



OLYMPIC COMMUNITY
OF HEALTH

Olympic Community of Health Interim Leadership Meeting

November 2, 2015

Port Gamble, Hood Canal Vista Room

4:00 p.m. – 5:00 p.m.

Agenda

Regional Vision, Local Action

- I. Review/Approve ILC Agenda Summary
- II. Debrief Stakeholder Meeting
 - Overall
 - Specifically, Community Assessment & Sector/Stakeholder Engagement
- III. Review and comment on DRAFT components of the Readiness Proposal
 - Governance Planning
 - Sustainability Pathway
 - Community Engagement Strategy/Communications Plan
 - Process for continued review and approval Readiness Proposal
- IV. ILC Responsibility with HCA, Backbone and other ACHs
- V. Logo Decision
- VI. Next Meeting - when, where, and how would you next like to convene?

Attachments:

1. Agenda Summary 10-19-15
2. ILC Charter, as approved 10-19-15
3. DRAFT Readiness Proposal Documents for review/edit
 - A. Subcommittee work to be reviewed
 - Governance Planning
 - Sustainability Pathway
 - Community Engagement Strategy/Communications Plan
 - B. Community Engagement (corrections/additions to)
 - ILC Roster including Subcommittees
 - Sector Representative and Participant Roster (to be continuously enlarged)

**Olympic Community of Health
Interim Leadership Council Meeting
October 19, 2015**

Date: 10/21/2015 **Time:** 3:30 – 5:00 p.m. **Location:** Silverdale Beach Hotel, Anchor Rm., Silverdale, WA

Meeting Scribe: Kathy Greco

Attendees: Rochelle Doan, Barbara Malich, Doug Washburn, Larry Eyer, Scott Daniels, Kurt Wiest, Peter Casey, Jean Baldwin, Eric Lewis, Katie Eilers, Michael Anderson (for David Schultz), Hilary Whittington, Mike Glen, Siri Kushner, Adam Marquis, and Kathy Greco

Person Responsible for Topic	Agenda Topic	Discussion/Outcome	Action/Results
Rochelle Barbara	Welcome and Introductions	Program Coordinators, Rochelle and Barbara thanked everybody for their time and commitment to the OCH Interim Leadership Council. Introductions, with sector affiliation, were made.	
Rochelle	Charge of Interim Leadership Council	The purpose of the OCH Interim Leadership Council (ILC) is to support the formation of an Accountable Community of Health and its desired future ACH designation in 2016 by the Washington State Healthcare Authority (ACH). The ILC is tasked to work together until the formation of a new entity (possibly a non-profit organization) and a Governing Board is established (no sooner than February, 2016 and possibly later). The Accountable Community of Health (ACH) Readiness Proposal is due to Scott on 11/15/15. It is due to the State of WA on 11/30/15. Kitsap Public Health District is the administrator for the Health Care Authority (HCA) Grant. Scott and Kathy represent the backbone organization that will provide administrative support to the OCH.	
Rochelle	Governance Structure: Charter	Rochelle led the Council through a review of the, Draft ACH Readiness Proposal Category, Interim Leadership	

	Review and Discussion	Council Charter. This will be an evolving document until a new organization and its Governing Board is formed. After full review of the Charter, the Council approved moving forward on the ILC Charter after incorporating the following changes: <u>Page 3, Section 1.1.3 (Access to “Whole Person” Support):</u> • Add Health Disparity Equity • Add Aging/Elderly Care (dementia/palliative care) <u>Page 3, Section 1.1.4 (OCH Guiding Principles), #4</u> • Savings Reinvestment, “Gain-sharing” vs. “rationing of care”. <u>Page 3, Section 1.1.4 (OCH Guiding Principles), #5</u> • It was noted that the all three county Community Health Needs Assessments are excellent resources for data and should be utilized. • <u>Page 9, 1.3.1 (ILC & Backbone Support Organization Roles and Responsibilities)</u> • Add: Reporting Role of Project Managers to ILC. • Clarify Relationship of the OCH and HCA/state Jean moved and Michael seconded the motion to approve the ACH Readiness Proposal, Interim Leadership Council Charter (to include the above changes). The motion was approved unanimously.	Rochelle will update the Charter and email to ILC members for final review. Scott will email a copy of the ACH contract to Committee members. Time will be allotted at the November 2, 2015 Stakeholder Meeting to discuss #4 on page 3, the “Savings Reinvestment” Rochelle will update the Charter and highlight the changes incorporated. She will email to ILC members for final review before presenting to the Stakeholder meeting on 11/02.
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Barb	Moving Forward: a. Update on ACH Expectation and Support to Regional ACH's	Each sector is expected to determine what type of communication plan they will use to communicate within their group. For Example: Barb is working on communications with all Tribes and two Federally Qualified Health Centers.	Council members will identify their contacts and send them to Kathy at Kathy.greco@kitsappublichealth.org who will keep a master list. This will help identify who is missing and any overlaps.
Barb	b. Sub Committee (SECTOR) Formation	It is time in the process for the ILC to form three Sub-Committees. Barb reviewed the charge and responsibility for each Sub-committee. The Sub-Committees and those that volunteered are: <u>Governance Committee – Barbara Malich</u> • Eric Lewis • Doug Washburn • Adam Marquis • Rochelle Doan <u>Sustainability Committee – Barbara Malich</u> • Hilary Whittington • Katie Eilers <u>Planning and Assessment – Rochelle Doan</u> • Jean Baldwin • Roy Walker • Katie Eilers • Larry Eyer • Michael Anderson • Kurt Weist • Siri Kushner • Gay Neal	The ILC will meet monthly The Governance, Community Health Assessment and Planning and Sustainability Sub committees will meet on a need by basis.
Barb	c. Preparing Readiness Proposal by 11/30 for ACH Designation d. Timelines	Barb reviewed the Readiness Proposal expectations and deadlines.	The Readiness Proposal is due to Scott by November 15, 2015 and due to the state on November 30, 2015.

Rochelle Barbara & Council	e. Stakeholder Engagement: Setting the November 2, 2015 Agenda	The November Stakeholder Meeting was discussed and several possible agenda topics discussed. • Service Gaps • Big Picture, “Where are we Going • Hear the Stressors and struggles learned by Cascade Pacific through their process. • Panel discussion • Community Engagement (Energize and excite the Stakeholders) • ACH/ACO – What is the Difference? • Develop a one page Q&A flyer • ILC Charter Update • Assessment (of work so far) In order to meet the immediate deadlines for the Readiness Proposal, the Council will focus on three agenda topics at the Stakeholder meeting: • Community Engagement (energize and excite the Stakeholders • ILC Charter Update • Assessment (of work so far) A suggestion was made to create a Q&A flyer that could be used as a resource to the Stakeholders.	The meeting on November 2, 2015 will be as follows: 1:00-4:00 p.m. Stakeholder Meeting 4:00-5:00 p.m. ILC Meeting.
Council	f. OCH Logo	The Council discussed the many options for a new logo. Kitsap Public Health is working with a Design Consultant who will provide samples for the ILC review. Also, Jefferson Hospital of drafting a few logos for ILC review.	Use current logo until final decision made.
Barb	g. Close	We went around the table and identified this work is important and why each is committing time and talent.	Once the draft logos are ready they will be emailed out to the ILC for review and feedback.
Rochelle	Other	There being no further business the meeting was adjourned at 5:00p.m.	Repeat this exercise in an abbreviated way at Stakeholders.



ACH Readiness Proposal Category 1.1

INTERIM LEADERSHIP COUNCIL CHARTER

Better Health. Better Care. Lower Cost.

1.1.1 History and Purpose of this Charter

The purpose of this Olympic Community of Health (OCH) Interim Leadership Charter is to support the formation of an Accountable Community of Health (ACH) and its desired future formal ACH designation in 2016 by the Washington State Health Care Authority (HCA) for the Olympic region consisting of Clallam, Jefferson, and Kitsap counties. The Charter was developed by the Governance Subcommittee of the initiating OCH Steering Committee with the intent to move our region's ACH to its next stage of development, and to document the work to date to create and implement a regional health improvement plan. The Charter was prepared based on review of existing HCA guidance and other regional ACH governance documents, and widely shared with stakeholders for comment in summer 2015. This Charter for the Interim Leadership Council has been reviewed and approved by the initiating OCH Steering Committee so as to provide guidance for the OCH Interim Leadership Council as it meets this October, was subsequently approved by the OCH Interim Leadership Council October 19, 2015, and is recommended for adoption by OCH stakeholders as a whole November 2, 2015.

The charter is a work in progress, and is not yet inclusive of all elements we may choose to address in the future. It is intended to establish a basis by which an OCH Interim Leadership Council (ILC) can readily meet its primary objectives to prepare for official designation as an ACH by November 30, 2015, and make recommendation by year end to the OCH stakeholders for adoption of a more permanent governance structure in which oversight will be provided through an OCH Governing Board. The Interim Leadership Council will meet beginning fall 2015 and as frequently thereafter as necessary to fulfill its responsibilities. The OCH Governing Board will replace the ILC and will take on leadership of the Olympic Community of Health no later than February 2016.

The Interim Leadership Council consists of a multi-sector group of leaders necessary to rapidly build on the work accomplished through prior OCH planning conversations. Driven in part by a short timeline and by the deliverables included in HCA's ACH Design Grant to the region, certain agreements will need to be reached by late 2015 regarding the functions and governance of the OCH moving forward, and what stakeholders and/or sectors will play which roles in the future to effectively mobilize the region around real health improvement. This leadership council is an "interim" one because its work will include recommending, by end of 2015, an ongoing governance structure. In order to assure testing and adjustment of the governance structure for the Olympic Community of Health, the Governance Subcommittee of the OCH will focus on continued review and revision to the structure during 2016, and as necessary thereafter.

1.1.2 Olympic Community of Health (OCH) Purpose and Rationale

The purpose of the Olympic Community of Health is to improve the health of our communities in Clallam, Jefferson, and Kitsap Counties through achievement of the *Triple Aim*:

- Improving patient care, including quality and satisfaction;
- Reducing the *per-capita* cost of health care; and
- Improving the health of the population.

Major changes are coming to our health care system, and it is critical for our communities to have a strong voice in that process. The OCH is the primary vehicle through which our communities can be heard and can participate in the process of change.

1.1.3 “Regional Vision, Local Action”: The Motto of Olympic Community of Health

The motto of the Olympic Community of Health is “Regional Vision, Local Action”. The OCH agrees that it is critical to have a regional vision and take local action to improve the health of our communities by:

- **Focusing on improving health outcomes across the population**, not simply improving the health care system.
- **Sharing a unified, regional voice** for the Olympic region regarding health priorities.
- **Collaborating across systems** to improve our community safety and well-being.
- **Utilizing a collaborative infrastructure** that creates efficiency and scale.
- **Delivering culturally competent services**, which include language access.
- **Driving action oriented measureable outcomes** through the use of data and local voice.

Additionally, we agree on the following broad areas of focus:

Access to Care

- Increase the number of insured individuals in our region.
- Increase network adequacy for Primary Care Providers, Specialty Care Providers, Behavioral Health Services Providers and Oral Care Providers.

Population Health Improvements

- Ensure every county has a plan to increase population health with a specific focus on reducing the prevalence of diabetes, high blood pressure, obesity, child abuse and neglect, mental illnesses, and substance abuse.
- Ensure every county has a plan to address key areas that effect overall health, including affordable and adequate housing, education, poverty, employment, health workforce development, crime, transportation, and environment.
- Participate in selecting and piloting regional and state innovations.

Access to “Whole Person” Support

- Increase affordable housing options and food security throughout the region.
- Increase the number of individuals who have Medical Health Homes and integrated behavioral health and oral health services.
- Increase knowledge of, and integrate service delivery to address, Social Determinants of Health and Adverse Childhood Experiences.
- Increase care coordination and utilize social services support.
- Increase supports for age friendly communities, aging in place, in particular options for dementia and palliative care.

Data Management/Region-Wide Infrastructure

- Promote region-wide data sharing and infrastructure to increase measurement, accountability, and coordination of care.

1.1.4 Olympic Community of Health Guiding Principles

1. To achieve the changes needed for improvement in the health and health care of our communities, purposeful collaboration between health care, public health, social services, government, education, business, community-based sectors, and health care consumers is required. To be successful, communities must be engaged to shape their goals and strategies for community health improvement.
2. Reform efforts will present serious challenges, and in some cases even survival threats, to health care organizations in this region. Providers in rural areas face challenges different from those seen in more densely populated areas. An important purpose of OCH is to assure that rural providers and health care organizations in this region have a voice in upcoming health system changes, and that the needs of rural communities are recognized as state, regional and local health care system decisions are made.
3. To improve overall community health, we need to address upstream determinants of health and health disparities, and strengthen the system of home and community-based supports that can stabilize the health of our most vulnerable community members of all ages.
4. A substantial percentage of savings from population health improvement and health care delivery system improvement should be reinvested through gain sharing in effective community-based prevention programs and initiatives identified at the local level through community health improvement plans and related efforts.
5. Improved data on health and health care is a critical tool informing our decisions and will empower us to leverage best and promising practices. Each county conducts a Community Health Improvement Process (CHIP) that engages local stakeholders to identify local health priorities. As a mechanism for broad community involvement in setting local priorities, results will inform OCH direction and decision-making. Multiple sector specific and related community needs assessment and planning processes which engage the community and utilize sector expertise are also included in OCH’ prioritizing and decision making process.

6. It is critical for OCH to operate in a transparent and inclusive manner. Meetings are open to all interested parties to the extent possible, and partners from various sectors are encouraged to attend.
7. OCH leaders are chosen in part because of the organizations, sectors, or communities they represent. It is appropriate for them to assure that the views and interests of those they represent are included in OCH discussions. When making OCH decisions, however, members must consider issues from a regional perspective, rather than from the narrower perspective of their organization, affiliations, or locality.
8. The Interim Leadership Council will allow regular opportunities for public comment at its meetings.

1.1.5 Interim Leadership Council (ILC) Membership

As the Olympic Community of Health, we strive for balance across the region to make equitable policy decisions in which we all have a piece of the vision. Therefore we seek to achieve a balance of representation by each county. Nomination to the ILC is to be made among and by stakeholders of the sector for whom the individual serves as representative. Stakeholders are to be inclusive of their peers within the tri-county region in making the selection for representation, and to inform their representative by meeting regularly and independently of the OCH. Representatives are expected to communicate on behalf of and represent the sector as a whole and to ensure a system for regular communication and feedback within their sector and as a responsibility of their ILC membership. Sector stakeholders may identify an alternate if their representative is unable to attend. Each sector will constitute one “vote” in decision making.

Terms for the Interim Leadership Council will be one year or less, by which time the transition to a Governing Board will be complete and the ILC will disband. Immediate focus for developing the Interim Leadership Council includes Stakeholder Sectors identified by the Cambridge Management Group as representing a Health and Recovery Services focus within a systems framework for health (Formative Focus). Wider representation from the Community Services System Sectors will be sought out and developed late Fall 2015 through Spring 2016. These additional sectors will then be considered for inclusion in the OCH Governing Board which replaces the ILC. After the governance structure is formalized in early 2016, sector membership composition will be reviewed the first quarter of each subsequent year for geographic balance, sector inclusion, community voice, and membership terms.

Interim Leadership Council membership will include one representative for each sector as listed below:

Formative Focus: Health & Recovery Services

- Behavioral Health Organization (Staff, by Executive Committee Appointee)
- Chemical Dependency (Medicaid Provider)
- Chronic Disease Prevention Across the Lifespan
- Community Action Program/Social Service Agency
- Dental Health
- Federally-Qualified Health Center

- Private/Not for Profit Hospital
- Housing/Homeless
- Long-Term Care/Area Agency on Aging/Home Health
- Medicaid Managed Care Representative
- Mental Health (Medicaid Provider)
- Primary Care
- Public Health
- Public Hospital
- Rural Health
- Tribes

Total Voting Members: 16

The following sectors are identified as important to be developed and invited for representation on the Interim Leadership Council and/or Governing Board.

Widening Focus: Community Services System

- Economic Development
- Education (early learning through higher education)
- Law & Justice
- Nutrition & Active Living
- Philanthropy
- Transportation
- Workforce Development
- Other sectors yet to be identified

1.1.6 Functioning of the OCH Interim Leadership Council

The Governance Subcommittee is recommending to the existing Steering Committee and OCH stakeholders as a whole that an Interim Leadership Council be established to serve in a transitional role prior to adopting a more permanent Governing Board structure in early 2016. Early planning for the OCH has continued through existing stakeholder interactions, and as the ILC takes on its role, the governance structure will become more formalized, although it will continue to evolve as the ILC, supported by the Governance Subcommittee, works to hone a governance model late 2015 through early 2016. The ILC will convene October 2015 and meet at least once monthly to begin its role in moving the OCH to readiness for ACH designation and to ensure the expectations and deliverables associated with being an accountable community of health are underway and ultimately, met. At this juncture, the initiating Steering Committee will cease, and turn its role over to the ILC. Recognizing the need to meet the tight timelines involved in creating a rapidly functioning governance structure, OCH

Stakeholders approved the ILC structure in principle at their July 2015 meeting, so that the ILC could begin its initial work in September 2015. OCH Stakeholders will convene in November to review and comment on progress, and to formally adopt the ILC governance structure. OCH Stakeholders as a whole will convene at least twice annually.

The Interim Leadership Council is convened now for the purpose of supporting Olympic OCH Stakeholders, overseeing the work of OCH staff and consultants, managing the Work Plan and Budget, maintaining project momentum, developing an engagement strategy and community mobilization plan, and resolving problems and issues. In addition to assuring the OCH is focused on regional planning and projects that will substantively meet the Triple Aim, the ILC is expected to assure that the OCH includes as its focus regional health system supports regarding health care financing, practice changes, workforce development, and the regulatory environment. Its work must also develop and begin implementation of a long-term plan for administration, financing and sustainability of the OCH.

1.1.7 Interim Leadership Council Subcommittees

To support the work of the OCH Interim Leadership Council, three subcommittees will be formed. The ILC may also elect to establish other committees or work groups as needed. As with the ILC, these committees disband when the final governance structure is adopted and the Governance Board initiates its first meeting in 2016, or as otherwise determined by the Governance Board.

The three ILC Subcommittees will include 1) Governance, 2) Community Health Assessment and Planning, and 3) Sustainability. The ILC may invite additional OCH stakeholder representatives to participate in subcommittees, however, at least two participants in each subcommittee must be members of the ILC, one of whom will serve as the Subcommittee Chair. Subcommittees are expected to draw upon community health improvement plans and priorities as identified by each county's citizenry and providers, and other available information and data, and to draw upon the expertise of the OCH Stakeholders to most effectively carry out their charge. Recommendations from these subcommittees are then to flow through from each subcommittee via its Chair to the ILC for planning, prioritization, and decision-making.

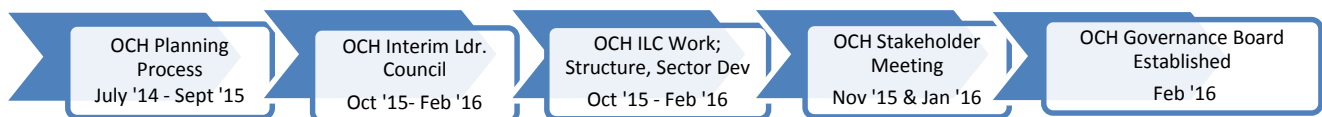
- 1. Governance Subcommittee:** Researches and recommends a governance structure for the OCH, to include decision-making, conflict of interest, and conflict resolution processes. The Governance Subcommittee assembles and reviews existing ACH governance documents, and will prepare an interim governance structure for stakeholders to approve by November 2015. Recommendations on the legal form of the OCH including by-laws and articles of incorporation will be made by end of 2015, and work initiated in 2016 to create a legal ACH entity, if indicated. The work of the Governance Subcommittee is completed when the governance structure, legal entity determination and any associated tasks are completed, and the Governing Board is fully established and operational. At that point, the Governance Subcommittee may be dissolved and other subcommittees may be initiated to support next steps. The Governance Subcommittee consists of 4 – 8 members, and will meet at least monthly.

2. **Community Health Assessment and Planning Subcommittee:** Facilitates the development of a single, cross-sector health data and needs inventory and multi-year regional health improvement plan to consolidate community health planning efforts required by various agencies and funders across the region; works on plan performance measures, and with other ACHs and the State, develops and implements a set of statewide performance measures. A collective impact approach to shared priorities, which will involve regionally-aligned voluntary engagement of independent stakeholders from the local level will be applied. The local Community Health Improvement Process (CHIP) and projects in each of the counties will continue to serve as a means to improve the health of the region. Service innovations may also be evaluated and recommended. This work will be ongoing. The Community Health Assessment and Planning subcommittee will consist of 4 – 8 members and meet monthly. The Committee is ongoing and service innovations are likely to be generated, recommended and evaluated by this group.
3. **Sustainability Subcommittee:** Researches potential funders, identifies funding opportunities, and develops a short- and long-term plan to solicit resources in support of the OCH. This *may* include establishment of a Wellness Fund for shared savings, identifying possible revenue sources for the OCH which may include, but may not be limited to, private and public sector funding, membership dues, and in-kind support, and research and support for new health care payment models. The Sustainability Committee will consist of 4 – 8 members and will meet at least monthly. The Committee is ongoing.

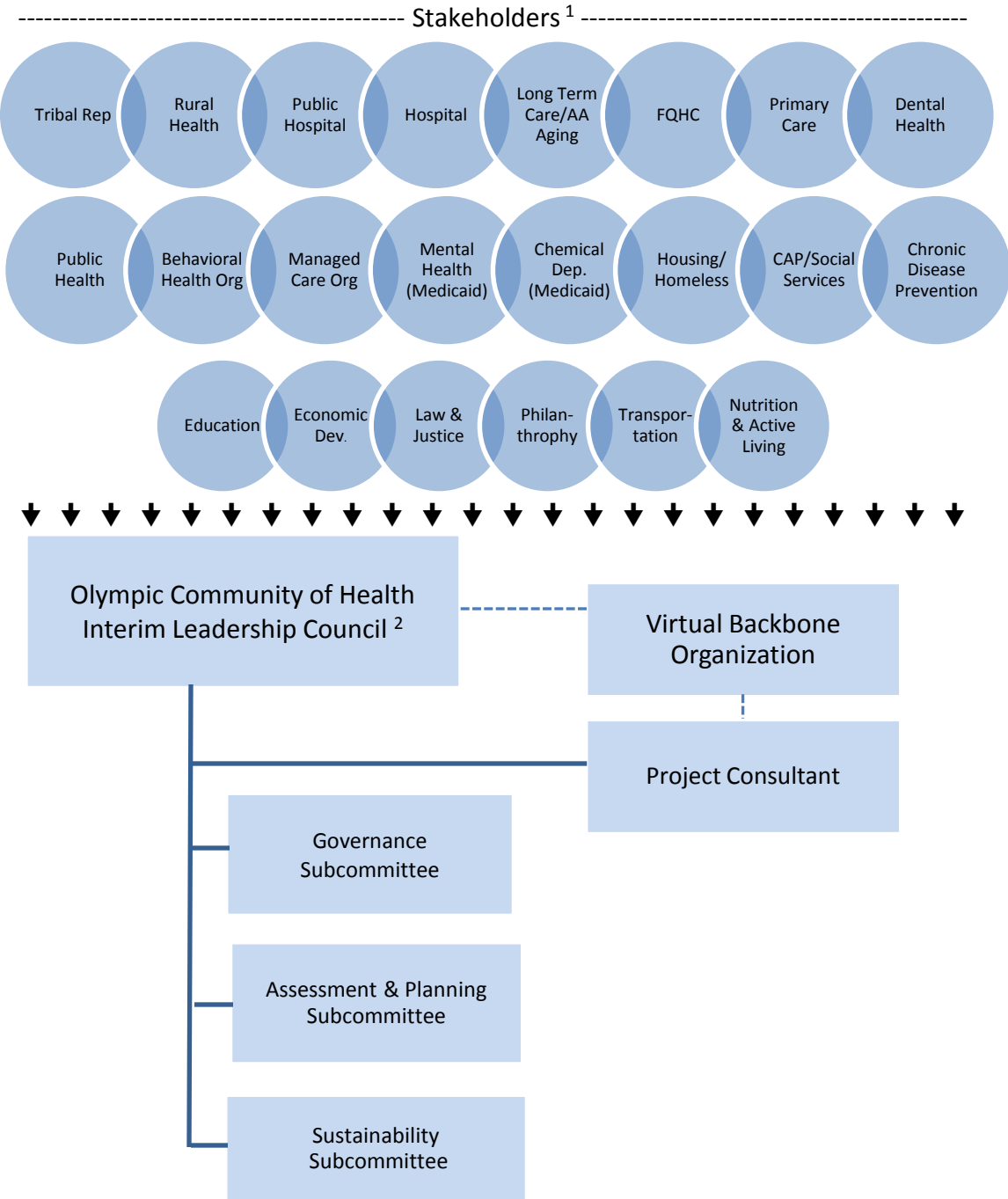
1.1.8 Duration of Interim Leadership Council

The OCH Interim Leadership Council agrees to work together from October 2015 until the formation of the Governing Board, expected to be in place by February 2016. In late 2015, as part of an anticipated shift to an ongoing ACH structure, the Interim Leadership Council will develop and execute a plan to transition from an interim to an ongoing structure.

OLYMPIC COMMUNITY OF HEALTH DEVELOPMENT TIMELINE



ACH Readiness Proposal Category 1.2 **VISUAL INTERIM GOVERNANCE STRUCTURE REPRESENTATION** **Olympic Community of Health Interim Leadership Governance Structure**



¹ OCH Stakeholders from all sectors will populate organizational entities.
² OCH Interim Leadership Council disbands after ACH design deliverables accomplished and formal governance structure for Governing Board in place.

ACH Readiness Proposal Category 1.3

OCH Interim Leadership Council & Backbone Support Organization Roles & Responsibilities

1.3.1 Roles and Responsibilities of the OCH Interim Leadership Council

- The ILC, with the Project Consultant/s, will prepare for official designation as an Accountable Community of Health from the Washington State Health Care Authority. With support from the Backbone Agency, the Readiness Proposal will be submitted in November 2015. The OCH, ILC and its subcommittees will work accountably with other ACH partnerships and with the State as the role of the ACH in health care redesign continues to evolve.
- With Governance Subcommittee, the ILC will develop a recommended OCH governance structure for stakeholder adoption by November 2015, and implement a transition plan to the more permanent governance structure no later than January 31, 2016. In early 2016, it will establish organizational preparedness, including review of benefits and recommendations for choice of organizational structure, development of bylaws, backbone support needed to support the OCH, its governance structure, and work plan. The Governance Subcommittee, as with the ILC and OCH in its entirety, will work accountably with other ACH partnerships and with the State as the role of the ACH in health care redesign continues to evolve.
- With the Sustainability Subcommittee, the ILC will recommend an initial plan for sustainability, including exploration of shared savings, and alternate forms of payment such as pay for performance, and creation of a Wellness Fund. In addition to assuring the OCH is focused on regional planning and projects that will substantively meet the Triple Aim, the ILC is expected to assure that the OCH includes as its focus regional health system supports regarding health care financing, practice changes, workforce development, and the regulatory environment. Its work must also develop and begin implementation of a long-term plan for administration, financing, and sustainability of the OCH including the backbone support functions. The Sustainability Subcommittee will work accountably with other ACH partnerships and with the State as the role of the ACH in health care redesign continues to evolve.
- With Assessment and Planning Subcommittee, the ILC will assure coherence of regional vision and initiatives, and work to support their success in ways appropriate to each to support a regional health improvement plan, including consideration of information technology infrastructure needs. It will recommend an ongoing regional-level health assessment and how to incorporate the Community Health Improvement Plan process into the OCH structure. This subcommittee may also in the planning process recommend measurable health outcome and evaluation goals. The Assessment and Planning Subcommittee will work accountably with other ACH partnerships and with the State as the role of the ACH in health care redesign continues to evolve.

- The ILC will recommend how administrative, fiscal management, coordination, convening, communication, and data support functions (backbone functions) will be carried out in the future structure and ensure a mechanism is put in place for periodic reaffirmation of the virtual backbone organization in order to allow for adjustments over time, as necessary. The current virtual backbone organization is the Kitsap Public Health District which provides administrative support and fiscal management; web communications support is also currently provided by in-kind support from the Kitsap County Human Services Department. The backbone organization for the immediate future, 2016, will require the ILC to either confirm the current structure and backbone organization, or identify another backbone structure agreed upon by the ILC.
- The ILC will be supported in its processes, business, and in carrying out OCH goals by staff who provide project management. Staff are directed by and accountable to the ILC as the governing body for the OCH.
- The ILC will provide input/recommendations to the State (and to the counties/cities, where appropriate) related to health innovation elements such as physical/behavioral health integration, aspects of Medicaid purchasing, the Healthier Washington Initiative, data analytics, and issues connected to ACH development and functions.
- Recognize and facilitate decision-making about how to respond to new cross-sector health improvement initiatives/opportunities as they arise.

1.3.2 Roles and Responsibilities of the Virtual Backbone Entity

During 2015, at the request of participating OCH Stakeholders, the virtual backbone entity selected to provide administrative support functions, including organizational, logistical, fiscal, and data support, was the Kitsap Public Health District. The Kitsap Public Health District will continue to serve in this role during 2016 if approved by the ILC to do so and if agreed upon by the Health District. Oversight of the Virtual Backbone Entity was initially provided by the OCH Steering Committee, and will subsequently be provided by the Interim Leadership Council and, when in place, the Governing Board.

The virtual backbone entity's role is to:

- Supply overall project and financial management, including serving as fiscal agent for grants and other funds.
- Provide administrative and clerical support necessary to meet grant deliverables including
 - Publications, web postings, and general communications.
 - Assisting in convening meetings and facilitating communications with stakeholders.
 - Recording and distributing minutes for OCH meetings.
 - Limited administrative support for the work of the OCH's various committees and groups.

- Manage associate consultant contracts to meet design grant deliverables including, but not limited to, project consultation, and epidemiology services for assessment and data, including support for development of a regional health improvement plan.
- Keep the OCH informed regarding ACH-related communications from the State, and about efforts statewide to implement the work.

Backbone support is also provided to the Interim Leadership Council, and Subcommittees by a Project Consultant who with the ILC and Stakeholders, carries out OCH strategies and manages work to meet the specific deliverables, including ACH Design Grant deliverables associated with ACH designation. The Project Consultant reports to the Interim Leadership Council and is contracted for services through the fiscal backbone.

The Project Consultant ensures connectivity with stakeholder groups to grow the OCH over time and assists the OCH in aligning its members to achieve its goals. Specifically the Project Consultant works with the Steering Committee to prepare objectives for various OCH meetings in order to effectively and quickly advance the OCH. Agenda and meeting materials will be distributed at least three (3) business days in advance, no fewer than five (5) business days when a decision-making item is on the ILC agenda. The Project Consultant, with backbone entity support staff, will record and distribute meeting summaries to the membership and post these on the OCH website for access by OCH stakeholders and the public. The website is maintained by Kitsap County Human Services Department.

ACH Readiness Proposal Category 1.4

OCH Decision Making Approach

Because achieving voluntary agreement and buy-in from different sectors is foundational to the work and success of an ACH, the Interim Leadership Council (ILC) and Governing Board will make decisions and recommendations by consensus. The approach encourages putting the good of the whole above the interests of a single organization, geography or sector, and finding solutions that all parties can support or at least live with. Decisions will be documented in meeting summaries and posted on the OCH website. This process is consistent with true collaboration to produce sustainable agreement. Key decisions will be made in person ILC or Governing Board meetings.

Every effort will be made to determine ILC decisions by consensus. Consensus in this context does not mean 100% agreement on all parts of every issue, but rather that all members review a decision in its entirety and say, "I can live with that." The Council or Board will work to understand and integrate perspectives until a solution is identified that is acceptable to everyone in a reasonable amount of time.

If an ILC or Board member cannot support an emerging agreement of the group, the member is obligated to make his or her concerns known, and the rest of the group is obligated to listen with an interest in resolving these concerns. Members are expected to work to address the concerns, including asking the concerned party to clarify any underlying interests or other dynamics that could be interfering with an agreement. All ILC and Board members are obligated to try to find an alternative that meets the interests of the concerned party as well as their own.

If the ILC makes a good faith effort to achieve consensus but finds that consensus is not possible, the decision will be submitted to a vote of the ILC or Governing Board and decided by a simple majority of members present, provided there is a quorum. Robert's Rules of Order will be used to facilitate ILC or Governing Board decision making.

ACH Readiness Proposal Category 1.5

Managing Real or Perceived Conflicts of Interest

Conflict is to some degree inherent and expected in an endeavor that brings different sectors together to work on issues addressed more successfully as a community than by individual sector or organization. The Interim Leadership Council and Governing Board acknowledge that conflicts, real or perceived, may surface in their work. This may occur within and among members of the ILC or Board, its multiple stakeholders, project consultants/staff, and state partners working on the initiative.

The ILC and Board seek to cultivate a culture of openness in talking about conflicts of interest as many of its members as well as those in project staff and facilitation roles may have contractual relationships with one another and/or with the State.

The Interim Leadership Council and Board will be intentional in identifying potential conflicts of interest. Members should raise or ask fellow members about potential conflicts related to the topics under discussion or decision making. Members, staff, and consultants are expected to disclose potentially relevant conflicts, at which time the Interim Leadership Council or Board will collectively decide how to address or manage the potential conflict on an issue-by-issue basis. Identified conflicts will be reflected, including dates on which those conflicts are declared, in meeting summaries.

ACH Readiness Proposal Category 1.6

Annual Governance Structure Review Policy

1.6.1 Annual Review Policy of the Governance Structure and Backbone Organization

We recognize the need to allow for adjustments to our ACH structure as it becomes more clearly defined in the near and longer term future. Collaboration is an iterative process, for the purposes of arriving at shared outcomes. While the governance structure of the Olympic Community of Health is yet under design and will undergo further review by the Interim Leadership Council, with approval for adoption requested of the OCH stakeholders during January 2016, recommendation of the current governance structure is described in sections 1.6.2 and 1.6.3 below.

1.6.2 Interim Leadership Council (current); Governing Board (February 2016)

On an annual basis, the governing body (Interim Leadership Council or Governing Board) will review the governance structure and affirm the current composition or make adjustments as issues and gaps emerge over time. Adjustments or the affirmation of the recommendation and decision to maintain or change the structure will be noted in summary documentation.

1.6.3 Backbone Organization

On an annual basis, the governing body will select or reaffirm the backbone organization. Such selection or affirmation will be noted in summary documentation.

OLYMPIC COMMUNITY OF HEALTH (OCH)

“The Pathway to Governance Decision-Making”

10-22-15

Current Governance Position

The initial organizing steps have been completed, but are characterized as “interim”. OCH has now adopted a “start-up” model that includes the seating of an Interim Leadership Council to provide an authorizing role and planning/decision-making function until the next steps in governance are identified and implemented. There is no set time frame for this work, but it is hoped that the work can be expedited and completed over the next 6-8 months.

Next Steps

Review and consider multiple organizational structures to support the role of the OCH. These options include (but are not limited to):

- Continue as a Multi-Partner Collaborative with a Financial/Administrative partner (backbone organization) to manage the business and deliver the work.
- Seek an existing Nonprofit or Government Agency to “take the lead” on the work as a managing partner---structure would defer to the host structure and the OCH would essentially just be a program within the host organization.
- Create a new, Integrated Legal Entity (Non-profit, Government, or For Profit) There are multiple options within each of these categories!

Core Principles

- **Accountability** that reflects - Transparency, Community Representation, Strategic Planning and Goals and Commitments
- **Neutrality** – balancing the three county model, large v. smaller partners, urban v. rural, and committing to growing the partnership/collaboration
- **Flexibility** – As a “start-up” we have no restrictions at present on our choices. The more defined the state expectations become, this flexibility may change
- **Sound Governance** – whatever the pathway, the commitment to excellence in the face of a changing environment must be a primary consideration for the partners/stakeholders

Key Elements for Consideration

- ACHs are emerging, evolving and experimental
- Collaboration/Collective Impact work is challenging, hard, and potentially rewarding
- OCH presents a real opportunity for:
 - Holistic Problem Solving
 - Alignment and Empowerment
 - Building New Relationships
 - Improving Communication
 - Realizing the goals of better health, better care and lower cost
 - An opportunity to do this work closer to home where we can be directly engaged in the pathways to progress, but recognize we must step up to the opportunity by commitment of time, resources, and reflect a willingness to embrace change.

Olympic Community of Health

Sustainability Planning

November, 2015

The purpose of this document is to further the conversation regarding developing a pathway to sustainability for the Olympic Community of Health (OCH) infrastructure and later program initiatives. The OCH Committee for Sustainability will inform and shape the conversation that will then be undertaken by the Interim Leadership Council (ILC). The goals, working together with the Governance Committee, will be to identify necessary next steps to assure a successful organizational launch and subsequently to create stability and infrastructure development. Program initiatives and projects will be identified, but specific funding streams for such will be considered as they are approved. It should be noted that no specific governance model has been adopted and all the options are in consideration.

The Charge of the Sustainability Committee is to research and recommend an OCH sustainability plan and subsequently engage in the role of health care payment models as part of the on-going work.

Currently there are three competing priorities to guide our thinking around sustainability:

1. OCH has established existing contracts for the development of deliverables to submit with the ACH Readiness Proposal due November 30, 2015. The current HCA grant for Readiness Planning will expire January 31, 2016—with a subsequent final report due by February 29, 2016.
2. Following Designation as an Accountable Community of Health, the OCH will continue working toward a viable organizational model that will require a firm and diversified financial platform. While it is expected the State of Washington Health Care Authority (HCA) will continue to support the development of regional ACHs with grant dollars, to truly be effective and community based, additional resources will need to be garnered from throughout the region.
3. The “Right” work will be undertaken by the OCH as the organization matures, the health planning and assessment committee will identify targeted opportunities, and then resources will be identified sufficient to impact community health, quality of care, and strive to reduce costs.

The current direction from the Interim Leadership Council is not prescriptive. The committee is urged to consider the following broad questions: What does it mean to be sustainable? What are we sustaining? How can goals be defined and achieved? Is Sustainability as a concept evolutionary or revolutionary?

Consider these steps to achieve sustainability—the “Sustainability Pathway”:

Step 1. What is the “Value Proposition”? A critical first step in the path to sustainability for OCH infrastructure and activities is to develop a value proposition that resonates with all the partners and stakeholders.

- The OCH is considered to be an “asset” to all involved
- OCH is a driver in other regional initiatives providing funding or financial resources
- OCH is one potential avenue for consumer-driven care
- One goal of the OCH is to reduce administrative complexity for partner organization in the tracking and monitoring of performance/quality measures
- By centralizing duplicative tasks within the region, could the OCH deliver cost savings to partner organizations?

Step 2. Resources (Identify a list of possible financial resources)

- State and federal funds
- Philanthropic grants, major gifts and donations
- Social Impact Bonds
- Health Plans and Hospitals
- City/County Funds
- Private business
- In-kind investments
- Venture capital
- Others to be identified

Step 3. Possible mechanisms (Identify a list of possible revenue-generating mechanisms that align with the goals of the OCH.)

- We must be accountable in order to expect investments to flow to the OCH.
- Partner with health plans on projects of mutual benefit such as jail/institutional transitions, community health workers, or other strategies to address our regional health needs priorities and in doing so reduce costs and improve care.
- Shape health care purchasing to align with OCH priorities and include specific language related to shared savings for OCH
- Contracts or fees for services with entities benefiting from such services
- Engage with Federal Reserve of San Francisco for community building and engagement especially in relationship to engagement with Tribal Nations
- Leverage membership in the OCH for in-kind donations such as space, equipment, supplies, and personnel. Track these donations.
- Create an OCH membership fee structure
- Research through the Practice Transformation Hub and share ideas with other ACHs across the state to identify opportunities for resource development, shared savings, or other value-based reimbursement mechanisms.

Step 4. What are we doing together and what will it cost to sustain?

The concept of the Accountable Communities of Health is new. We do not have any idea about what we want the OCH to ultimately look like. Financial projection to one year is difficult and a five year projection is impossible. The immediate next step is to achieve designation as an ACH and then build the organization to respond to our regional health priorities. Achieving early wins will be optimal and then building on success will foster trust in the partners and in the process. Continuing with contracted staff at least for the short term is optimal. Building an authentic budget process will require time and some determination of programs and opportunities.

Step 5. Continue to expand community engagement by mobilizing Stakeholders and generating enthusiasm for the opportunities represented by the creation of the OCH. As the community becomes engaged in the OCH, the desire to sustain it will be generated and resources can be identified sufficient to the tasks.

Step 6. The OCH is evolutionary as it defines goals and opportunities, but the OCH must also be **revolutionary** to secure resources sufficient to impact our regional health priorities.

Olympic Community of Health

Pathway to Effective Communication and Community Engagement

November, 2015

Introduction: The focus for effective communication and collaboration within the stakeholder group at the regional level and subsequently in communities served by the Olympic Community of Health (OCH) is built on a foundation of trust. This foundational basis for all communication is forged by the emerging trusting relationship and the stakeholders' confidence that the integrity of the work being undertaken is valid and has at its core the desire to improve the health of local communities. In building the trusting relationship, target audience/stakeholders will be specifically identified and communications tools developed to support the engagement of the various groups. This conceptual framework is intended only as a starting point for communications planning to be developed in the future.

Purpose: The Communications and Community Engagement Pathway is to serve as a roadmap for effective communication and collaboration between stakeholders in participating local communities. The intent is to provide timely information, updates and an avenue for feedback. Communication must be consistent, clear, and encourage discussion and the exchange of ideas.

Audience: OCH brings many stakeholders from diverse sectors and communities to the table. Different groups may have different communication norms and preferences. The goal is to build communication platforms that can be used effectively across multiple stakeholders and communities.

Communications tools: OCH will employ a myriad of tools to build trust and community engagement. These tools will include, but are not limited to: In-person Meetings (including both training and shared learning), phone calls, website, email, and social media. Much of the work and engagement potential in the OCH is predicated on encouraging involvement in committees (currently Governance and Sustainability, and in the future Communication and Community Engagement).

Continuous Improvement: Effective communication is a two-way process. Evaluation of tools employed, planning and strategic development will be conducted on an ongoing basis. Feedback from target groups will be analyzed and used as a means to continually improve communications and ensure accountability to and engagement within our communities.

OCH Interim Leadership Council 2015**DRAFT** 10.15.2015

Name and Affiliation	County	Service Area	Sector (s)
Doug Washburn Director Kitsap County Human Services	Kitsap	Clallam Jefferson Kitsap	Behavioral Health Organization
Robin O'Grady Executive Director Westsound Treatment Center	Kitsap	Kitsap	Chemical Dependency (Medicaid Provider)
Katie Eilers Assistant Director, Community Health Kitsap Public Health District	Kitsap	Clallam Jefferson Kitsap	Chronic Disease Prevention Across the Lifespan
Larry Eyer Executive Director Kitsap Community Resources	Kitsap	Kitsap	Community Action Program/ Social Service Agency
Tom Locke	Clallam	Statewide	Dental Health (State Rep)
Barbara Malich PCHS Consultant Peninsula Community Health Services	Kitsap	Kitsap	Federally Qualified Health Center
David Schultz Market President for the Peninsula Region; CHI/Harrison Medical Center	Kitsap	Clallam Jefferson Kitsap	Private/Not for Profit Hospital
Kurt Wiest Executive Director Bremerton Housing Authority	Kitsap	Kitsap	Housing/Homeless
Roy Walker Executive Director Olympic Area on Aging	Clallam Jefferson	Clallam Jefferson	Long Term Care/Area Agency on Aging/ Home Health
TBD	Statewide	Statewide	Medicaid Managed Care TBD by MCOs 10/23/15
Peter Casey Executive Director Peninsula Behavioral Health	Clallam	Clallam	Mental Health (Medicaid Provider)

Justin Sivill
Director, Operations
Harrison Health Partners

Kitsap

Clallam
Jefferson
Kitsap

Primary Care

Jean Baldwin
Director
Jefferson County Public Health

Jefferson

Clallam

Public Health

Eric Lewis
Chief Executive Officer
Olympic Medical Center

Clallam

Clallam

Public Hospital

Hilary Whittington
Chief Financial Officer
Jefferson Healthcare

Rural Health

TBD

Tribal Representative
Under discussion, to be
determined 10/26

ILC Subcommittees 10.19.15

Community Assessment & Planning Subcommittee

Michael Anderson	Kitsap	Hospital
Jean Baldwin	Jefferson	Public Health
Rochelle Doan	Kitsap	Project Manager
Larry Eyer	Kitsap	Community Action Program
Siri Kushner	Kitsap	Epidemiologist, Public Health
Eric Lewis	Clallam	Public Hospital
Gay Neal	Kitsap	Behavioral Health
Roy Walker	Clallam	Aging & LTC
Kurt Wiest	Kitsap	Housing/Homelessness

Governance Subcommittee

Eric Lewis	Clallam	Public Hospital
Rochelle Doan	Kitsap	Project Manager
Barbara Malich	Kitsap	Project Manager
Adam Marquis	Jefferson	Mental Health
Doug Washburn	Tri County	Behavioral Health Organization

Sustainability Subcommittee

Katie Eilers	Kitsap	Public Health
Barbara Malich	Kitsap	Project Manager
Hilary Whittington	Jefferson	Rural Health



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