, and financial policies.

The long-term financial objectives for Olympic Community of Health are reviewed and approved by the Board of Directors following recommendations from the Finance Committee, presented by the Executive Director and/or the Treasurer. Expenditures and revenue objectives are recommended for Olympic Community of Health in accordance with the Board approved long-term plans annually reviewed at an annual Board Strategic Planning Retreat.

The Board Treasurer, with oversight by the Board of Directors, shall have oversight over the accuracy of the accounting records. The Executive Director shall provide the Treasurer with detailed monthly financial information, such as the Chart of Accounts, Reporting Formats, Accounts Payable Processing, Payroll input and Payroll processing, Cash Receipts input, Journal Entries for General Ledger, Form 1099 reporting, and Form 990 reporting as well as Bank Reconciliations and any other accounting as required.

STAFF

Olympic Community of Health's Executive Director implements general and daily financial management and reporting. The Executive Director acts as the primary fiscal agent, implementing all financial policies and procedures. In addition to general and daily management activities, the Executive Director develops and presents staff compensation ranges to the Board of Directors for approval. Such ranges shall be used in the preparation of the annual budget. The Executive Director is also responsible for preparing the annual operational budget for approval by the Board, financial reports analyzing performance to the budget, and periodic cost and productivity analyses.

BUDGETING & REPORTING

Olympic Community of Health regularly prepares both internal and external financial statements. At the outset, the Olympic Community of Health's financial statements are prepared on the cash basis. At the earliest possible phase in the organization's development, the Executive Director, with oversight from the Finance Committee, will transition from a cash basis to an accrual basis. Henceforth the organization will operate on an accrual accounting basis.

FINANCIAL STATEMENTS

Presentation of the Financial Statements shall describe net assets and revenues, expenses, gains, and losses, classified based on the existence or absence of donor-imposed restrictions. Accordingly, the net assets of Olympic Community of Health and changes shall be classified as unrestricted, temporarily restricted, and permanently restricted.

Unrestricted net assets include amounts that are not subject to imposed stipulations that are used to account for resources available to carry out the purposes of Olympic Community of Health in accordance with the limitations of its charter and bylaws. The principal sources of unrestricted funds are grants, contributions, and investment income.

Temporarily restricted net assets are those resources available for use only for purposes specified by the donor or grantor and may or will be met by the actions of Olympic Community of Health and/or the passage of time, or as specified by the restriction. Such resources originate from grants and contributions restricted for specific purposes or a specific future time frame. When a donor or grantor restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of activities as net assets released from restrictions.

Permanently restricted net assets are those resources that are required to be maintained permanently, but which Olympic Community of Health is allowed to use up or to expend all or part of the income that is derived from the donated assets.

INTERNAL REPORTING

Financial Statements shall be prepared monthly. The Financial Statements include information about all Organization's Funds and cash position as of the end of each month and are reviewed by the Treasurer and the Executive Director prior to submission to the Finance Committee. The Financial Statements are submitted to the Board of Directors by the Treasurer for final review and approval, at least every quarter.

FRAUD AND EMBEZZLEMENT

The Executive Director will notify the Board Chair and all major funding sources not later than one working day after the date any alleged fraud activity comes to her/his attention. Organizational personnel will develop the case and notify the proper authorities. If any fraud or embezzlement is identified as part of the annual financial audit and if the Executive Director is implicated, the auditor shall inform the Board chair immediately. After the investigation and resolution of the issue, the organization will make internal control changes to satisfy management and the Board of Directors.

REVENUE GOALS

The responsibility for reaching Olympic Community of Health's budgeted revenue goals on a yearly basis is shared by the Executive Director and the Board of Directors. The Executive Director in conjunction with the Board of Directors and the Treasurer develops and proposes revenue goals and objectives and submits them to the Board prior to discussion and approval at annual Board Strategic Planning Retreat each year.

The Executive Director prepares regular reports on the status of revenue generating activities and presents it to the Board and Executive Committee at regularly scheduled meetings. The Executive/Finance Committee reviews regular reports of revenues and expenditures and if necessary makes recommendations to the Board and to the Executive Director of Olympic Community of Health related to managing expenditures relative to the results of fund development activities.

COST ALLOCATION

Costs not directly attributable to one program and one funding source are initially posted to a common cost center, which are then distributed proportionately to the variety of Olympic Community of Health cost centers. These include, but are not limited to costs shared by all programs in the organization, e.g. telecommunications, maintenance, utilities fees and licenses, janitorial.

Allocation of costs are based on labor. Labor percentages are derived from the relative number of hours worked and documented on staff monthly timesheets for each Olympic Community of Health program or initiative. Most common costs, e.g. printing and postage, office supplies, telecommunications, bookkeeping, fiscal audits, are distributed to programs based on the hours worked in each program or initiative as a percentage of the total staff hours working in a month. Allocation criteria are evaluated on a regular basis e.g. annually unless significant program/initiative changes occur more frequently.

Pure administrative costs are tracked separately and include expenses that are not directly attributable to the programs/initiatives of the organization. They may include Board meeting and related Board expenses, administrative staff costs and other expenses related to maintaining the organization. Administration is allocated to programs/initiatives on the basis of FTE. Since some funding sources restrict the level of reimbursable administrative overhead, the "excess" administration will be charged to other sources of funding or to "no source" if no other funding sources are available, leaving the program or initiative in a deficit which may be supported by other unrestricted revenues or the investment income/corpus.

BUDGETING PROCESS

The Finance Committee and Olympic Community of Health's Executive Director shall continuously plan for the long-term financial stability the organization in accordance with Olympic Community of Health's long-term plans that are reviewed annually, and adjusted as necessary.

Olympic Community of Health's Executive Director and the Treasurer shall be responsible for preparing and presenting to the Finance Committee an annual operating budget draft for Board approval prior to the beginning of each fiscal year (January). Prior to submission to the Board, the Executive Director shall review the specific revenue goals tied to the fundraising activities of Olympic Community of Health, and make recommendations to the Treasurer and Finance Committee. In addition, all relevant staff shall actively participate in the planning of upcoming program expenditures and formulate recommendations to the Executive Director as the annual operating budget is being finalized for presentation to the Board.

CASH MANAGEMENT

Cash and cash equivalents include all cash balances and highly liquid investments with maturity of six months or less. Olympic Community of Health investments shall be reviewed quarterly by the Finance Committee, led by the Board Treasurer. Investment policy is reviewed and updated as needed by the Board. The Finance Committee shall use due diligence in overseeing the investments of Olympic Community of Health funds, by establishing and monitoring an investment strategy that gives proper recognition to risk and return. The Board reviews the investment strategy and objectives every year and modifies by vote of the Board.

FUNDS AND BANKING

Funds of Olympic Community of Health shall be deposited in Olympic Community of Health's bank accounts designated by the Board of Directors. Olympic Community of Health maintains a checking account and savings account. These accounts may be changed as Olympic Community of Health's financial conditions and requirements change. The Treasurer will receive, review, and hand over all bank statements for the organization to the Executive Director who will assure the bank statements are reconciled timely. The Executive Director shall maintain and oversee bank accounts, and ensure Olympic Community of Health's day-to-day financial operations.

All checks, cash, money orders, and credit card deposits, are deposited in the appropriate accounts. The Executive Director may transfer monies from the Savings Account into the Checking account when necessary. Checks are written monthly based on staff completed check request forms and/or regular approved vendor invoices each month to meet monthly Olympic Community of Health financial obligations, or ongoing operational expenditures. Monthly checking accounts statements are reconciled monthly and serve as an internal control to assure all entries have been made to the general ledger system and possibly discover bank errors or theft.

INVESTMENTS

Investments, if applicable, are reported with the financial statements at the market value. The Finance Committee evaluates the general investment strategy for organization's quarterly, to ensure the portfolio's proper diversification, security and return on investments. A summary of the strategy and results to plan are presented to the Board annually for review and possible revision.

FUND ACCOUNTING

In observance of limitations and restrictions placed on the use of resources available to Olympic Community of Health, the accounts of Olympic Community of Health are maintained in accordance with the principles of fund accounting. Under these procedures, resources for various purposes are classified for accounting and maintained for each fund.

SIGNATURE AUTHORIZATION

The Executive Director, the Board Treasurer, President, and Vice President are authorized to sign all checks, drafts, or orders for payment of money issued in the name of Olympic Community of Health and have signed required documents at Olympic Community of Health's bank.

All contracts, commitments for services in the name of Olympic Community of Health, and other legal obligations shall be signed by the Executive Director and at least one of the following: the Treasurer, President, or Vice President of the Board unless otherwise decided by the Board. The Executive Committee will review contracts over \$50,000 and, together with management, recommend approval by the Board of Directors. If, for some reason, this is not possible, then the Board authorizes the Executive Committee to approve these contracts with an immediate notice to the Board of Directors.

CASH OPERATIONS

Olympic Community of Health's bookkeeper and accountant maintain standard accounting records containing all aspects of Olympic Community of Health's financial operations. They include but are not limited to: A general ledger, a check register, and a payroll register.

REVENUE RECOGNITION

All contributions shall be recorded in accordance with GAAP, with specific attention to standards ASC 958-605-25. Contributions are recorded as pledged or received in accordance with ASC 958-605-25, and must be credited to the appropriate revenue lines as presented in the annual budget and coded with the appropriate account number as designated in Olympic Community of Health's Chart of Accounts.

CASH RECEIPTS

The following procedures for cash/checks received through the mail or given to an Organization Representative shall be in place: Mail is sorted by Olympic Community of Health's Host Organization. Mail is then distributed to the Olympic Community of Health Program Coordinator who will log them and then send checks immediately to the Executive Director for processing. Cash and checks are deposited in Olympic Community of Health bank account. A log of deposits is included in the bank register which is given to the Executive Director on a regular (weekly) basis for review of both deposits and all checks that have been written on the account.

A copy of the bank deposit slip is retained in chronological order with copies of the deposited checks. All cash and checks shall be deposited weekly.

Deposit tickets endorsed by the bank are forwarded to the Bookkeeper who records these transactions in the General Ledger. The Bookkeeper shall reconcile all logs of incoming cash/checks with the deposit slips to ensure that all cash has been deposited.

The same procedures followed for cash receipts shall be followed when monies are received by employees as contributions during Special Events.

RECEIPTS TO DONORS

All donors and contributors shall be properly acknowledged of their contributions in accordance with IRS Guidelines. The Executive Director shall ensure proper recognition of contributors and grantors, utilizing the financial reporting systems.

CASH DISBURSEMENTS

APPROVAL PROCESS

All expenditures shall be approved by a project director and then sent to the Executive Director for final approval. The Board shall authorize the Executive Director to make whatever purchases are needed for the day-to-day operation of Olympic Community of Health and in accordance with the approved annual organization budget and bylaws, which authorizes non-budgeted expenditures under \$5,000. All authorized expenditures shall be coded by account number using Olympic Community of Health's Chart of Accounts.

Any non-routine expenditure in excess of Two Thousand Five Hundred Dollars (\$2,500.00) for the purchase of a single item should have bids from three (3) suppliers if possible. For all fixed asset purchases, reasonable diligence should be exercised to comparatively shop for available sources.

Invoices shall be forwarded to the Executive Director for approval. Following the review and approval, the Executive Director will forward to the bookkeeper to log into Quickbooks and prepare checks and then forward them to the Executive Director for check signing. Upon payment of a bill, copy of the check or duplicate of stub shall be stapled onto the bill. The paid invoices and check stubs shall be filed by check number and kept in monthly folders. These folders are for use in preparing the monthly financial reports.

Voided checks shall be marked "VOID" boldly written in ink across the face of the check and the signature portion of the check will be torn off. The voided check shall be filed with other canceled checks upon review of documentation by the Treasurer.

REIMBURSEMENTS

Expenses pre-approved and directly related to Olympic Community of Health business activities (mileage, meals, hotel, supplies, etc.) will be reimbursed to employees upon submission of an Expense Reimbursement Form. The use of the Olympic Community of Health credit card(s) by Olympic Community of Health's Executive Director is authorized upon the discretion of the Executive Director. Monthly credit card expenditure reports and card invoices are reviewed and approved by the Treasurer and appropriate corresponding receipts will be attached for each expenditure.

PETTY CASH

Olympic Community of Health will not maintain any petty cash funds.

BANK RECONCILIATIONS

All Bank Statements, Credit Card Statements, and other required reporting will be downloaded by the hired CFO service provider (CFO) and accountant. Each month, the CFO will review and reconcile all statements before giving the reconciliation reports to the Executive Director for verification. All financial records will be kept in Olympic Community of Health's office. These monthly checking accounts statement reconciliations serve as an internal control to assure all entries have been made to the general ledger system and possibly discover bank errors or theft.

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Deleted: Bank reconciliations shall be completed monthly by the Executive Director and the bookkeeper. In addition, all Bank Statements, Credit Card Statements, and other required reporting are reconciled every month by the Bookkeeper

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A check outstanding for more than six (6) months will be voided with a possible stop payment request to the bank upon approval of the Executive Director. All voided checks will be kept on file whenever possible.

OTHER POLICIES & PROCEDURES

CONFIDENTIALITY AND RECORDS SECURITY

Financial records are restricted materials with limited access. Only the Executive Director, Program Coordinator, and the Treasurer (or others so authorized by the Board) shall have access to financial records (vendor files, checks, journals, payroll, etc.). All payments, transactions and invoices shall be filed with supporting documentation, and files should be kept confidential.

DEEDS, CONVEYANCES, LEASES & CONTRACTS

Olympic Community of Health leases space to conduct its normal business activities.

- ◆ Leases will correspond to the fiscal year whenever possible.
- ◆ Copies of all leases will be maintained in the Olympic Community of Health office.

DONATED MATERIALS AND SERVICES

Donated materials and equipment shall be reflected in the Financial Statements at their estimated values measured on the date of receipt.

DONOR-IMPOSED CONDITIONS

Transfers of assets and promises to give with donor-imposed conditions should be recognized as contribution revenue when the conditions have been substantially met or when the conditions have been explicitly waived by the donor, i.e. a contribution of cash or a promise to give cash in support of a proposed program should be recognized when the program is undertaken. Transfers of assets with donor-imposed conditions should be reported as refundable advances until the conditions have been substantially met. Transfers of assets on which resource providers have imposed conditions should be recognized as contributions if the likelihood of not meeting the conditions is remote.

DONOR-IMPOSED RESTRICTIONS

Contributions may be received with donor-imposed restrictions. Some restrictions may permanently limit Olympic Community of Health's use of contributed assets. Other restrictions are temporary in nature, limiting Olympic Community of Health's use of contributed assets to (a) a later period or after a specific date (a time restriction), (b) a specific purpose (a purpose restriction), or (c) both.

Restrictions may (a) be stipulated explicitly by the donor in a written or oral communication accompanying the contribution or (b) result implicitly from the circumstances surrounding receipt of the contributed asset – i.e. making a gift to a capital campaign. Contributions of unconditional promises to give with payments due in future periods should be reported as temporarily restricted contributions unless the donor expressly stipulated or circumstances

surrounding the receipt of the promise make clear that the donor intended it to be used to support activities of the current period.

Unconditional contributions received without donor-imposed restrictions should be reported as unrestricted support that increases unrestricted net assets. Unconditional contributions received with donor-imposed restrictions should be reported as restricted support that increases permanently restricted or temporarily restricted net assets, depending on the nature of the restriction.

GRANT CONTINGENCIES

Grants often require the fulfillment of certain conditions as set forth in the related instrument. Failure to fulfill the conditions could result in the return of funds to the grantors. It is the responsibility of the Executive Director to oversee the fulfillment of grant conditions. All grants shall be properly acknowledged in accordance to IRS regulations and all grantors shall be properly recognized.

INCOME TAXES

Olympic Community of Health intends to be exempt from federal income taxes under Section 501 (c) (3) of the Internal Revenue Code before filing taxes. Accordingly, for income tax purposes, we will operate as a nonprofit and reflect this in our financial statements. Olympic Community of Health tax ID is: 81-4591222.

INDEPENDENT AUDIT

Olympic Community of Health will have an audit of its financial statements annually, beginning in 2017.

The Treasurer shall recommend to the Board of Directors for approval, the selection of a firm to conduct the annual Olympic Community of Health audit. In addition, the Finance Committee shall assist when necessary in the audit preparation, and report the final results to the Board of Directors. A representative of the audit firm will be invited to attend a Board Meeting to make a presentation to the Board if the audit report is other than unqualified, or if the auditors report material weaknesses in internal controls or reportable conditions.

All reports which result from reviews of audits of the accounting and other financial systems will be routed immediately to the Executive Director, who will then share this information with the Board of Directors. The Executive Director will be responsible for preparing any needed written response to the review or audit recommendations. She/he will be responsible for providing any necessary corrective action. The auditor or other reviewing agency will be notified within three months of the issuance of the recommendations of the actions that will be taken by the agency and the projected timetable for these actions.

INSURANCE AND BONDING

Reasonable and adequate coverage is maintained to protect Olympic Community of Health's interests as well as the Board of Directors. The following insurance policies shall be kept on a

yearly basis: General Liability Insurance, Directors and Officers Liability Insurance, Workers Compensation Insurance, and Employees Health Insurance and Dental Insurance.

Insurance policies shall be maintained with the insurance files on a yearly basis. Insurance policies shall correspond to the fiscal year whenever possible. Insurance Policies shall be reviewed by Olympic Community of Health's Executive Director before renewal each year.

PAYROLL-RELATED TRANSACTIONS

Payroll is executed monthly (on the fifth day of the following month of work) using a payroll service. Time is entered into a timekeeping system, approved by the Executive Director weekly, then reported to the payroll service for payment to individual staff. Direct deposit of payroll to individual staff bank accounts will be the preferred method of payment, once available. Our payroll service provides on line payroll reports that are in turn reconciled with checking account reports by Olympic Community of Health Executive Director.

It shall be the responsibility of the Executive Director to ensure that existing employees who resign, are terminated or who are retiring pay any amounts due to Olympic Community of Health, and return all Olympic Community of Health property before a final paycheck is issued.

Each Olympic Community of Health staff person completes a timesheet using our online timekeeping system documenting daily hours worked on each assigned project and these on-line timesheets are used in preparing the monthly financial statements and grant reporting requirements.

PROPERTY AND EQUIPMENT

Property and equipment shall be stated at historical cost. Depreciation is computed over the estimated useful lives of the assets using the straight-line method. A Depreciation schedule shall be prepared and implemented by Olympic Community of Health's accountant on an annual basis, taking into consideration the annual equipment inventory.

TRAVEL

Travel expense reports for authorized local and out of state travel are completed by each employee, as appropriate and then submitted to the Executive Director for payment on a monthly basis. Mileage to and from the employee's residence to the place of work is not be paid by Olympic Community of Health. Parking expenses are reimbursable if a staff person is required to use their personal automobile for a work related reason. Mileage reimbursements will be based on the travel rate established annually by the IRS. Travel to out of state trainings, conferences and meetings must have prior approval by the Executive Director. The annual budgeting process includes funding for projected necessary staff travel and training and is approved by the Board of Directors. At the conclusion of approved travel, staff must attach expenditure receipts to the reimbursement request as a condition of payment. All reimbursement requests are reviewed and approved by the Executive Director. Expense reports for the Executive Director will be approved by the Board President.

A Board Member traveling to represent Olympic Community of Health as authorized by the Board of Directors to assist in Organization business will be reimbursed for travel and expenses in the same manner that staff members are reimbursed. These expenditures will be approved by the Board President, unless the travel is for the Board President, in which case the Vice President or Treasurer are also authorized to approve these expenditures.

RECORDS RETENTION

The following fiscal and personnel records shall be retained in Olympic Community of Health office files for a minimum of seven years following the end of a fiscal year (December 31st):

- Check registers, warrants or vouchers accounting for payments/expenses. Supporting documentation including original invoices and receipts
- Cash reconciliations for bank accounts from the bank statement to general ledger
- Any Investment reports
- Personnel files including required proof of citizenship or resident status, IRS withholding forms, emergency contact information
- Travel and other authorized expenses
- Payroll records
- Monthly and YTD budget, expense and revenue reports
- Copies of Bank deposit slips with copies of checks
- Monthly expense reports and copies of invoices submitted to funders
- Accounts payable and accounts receivable, including aging reports
- Capital Equipment inventory and depreciation schedules
- Contracts specifying services, duration and rate of compensation

Olympic Community of Health

Charter

Approved by the Board of Directors June 1, 2016; Revised and approved by the Board of Directors August 14, 2017
Officers elected July 6, 2016 by the Board of Directors; Officers re-elected July 10, 2017 by the Board of Directors

Executive Committee Charter Members

Name	Role	Agency or Affiliation
1 Roy Walker	President	Executive Director, Olympic Area on Aging
2 Jennifer Kreidler-Moss, PharmD	Vice President	CEO, Peninsula Community Health Services
3 Leonard Forsman	Secretary	Tribal Chair, Suquamish Tribe
4 Hilary Whittington	Treasurer	CFO, Jefferson Healthcare
5 Joe Roszak	At-Large	Executive Director, Kitsap Mental Health Services

Executive Committee Purpose

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

Executive Committee Operating Principles

- Committee membership will be comprised of five officer positions: President, Vice-President, Secretary, Treasurer, and At-Large (to be replaced by the immediate 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.
- Executive Committee members will be held to term limits outlined in the bylaws.
- The Executive Committee shall be accountable to the OCH Board and shall present all recommendations and actions for review at their next meeting.

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Responsibilities

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

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Timeline

The Executive Committee shall meet as needed.

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Executive Committee Charter

Approved by OCH Board August 14, 2017

Olympic Community of Health

Portfolio Recommendation Phase II

Recommended by the Executive Committee at the July 25, 2017 meeting

Presented to the Board of Directors at the August 14, 2017 meeting

Recap: Phase I Portfolio Recommendation (Approved July 10 Board Meeting)

- Do not submit Pathways project plan. Instead, begin pilot for Apple Integrator.
- Begin compiling* project plans for *FLAGSHIP PROJECTS*:
 1. 2A. Bi-Directional Integration and Primary Care Transformation
 2. 3A. Addressing the Opioid Crisis
 3. 2D. Diversion: Outward Bound
 4. 3D. Chronic Disease Prevention and Control (includes Chronic Care Model and Breathe Easy)

Summary: Phase II Portfolio Recommendation

- Move forward with **six projects categories**
- Add **Access to Oral Health Services** and **Maternal and Child Health** to the portfolio
- **Do not submit a project plan for the Transitional Care** project category.
- **Move Crossroads** (community health workers in jail) **into Diversion** project category
- **Refocus Maternal and Child Health** project on evidence-based program that will impact all P4P metrics

September Board Meeting

Explore remaining evidence-based diversion programs. Present further analysis on potential for these projects to impact the P4P measures and be sustained after the Demonstration.

- Diversion: Law Enforcement-Assisted Diversion (LEAD)
- Diversion: Community Paramedicine

RATIONALE: Why at six projects?

The number of projects impacts the amount of DSRIP funds we are eligible to earn in 2018. See scenarios below, based solely on project plan score and number of projects submitted.

Scenario	A	B	C	D	E
	Number of projects submitted	Project Plan Score	Eligible to Receive Unearned Funds	Earnable OCH 2018 DSRIP Funds	Lost Revenue
1	4	60%	No	\$3,732,000	(\$2,488,000)
2	5	60%	No	\$4,043,000	(\$2,177,000)
3	6	60%	Yes	\$4,354,000	(\$1,866,000)
4	4	80%	No	\$4,976,000	(\$1,244,000)
5	5	80%	No	\$5,287,000	(\$933,000)
6	6	80%	Yes	\$5,598,000	(\$622,000)
7	4	90%	No	\$5,598,000	(\$622,000)
8	5	90%	No	\$5,909,000	(\$311,000)
9	6	90%	Yes	\$6,220,000	\$0

Scenario for DSRIP maximum potential funding across the project categories – assuming a 90% score on the Project Plan Submission Assumes Six Projects (Exclude Pathways and Transitional Care)

DSRIP Project Pool Incentive Awards												
Project Categories	Total	2017	2018.1	2018.2	2019.1	2019.2	2020.1	2020.2	2021.1	2021.2		
Project Plan Assessment - "Year 1" Award	\$6,220,000	\$6,220,000										
2a - Bi-directional Integration of Care and Primary Care Transformation	\$15,813,000		\$2,141,500	\$2,141,500	\$1,582,100	\$2,636,900	\$978,500	\$2,935,500	\$424,600	\$2,972,400		
2B - Community-Based Care Coordination	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0		
2C - Transitional Care	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0		
2D - Diversion Interventions	\$6,424,100		\$870,000	\$870,000	\$642,800	\$1,071,300	\$397,500	\$1,192,500	\$172,500	\$1,207,500		
3A - Addressing the Opioid Use Public Health Crisis	\$1,976,000		\$267,500	\$267,500	\$197,625	\$329,375	\$122,250	\$366,750	\$53,125	\$371,875		
3B - Maternal and Child Health	\$2,471,000		\$334,500	\$334,500	\$247,125	\$411,875	\$153,000	\$459,000	\$66,375	\$464,625		
3C - Access to Oral Health Services	\$1,483,000		\$201,000	\$201,000	\$148,500	\$247,500	\$91,750	\$275,250	\$39,750	\$278,250		
3D - Chronic Disease Prevention and Control	\$3,953,000		\$535,500	\$535,500	\$395,625	\$659,375	\$244,500	\$733,500	\$106,125	\$742,875		
Total Project Incentive Pool Awards	\$38,340,100	\$6,220,000	\$4,350,000	\$4,350,000	\$3,213,775	\$5,356,325	\$1,987,500	\$5,962,500	\$862,475	\$6,037,525		
Lost Potential Project Incentive Pool Funding due to Project Plan Score	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0		
Lost Potential Project Incentive Pool Funding due to Performance	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0		

Phase I: Portfolio Summary (Approved July 10, 2017)

Project	Status	Transformation	Evidence-Base	Recommendation	Rationale	Baseline Assessment
2A. Bi-Directional Integration	Board voted FLAGSHIP 7.10.17 *Required*	Practice	Bree Collaborative; Collaborative Care Model; Millbank Report	Move forward with assessment. Tailor approach to each community of care. Build off existing momentum and innovation.	Required. High need. Strong willingness.	Mental health treatment penetration: OCH 44% vs. State 43% SUD treatment penetration: OCH 28% vs. State 27% Anti-depression Rx Management (acute): OCH 53% vs. State 52% Anti-depression Rx Management (cont.): OCH 36% vs. State 33%
3A. Opioid Response	Board voted FLAGSHIP 7.10.17 *Required*	Practice Systems	State's Interagency Plan; Six Building Blocks; CDC guidelines; AMDG guidelines	Continue with momentum from Three-County Coordinated Opioid Response Project	Required. High need. Strong willingness.	Medication assisted therapy OCH 17% vs. State 27% Patients on high dose chronic opioid Rx OCH 20% vs. State 20%
2.D. Diversion	Board voted FLAGSHIP 7.10.17	Workforce Clinical-community linkage	ER is for emergencies; Community health workers in ED	Move forward as flagship project	Low performers in ED utilization. Opportunity for workforce development.	Outpatient ED visits/1000 MM (18yo+) OCH 89 vs. State 68 Outpatient ED visits/1000 MM (< 18 yo) OCH 46 vs. State 37 Percent arrested OCH 6% vs. State 7%
3.D. Chronic Disease	Board voted FLAGSHIP 7.10.17	Practice Systems	Chronic Care Model; Stanford Chronic Disease Self-Management; Diabetes Prevention Program; Asthma home visiting/healthy homes	Move forward as flagship project	Emphasis on practice transformation. Strong willingness from clinical and non-clinical providers. Good preparation for value-based contracting.	Diabetes care: nephropathy OCH 83% vs. State 86% Diabetes care: HbA1c OCH 83% vs. State 84% Med Management for asthma OCH 29% vs. State 28%
Domain 1. Population Health Management/I.T.	Board voted to pilot Apple Integrator 7.10.17	Systems	Cloud-based e-referral and eventually care coordination system	Pilot first use case	Can do Pathways later. Create a community health shared information network. Supports entire portfolio. Right-sized and can be scaled. Can learn quickly what works.	Not applicable Depends on use case

Phase II: Portfolio Recommendation (August 14, 2017)

Project	Status	Transformation	Evidence-Base	Recommendation	Rationale	Baseline Assessment
2C. Transitional Care from Hospitals and Jails	Board voting 8.14.2017	Systems Workforce	Care Transitions Intervention	Do not move forward	Region performs well on measures. Will be challenging to earn incentives. Low volume of Medicaid hospitalization.	Plan all cause readmission rate OCH 14% vs. State 15% Follow-up after hospitalization for mental illness (7 days) OCH 72% vs. State 72.4% Follow-up after hospitalization for mental illness (30 days) OCH 84.5% vs. State 87.8%
	Board voting 8.14.2017	Systems Workforce	Jail Transitions	Do not move forward as "Transitional Care". Move into Diversion.	Strong community support but will not impact all measures in "Transitional Care" category. Rebase Transitional care DSRIP funds into other project categories	
3B. Reproductive Health, Child, and	Board voting 8.14.2017	Practice Systems Workforce	Bright Futures	Original proposal was to expand Nurse Family Partnership and Parents as Teachers. Recommend Bright Futures to refer to/from programs.	Original proposal will not move measures; therefore, project will not be sustained throughout the demonstration.	Childhood immunization status OCH 10% vs. State 12% Chlamydia screening OCH 49% vs. State 51% Contraceptive care – access to LARC OCH 7% vs. State 8% Contraceptive care – access to effective methods OCH 33% vs. State 8% Prenatal care in first trimester OCH 63% vs. State 65%
	Board voting 8.14.2017	Practice Systems Workforce	Expansion of FQHC dental; dental hygiene services in long term care settings; expansion of school based clinics; oral- primary care integration	Combine and move forward	Strong community interest. Strong community need. Project partners can deliver.	Dental sealants for high-risk kids (6-9yo) OCH 43.2% vs. State 37.9% Dental sealants for high-risk kids (10-14 yo) OCH 17.8% vs. State 14.7% Primary caries prevention as part of well child visit OCH 0.1% vs. State 0.4%
3C. Access to Oral Health Services	Board voting 8.14.2017	Practice Systems Workforce				

Project	Status	Transformation	Evidence-Base	Recommendation	Rationale	Baseline Assessment
2.D. Diversion	Board voting 8.14.2017	System Workforce	Jail Diversion Community health workers in jails	Move forward	Strong community support. Originally recommended in “Transitions” category. Better fit in “Diversion” as an extension of Outward Bound (CHWs in ED).	Outpatient ED visits/1000 MM (18yo+) OCH 89 vs. State 68 Outpatient ED visits/1000 MM (< 18 yo) OCH 46 vs. State 37 Percent arrested OCH 6% vs. State 7% Percent homeless OCH 5% vs. State 5%
	Board voting 9.11.2017	System Workforce	Community Paramedicine	Hold for vote in September: Phase III	Staff evaluating potential pilots and exploring sustainability mechanisms following the Demonstration	
	Board voting 9.11.2017	System Workforce	Law Enforcement Assisted Diversion			

OCH Baseline Status on Available Toolkit Measures, updated August 7, 2017											Assessment of OCH Performance by Demonstration Yr													
Name	OCH Notes	OCH value	numerator	denominator	State value	Data source, date	Measure Description	Statewide Accountability Measure	Method for Assessment of ACH Performance: Gap to Goal, Improvement Over Self	Reporting Responsibility	DY 3 (2019)	DY 4 (2020)	DY 5 (2021)	Associated Project Areas	Integration	Pathways	Transitions	Diversion	Opioids	MCH	Oral Health	Chronic dz	SAM	
Antidepressant Medication Management	Acute and continuation measures available	Acute=53% Cont=36%	Acute=1072 Cont=704		Acute=52% Cont=33%	HCA dashboard 10/1/15-9/30/16; numerator RHN1 p3, 2015	The percentage of Medicaid enrollees 18 years of age and older with a diagnosis of major depression and were newly treated with an antidepressant medication, and who remained on an antidepressant medication treatment.	Y	Gap to Goal	State (HCA)	P4P	P4P	P4P	2.a	x									
Utilization of Dental Services by Medicaid Beneficiaries	all ages	overall=30% preventive=21%	overall=29671 prev=20483	both=99081	overall=38% prev=29%	HCA	Dental service utilization among eligible members; reported separately: overall services and preventative services, by age. Percent of Medicaid enrollees with a mental health service need who received at least one qualifying service during the measurement year. Separate reporting by age groups: 12-17 years and 18-64 years.	N	Improvement over self	State (HCA)	P4P	P4P	P4P	3.c			x							
Mental Health Treatment Penetration (Broad Version)	all ages, includes duals	44%	7904	17861	43%	RDA decomp, 2015	The percentage of Medicaid enrollees with a substance use disorder treatment need who received substance use disorder treatment in the measurement year. Separate reporting by age groups: 12-17 years and 18-64 years. The percentage of Medicaid enrollees 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure (BP) reading is <140/90 mm Hg. The percentage of Medicaid enrollees 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control).	Y	Improvement over self	State (DSHS-RDA)	P4P	P4P	P4P	2.a, 2.b, 3.b		x				x				
Substance Use Disorder Treatment Penetration	all ages, includes duals	28%	2237	7949	27%	RDA decomp, 2015	The percentage of Medicaid enrollees 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. The percentage of Medicaid enrollees age 312 who were screened for clinical depression using a standardized tool and, if screened positive, who received appropriate follow-up care. This measure is adapted from a provider-level measure stewarded by CHS (NQF 0418). Planned for HEDIS implementation in 2018.	Y	NA	State	NA	NA	NA	NA: Statewide Accountability Measure			x							
Comprehensive Diabetes Care: Blood Pressure Control	HCA has not released							Y	NA	State	NA	NA	NA	NA: Statewide Accountability Measure									x	
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	HCA has not released							Y	NA	State	NA	NA	NA	NA: Statewide Accountability Measure									x	
Controlling High Blood Pressure	HCA has not released							Y	NA	State	NA	NA	NA	NA: Statewide Accountability Measure									x	
Depression Screening and Follow-up for Adolescents and Adults	HCA has not released							N	Improvement over self	ACH	Inactive	P4R	P4R	2.a		x								
Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence	HCA has not released							N	Gap to goal	State (DSHS-RDA)	Inactive	P4P	P4P	2.a, 2.b, 2.c		x		x						
Inpatient Hospital Utilization	HCA has not released							N	Improvement over self	State (HCA)	Inactive	P4P	P4P	2.a, 2.b, 2.c, 3.a, 3.d		x		x					x	
Ongoing Care in Adults with Chronic Periodontitis	HCA has not released							N	Improvement over self	State (HCA)	Inactive	P4P	P4P	3.c			x							
Patients with concurrent sedatives prescriptions	HCA has not released							N	Improvement over self	State (HCA)	P4P	P4P	P4P	3.a					x					
Periodontal Evaluation in Adults with Chronic Periodontitis	HCA has not released							N	Improvement over self	State (HCA)	Inactive	P4P	P4P	3.c							x			
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	HCA has not released							N	Improvement over self	State (HCA)	Inactive	P4P	P4P	3.d									x	
Substance Use Disorder Treatment Penetration (Opioid)	HCA has not released							N	Improvement over self	State (DSHS-RDA)	Inactive	P4P	P4P	3.a		x								

OCH Baseline Status on Available Toolkit Measures, updated August 7, 2017											Assessment of OCH Performance by Demonstration Yr												
Name	OCH Notes	OCH value	numerator	denominator	State value	Data source, date	Measure Description	Statewide Accountability Measure	Method for Assessment of ACH Performance: Gap to Goal, Improvement Over Self	Reporting Responsibility	DY 3 (2019)	DY 4 (2020)	DY 5 (2021)	Associated Project Areas	Integration	Pathways	Transitions	Diversion	Opioids	MCH	Oral Health	Chronic dz	SAM
Well-Child Visits in the First 15 Months of Life	HCA has not released						The percentage of Medicaid-covered children 15 months old enrolled in Medicaid who had their recommended number of well-child visits with a primary care provider during their first 15 months of life.	N	Gap to Goal	State (HCA)	Inactive	P4P	P4P	3.b		X							
Medication Assisted Therapy (MAT): With Buprenorphine or Methadone	HCA provided a separate count for Bup and Methadone	17%	330 Bup; 115 Methadone	2636	27%	RHNI phase 3 opioid data, FY2016	The count and percentage of Medicaid members with a documented diagnosis of opioid abuse/dependence who are engaged in Medication Assisted Treatment (MAT): Buprenorphine or Methadone.	N	Improvement over self	State (HCA)	P4P	P4P	P4P	3.a					X				
Childhood Immunization Status	HCA RHNI p3 data for this measure are from 2015; definition changed and 2016 rates are much lower	10%			12%	HCA dashboard 2016	Percentage of children 2 years of age who received the combo 10-HEDS vaccine series (4DTaP/DT/Td, 3 Hib, 3 polio, 3 Hep B, 1 MMR, 1 Varicella, 2 Hep A, 2 flu, 4 PCV, 2 rotavirus) during the measurement period.	N	Gap to goal	State (DOH)	Inactive	P4P	P4P	3.b						X			
Contraceptive Care – Postpartum	HCA RHNI p3 had 2 separate measures; toolkit definition appears to be a combination	Most/mod=36.9% LARC=9.4%	most/mod=445 LARC=113	1205 for both	Most/mod=41.2% LARC=15.8%	HCA RHNI p3, 2015	Among female Medicaid enrollees ages 15 through 44 who had a live birth, the percentage that is provided: 1) A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery. 2) A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.	N	Improvement over self	State (HCA)	Inactive	P4P	P4P	3.b						X			
Chlamydia Screening in Women Ages 16 to 24	not sure of age range of data from HCA (WA Hlth Alliance) rates are for ages 0-17 and 18+, ages 10-17, 18-64 and 65+ not available	49%			51%	HCA RHNI p3, 7/14-6/15	The percentage of female Medicaid enrollees 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	N	Gap to Goal	State (HCA)	P4P	P4P	P4P	3.b							X		
Outpatient Emergency Department Visits per 1000 Member Months		0-17=46 per 1000MM 18+=89 per 1000MM			0-17=37 per 1000MM 18+=68 per 1000MM	Dashboard, 10/1/15-9/30/16	The rate of Medicaid enrollee visits to emergency department per 1000 member months, including visits related to mental health and chemical dependency. Separate reporting for age groups 10-17, 18-64, and 65+.	Y	Improvement over self	State (HCA)	P4P	P4P	P4P	2.a, 2.b, 2.c, 2.d, 3.a, 3.b, 3.c, 3.d	X	X	X	X		X	X		X
Follow-up After Hospitalization for Mental Illness	RDA decomp is for age 18-64; toolkit measure is 6+	7d=72% 30d=84.5%	7d=172 30d=202	7d=239 30d=239	7d=72.4% 30d=87.8%	RDA decomp, 2015	The percentage of discharges for Medicaid enrollees 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: (1) The percentage of discharges for enrollees who received follow-up within 30 days of discharge; (2) The percentage of discharges the enrollees who received follow-up within 7 days of discharge.	N	Gap to goal	State (DSHS-RDA)	Inactive	P4P	P4P	2.a, 2.b, 2.c	X	X	X						
Patients on high-dose chronic opioid therapy by varying thresholds	used no cancer history denominator; #s are for >50MED, >90 not available	20%	2247	11488	20%	RHNI phase 3 opioid data, FY2016	Measure specification in development. Among Medicaid enrollees, the percentage of chronic opioid therapy patients receiving doses: >50 mg MED in a quarter, doses >90 mg MED in a quarter.	N	Improvement over self	State (HCA)	P4P	P4P	P4P	3.a					X				
Child and Adolescents' Access to Primary Care Practitioners		12-24mo: 99% 2-6 yr: 86% 7-11 yr: 90% 12-19 yr: 91%			12-24mo: 94% 2-6 yr: 86% 7-11 yr: 91% 12-19 yr: 90%	HCA dashboard 10/1/15-9/30/16	Percent of children enrolled in Medicaid who had a visit with a primary care provider. Reported separately for the following age groups: 12-24 months, 2-6 years, 7-11 years, and 12-19 years.	N	Gap to Goal	State (HCA)	P4P	P4P	P4P	2.a, 3.d	X								X
Comprehensive Diabetes Care: Eye Exam (retinal) performed		29%	519		31%	HCA dashboard 10/1/15-9/30/16; numerator RHIP3, 2015	Percentage of Medicaid enrollees 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.	N	Gap to Goal	State (HCA)	Inactive	P4P	P4P	2.a, 3.d	X							X	
Comprehensive Diabetes Care: Hemoglobin A1c Testing		83%	1556		84%	HCA dashboard 10/1/15-9/30/16; numerator RHIP3, 2015	The percentage of Medicaid enrollees 18–75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	N	Gap to Goal	State (HCA)	P4P	P4P	P4P	2.a, 3.d	X								X
Comprehensive Diabetes Care: Medical Attention for Nephropathy		83%	1610		86%	HCA dashboard 10/1/15-9/30/16; numerator RHIP3, 2015	The percentage of Medicaid enrollees 18–75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	N	Gap to Goal	State (HCA)	P4P	P4P	P4P	2.a, 3.d	X								X
Contraceptive Care – Access to LARC		7%	1003	13664	8%	HCA RHNI p3, 2015	Percentage of female Medicaid enrollees aged 15-44 years at risk of unintended pregnancy that is provided a long-acting reversible method of contraception (i.e., implants, intrauterine devices or systems (IUD/IUS).	N	Improvement over self	State (DSHS-RDA)	Inactive	P4P	P4P	3.b							X		

OCH Baseline Status on Available Toolkit Measures, updated August 7, 2017										Assessment of OCH Performance by Demonstration Yr													
Name	OCH Notes	OCH value	numerator	denominator	State value	Data source, date	Measure Description	Statewide Accountability Measure	Method for Assessment of ACH Performance: Gap to Goal, Improvement Over Self	Reporting Responsibility	DY 3 (2019)	DY 4 (2020)	DY 5 (2021)	Associated Project Areas	Integration	Pathways	Transitions	Diversion	Opioids	MCH	Oral Health	Chronic dz	SAM
Contraceptive Care – Most & Moderately Effective Methods		33%	4518	13664	31%	HCA RHNI p3, 2015	Percentage of female Medicaid enrollees aged 15-44 years at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved methods of contraception.	N	Improvement over self	State (HCA)	Inactive	P4P	P4P	3.b						X			
Dental Sealants for Children at Elevated Caries Risk	ages 9=43.2% age10-14=17.8%		ages 9=707 age10-14=253	ages 9=1638 age10-14=1421	ages 9=37.9% age10-14=14.7%	HCA WDSF xslx, FY 2016	Percentage of children enrolled in Medicaid in at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent first molar tooth within the reporting year. Reported separately by age category: 6-9 years, 10-14 years.	N	Improvement over self	State (HCA)	Inactive	P4P	P4P	3.c							X		
Medication Management for People with Asthma (5 – 64 Years)		29%			28%	HCA dashboard, 10/1/15-9/30/16	The percentage of Medicaid enrollees 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.	Y	Gap to Goal	State (HCA)	P4P	P4P	P4P	2.a, 3.d	X								X
Percent Arrested		6%	2414	38529	7%	RDA decomp, 2015	Percent of Medicaid enrollees who were arrested at least once during the measurement year.	N	Improvement over self	State (DSHS-RDA)	Inactive	P4P	P4P	2.d				X					
Percent Homeless (Narrow Definition)		5%	2015	38928	5%	RDA decomp, 2015	Percent of Medicaid enrollees who were homeless in at least one month in the measurement year. Excludes “homeless with housing” ACES living arrangement code	N	Improvement over self	State (DSHS-RDA)	P4P	P4P	P4P	2.b, 2.c, 2.d		X		X					
Plan All-Cause Readmission Rate (30 Days)		14%			15%	HCA dashboard, 7/1/15-6/30/16	The proportion of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission within 30 days among Medicaid enrollees ages 18-64 years old.	Y	Gap to Goal	State (DSHS-RDA)	P4P	P4P	P4P	2.a, 2.b, 2.c	X		X						
Prenatal care in the first trimester of pregnancy		63%	1013	1620	65%	HCA RHNI p3, 2015	Percentage of pregnant women enrolled in Medicaid who began prenatal care in the first trimester of pregnancy during the measurement period.	N	Gap to Goal	State (DSHS-RDA)	Inactive	P4P	P4P	3.b						X			
Primary Caries Prevention Intervention as Part of Well/In Child Care as Offered by Primary Care Medical Providers		0.1%	3	5376	0.4%	HCA WDSF xslx, FY 2016	Among eligible Medicaid enrollees, the measure quantifies a) the application of fluoride varnish (FV) as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) examination by the PCMP or clinic and b) each billing entity’s use of the EPSDT with FV codes increases from year to year.	N	Improvement over self	State (HCA)	P4P	P4P	P4P	3.c							X		
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life		59%	3729		61%	HCA dashboard, 10/1/15-9/30/16, numerator RHNI p3, 2015	The percentage of Medicaid-covered children 3-6 years of age who had one or more well-child visits with a primary care provider during the measurement year.	Y	Gap to Goal	State (HCA)	P4P	P4P	P4P	3.b									

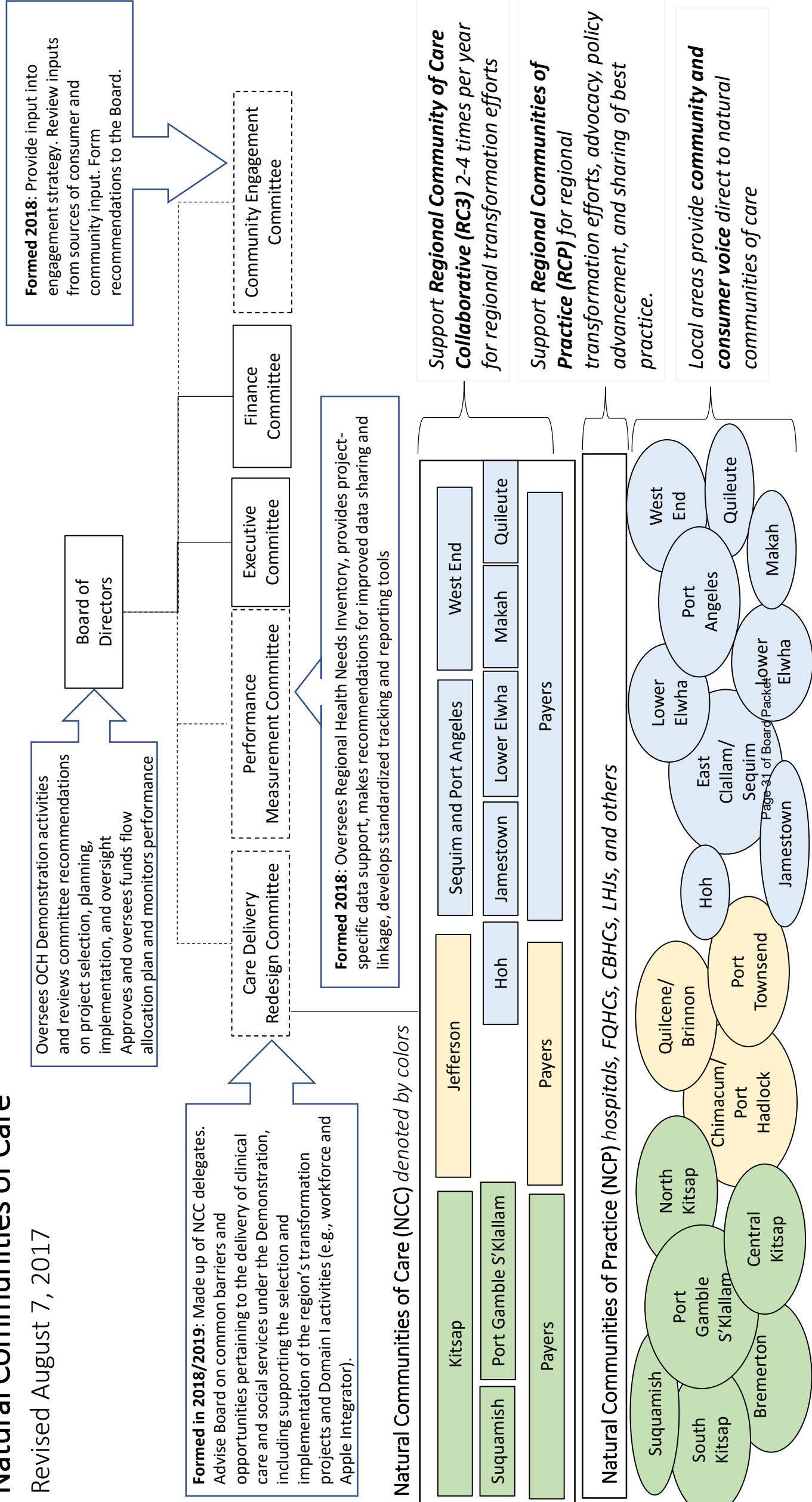
Purpose: The purpose of this S.W.O.T. analysis is design our strategy to submitting a competitive, high-quality project plan in November. The strategy under question is whether to contract with a DSRIP consulting firm. The role of the firm would be to help strategize and write the OCH project plan due November 2017. Examples of firms include: Health Management Associates, MS Hall and Associates, COPE Health Solutions, and KPMG. Nearly all ACHs have, or plan to have, a contract with at least one of these firms (HMA and KPMG) for this purpose.

	Helpful	Harmful
Internal	S.trengths - Would add needed capacity and skill set - OCH has had considerable challenges staffing up	W.eaknesses - Managing the contract will add additional duties and attention - Extremely expensive (≥\$100,000)
External	O.pportunities - Firms have DSRIP experience from New York - Increased score of Project Plan submission and associated earnable DSRIP revenue	T.hreats - Firm may provide same or similar advice to multiple ACHs, undermining competitive edge - Firm may lack bandwidth to provide attention and focus due to multiple ACH contracts with same demands and timelines - Undermine community’s expertise, trust and ownership in process

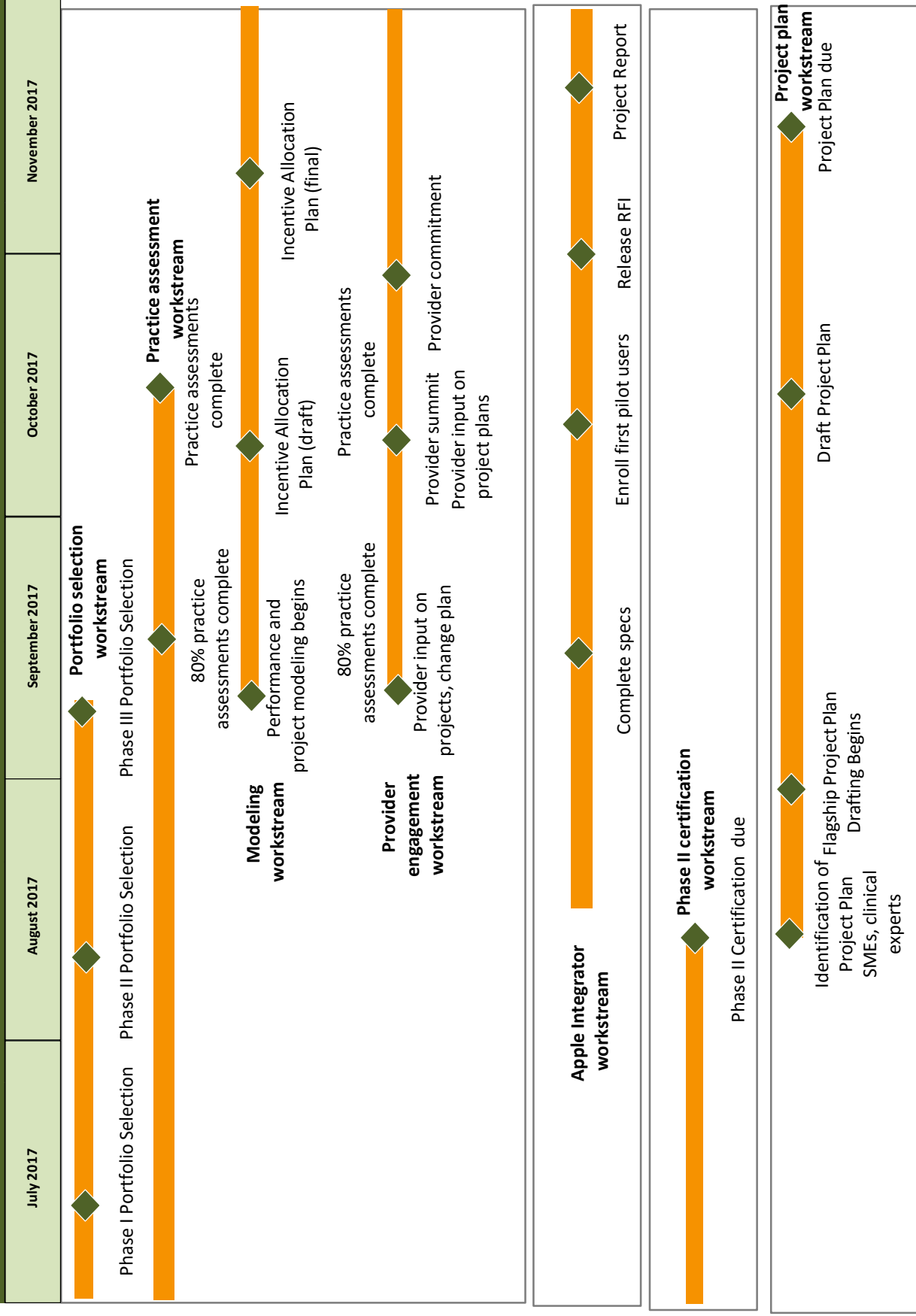
Recommendation from staff: Do not pursue a contract with a firm at this time. May need assistance with funds flow in 2018.

Natural Communities of Care

Revised August 7, 2017



Olympic Community of Health Demonstration Workplan



Olympic Community of Health

S.B.A.R. Technical Assistance to Prepare for Value-Based Contracting

Presented to the Board of Directors August 14, 2017

Situation

Under the Demonstration, the ACHs are held to the adoption of regional strategies to support attainment of, and readiness to, achieve value-based payment (VBP) targets (2019: 80%, 2021: 90%). ACHs have no authority over providers or payers to achieve these targets.

Background

The MCO role on the OCH has been participating on Boards and committees. During and after the Demonstration, the MCO role will have an active role as a contracting VBP partner. Preparing for VBP will be a challenge in our region:

- Clallam (mostly 1 MCO present): New to managed care and therefore new to MCO value-based contracting
- Jefferson (mostly 2 MCOs present): Small number of Medicaid lives (7,600)
- Kitsap (5 MCOs present): Varying levels of readiness between providers

County commissioners elected to not be a mid-adopter of fully integrated managed care. The associated \$5 million-dollar mid-adopter incentive for the region was reabsorbed into the VBP incentive pool (\$169 million). One-third of these will be distributed to the MCO Challenge Pool and two-thirds to the Reinvestment Pool for participating providers.

Action

Invite the MCOs *off the bench* to actively support providers prepare for planned changes in health care financing. Invite commercial payers and the Salish Behavioral Health Organization to also participate. **Goal: providers prepare for and ultimately succeed in providing value-based care, creating a win-win-win for providers, payers, and patients.**

Proposed Recommendation

Convene a taskforce to develop a concept paper that outlines several options for how payers can provide technical assistance (TA) to providers for value-based contracting. Recommend the concept paper include, at a minimum:

1. Guiding principles of process & definition of success
2. Definition of a minimum set of standardized VBP TA for the region
3. Menu of potential, customizable TA options
4. Mechanism to implement plan
5. Role of OCH

Recommend that the taskforce has representation from each county, urban and rural providers, and, at a minimum, the following sectors:

1. Hospital
2. Federally qualified health clinic
3. Community behavioral health clinic
4. Tribal clinic
5. Salish Behavioral Health Organization
6. MCOs

S.B.A.R. Apple Integrator Pilot Recommendation

Presented to the Board of Directors August 14, 2017

Situation

Staff is requesting Board decision on the first use case and authorization to contract for an Apple Integrator pilot.

Background

In July, the Board authorized moving forward with an Apple Integrator Pilot. Since, staff identified an I.T. contractor, Rob Arnold, and convened a subcommittee to identify options for a first use case. The short-term goal of the pilot is to show value and build confidence before the project plan is submitted in November 2017. The long-term goal of A.I. is to help connect people to the care they need while also streamlining workflows for providers.

Action: Contenders for 1st use case:

E-Referral Use Case Pilot	Reason for	Project Risks/Reason Against	Strategies to Mitigate Risks
1. Opioid Use Disorder a) Medication Assisted Treatment (MAT) Providers ↔ Substance Use Disorder (SUD) Treatment Providers b) Jail/correctional providers → MAT and SUD providers c) EMS/first responders → MAT and SUD providers	- High need - Consensus among partners - Leverage existing infrastructure (Opioid Treatment Workgroup) - Easy to add additional referrals to elder services, housing services, etc...	- More complicated use case/IT integration points to support in the pilot test - Requires 42 CFR part two to be designed into test system - Extends cost and timeline	- Will follow “minimally viable” development methodology to create and test use case - Will limit use case/test variables to manage costs and schedule
2. Maternal and Child Health Clinical providers ↔ community-based services	- Focus on prevention - Break intergenerational cycle of adverse childhood events (ACE) - Willing partners	- Need is not as urgent as opioid crisis	- Will focus on high risk/ need users first

Proposed Recommendation

- Board asks the Opioid Treatment Workgroup to identify a minimally viable set of MAT and SUD providers to pilot A.I.
- Board authorizes the Executive Director to enter into a six-month contract with Rob Arnold (est. \$45,000) and various software and cloud-based vendors (est. \$135,000) to pilot A.I. drawing down Design Funds (total est. contracted amount not to exceed \$180,000).

Rob Arnold-Project Portfolio

4641 225th Ave SE, Sammamish, WA 98075 | 425-246-7068 | roba@quadaimpartners.com

Skills

- I know healthcare and technology—I understand what it takes to build great teams, great products and deliver them to successfully to the market
- Ability to bring different points of views together and align teams to common mission/goal
- Incredibly fortunate to be surrounded by exceptional people with a passion and determination to make healthcare affordable healthcare accessible by all

Healthcare Consulting Experience

HEALTHCARE INNOVATION CONSULTANT | JANUARY 2012-PRESENT

Executive in Residence-University of WA and Oregon Health Science University-Present

- Business Advisory Programs
 - Foster School Health Innovation Challenge
 - Healthcare Industry Essentials Certificate Advisory Board
 - IT Commercialization Committee
 - Instructor, CoMotion Innovation Workshop
- Clinical/Technical Programs
 - Engineering in Medicine
 - Primary Care Innovation Lab
 - Surgical Outcomes Research Team
 - TelePain Virtual Care Program
 - Digital Health Innovation Group

Board Member and Investor- TransformativeMed | (www.transformativemed.com)-Present

- Helping develop business strategy and commercialization plan to bring shareable EMR workflows to market
- Recruited advisory board members and CEO
- Raised and led first round of funding

Corporate Development Advisor- Clario Medical (www.clariomedical.com)-Present

- Helping CEO create scalable sales and marketing strategy
- Recruited new CFO and helped realign capital structure
- Realigned reseller/partner network to help business achieve scale revenue
- Managing development of the company's first Artificial Intelligence product

Business and Technical Advisor to Chief Data Officer, Seattle Children's Hospital – 2013-2015

- Recruited by Chief Data Officer to create data analytics core lab our of research program
- Delivered new prediction and benchmarking service in use today by Chief Medical Officer

CEO/Commercialization Experience

CEO | METAJURE | 2013-PRESENT

Recruited by investors to turnaround of legal software company

- Repackaged and realigned product to meet needs of small/med law firm market
- Hired all new sales, marketing and customer delivery team
- Develop new partner/reseller program from scratch
- Won Techno Lawyer Top 10 award for best new product
- Doubled growth each year since relaunch

CEO | GEOSPIZA | 2003-2012

Recruited by company founders to lead development, financing and commercialization of industry leading laboratory information management and analysis system used by DNA sequencing labs.

- Recruited development, QA, support, sales and marketing professionals to the company
- Developed strategic partnerships with industry leading DNA sequencing instrument makers including Applied Biosystems and Illumina
- Raised 3 rounds of capital
- Sold the company to Perkin Elmer in May of 2011
- Served on Perkin Elmer's division leadership team during integration period

CEO | CROSSPORT SYSTEMS | 2000-2003

Founded Crossport System to address corporate internet security needs for the small office/remote office/teleworking market.

- Raised venture capital to create high performance, low cost VPN appliance to roll out with low cost broadband networks
- Identified and sourced hardware/manufacturing supplier in Australia and Singapore to create design spec for fast, efficient network encryption
- Partnered with leading antivirus maker to create market's first complete security solution for remote offices
- Closed sales with Verizon, EarthLink and Countrywide Home Loans and other leading companies
- Sold company to Lineo/Metrowerks, a division of Motorola

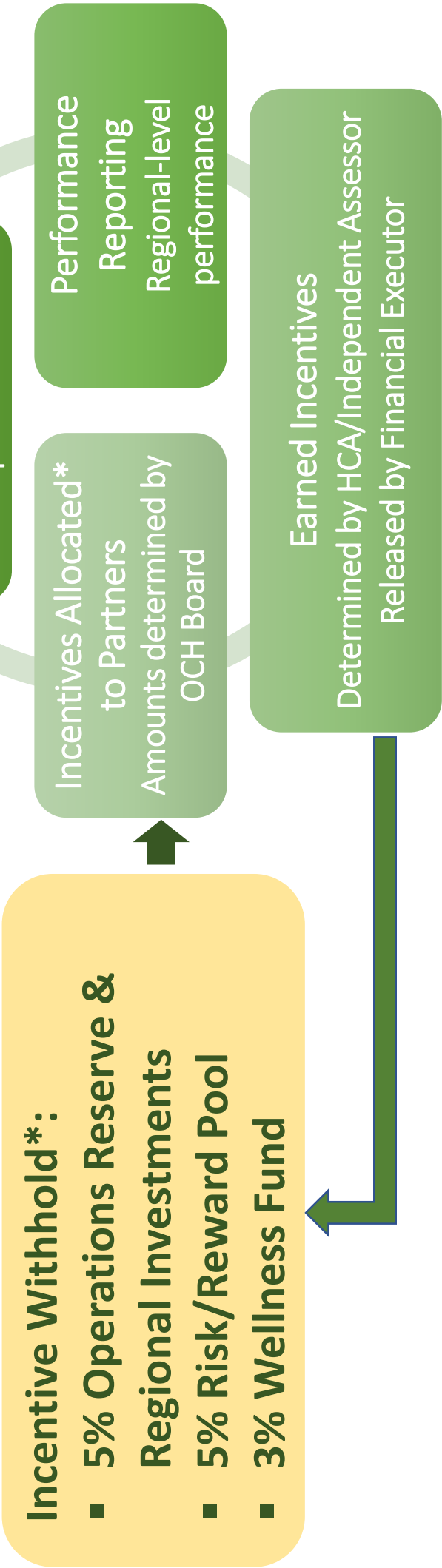
CHAIRMAN AND CEO | ST LABS | 1992-2000

Co-founded ST Labs with groups of software testers from Microsoft and Aldus. Grew company from founding team to 250 employees with four remote offices.

- Won Microsoft's primary testing contract with Volt Services Corp to create first outsourced test center, with connectivity to Microsoft's corporate network and test/QA training program
- Won HP's printer testing contract in Boise, Idaho
- Won numerous awards including WSA Service Provider of the Year
- Recognized as the 24th fastest growing company on D&T's Fast 500 list (<http://www.prnewswire.com/news-releases/st-labs-among-top-25-recipients-of-deloitte--touche-technology-fast-500-award-77584257.html>)
- Sold company to Data Dimensions in 1998 and served as Exec VP of Testing Services through the integration period

Approach to Demonstration Incentive Payment

Incentive Withholds and Contracting Authority



*[Incentive allocations guided by interlocking agreements between OCH and its project partners. Percentage withholds are for discussion purposes only.

Create **Olympic Community of Health Contracting Authority**

- comprised of representatives of OCH and project partners
- receives full allocation from financial executor and allocates directly to project partners

Withhold 5% for **OCH operational reserves and regional investments**

- regional investment examples: Apple Integrator, I.T. investment, workforce

Withhold 5% for a **Risk/Reward Pool**

- reward **outstanding** provider performance
- contingency planning for **underperformers**

Withhold 3% for a **Wellness Fund**

- support projects not supported under the Demonstration that address upstream, social influences of health (e.g., early childhood and family supports)
- these would be projects that align with the OCH five-year strategic plan (e.g., obesity, housing, oral health)

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

	<u>Jun 30, 17</u>
ASSETS	
Current Assets	
Checking/Savings	
First Federal Checking	1,260,915
First Federal Savings	<u>1</u>
Total Checking/Savings	<u>1,260,916</u>
Other Current Assets	
Prepaid Expenses	<u>504</u>
Total Other Current Assets	<u>504</u>
Total Current Assets	<u>1,261,420</u>
TOTAL ASSETS	<u><u>1,261,420</u></u>
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
Accounts Payable	<u>26,085</u>
Total Accounts Payable	<u>26,085</u>
Other Current Liabilities	
Deferred Grant Revenue	
SIM	
KPHD Carryover	168,734
Opioid SIM Funds	<u>15,272</u>
Total SIM	<u>184,006</u>
Design Funds	1,000,000
Opioid Contributions	<u>14,000</u>
Total Deferred Grant Revenue	<u>1,198,006</u>
Wages Payable	17,996
Payroll Taxes Payable	16,224
SEP Payable	<u>3,110</u>
Total Other Current Liabilities	<u>1,235,336</u>
Total Current Liabilities	<u>1,261,420</u>
Total Liabilities	<u>1,261,420</u>
TOTAL LIABILITIES & EQUITY	<u><u>1,261,420</u></u>

Olympic Community of Health
Profit & Loss Budget vs. Actual
February through June 2017

	<u>Feb - Jun 17</u>	<u>Budget</u>	<u>Variance</u>
Ordinary Income/Expense			
Income			
Grant Income	193,952	158,607	35,345
Partner Contributions	-	-	-
Waiver Administrative Ramp-Up	-	-	-
Designated Reserve	-	-	-
Total Income	<u>193,952</u>	<u>158,607</u>	<u>35,345</u>
Expense			
Administrative Services			
CPA services	1,000	5,909	(4,909)
Payroll & Bookkeeping expense	2,116	5,922	(3,806)
Total Administrative Services	<u>3,116</u>	<u>11,831</u>	<u>(8,715)</u>
Employee Benefits			
Health Insurance	6,800	10,182	(3,382)
SEP Expense	3,110	4,480	(1,371)
Total Employee Benefits	<u>9,910</u>	<u>14,662</u>	<u>(4,753)</u>
Events			
Food	378	2,500	(2,122)
Rental (venue, A/V)	-	682	(682)
Total Events	<u>378</u>	<u>3,182</u>	<u>(2,804)</u>
Insurance Expense	504	1,174	(670)
Miscellaneous	724	682	42
Office Expense			
Supplies	3,398	1,806	1,592
Communications	1,564	883	681
Office Space	4,926	510	4,416
Postage	92		
Information Technology	-	3,419	(3,419)
Total Office Expense	<u>9,980</u>	<u>6,618</u>	<u>3,362</u>
Payroll Expenses			
Wages			
Executive Director	52,083	43,108	8,975
Staff Salaries	49,417	37,542	11,875
Total Wages	<u>101,500</u>	<u>80,650</u>	<u>20,850</u>
Payroll Taxes			
FICA	7,541	6,855	686
FUTA	126	294	(168)
SUTA	1,105	2,651	(1,546)
L&I	380	334	46
Total Payroll Taxes	<u>9,151</u>	<u>10,134</u>	<u>(982)</u>
Total Payroll Expenses	<u>110,651</u>	<u>90,784</u>	<u>19,868</u>
Professional Development	1,085	2,841	(1,756)
Professional Services			
Legal	-	2,273	(2,273)
Contract Services	49,013	20,973	28,040
Total Professional Services	<u>49,013</u>	<u>23,246</u>	<u>25,767</u>
Travel Expense	8,591	3,587	5,005
Total Expense	<u>193,952</u>	<u>158,607</u>	<u>35,345</u>
Net Income	<u>0</u>	<u>0</u>	<u>(0)</u>

Olympic Community of Health Profit Loss Budget vs. Actual

February through June 2017

	1 - Administration & Governance	2 - Health Improvement Planning	3 - Health & Delivery System	3a - Opioid Project	5 - DSRIP Funds	TOTAL
Ordinary Income/Expense						
Income						
Grant Income	125,801	26,990	26,127	14,728	307	193,952
Total Income	125,801	26,990	26,127	14,728	307	193,952
Expense						
Administrative Services						
CPA services	1,000	-	-	-	-	1,000
Payroll & Bookkeeping expense	2,116	-	-	-	-	2,116
Total Administrative Services	3,116	-	-	-	-	3,116
Computer and Internet Expenses	-	-	-	-	-	-
Employee Benefits	-	-	-	-	-	-
Health Insurance	6,800	-	-	-	-	6,800
SEP Expense	3,110	-	-	-	-	3,110
Total Employee Benefits	9,910	-	-	-	-	9,910
Events						
Food	71	-	-	-	307	378
Total Events	71	-	-	-	307	378
Insurance Expense	504	-	-	-	-	504
Miscellaneous	724	-	-	-	-	724
Office Expense						
Supplies	3,398	-	-	-	-	3,398
Communications	1,267	297	-	-	-	1,564
Office Space	4,926	-	-	-	-	4,926
Postage	92	-	-	-	-	92
Office Expense - Other	-	-	-	-	-	-
Total Office Expense	9,682	297	-	-	-	9,980
Payroll Expenses						
Wages						
Executive Director	33,385	13,232	4,463	1,003	-	52,083
Staff Salaries	22,527	4,385	10,237	12,268	-	49,417
Total Wages	55,912	17,617	14,700	13,271	-	101,500
Payroll Taxes						
FICA	4,168	1,305	1,080	988	-	7,541
FUTA	75	9	24	18	-	126
SUTA	687	199	140	79	-	1,105
L&I	240	57	42	41	-	380
Total Payroll Taxes	5,169	1,570	1,287	1,126	-	9,151
Total Payroll Expenses	61,081	19,187	15,987	14,396	-	110,651
Professional Development	1,085	-	-	-	-	1,085
Professional Services						
Contract Services	32,071	7,399	9,543	-	-	49,013
Total Professional Services	32,071	7,399	9,543	-	-	49,013
Telephone Expense	-	-	-	-	-	-
Travel Expense	7,557	106	597	331	-	8,591
Total Expense	125,801	26,990	26,127	14,728	307	193,952
Net Ordinary Income	-	-	-	-	-	-
Net Income	-	-	-	-	-	-