Olympic
COMMUNITY of HEALTH

May 5, 2016

CLALLAM • JEFFERSON • KITSAP

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

Dear Mr. Napier:

On behalf of the Olympic Community of Health (OCH), it is our pleasure to submit the enclosed deliverables for contract K1434, amendment 2. These deliverables were reviewed and approved by the OCH Board of Directors on May 4, 2016 in full session. They are inclusive of all OCH developments from the submission of the Readiness Proposal on November 20, 2015 through May 4, 2016.

Included with this letter is an update within five areas:

1. 2016-2018 Budget
2. Backbone organization
3. Governance
4. Communications and engagement
5. Regional Health Needs Assessment and Improvement Plan

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

Sincerely,

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

Roy Walker
Chair, Olympic Community of Health
Executive Director, Olympic Area Agency on Aging

Scott Daniels
Administrator, Kitsap Public Health District
Backbone agency to the Olympic Community of Health

OLYMPIC COMMUNITY OF HEALTH

2016-2018 HCA BUDGET

Leadership Council - Action Item

APPROVED 5/4/2016

Grantee Name: Olympic Community of Health supported by Kitsap Public Health District
Contract #: K1434-02
Contact Person: Elya Moore **Phone:** (360) 633-9241 **Email:** elya.moore@kitsappublichealth.org

Instructions:

Initial budget projection are due by April 29, 2016 with an update anticipated in Quarter 3 of 2016. Please align with the following parameters and

Budget Line Item	2016	2017	2018	2016-2018 Total	Notes
1: Governance Structure and Administrative Capacity (SIM $)	$159,877.21	$102,972.94	$25,954.42	**$288,804.57**	Matched contributions expected from OCH partners. $10,000 pledged for 2016.
1.a. Match (if applicable):	$10,000.00	$80,000.00	$160,000.00	**$250,000.00**	
1.b. In-Kind Staffing:	$0.00	$0.00	$0.00	**$0.00**	Backbone agency tracked $4,000 in in-kind support for January 2016. Too soon to extrapolate this out for three years. In-kind contribution will be captured in updated September 2016 budget projection.
2: Health Improvement and Measurement Planning (SIM $)	$70,782.17	$76,238.73	$77,481.01	**$224,501.90**	
2.a. Match (if applicable):	$0.00	$0.00	$0.00	**$0.00**	
2.b. In-Kind Staffing:	$0.00	$0.00	$0.00	**$0.00**	
3: Health and Delivery System Transformation (SIM $)	$42,469.30	$45,743.24	$46,488.60	**$134,701.14**	Domain 1: est. 60% of total budget Domain 2: est. 25% of total budget Domain 3: est. 15% of total budget
3.a. Match (if applicable):	$0.00	$0.00	$0.00	**$0.00**	
3.b. In-Kind Staffing:	$0.00	$0.00	$0.00	**$0.00**	
Total	**$283,128.69**	**$304,954.90**	**$309,924.03**	**$898,007.62**	Refer to '16-'18 budget for more detail

Optional : Any match expenditures that do not fit within your budget line item categories can be projected under the "Other" line item. Please add a brief description

*** Also optional: Please provide in-kind resource or hour estimations based on staffing that supports the contract categories (i.e., this is meant to project a more*

Olympic COMMUNITY of HEALTH

OLYMPIC COMMUNITY OF HEALTH
2016-2018 APPROVED BUDGET
Leadership Council
May 4, 2016

This budget provides the backend details for the 2016-2018 budget deliverable for the HCA and assumes that the OCH incorporates by 2017 and/or bids for a new backbone organization. The estimates herein are drawn from 2016 operational budget approved by the OCH Interim Leadership Council on February 24th, 2016. In-kind contributions have not yet been incorporated. Please note that the future is extremely uncertain; therefore the details provided in this budget may change, especially if the backbone or legal entity status of the OCH changes or if/when the waiver activity beging. The HCA confirmed that this is expected and would not have a negative impact on our contract.

REVENUES 2016

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

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

REVENUES 2017

Description	Total
HCA ACH Phase 2 Grant	231,000
Designated reserve	206,871
Partner contributions (TBD)	80,000
TOTAL REVENUES	**517,871**

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

REVENUES 2018

Description	Total
HCA ACH Phase 3 Grant	99,000
Designated reserve	212,916
Partner contributions (TBD)	160,000
TOTAL REVENUES	**471,916**

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

2016
January 1, 2016-December 31, 2016

EXPENDITURES

Personnel	Salaries	Benefits[1]	Total
Director: 1.0 FTE for 9 months	79,362	23,809	103,171
Program Coordinator: ~~1.0~~ 0.5 FTE for ~~8~~ 4 months	14,923	4,477	19,399
Epidemiologist: 0.5 FTE for 11 months	37,279	11,184	48,463
Assistant 0.4 FTE for ~~12~~ 10 months	15,528	4,658	20,186
Subtotal Personnel Costs	**147,092**	**44,127**	**191,219**
Non-Personnel			**Total**
Professional Services:			
Interim Project Manager (Jan. - March 2016)			23,605
Communications Support (website)			3,500
Legal or other consultant[2]			5,000
Travel			4,000
Supplies			3,000
Event/Meeting Expenses			5,000
Other			0
Subtotal Non-Personnel Costs			**44,105**
Indirect Costs (25% of salaries & benefits)[1]			47,805
TOTAL EXPENDITURES[3]			**283,129**
DESIGNATED RESERVES[4]			**206,871**

2017
January 1, 2017-December 31, 2017

EXPENDITURES

Personnel	Salaries	Benefits[1]	Total
Executive Director: 1.0 FTE for 12 months	107,932	26,983	134,915
Assistant: 1.0 FTE for 12 months	47,516	11,879	59,395
Subtotal Personnel Costs	**155,448**	**38,862**	**194,310**
Non-Personnel			**Total**
Professional Services:			
Legal or other consultant[2]			2,000
Program Coordinator: 80 hrs/month for 12 months			52,800
Epidemiologist: 20 hrs/month for 12 months			15,698
Travel			4,500
Supplies			1,500
Event/Meeting Expenses			5,000
Other			0
Subtotal Non-Personnel Costs			**81,498**
Indirect Costs (15% of salaries & benefits)[1]			29,147
TOTAL EXPENDITURES[3]			**304,955**
DESIGNATED RESERVES[4]			**212,916**

2018
January 1, 2018-December 31, 2018

EXPENDITURES

Personnel	Salaries	Benefits[1]	Total
Executive Director: 1.0 FTE for 12 months	110,091	27,523	137,614
Assistant: 1.0 FTE for 12 months	48,466	12,116	60,582
Subtotal Personnel Costs	**158,557**	**39,639**	**198,196**
Non-Personnel			**Total**
Professional Services:			
Legal or other consultant[2]			2,000
Program Coordinator: 80 hrs/month for 12 months			52,800
Epidemiologist: 20 hrs/month for 12 months			15,698
Travel			5,000
Supplies			1,500
Event/Meeting Expenses			5,000
Other			0
Subtotal Non-Personnel Costs			**81,998**
Indirect Costs (15% of salaries & benefits)[1]			29,729
TOTAL EXPENDITURES[3]			**309,924**
DESIGNATED RESERVES[4]			**161,992**

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

Items in red in 2016 budget are revisions from the approved February 2016 budget
Assumes a 2% cost of living wage increase

KITSAP PUBLIC HEALTH DISTRICT

CLASSIFICATION

OLYMPIC COMMUNITY OF HEALTH DIRECTOR

DEFINITION

The Olympic Community of Health Director is responsible for planning, organizing, directing, and administering the operations of a small team within the Kitsap Public Health District that effectively and efficiently supports a large, highly complex and politically nuanced population health improvement project across a three-county region, called the Olympic Community of Health (OCH). The OCH Director may serve as a member of the District's Executive Leadership Team and works collaboratively to advise the Team on how best to carry out the mission of the District as it relates to the work of the OCH. The OCH Director contributes to the goal of creating and maintaining an integrated, comprehensive health service delivery system through effective collaboration with stakeholders, employees, other government agencies, community organizations, and contractors. The incumbent makes professional and technical decisions, exercising considerable independence in decision making on complex and significant issues which impact overall OCH operations and may have a significant impact on health system reform on a long-term basis. The OCH Director serves at will and is directly responsible to the OCH's governing body and the Administrator. Because the incumbent is a highly professional and effective leader, he/she operates generally independently, while receiving broad, long-term, administrative direction in terms of system-wide policy and advice for dealing with potentially major controversies, emergencies, or crises.

DISTINGUISHING CHARACTERISTICS

Support and Guide the Governing Body as It Leads the OCH

The OCH Director's work involves interaction with a culturally diverse population of employees, consumers, educational institutions, governmental agencies, businesses, healthcare providers, and community-based coalitions to address health and environmental issues affecting the public's safety and welfare. The OCH Director acts as a resource for setting strategy for the OCH. The position leads engagement of the Board, and all constituencies. As an agent of the Board, the position monitors work and ensures that all contract expectations are met along expected timelines. The position sets a tone of understanding, and uses sensitivity in addressing cultural differences and health disparities. The position advocates for the interests of the region.

Support Committees and Activities

The OCH Director will work to support various committees, and prepare materials for use by committees and constituents. The OCH Director supports OCH design and policy development, and duties require related professional expertise, knowledge of managerial principles, and extensive management experience. Duties require advanced expertise in broadly evaluating options, presenting plans, and uniting others in support of programs critical to key goals and objectives to ensure the OCH's success.

Engagement and Communications

The OCH Director organizes and carries out public engagement for the OCH and serves as the public voice of the OCH. Incumbent is a key resource in communicating OCH activities to external audiences, gathering input from constituencies, and keeping OCH stakeholders informed of health system reform work. The position organizes and carries out the OCH's communications strategy and activities.

Coordinate and Develop Plans and Analyze Options for Action
The OCH Director provides data analysis or uses existing data analysis. The incumbent develops and steward planning processes and plans as required, emphasizing synthesis of existing plans. The position assists with prioritization and staffs planning committees. The Director conducts research and policy assessment with an eye toward understanding local perspectives and needs, and reflecting these forward to policy makers.

Manage One or More Implementation Projects
The OCH Director will manage collective impact projects related to OCH goals, concordant with regional health improvement priorities. The incumbent will staff relevant committees and engage needed project partners.

Management and Supervision
The OCH Director has responsibility for a work unit supporting a complex three-county public health improvement effort with significant interactions with key community and business leaders, and having critical impact upon the public's health. The position is responsible for ensuring that deliverables are met and budget monitored and managed. The supervision administered by the OCH Director includes leading, directing and coaching staff; responsibility for such personnel actions as hiring, formal progressive discipline, responding to employee grievances, conducting performance evaluations, and making effective recommendations on termination of employment. The OCH Director promotes and contributes to positive, collaborative District relationships based on the District's organizational values and interest-based decision making.

This description reflects the general concept and intent of the classification and should not be construed as a detailed statement of all the work requirements that may be inherent in the position.

ESSENTIAL FUNCTIONS

- The OCH Director's work balances contributions to the District's mission with the complex work required to bring together multiple stakeholders and interested parties to create forward progress in transforming the public's health in a three-county region. The incumbent assures that team members (whether District co-workers or OCH collaborators) are clear on their specific roles, deliverables, and accountabilities relative to the overall OCH work plan. The incumbent fosters effective communication among members of these teams and participates in team meetings to support strong communication across the larger portfolio of Healthier Washington-related initiatives.
- Coordinates the start-up and functioning of a cross-sector governing body and associated committees and work groups. Assures the development and use of effective charters or operating agreements, work plans, and deliverables. Supports the work of the governing body to create a formal legal structure that will ensure the sustainability of the entity as the work of Healthier Washington moves forward, to ensure maximum population health impact across the region.
- Develops strong working relationships with governing body members; works to understand perspectives and create an environment of mutual respect, trust, and buy-in. Supports the governing body in identifying potential conflicts of interest and methods for addressing them. Guides the governing body as it leads the OCH, leading them in strategic planning, priority-setting, sustainability and assessment activities.
- Conceptualizes critical paths for achievement of deliverables, gathers and analyzes feedback and information, develops outcome-based agendas, and facilitates meetings. Supports the governing body in having effective discussions regarding future governance structures and other decision

making. Strategizes with OCH members, colleagues, and stakeholders on effective pathways to move the work forward.

- Develops and manages the OCH budget, ensuring budget compliance, monitoring, tracking, and ensures that all work stays within budgetary constraints. Works to develop other sources of funding, including potential membership contributions. Manages subcontracts when external expertise is required, within budget, ensuring that the contractor performs as agreed.
- Assesses needs for technical expertise and consultation throughout the project. Makes recommendations for and procures consultant services, within available budget. Manages consultant work in support of OCH governing body objectives.
- Provides the chief public presence and voice of the OCH as empowered to do so by the governing body, and acts as the lead spokesperson and public presence for the OCH and its community initiatives.
- Creates, reviews and approves summaries and/or reports which provide information, status updates and program justification for all components of the work. Provides regular status reports to internal and external audiences. Flags issues that need attention from colleagues, District leadership, or the OCH members to remove barriers.
- Engages a wide range of stakeholders to ensure full representation and participation of groups and demographics associated with the work, including healthcare and public health consumer involvement. Ensures the sustained collaborative involvement of the right local and state partners.
- Brings stakeholders together to analyze data, evaluate evidence-based projects, and implement projects that can effectively improve the public's health across the region.
- Prepares straw proposals, briefing documents, speaking points, presentations, reports, applications, budgets and/or other documents associated with moving work plans forward.
- Liaisons with the Washington State Health Care Authority, and other agencies involved in the Healthier Washington work, to ensure maximum coordination between the various arms of the effort in the OCH. Participate in planning and technical assistance sessions with other Accountable Community of Health projects across the state, as appropriate.
- Oversees grant funding procurement and develops proposals based on OCH governing body guidance; monitors and ensures OCH design grant implementation, funding, milestone achievement, evaluation, and reporting.
- Provide direction, administration and short- and long-term planning and evaluation for the OCH team. Plans, organizes, and supervises the work of staff. Recommends selection of staff, develops procedures and performance standards, provides training, monitors progress, provides discipline and evaluates employee performance. Collaborates in staff development, communications, program planning, implementation, and evaluation, including community partners as appropriate.
- Investigates citizen complaints regarding staff, policies, etc., and in conjunction with the Administrator, plans and initiates appropriate actions to resolve problems.
- Serves as a resource person for staff; motivates and mentors staff in providing quality and appropriate quantity of work in assigned area utilizing resources efficiently; models and promotes team building skills among assigned staff.
- Coordinates, reviews and evaluates the program work plan(s); meets with staff to identify and resolve problems; assigns work activities and projects; monitors work flow; reviews and evaluates work products; methods and procedures.
- Prepares a variety of letters, memos, minutes, contracts, forms, reports, and other documents; operates computers to produce documents with clearly organized thoughts using proper sentence construction, punctuation, and grammar.
- Establishes and maintains cooperative, effective working relationships with a diverse population of government officials, community-based agencies, coworkers, other District employees, and the

general public using principles of good customer service.
- Responds to public health emergencies as required by the District.
- Reports for scheduled work with regular, reliable and punctual attendance.
- Performs other related duties as assigned.

REQUIRED KNOWLEDGE, SKILLS & ABILITIES

Knowledge of:
- Theories, principles, techniques, and practices of carrying out complex multi- and cross-sector planning in the health, human services and/or community development fields, and managing groups with multiple perspectives and interests. This includes data analysis, and the ability to lead others in priority setting.
- Grant, project and contract management.
- Effective leadership principles, managerial practices and group/organizational dynamics.
- Principles and practices of management, including budgeting, personnel, planning, program analysis, and evaluation.
- Principles of public relations and customer service.
- Current literature, trends, and developments in healthcare and health system reform in Washington State.
- Project management, including planning, scheduling, monitoring, and problem solving.

Skill and Ability to:
- Establish and maintain effective working relationships with diverse populations of stakeholders and customers, community based organizations, agencies, businesses, healthcare providers and coworkers.
- Communicate effectively verbally and in writing, presenting complicated issues in understandable ways, using tact and diplomacy to gain collaboration. This includes public speaking and presentations.
- Use and create computer-based documents, email, calendars, and other electronic tools to ensure efficient, accessible, accountable work.
- Market public health interventions and prevention work effectively.
- Manage and facilitate events and meetings.
- Lead, direct, manage and evaluate the work of staff efficiently and effectively.
- Provide effective guidance to staff through coaching, mentoring, training and delegation.
- Communicate effectively both orally and in writing to include giving public presentations, addressing governing boards and community forums, and compiling written reports and speeches.
- Plan and organize activities to meet established objectives.
- Use systems thinking; understand, interpret, explain and apply best practices, laws, rules and regulations within assigned specialized areas.
- Make timely decisions considering relevant factors and evaluating alternatives, exercising discretion and sound independent judgment.
- Gather and analyze data and develop clear, concise and comprehensive reports, correspondence and other written materials.
- Create and meet schedules, time lines and work independently with little direction.
- Utilize computers and related software and automated equipment to produce documents and reports, typing with sufficient speed and accuracy to accomplish assignments in a timely manner.

- Perform duties in confidence and under pressure for deadlines, and to maintain professional composure and tact, patience and courtesy at all times.
- Work effectively in a dynamic environment that is constantly changing, resulting in continually re-evaluating and shifting priorities.
- Work both independently and within a collaborative team-oriented environment; contribute openly, respectfully disagree, understand the ideas of others, listen well and work for consensus.

WORK ENVIRONMENT & PHYSICAL DEMANDS

- Work is performed primarily indoors in an office environment, with frequent travel to meet with regional stakeholders, and to attend meetings, conferences, seminars, etc.
- Requires the ability to communicate with others orally, face to face and by telephone. Requires manual and finger dexterity and hand-eye-arm coordination to write and to operate computers and a variety of general office equipment. Requires mobility to accomplish other desktop work, retrieve files, and to move to various District locations. Requires visual acuity to read computer screens, printed materials, and detailed information. Essential duties may involve occasional kneeling, squatting, crouching, stooping, crawling, standing, bending, and climbing (to stack, store or retrieve supplies or various office equipment).
- Frequently assigned to respond to on-call coverage, including evenings, weekends and holidays.
- Duties require carrying a cell phone or other electronic device as well as being available to work as needed to meet District needs, which may include evenings, weekends and holidays.
- This is an overtime-exempt position, which may require working beyond the normally scheduled workweek, modifying existing work schedules, or flexing hours.
- Exposure to individuals from the public who are upset, angry, agitated and sometimes hostile, requiring the use of conflict management and coping skills.
- Frequently required to perform work in confidence and under pressure for deadlines, and to maintain professional composure and tact, patience and courtesy at all times.
- The environment is dynamic and constantly changing, resulting in continually re-evaluating and shifting priorities.
- May be required to stay at or return to work during public health incidents and/or emergencies to perform duties specific to this classification or to perform other duties as requested in an assigned response position. This may require working a non-traditional work schedule or working outside normal assigned duties during the incident and/or emergency.

EDUCATION & EXPERIENCE REQUIREMENTS

- Master's degree from an accredited institution in a job-related field which includes an administrative component and eight (8) years of progressively responsible and relevant professional experience, of which at least three years have been of recent relevant management experience.
- Alternatively, an equivalent combination of education, experience and professional certification may be qualifying, provided the individual's background demonstrates evidence of the knowledge, skills and abilities required to perform the duties of the position.

LICENSES, CERTIFICATIONS & OTHER REQUIREMENTS

- A valid Washington State driver's license and proof of appropriate auto insurance are required at the time of appointment or at a time set by the District.

- All required licenses must be maintained in an active status without suspension or revocation throughout employment.

JOB CLASS INFORMATION & DISCLAIMERS

FLSA Status	Exempt
EEO Category	Officials and Administrators
Bargaining Unit Status	Executive Management
Classification History	New
Adopted	February 2, 2016

The statements contained herein reflect general details as necessary to describe the principal functions for this job, the level of knowledge and skill typically required and the scope of responsibility, but should not be considered an all-inclusive listing of work requirements. Individuals may perform other duties as assigned including work in other functional areas to cover absences or relief, to equalize peak work periods, or to balance the workload.

The physical demands described above are representative of those that must be met by an employee to successfully perform the essential functions of the job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Kitsap Public Health District

OLYMPIC COMMUNITY OF HEALTH
2016 PROPOSED OPERATING BUDGET
Revised 2/5/2016

REVENUES

Description	Total
HCA ACH Phase 1 Grant *(See Note Below)*	350,000
Clallam County	10,000
TOTAL REVENUES	**360,000**

Note : $130,000 of the total Year 2 HCA ACH Design Grant funding amount of $480,000 is reserved for 2017. Total grant funds remaining for 2017 and 2018 equal $460,000 (or $230,000/year).

EXPENDITURES

Personnel	Salaries	Benefits
Director: 1.0 FTE for 9 months	79,362	23,809
Program Coordinator 2: 1.0 FTE for 8 months	47,752	14,326
Epidemiologist: 0.5 FTE for 11 months	37,279	11,184
Secretary: 0.4 FTE for 12 months	18,634	5,590
Subtotal Personnel Costs	**183,027**	**54,908**
Non-Personnel		
Professional Services: Interim Project Manager (Jan. - March 2016)		
Professional Services: Communications Support		
Travel		
Supplies		
Event/Meeting Expenses		
Other (Balancing Amount)		
Subtotal Non-Personnel Costs		
Indirect Costs (25% of salaries & benefits)		
TOTAL EXPENDITURES		

Total
103,171
62,078
48,463
24,224
237,935

Total
22,880
25,000
4,000
3,000
5,000
2,702
62,582
59,484
360,000

ACH Readiness Proposal Category 1.1
LEADERSHIP COUNCIL CHARTER
Better Health. Better Care. Lower Cost.

1.1.1 History and Purpose of this Charter

The purpose of this revised Olympic Community of Health (OCH) Leadership Charter is to support the continued maturation of the OCH as a designated Accountable Community of Health (ACH) for the Olympic region, consisting of Clallam, Jefferson, and Kitsap counties. The original Charter was approved by an Interim Leadership Council October 19, 2015 and subsequently approved by OCH Stakeholders November 2, 2015. The Charter was created with the intent to move the OCH to its next stage of development, and to document and implement a regional health improvement plan. Both the original Charter and this 2016 revision were prepared based on review of existing HCA guidance and other regional ACH governance documents. The 2016 revisions were approved by the Interim Leadership Council February 29, 2016, conditional on the addition of a Leadership Council Steering Committee (Section 1.1.6). The newly revised Charter will be recommended for adoption by OCH stakeholders as a whole by March 2016. Then as directed by the original ILC Charter, the ILC will disband following its April 2016 meeting and reconstitute itself as the governing body for the OCH. From this point forward it will serve as the OCH Leadership Council, meeting monthly and as frequently thereafter as necessary to fulfill its responsibilities.

Even with these revisions, the Charter remains a work in progress, and is not yet inclusive of all elements we may choose to address in the very near future. It has established a basis by which an OCH Leadership Council (LC) can readily meet its primary objectives to maintain official designation and carry out the responsibilities of an ACH. Recommendation of an optimal OCH governance structure is supported by research and technical assistance, including from the Washington State Health Care Authority, discussion and recommendations by the OCH and time for testing and adjustments. The LC Governance Subcommittee will focus on continued review and revision to the structure during the first nine months of 2016, and as necessary thereafter. By April 2016 it is anticipated the Health Care Authority will outline a significant new role for ACH's related to approval of Washington's Global Medicaid Waiver 1115 that also may require a more formal governance structure be put in place. This revised Charter therefore is a bridge between the intentionally short term Interim Leadership Council (October 2015 – February 2016), formalization of a Leadership Council under this Charter (April 2016), and the awareness that during 2016 a legal, formal governance structure will likely be chosen and put in place.

The Leadership Council consists of a multi-sector group of leaders necessary to continue rapidly building on the work accomplished during preparations for ACH designation and the Regional Health Improvement Plan process. We anticipate the Leadership Council's work will be driven short timelines, by the deliverables included in HCA's ACH Award to the region, and agreements that will need to be reached by mid-2016 regarding the functions and

governance of the OCH moving forward as an ACH if agreement with the Center for Medicaid Services is reached regarding a Global 1115 Medicaid Waiver, and what stakeholders and/or sectors will play which roles in the future to effectively mobilize the region around real health improvement.

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 and vulnerable adult 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 Leadership Council will allow regular opportunities for public comment at its meetings.

1.1.5 Leadership Council (LC) Representation

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 LC 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 LC participation. Sector stakeholders may identify an alternate if their representative is unable to attend either in person or via conference call when it is an available option. Each sector will constitute one "vote" in decision making.

NEW, ILC Approved: Terms for the Leadership Council will be made up of eight participants appointed for one year terms, eight participants for two year terms, and seven participants will serve for three-year terms. Individuals may be appointed by their sector as meeting designee should it be necessary for them to be absent, or appointed by their sector to fill a vacancy for the remainder of the term. Should additional sectors be added over time as the Leadership Council continues to broaden its scope of representation, terms shall be assigned so as to maintain a balance of year rotations. LC Sector representative composition will be reviewed the first quarter of each subsequent year for geographic balance, sector inclusion, community voice, and terms.

Leadership Council participation 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
- Federally-Qualified Health Clinic
- Private/Not for Profit Hospital
- Hoh Tribe
- Housing/Homeless

- Jamestown S'Klallam Tribe
- Long-Term Care/Area Agency on Aging/Home Health
- Lower Elwah Klallam Tribe
- Makah Tribe
- Medicaid Managed Care Representative
- Mental Health (Medicaid Provider)
- Oral Health
- Port Gamble S'Klallam
- Primary Care
- Public Health
- Public Hospital
- Quileute Tribe
- Rural Health
- Suquamish Tribe

Total Voting Members: 23

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

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 Leadership Council

The Leadership Council will meet at least once monthly to continue its role in moving the OCH toward status as a formal, independent structure capable of meeting the criteria of a Coordinating Entity, and to ensure the expectations and deliverables associated with being an Accountable Community of Health are underway and ultimately, met. A primary function of the Leadership Council's role is to support the Olympic OCH Stakeholders, oversee the work of OCH staff and consultants, manage the work plan and budget, maintain project momentum, further develop an engagement strategy and community mobilization plan, and resolve problems and issues. In addition to assuring the OCH is focused on regional planning and projects that will substantively meet the Triple Aim, the LC 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 continue development and implementation of the long-term plan for administration, financing and sustainability of the OCH.

NEW: A Steering Committee will exist that is responsible for working with the Chair and staff assigned to the OCH Leadership Council so as to conduct the routine business of the organization (such as agenda setting), and to hear and decide on pressing matters of business which may arise between regularly scheduled OCH Leadership Council meetings which require a decision before the next meeting. The OCH Leadership Council can also delegate specific decision making authority to the Steering Committee on a case by case basis. The Steering Committee is comprised of the OCH LC Chair and at least 2 and no more than 5 LC representatives who reflect varied sector LC representation. The Steering Committee is accountable to the OCH LC.

1.1.7 Leadership Council Subcommittees

To support the work of the OCH Leadership Council, three subcommittees have been formed. The LC may also elect to establish other committees, action groups as needed, in particular, committees or action groups associated with the carrying out the Regional Health Improvement Plan process and Community Engagement. These committees may disband when a final governance structure is adopted as determined by the Leadership Council.

The three LC Subcommittees include 1) Governance, 2) Community Health Assessment and Planning, and 3) Sustainability. The LC may invite additional OCH stakeholder representatives to participate in subcommittees, however, at least two participants in each subcommittee must be members of the LC, 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, sovereign tribal nations, and service 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 LC 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 a revised, but not yet final, governance structure for stakeholders to approve March 2016. Recommendations on the legal form of the OCH including by-laws and articles of incorporation will be made by June 2016, and work initiated during 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 a 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 persons, 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

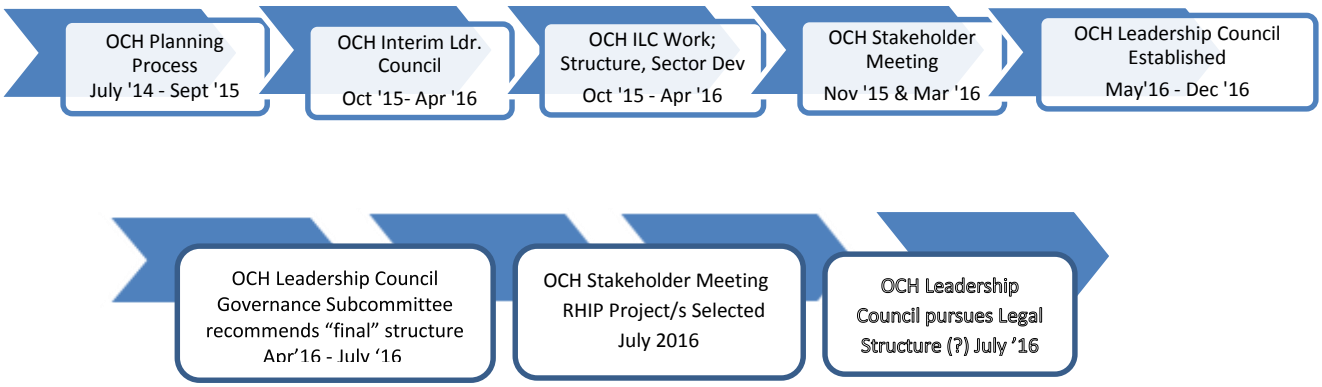
consolidate community health planning efforts required by various agencies and funders across the region; works on plan performance measures, and with other ACHs and the State, develops and implements a set of statewide performance measures. A collective impact approach to shared priorities, which will 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 persons and meet monthly. The Committee is ongoing and service innovations, including Medicaid Transformation Projects, are likely to be generated, recommended to the LC for implementation, 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 persons and will meet monthly. The Committee is ongoing.

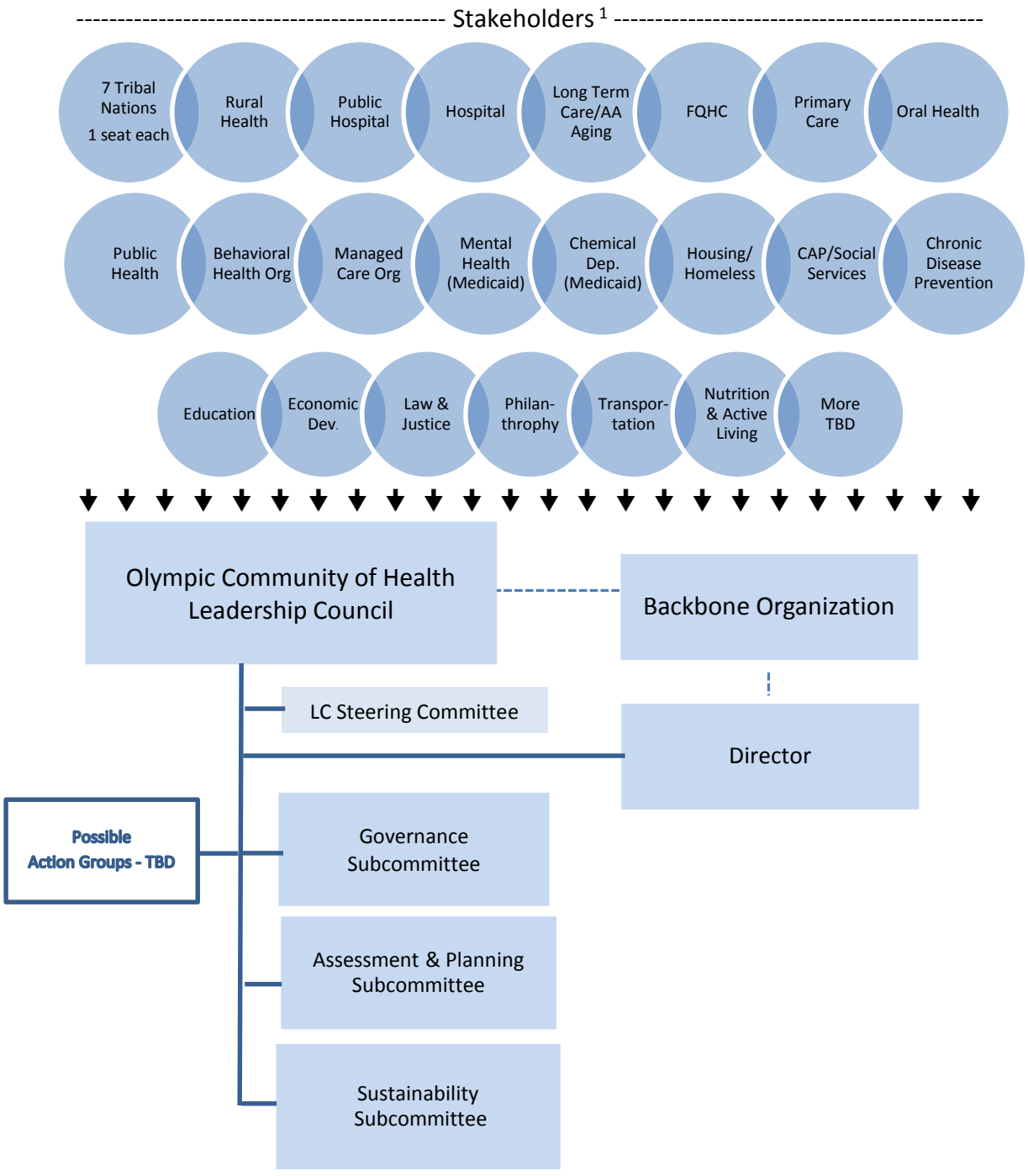
1.1.8 Duration of Leadership Council

The OCH Leadership Council agrees to work together, convening monthly meetings, until the formation of a formal entity with bylaws and Board exists, expected to be in place by December 2016. In late 2016, as part of an anticipated shift to an ongoing ACH structure, the Leadership Council will develop and execute a plan to transition from a transitional to an ongoing structure.

OLYMPIC COMMUNITY OF HEALTH DEVELOPMENT TIMELINE



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



[1] OCH Stakeholders from all sectors will populate organizational entities.

ACH Readiness Proposal Category 1.3
OCH Leadership Council & Backbone Support Organization
Roles & Responsibilities

1.3.1 Roles and Responsibilities of the OCH Leadership Council

- The LC, with the Project Director will continue to substantiate it's designation as an Accountable Community of Health from the Washington State Health Care Authority. With support from the Backbone Agency, updates to the existing Readiness Proposal will be submitted in November 2016. The OCH, LC 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 LC will develop a final recommended OCH governance structure for stakeholder adoption by November 2016, and implement a transition plan to the more permanent governance structure no later than January 31, 2017. 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 LC 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 LC will recommend and begin implementation of 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 LC 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 LC 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 LC 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 the mechanism is implemented for periodic reaffirmation of the virtual backbone organization in order to allow for adjustments over time, as necessary. The current 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 LC.

- The LC 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 LC as the governing body for the OCH.

- The LC 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 Backbone Entity

During 2015, at the request of participating OCH Stakeholders, the 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 as approved by the LC to do so and as agreed upon by the Health District. Oversight of the Backbone Entity was initially provided by the OCH Steering Committee, and will subsequently be provided by the Leadership Council.

The 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 provided to the Leadership Council, and Subcommittees by a Project Director who with the LC 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 Director reports to the Leadership Council and is contracted for services through the fiscal backbone.

The Project Director 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 Director 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 LC agenda. The Project Director is supported by backbone entity support staff who record and distribute meeting summaries to the membership and are responsible to post these on the OCH website for access by OCH stakeholders and the public. The website is maintained by Kitsap County Human Services Department. Expanded website development to be initiated April 2016.

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 Leadership Council (LC) 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 (or via conference call if necessary and when available) at LC meetings.

Every effort will be made to determine LC 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 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 LC representative cannot support an emerging agreement of the group, the representative 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 LC representatives are obligated to try to find an alternative that meets the interests of the concerned party as well as their own.

If the LC 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 LC and decided by a simple majority of sector representatives present, provided there is a quorum (50% of voting representatives). Robert's Rules of Order will then be used to facilitate LC 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 Leadership Council acknowledge that conflicts, real or perceived, may surface in their work. This may occur within and among sector representatives of the LC, its multiple stakeholders, project staff/consultants, and state partners working on the initiative.

The LC seeks 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 Leadership Council will be intentional in identifying potential conflicts of interest. Sector representatives should raise or ask fellow representatives about potential conflicts related to the topics under discussion or decision making. Representatives, staff, and consultants are expected to disclose potentially relevant conflicts, at which time the Leadership Council 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 Leadership Council, with approval for adoption requested of the OCH stakeholders by November 2016, recommendation of the current governance structure is described in sections 1.6.2 and 1.6.3 below.

1.6.2 Leadership Council

On an annual basis, the Leadership Council 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

Governance SBAR – Attachment 9

Leadership Council – Action Item

May 4, 2016

Situation | Background | Assessment | Recommendation

Situation

To be a successful ACH, our governance structure must accommodate the following functions:

1. Selection and strategic oversight of a regional health improvement project, and
2. Becoming the single point of authority for transformation project implementation and oversight for the Olympic region under the Medicaid waiver. (See HMA memos, attachment 2)

Over the next 3 months, the state will ask the OCH to submit deliverables and make decisions on both of the above counts.

Background

The approved governance structure in the *Interim Leadership Council Charter* and the *Pathway to Governance Decision-Making* provides a solid foundation:

- ✓ Moving from the Interim Leadership Council to a Governing Body
- ✓ Forming a Steering Committee
- ✓ Employing a balanced, multi-sector composition with one vote per sector
- ✓ Inviting all 7 Tribes to participate
- ✓ Deploying subcommittees
- ✓ Calling out term limits
- ✓ Beginning conversations on becoming a legal entity

Assessment

The OCH assembled its current governance structure for the first phase of ACH development. In March of 2016 it became clear that the functions asked of the ACHs will be substantially more sophisticated than originally thought. Health Management Associates (HMA) (See HMA memos, attachment 2) recommended to the state that "*there must be a single entity that retains final decision-making authority, serves as the contract partner for the state, and is held accountable for fulfilling the terms of the contract*." **From this, the HCA has confirmed that the OCH must have certain essential components, including: defined legal entity, accountability written into bylaws (convener, needs assessment, project planning and others), multi-sector representation, financial administration and management capacity, and operations capacity (e.g., transformation projects).**

Recommendations

Below are a set of recommendations offered for discussion and decision. Each recommendation can be treated individually; however, careful consideration should be given to ensure a holistic governance structure is created.

Recommended Action 1. Establish a **board of directors** that is largely made of up of the existing Leadership Council, with a few caveats.

To keep the board to a manageable size, minimize duplication of sector representation wherever possible. There are three sectors that may be considered over-represented: 1) primary care (represented in federally

qualified health center), 2) chemical dependency (represented in county-based human services and mental health services) and 3) housing (represented in community action agency). If agreed, by removing these redundancies the Board will consist of 19 voting members. As stated in the charter, only members of the Board may vote**.** Here would be the current voting members by sector:

#	Name and Affiliation of VOTING member	County	Service Area	Sector(s)
1	**Doug Washburn** Director Kitsap County Human Services	Kitsap	Clallam Jefferson Kitsap	1. **Behavioral Health Organization** 2. **Chemical Dependency** (Medicaid Provider) 3. **Housing/Homelessness**
2	**Peter Casey** *(Retiring in August)* Executive Director Peninsula Behavioral Health	Clallam	Clallam	**Mental Health** (Medicaid Provider)
3	**Michael Anderson, MD** (*to be replaced by David Schutz CEO)* Chief Medical Officer CHI Franciscan Harrison Medical Center	Kitsap	Clallam Jefferson Kitsap	**Private/Not for Profit Hospital**
4	**Eric Lewis** Chief Executive Officer Olympic Medical Center	Clallam	Clallam	**Public Hospital**
5	**Hilary Whittington** Chief Financial Officer Jefferson Healthcare	Jefferson	Jefferson	**Rural Health**
6	**Jennifer Kreidler-Moss, PharmD** Chief Executive Officer Peninsula Community Health Services	Kitsap	Kitsap	1. **Federally Qualified Health Clinic** 2. **Mental Health** 3. **Primary Care**
7	**Kat Latet** Community Health Plan of WA	Statewide	Statewide	**Medicaid Managed Care** (rotating chair by MCOs)
8	**Thomas Locke, MD** County Health Officer, Jefferson CEO, Jamestown Family Health Clinic Board President, Washington Dental Service Foundation	Jefferson	Statewide	1. **Oral Health** 2. **Public Health** 3. **Philanthropy** 4. **Tribe**
9	**Katie Eilers** Assistant Director, Community Health Kitsap Public Health District	Kitsap	Clallam Jefferson Kitsap	**Chronic Disease Prevention Across the Lifespan**
10	**Chris Frank, MD** Health Officer Clallam County Public Health	Clallam	Clallam	**Public Health**
11	**Roy Walker** Executive Director Olympic Area on Aging	Clallam Jefferson	Clallam Jefferson	**Long Term Care/Area Agency on Aging/ Home Health**
12	**Larry Eyer** Executive Director Kitsap Community Resources	Kitsap	Kitsap	1. **Community Action Program/ Social Service Agency** 2. **Housing/Homeless**
13	**Maria Lopez***	Clallam		**Tribe**

	Tribal Chairwoman Hoh Tribe			
14	**Andrew Shogren*** Health Director Quileute Tribe	Clallam		**Tribe**
15	**Timothy Green Sr.*** Tribal Chair Makah Tribe	Clallam		**Tribe**
16	**Frances Charles*** Tribal Chairwoman Lower Elwah Klallam Tribe	Clallam		**Tribe**
17	**Ron Allen*** Tribal Chair Jamestown S'Klallam Tribe	Clallam		**Tribe**
18	**Jeromy Sullivan*** Tribal Chair **Kelly Sullivan*** Executive Director, Tribal Services **Kerstin Powell*** Health Center Business Office Manager Port Gamble S'Klallam Tribe	Kitsap		**Tribe**
19	**Leonard Forsman*** Tribal Chair Suquamish Tribe	Kitsap		**Tribe**
	Justin Seville Director, Operations Harrison Health Partners	Kitsap	Kitsap	**Primary Care**
	Robin O Grady Executive Director West Sound Treatment Center	Kitsap	Kitsap	**Chemical Dependency**
	Kurt Weist Executive Director Bremerton Housing Authority	Kitsap	Kitsap	**Housing/Homelessness**

**Tribal representative identification is still under development*

Postpone adding the two newly identified sectors by HMA as part of the minimum set of sectors. These are *Medicaid consumer* and *government official*. HCA has not yet endorsed these as a mandate for ACHs.

Postpone adding the additional sectors called out in section 1.15 of the *Leadership Council Charter* until the next round of governance iterations. This is partly due to our challenging timeline, but more so due to the nice balance that is currently in our existing Leadership Council.

Recommended Action 2. Form an **executive committee** of 5-7 individuals from within the Board. The primary responsibilities of the executive committee are: 1) working with the

director on ongoing issues regarding the business of the OCH, 2) listening and deciding on pressing matters of business which may arise between regularly scheduled board meetings, and 3) receiving tasks delegated by the board on a case-by-case basis.

Form an *ad hoc* nominating committee of at least three board members who are not interested in serving on the executive committee. Call out for executive committee nominees for vetting and recommend a slate to the board. Vote on the slate of nominees at the June board meeting.

Recommended Action 3. Convert the current assessment and planning subcommittee into an ongoing **regional health assessment and planning committee** that is accountable to the board and whose primary responsibility is to 1) continually assess and build the OCH regional health assessment and 2) advise the board on planning and project selection. (More discussion in agenda item 6)

Recommended Action 4. The **governance committee** will meet one more time to recommend next steps for the governance of the OCH, and then transfer its duties to the executive committee.

Recommended Action 5. The work of the **sustainability committee** will become the responsibility of the OCH director, with the support of the executive committee as needed. The director will meet with the chair of this committee for a warm hand off.

Recommended Action 6. Each committee will use the same (or similar) **charter** (see charter template) that clearly defines membership, objectives, responsibilities and timeline. All charters will be approved by the board.

Recommended Action 7. When a board member **retires or changes employment into a new sector**, that member must caucus with his or her sector to declare a replacement on the board. In the event this cannot or does not happen, an *ad hoc* nominating committee will be established to call for nominees from that sector.

Next steps	Amend the OCH charter to reflect the changes decided today. The Director will research and work with the board, state, and other ACHs about the process, risks and benefits of becoming a legal entity. Based on the information available at present, pages 5&6 illustrate a potential a potential evolution of our governance structure over the next several years.

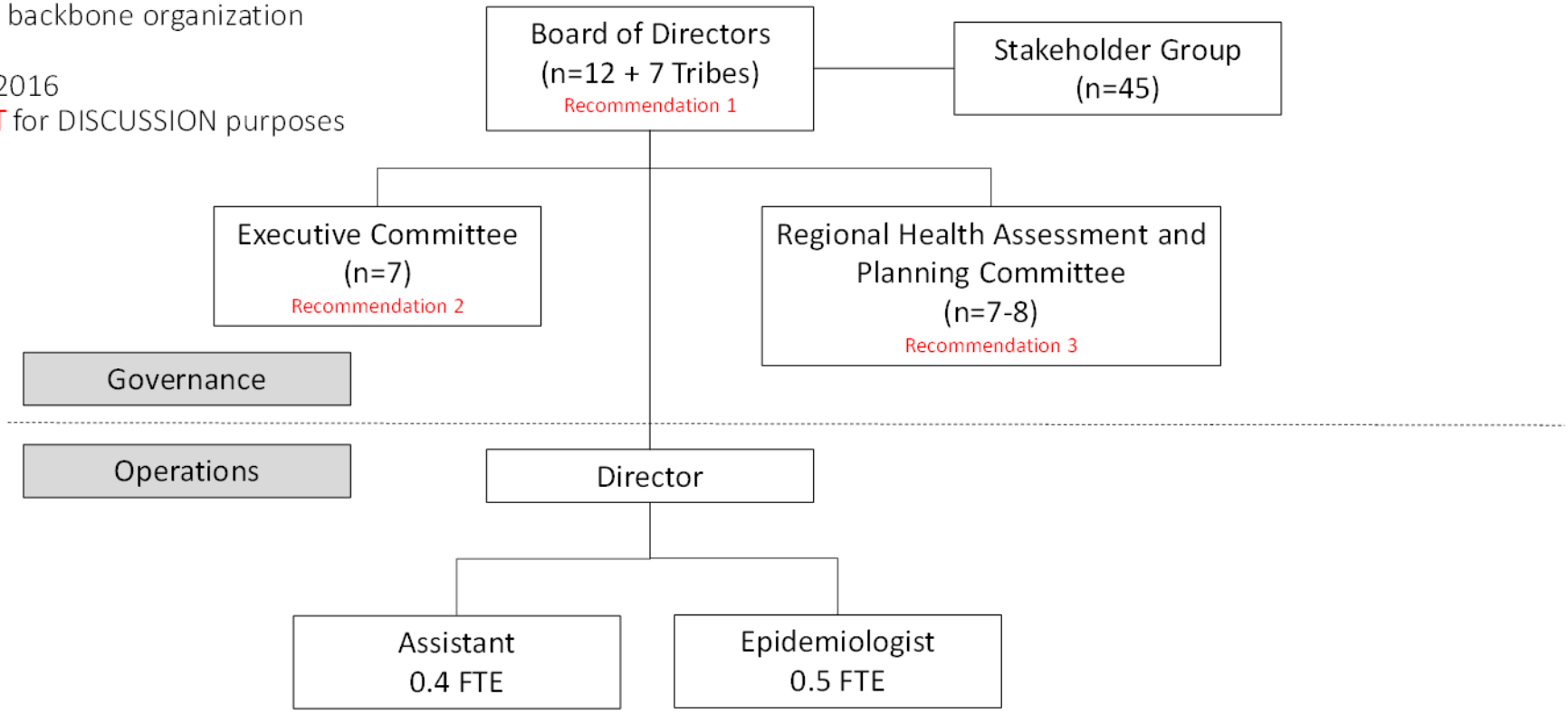
Olympic Community of Health

Proposed structure for Phase II of iterative governance process

Assumes Kitsap Public Health District is operating as the backbone organization

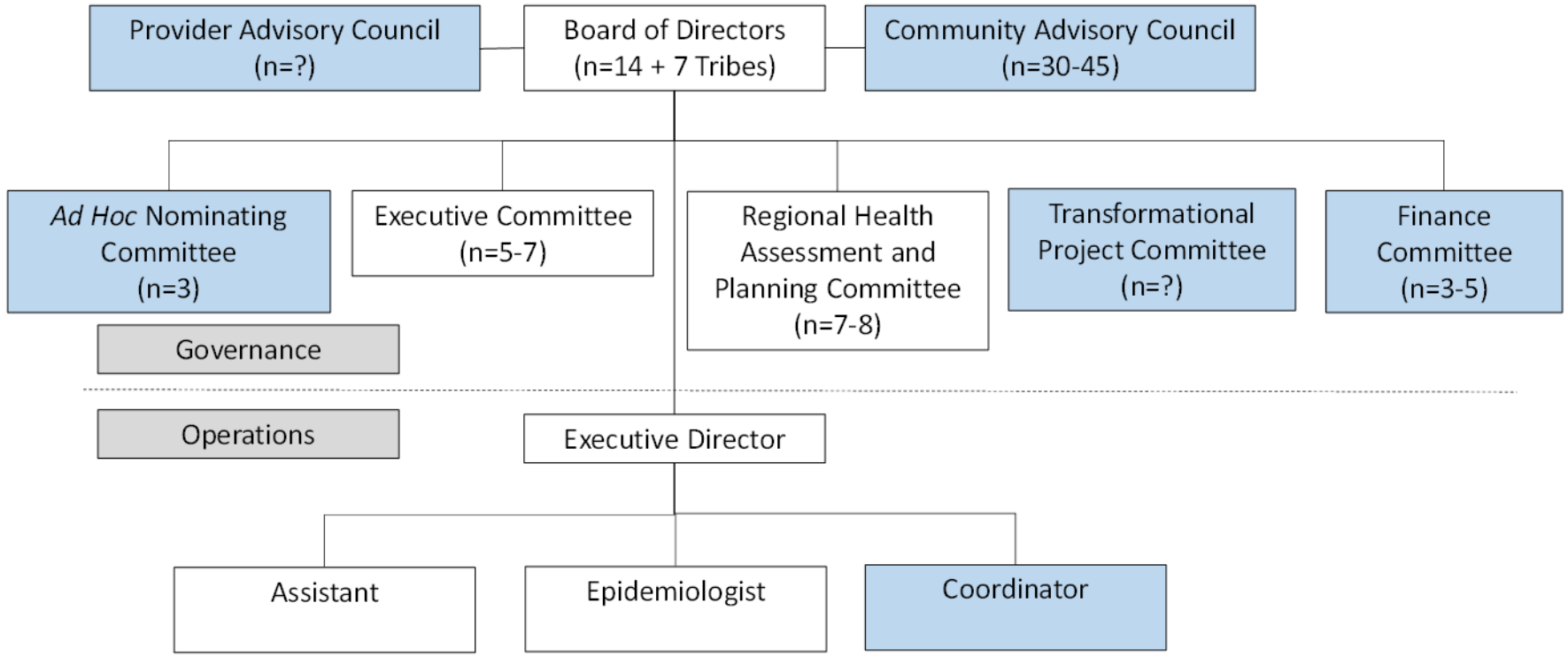
4/20/2016

DRAFT for DISCUSSION purposes



Olympic Community of Health

Possible structure for Phase III of iterative governance process
Assumes OCH is (or is close to) operating as its own legal entity
4/20/2016
DRAFT for DISCUSSION purposes



Olympic Community of Health

Regional Health Assessment & Planning SBAR – Attachment 11

Leadership Council – Action Item

May 4, 2016

Situation | Background | Assessment | Recommendation

Situation

- ✓ Assessment and planning are core functions of the OCH: they keep us grounded and focused on addressing the health needs of our communities.
- ✓ To meet our contractual obligations, the OCH must continually develop our Regional Health Needs Assessment (RHNA) and Regional Health Improvement Plan (RHIP). We must identify one or more "early win" projects by July and submit an action plan by October 2016.

Background

- ✓ OCH stakeholders selected five regional health priority areas: access, aging, behavioral health, chronic disease and early childhood.
- ✓ The HCA has disseminated a Framework for the Project Toolkit (attachment 3) with guidance on the transformation projects that will be included in the toolkit for the Medicaid waiver. Waiver projects are slated to begin January 1, 2017.

Assessment

- ✓ Health assessment and planning is an ongoing process and is a core activity for the OCH.
- ✓ Kicking off an "early win" project will show HCA how our region can collaborate and that we have the capacity to coordinate waiver projects.
- ✓ The "early win" project can build off of existing projects in the region that address our regional health priority areas.
- ✓ There are organizations within our OCH region that do routine assessment and planning as part of their scope of work.

Recommendation

Form a Regional Health Assessment and Planning Committee (RHAPC) that consists of a core minimum set of technical experts from organizations with an internal assessment component:

1. local health jurisdiction
2. area agency on aging
3. hospital
4. community action agency
5. Tribe
6. behavioral health organization

Members on this committee are not necessarily board members; however at least one board member is on this committee. Given the tight contract timelines, the RHAPC is formed immediately and frontloaded with the work necessary for project selection, implementation and oversight ahead of the waiver start date and in line with our HCA contract.

The RHAPC will have the following responsibilities:

- ✓ Update the RHNA as new information comes available.
- ✓ Develop a RHIP.
- ✓ Submit the RHNA and RHIP to the board for adoption at regular intervals.
- ✓ Vet potential project proposals using a template provided by the HCA and criteria developed by the RHAPC, with an eye towards the potential waiver projects.
- ✓ Submit the most promising project ideas to the board for discussion and approval.
- ✓ Share developments on the RHNA and RHIP with the OCH Stakeholder Group for feedback.

Name of Committee

Committee Members

1	5
2	6
3	7
4	8

Overview

Objective

Responsibilities

-
-
-
-

Timeline (for time-limited committees or committees with concrete deadlines)

OLYMPIC COMMUNITY OF HEALTH

REGIONAL HEALTH IMPROVEMENT PLAN OVERVIEW

"REGIONAL VISION, LOCAL ACTION"

OLYMPIC COMMUNITY OF HEALTH includes Clallam, Jefferson, and Kitsap Counties.

FOCUS AREAS:

- Access to Care
- Access to whole person support
- Population health improvements
- Data/regional infrastructure

SHARED REGIONAL PRIORITY AREAS:

WHAT IS A REGIONAL HEALTH IMPROVEMENT PLAN?

A regional plan that identifies and drives action for projects that address priority areas for health improvements throughout the service area, including the social determinants of health. The OCH RHIP process is guided by a subcommittee of the Leadership Council.

RHIP PROCESS

RHIP STATUS AND NEXT STEPS

ACTIVITY/STRATEGY	TARGET	STATUS
• Identify community data, assessments, plans, initiatives, measures and gather stakeholder input	11-2015	✓
• Develop matrix of shared priorities	12-2015	✓
• Subcommittee and ILC review synthesis of findings and develop preliminary priorities	1-2016	✓
• Stakeholders finalize shared regional priorities	3-2016	✓
• Begin development of the Regional Health Improvement Plan	5-2016	
• Finalize selection of at least one regional SIM project	7-31-16	
• Finalize action plan for regional SIM project	10-31-16	
• Publish progress dashboard and progress reports	Quarterly	
• RHIP reviewed to monitor progress and assess gaps	Annually	

ACCESS	AGING	BEHAVIORAL HEALTH	CHRONIC DISEASE	EARLY CHILDHOOD

OLYMPIC COMMUNITY OF HEALTH

REGIONAL HEALTH NEEDS AND ASSESSMENT INVENTORY OVERVIEW

"REGIONAL VISION, LOCAL ACTION"

OLYMPIC COMMUNITY OF HEALTH includes Clallam, Jefferson, and Kitsap Counties.

FOCUS AREAS:

- Access to Care
- Access to whole person support
- Population health improvements
- Data/regional infrastructure

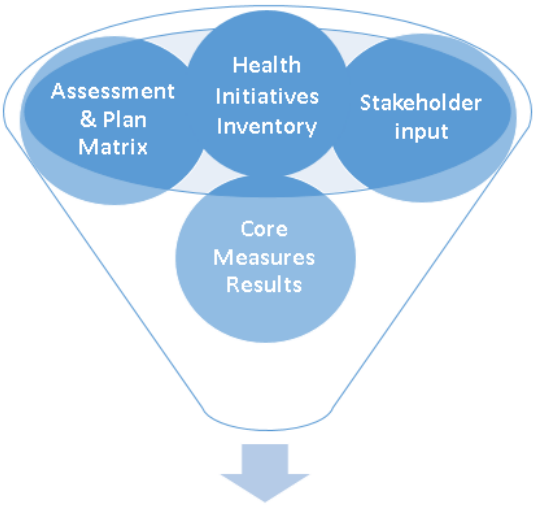
SHARED REGIONAL PRIORITY AREAS:

WHAT IS THE REGIONAL HEALTH NEEDS AND ASSESSMENT INVENTORY (RHNI)?

A compilation and synthesis of needs assessment reports, strategic planning reports, identified priorities, current initiatives, and stakeholder input on assets, gaps, and opportunities across the 3-county region. The inventory informs identification of shared regional priority areas and development of a Regional Health Improvement Plan (RHIP). The RHNI will be updated as new information becomes available.

FROM RHNI TO RHIP 2016 PROCESS

The first OCH RHNI included information from across the 3-county region in four *input* categories (see graphic).



These inputs informed selection of five regional health priority areas by OCH stakeholders on March 22, 2016 (bottom of page).

Development of the Regional Health Improvement Plan (RHIP) is beginning. The RHIP will include strategies and projects to address the shared regional priorities. By July 31, 2016, the OCH will select its first shared regional priority project to demonstrate a coordinated, collaborative effort that aims to improve the health and well-being of the residents of the region.

ACCESS	AGING	BEHAVIORAL HEALTH	CHRONIC DISEASE	EARLY CHILDHOOD