The Central Oregon Health Council Board of Directors reserves the right to transition into an executive session at any point during the Board meeting.
MINUTES OF A MEETING OF
THE BOARD OF DIRECTORS OF
CENTRAL OREGON HEALTH COUNCIL
HELD VIRTUALLY VIA ZOOM

May 13, 2021

A meeting of the Board of Directors (the “Board”) of Central Oregon Health Council, an Oregon public benefit corporation (the “Corporation”), was held at 12:30 p.m. Pacific Standard Time on May 13, 2021, online via Zoom. Notice of the meeting had been sent to all members of the Board in accordance with the Corporation’s bylaws.

Directors Present:    Rick Treleaven, Chair
                      Linda Johnson, Vice Chair
                      Patti Adair
                      Gary Allen, DMD
                      Eric Alexander
                      Paul Andrews, Ed.D
                      Tammy Baney
                      Megan Haase, FNP
                      Brad Porterfield
                      Divya Sharma, MD
                      Iman Simmons
                      Justin Sivill
Dan Stevens

Directors Absent: Seth Crawford
Kelly Simmelink

Guests Present: MaCayla Arsenault, Central Oregon Health Council
Rick Blackwell, PacificSource
Muriel DeLaVergne-Brown
Rebecca Donell, Oregon Health Authority
Gwen Jones, Central Oregon Health Council
Kat Mastrangelo, Volunteers in Medicine
Donna Mills, Central Oregon Health Council
Leslie Neugebauer, PacificSource
Kelsey Seymour, Central Oregon Health Council
Kristen Tobias, PacificSource
Renee Wirth, Central Oregon Health Council

Mr. Treleaven served as Chair of the meeting and Ms. Seymour served as Secretary of the meeting. Mr. Treleaven called the meeting to order and announced that a quorum of directors was present and the meeting, having been duly convened in accordance with the Corporation’s bylaws, was ready to proceed with business.

WELCOME
Mr. Treleaven welcomed all attendees to the meeting.

PUBLIC COMMENT
Mr. Treleaven welcomed public comment.
Ms. Mills announced the Joint Management Agreement (JMA) funds from 2019 totalling close to $4.2M have been awarded to behavioral health causes in Central Oregon.

**CONSENT AGENDA**
The consent agenda included the April minutes, the ED Evaluation Process, and the ED Job Description. Ms. Johnson asked to remove the ED Evaluation Process from the Board’s consent agenda so the Governance Committee can review it first.

MOTION TO APPROVE: Ms. Johnson motioned to approve the consent agenda sans the ED Evaluation Process; Ms. Baney seconded. The motion was approved unanimously.

**PATIENT STORY**
Dr. Sharma shared the story of a patient undergoing gender-affirming treatment in La Pine who experienced severe anxiety as well as suicidal ideation while she was in her misgendered state. The patient was intent on starting treatment, and continued treatment through video calls during the pandemic. Dr. Sharma shared that during this process, a second patient from La Pine came to her for treatment. She noted that both patients believed they were the only person in their area undergoing gender-affirming treatment, and that they have agreed to allow Dr. Sharma to share their contact information. Dr. Sharma is considering setting up a transgender support group in La Pine, as she knows there are other patients in the area likely feeling alone.

**BOARD POLICY BOOK**
Ms. Johnson shared a suggested insert for the Board Policy Book that removes all mention of “Policy Governance” and instead describes what is intended by the book.

MOTION TO APPROVE: Ms. Baney motioned to approve the Board Policy Book as presented; Mr. Alexander seconded. All were in favor, the motion passed unanimously.

**CCO QUARTER 1 2021 REPORT**
Ms. Neugebauer shared the new format for the CCO quarterly report. She noted the Supporting Health for All Through Reinvestment (SHARE) initiative will require CAC involvement to invest dollars into the community. She added the CCO has a new member access to care survey, and they are working to increase the response rate before reporting out on the results.

**SENATE BILL 889**
Ms. Neugebauer explained that SB 889 passed in 2019 as a mandate to curtail the increasing cost of health care, which has evolved into the Value Based Payment Voluntary Compact. Ms. Haase asked how the COHC Board can be involved. Ms. Neugebauer noted there are no actions for the Board to take at this time.

**COST AND UTILIZATION STEERING COMMITTEE (CUSC)**

Dr. Sharma shared the small group revitalizing the CUSC has met once to discuss PacificSource’s 5-Point-Plan and will meet again soon.

**SB 741**

Ms. Mills announced she gave testimony at the House Committee on Health Care in support of SB 741. She thanked Commissioner Adair for speaking in support.

**SEPTEMBER RETREAT**

Ms. Mills announced the September Retreat will be held virtually, not in person. She explained there will be a Board self-evaluation to discuss, with participation from the Community Advisory Council (CAC) as well.

**REALD (RACE, ETHNICITY, AGE, LANGUAGE, DISABILITY) DATA**

Ms. Jones explained that REALD data is a research-based method of data collection. She asked Board members to complete a survey of their own REALD data.

**STRATEGIC PLAN REPORT OUT**

Ms. Berry reviewed the 2020-2025 Strategic Plan structure and layout. She pointed out upcoming items of interest that will require Board member involvement.

**REGIONAL HEALTH IMPROVEMENT PLAN (RHIP) REPORT OUT**

Ms. Jones shared that each of the six RHIP Workgroups is going through a Structured-Problem-Solving method to help identify areas of need and strategies to address them. Ms. Arsenault shared that collectively the workgroups have spent just under $1M, and each workgroup is committed to spending $500,000 each year at minimum until their funds are exhausted. She added that a RHIP Advisory Group has been formed out of the Operations Council to identify alignment with Quality Incentive Measures and provide feedback and support. Ms. Wirth recounted the current areas of focus for each workgroup.
Dr. Allen asked if there are gaps in who is participating in the workgroups. Ms. Wirth explained that participation suffered early on because of COVID-19, but it isn’t a concern at present. Mr. Sivill invited feedback from the workgroups on Summit Health’s performance in their priority areas.

**ADJOURNMENT**

There being no further business to come before the Board, the meeting was adjourned at 2:08 pm Pacific Standard Time.

Respectfully submitted,

_________________________
Kelsey Seymour, Secretary
**Policies and Procedures**

<table>
<thead>
<tr>
<th>Policy Title:</th>
<th>Executive Director Performance Evaluation Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date initiated:</td>
<td></td>
</tr>
<tr>
<td>Executive Director Signature:</td>
<td>Date reviewed/revised:</td>
</tr>
</tbody>
</table>

**Policy:** Systematic and rigorous monitoring of ED job performance is a key part of the Board’s responsibility to oversee organizational performance. The Board shall perform an annual evaluation of performance in November of each year. In performing the review, attention will be focused on the expected ED job outputs: organizational accomplishment of Strategic Plan initiatives and linkage with stakeholders; Board priorities and goals established during prior year reviews, and performance areas identified in the Board Policy Book Section 3 Executive Limitations.

**Goal or Purpose of the Policy:** To monitor and assure that Board and organizational purposes are met through annual performance reviews of the Executive Director.

**Procedures:** *ED, Executive Team, and Board of Directors:*

1. Each September, the ED will provide written input to the Executive Committee on his/her attainment of annual goals and objectives as established by the Board and ED the previous year.
2. The Executive Committee will review this with the ED for needed clarifications, edits, or concerns.
3. The Executive Committee will also review the current salary level of the ED and determine whether a compensation change should be recommended to the Board. The Executive Team will also review and advise the Board on whether the current salary range warrants adjustment.
4. In October, the Executive Team will schedule an Executive Session with the Board to discuss the prior year performance of the ED, and to determine whether additional input to the evaluation is needed. Additional input may include, but not be limited to staff, partner, and community input through a 360-review process or more focused surveys. At this meeting, the Board will also discuss salary recommendation from the Executive Committee. Finally,
the Board will discuss and recommend goals and priorities for the coming year. The ED will not be present during this session.

5. At the same meeting or a later one in October, the Board will meet in Executive Session with the ED to ask questions and clarify any ambiguities, to discuss Board findings regarding performance and salary and/or bonus decisions. The Board will also share its list of priorities and goals for the coming year for the ED's consideration in drafting a full set of goals for the coming year.

6. In December the ED will submit a proposed list of goals for the coming year for discussion, consideration and final approval.
Central Oregon Health Council

Executive Director Position Succession Plan

The process to assume responsibility of the Executive Director will be identified for the following circumstances, each with support from the Board Chair. Based on the current organizational plan and limited staff.

Position Open for Less than Three Months: The Grants & Metrics Manager (GMM) would assume the additional role of Interim Executive Director. Together with the Board Chair, and upon review of the Critical Information Inventory, Executive Director job description, and review of routine duties, the GMM would perform him/herself or selectively delegate to the staff the execution of the Executive Director responsibilities.

Position Expected to be Open for Up to Six Months and the Executive Director is Expected to Return: The plan would be similar to that of the short-term vacancy, but consideration should be given to adding additional staff resources to the organization, such as an additional administrative staff to support daily office/network functions.

Permanent Vacation of the Position: Within seven days of confirming that the Executive Director position is or will be permanently vacated, the Board of Directors will immediately authorize the Executive Committee to serve as the Transition and Search Committee. The Committee will carry out a plan for interim executive management, the recruitment and selection of an interim Executive Director and permanent replacement for the position. The Committee will consider and make a recommendation to the Board as to whether an executive search firm familiar with healthcare in the northwest and/or nationally should be engaged to conduct a formal search.

The Executive Director, if serving out a notice period, will be charged with updating the Critical Information Inventory and with recommending any suggested changes to his/her job description. To the extent that the separation with the departing Executive Director is proceeding professionally and amicably, the Board may consider further contracting with him/her to provide further informational assistance to the interim management and to the newly appointed Executive Director.

Process for Executive Director Search: The board will conduct an orderly and thorough process for the identification, selection, and transition of executive leadership for the COHC.
Considerations:

1. ED qualities and characteristics. The Board will identify the skills, experience, character and values they would seek in a candidate for a leadership change. It could be informed by the positive attributes of the current leader as well as the experience of the Board in working with other leaders. It also would be influenced by the current and envisioned future state of the organization.

2. Present and future operating environment. The Board should consider the landscape in which the organization operates through the lenses of politics and influence; brand and reputation; capacity; finances; quality; and culture.

3. The organization’s own vision and strategic plan. Obviously, the Board will have a feel for this through the Purpose Statement and its planning process and goals. These should be used to see how a new leader would stack up against what the Board wants for the organization going forward.

4. Stakeholders. It would be important for the Board to know who the organization’s key stakeholders are to assure they are aware of any transition process. These may include: its staff and volunteers; Board members and the constituencies they represent; non-profit and community partners; and, depending on circumstances, the general public.

5. Internal preparations for the search process. Key basic aspects include development of a job description. It should also seek input on qualities and characteristics, and specific education and experience requirements for the job to guide the search process. Identification of a board leader to head up the search process; development of a checklist of activities and timeline; development of interview questions and process and identifying decision criteria for final vetting and selection all are important pre-search steps. Finally, development of a proposed contract and components such as salary, benefits, etc. should be done.

6. Potential candidates; internal versus external. The Board should determine how it wants to proceed with seeking qualified candidates and the decision about considering internal candidates should be made well in advance.

7. The exiting ED’s role. This is often controversial because any ED will have opinions about their staff and making them objective will always be difficult. Yet the ED’s opinion should be known. It is, however, one data point and is not to be framed as a deciding influence. This is the Board’s decision alone.

8. Process. The general search, vetting and decision process is comprised of the following: position announcement; collection and vetting of resumes to arrive at a
list of applicants; further vetting of applicants to arrive at a lesser number of qualified candidates who will then be interviewed. Consideration should be given to how stakeholders will be involved in the process.

9. Confidentiality. A change in leadership impacts virtually all facets of the organization. The Board shall identify who shall speak publicly about the process.

10. Communications. Careful, respectful and accurate communications are important throughout the process. The Board will need to determine how to keep selected publics apprised in the right manner at the appropriate times. It is important to consider internal audiences as primary stakeholders so that they know important information first and do not read, see, or hear about it in the media.

**ED Job Description**

Job Description – Executive Director

Provide effective leadership and management to the entity that is the Central Oregon Health Council (COHC), supporting the governance entity (the Board) and guiding the various Councils and Committees to success in the design, development, implementation and study of strategic initiatives and imperatives in support of the Coordinated Care Organization and in service to the mission of better health, better care and better value for healthcare in the Central Oregon region. The Executive Director shall promote and further the values, mission, and goals of the organization.

Develop & Maintain COHC Governance

In conjunction with the COHC Board of Directors, build and maintain effective governance for the Board. Includes development of effective committee charters, role delineation, facilitation, and Board member and committee member development.
- Oversee Board training needs and ongoing educational support.
- Ensure, provide, and oversee effective staff and project support for the Board,
• Community Advisory Committee, Provider Engagement Panel, and Operations Council, and other committees, work groups, and task forces as and when formed by the Board.
• Monitor key initiatives on behalf of Board and committees.
• Ensure staff, Board, and committee members follow up on deliverables.
• Interact with PacificSource regarding development and reporting of global budget, shared deliverables, and CCO contract requirements.
• Provide input and content to help inform deliverables shared with community members.
• Summarize and present key performance and budget metrics (COHC, CCO, and other) to the Board on a regular basis.
• Serve as the COHC’s liaison to OHA and other statewide workgroups or task forces, as applicable.
• Manage COHC legislative needs and advise the Board on legislative developments.
• Create and maintain governance calendars.

Maintain Stakeholder and Community Relations
• Maintain stakeholder outreach and engagement and media relationships.
• Build and retain effective working partnerships in the community.
• Analyze current policies and determine opportunities for development of policies to support community work.
• Develop and maintain regular communication and relationships with CCO stakeholders.
• Take part in external activities, which may include serving on boards or committees for various organizations aligned with the COHC goals and objectives or participating in grant activities.
• Identify and maximize opportunities to keep the general community and its leaders informed of the activities, goals, challenges and successes of the COHC, and seek opportunities for input and feedback from the region’s population.

Strategy & Planning

• In conjunction with the Board, develop and implement long-range plans, goals, and objectives for the COHC utilizing the Regional Health Improvement Plan, COHC Strategic Plan, and other key documents as guides.
• Develop and implement investment and evaluation strategies for COHC projects and funding opportunities.
• Participate in, track, and support the development and implementation of key long-range plans, goals and objectives for the COHC and CCO.
• Ensure stakeholder involvement and integration in decision-making, strategic planning, and budgeting for COHC and CCO through communication, committee participation, and engagement.

Program Development & Implementation
• Develop and implement initiatives and projects, including transformation and integration projects. Track and review metrics and report result to the Board.
• Identify and access grant opportunities to fund initiatives aligned with the COHC priorities and to support committee projects that advance the RHIP.
• Convene community stakeholders to develop the Regional Health Assessment and the Regional Health Improvement Plan.
• Track, manage, and fulfill COHC deliverables per the JMA.
• Align COHC staff work and resource management with the COHC's mission, vision, and values.

Operations Oversight
• Supervise, mentor, support, and develop the COHC staff.
• Fulfill requirements of the COHC Accounting Policies and Procedures.
• Manage electronic storage and cloud storage system to assure that essential documents are safely and securely maintained.
• Serve as HIPAA Compliance/Security Officer.
• Manage completion and submission of annual Form 990 document and related state documents.
• As applicable, arrange, perform, or be responsible for the COHC core corporate functions and maintenance of COHC as an entity, including required filings, budget, tax accounting, insurance, and legal.
• Adopt and implement operational COHC policies.
Central Oregon Health Council
Statement of Financial Position
YTD 3.2021

ASSETS

<table>
<thead>
<tr>
<th>General Fund</th>
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<tbody>
<tr>
<td>Checking/Savings</td>
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<tr>
<td>Total Checking/Savings</td>
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<td>Accounts Receivable</td>
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LIABILITIES & EQUITY

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<td>TOTAL LIABILITIES &amp; EQUITY</td>
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<th>Revenue</th>
<th>Actual</th>
<th>Budget</th>
<th>% Variance</th>
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* Community Impact Funds - Top 4 funded 2021
  - THRIVE Central Oregon P4P $50,000
  - COVID-19 Mini Grants (NTE $5K) $94,046

**Variance is due to timing of Community Impact Funds revenue and distribution of funds through Grants in different years.

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<th>CCO Financials</th>
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<tr>
<td>Recapture Board trigger</td>
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## Central Oregon Health Council
### Statement of Financial Position
#### YTD 4.2021

### ASSETS

<table>
<thead>
<tr>
<th>General Fund</th>
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<tbody>
<tr>
<td><strong>Checking/Savings</strong></td>
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<td>COPA - Security Deposit</td>
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<td><strong>TOTAL CHECKING/SAVINGS</strong></td>
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<td><strong>TOTAL ASSETS</strong></td>
<td>$23,966,979</td>
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### LIABILITIES & EQUITY

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<td><strong>TOTAL LIABILITIES</strong></td>
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<td>RHIP 2020-2024 Payable</td>
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<td>2019 JMA Settlement</td>
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<td><strong>TOTAL LIABILITIES &amp; EQUITY</strong></td>
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<td>Net assets without donor restrictions</td>
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<td>Net assets with donor restrictions (OABHI)</td>
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<tr>
<td>Net Income/(loss)</td>
<td>$765,948</td>
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<tr>
<td><strong>TOTAL LIABILITIES &amp; EQUITY</strong></td>
<td>$23,966,979</td>
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### Revenue

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<th>Actual</th>
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### Expenses

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### Net Income

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<tr>
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<td>$765,948</td>
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<tr>
<td>(583,906)</td>
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### Community Impact Funds - Top 4 funded 2021

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>THRIVE Central Oregon P4P</td>
<td>$50,000</td>
</tr>
<tr>
<td>COVID-19 Mini Grants (NTE $5k)</td>
<td>$157,893</td>
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<tr>
<td>All other</td>
<td>-</td>
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<td><strong>TOTAL</strong></td>
<td>$207,893</td>
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</tbody>
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**Variance is due to timing of Community Impact Funds revenue and distribution of funds through Grants in different years.
# Table of Contents

I. Introduction ................................................................................................................................. 3  
   Board of Directors........................................................................................................................ 4  
   Executive Director ......................................................................................................................... 4  
   Administrative Assistant and/or Project Coordinator................................................................. 4  
   Bookkeeper ................................................................................................................................ 5  
V. Inter-Account Bank Transfers ................................................................................................. 8  
VI. Disbursements & Expense Allocations .................................................................................. 9  
VII. Debit Card Policy and Charges ............................................................................................. 11  
IX. Bank Account Reconciliations ............................................................................................... 12  
XI. Property and Equipment ........................................................................................................ 13  
XII. Personnel Records ............................................................................................................... 14  
XIII. Payroll Processing .............................................................................................................. 15  
XIV. End of Month and Fiscal Year-End Close ......................................................................... 16  
XV. Financial Reports .................................................................................................................. 17  
XVI. Fiscal Policy Statements ...................................................................................................... 18
I. Introduction

The purpose of this manual is to describe all accounting policies and procedures currently in use at the COHC and to ensure that the financial statements conform to generally accepted accounting principles; assets are safeguarded; guidelines of grantors and are complied with; and finances are managed with accuracy, efficiency, and transparency.

All COHC staff members with a role in the management of fiscal and accounting operations are expected to comply with the policies and procedures in this manual.

These policies will be reviewed annually and revised as needed by the staff and approved by the Executive Director and the COHC Board of Directors.
II. Division of Responsibilities

The following is a list of personnel who have fiscal and accounting responsibilities:

**Board of Directors**

1. Reviews and approves the annual budget (which proposed budget is first reviewed by the COHC Finance Committee)
2. Reviews annual and periodic financial statements and information (which reports are also reviewed by the COHC Finance Committee)
3. Reviews Executive Director’s performance annually and establishes the salary
4. The Chair of the Board and Executive Director will be the authorized signers on the bank accounts.
5. Reviews and approves all contracts, non-budgeted, over $5,000
6. Reviews and approves all non-budgeted expenditures over $5,000
7. Reviews and advises staff on internal controls and accounting policies and procedures

**Executive Director**

1. Reviews and approves all financial reports including cash flow projections
2. Sees that an appropriate budget is developed annually
3. Reviews and signs all issued checks and/or approves check signing procedures
4. Reviews and approves all budgeted contracts
5. Reviews and approves all grant submissions
6. Approves inter-account bank transfers
7. Is on-site signatory for all bank accounts
8. Opens all bank statements (or views them online), reviews for any irregularities, and reviews completed monthly bank reconciliations
9. Oversees the adherence to all internal controls
10. Reviews all payrolls and is responsible for all personnel files (in the event that COHC employees staff directly)
11. Monitors and approves asset retirement and replacement

**Administrative Assistant and/or Project Manager (“Project Manager”)**

1. Reviews all program or initiative expenditures
2. Monitors program and operational budget
3. Reviews and manages cash flow
4. Reviews all reimbursements and fund requests
5. Processes all inter-account bank transfers
6. Assists Executive Director with the development of annual and program budgets
7. Reviews all incoming and outgoing invoices
8. Receives and opens all incoming mail except bank statements
9. Monitors grant reporting and appropriate release of restricted funds
10. Oversees expense allocations
11. Reviews, revises, and maintains internal accounting controls and procedures
12. Reviews all financial reports

**Bookkeeper**

1. Overall responsibility for data entry into accounting system and integrity of accounting system data
2. Processes invoices and prepares checks for signature
3. Processes payroll entries
4. Maintains general ledger
5. Prepares monthly and year-end financial reports
6. Reconciles all bank accounts
7. Mails vendor checks (after they have been signed by the Executive Director and/or Board signatory, as applicable).
8. Manages Accounts Receivable

In the event any position listed above is vacant, the COHC Board of Directors shall appoint a designee to perform the listed functions.

### III. Chart of Accounts and General Ledger
COHC has designated a Chart of Accounts specific to its operational needs and the needs of its financial statements. The Chart of Accounts is structured so that financial statements can be shown by natural classification (expense type) as well as by functional classification (initiatives vs. administration). The Project Manager is responsible for maintaining the Chart of Accounts and revising as necessary. The Chart of Accounts is attached to this manual as an addendum.

The general ledger is automated and maintained using the bookkeeper’s accounting software. All input and balancing is the responsibility of the bookkeeper with final approval by the Executive Director.

The Executive Director should review the general ledger on a periodic basis for any unusual transactions.
IV. Cash Receipts and Deposits

Cash receipts rarely arise. If cash is received, these are the principal steps in the cash receipts process:

Any COHC staff member may collect incoming mail and forward it unopened to the Project Manager. The Project Manager opens, date stamps, and distributes the mail. The Project Manager enters all checks into a log, marks all “for deposit only,” and makes two (2) copies of each check. The checks are kept in a locked cabinet until handed to the bookkeeper for processing and deposit.

Monthly (or more often, if necessary), the Project Manager submits the following to the Bookkeeper for processing: the endorsed checks, the deposit logbook, and the correct account allocation for each deposit. The Bookkeeper processes the deposit and takes it to the bank for deposit. A copy of the deposit slip is attached to the deposit. The deposits are put in a file to attach to the bank statement.

All cash received will be counted, verified, and signed off by the Project Manager and another available COHC staff member. The cash will immediately be posted using the appropriate allocation. A receipt will be given to the paying party and a copy kept for internal purposes. The cash will be kept in a locked, secure location and deposited within 24 business hours.
V. Inter-Account Bank Transfers

The Project Manager monitors the balances in the bank accounts to determine when there is a shortage or excess in the checking account. The Project Manager recommends to the Executive Director when a transfer should be made to maximize the potential for earning interest. The Executive Director approves all transfers. The Project Manager performs all transfers. A copy or notice of the transfer is given to the Bookkeeper.
VI. Disbursements & Expense Allocations

Disbursements are generally made for:

1. Payments to vendors for goods and services
2. Taxes/license fees
3. Staff training and development
4. Memberships and subscriptions
5. Meeting expenses
6. Employee reimbursements
7. Committee materials

Checks are processed twice monthly. Invoices submitted to the Project Manager during the month will be processed and paid by the 15th or 30th (once submitted to the Bookkeeper).

Requests for disbursements are submitted in three ways:

1. Original invoice
2. Purchase request (submitted on approved form)
3. Employee expense report or reimbursement request

All invoices must have the account code or classification written on them and approved by the Executive Director prior to being submitted to the Bookkeeper.

Every employee reimbursement or purchase request must be documented on the approved form with travel authorization, receipts, nature of business, and funding source (if applicable) before approving for reimbursement as follows:

**Lodging** - an itemized receipt from the hotel detailing all charges, the person(s) for whom the lodging was provided, and the specific business purpose. Please refer to the [Travel and Other Expense Policy](#), as applicable.

**Meals and Entertainment** - a receipt must be provided showing the cost of food, beverage, and gratuities, including the names of every person for whom food or beverage was provided, and the specific business purpose. Please refer to the [Travel and Other Expense Policy](#), as applicable.

**Other Expenditures** - a receipt from the vendor detailing all goods or services purchased (including the class of service for transportation) and the specific business purpose.

The Project Manager reviews all requests for payment and:

1. Verifies expenditure and amount
2. Approves for payment if in accordance with budget
3. Provides or verifies appropriate allocation information
4. Provides date of payment taking into account cash flow projections
5. Submits to the Bookkeeper for processing

The Bookkeeper processes all payments (twice monthly) and:

1. Immediately enters them into the Accounts Payable module
2. Prints checks according to allocation and payment date provided by the Project Manager
3. Submits checks, with attached backup documentation, to Executive Director for approval and signature. All non-budgeted checks in excess of $2,500 require a second signature from an authorized board member, unless the checks are payment for 1) payroll reimbursement for a third party that manages or administers payroll for the COHC or 2) a contract that has previously been approved by the Board of Directors; non-budgeted checks in excess of $5,000 must be authorized by the Board of Directors, unless the checks are payment for 1) payroll reimbursement for a third party that manages or administers payroll for the COHC or 2) a contract that has previously been approved by the Board of Directors
4. Marks invoice “paid”
5. Mails checks and appropriate backup documentation, once the Executive Director and/or Board signatory has signed the check
6. Files all backup documentation in the appropriate file
7. Runs an accounts payable aging at the end of each month and submits to the Project Manager to assure timely payment of all invoices
VII. Debit Card Policy and Charges

All staff members who are authorized to carry an organization debit card will be held personally responsible in the event that any charge is deemed personal or unauthorized. Unauthorized use of the debit card includes: personal expenditures of any kind; expenditures that have not been properly authorized; meals, entertainment, gifts, or other expenditures that are prohibited by budgets, laws, and regulations, and the entities from which COHC receives funds.

The receipts for all card charges will be given to the Project Manager within one (1) week of the purchase along with proper documentation. In all cases, receipts must be submitted to the Project Manager by the end of the month in which the charges were incurred. The Project Manager will verify all card charges with the monthly statements. A record of all charges will be given to the Bookkeeper with applicable allocation information for posting.
IX. Bank Account Reconciliations

1. If the COHC receives paper statements (which it currently does not), all bank statements are given unopened to the Executive Director. If the COHC receives statements using a paperless function, the Executive Director logs into the online bank accounts after the close of each month and reviews the statements for unusual balances and/or transactions.

2. The Executive Director notifies the Bookkeeper to log into the online bank accounts to view them for timely reconciliation as follows: a comparison of dates and amounts of deposits as shown in the accounting system and on the statement, a comparison of inter-account transfers, an investigation of any rejected items, a comparison of cleared checks with the accounting record including amount, payee, and sequential check numbers.

3. The Bookkeeper will verify that voided checks, if returned, are appropriately defaced and filed.

4. The Bookkeeper will investigate any checks that are outstanding over six months.

5. The Bookkeeper will attach the completed bank reconciliation to the applicable bank statement, along with all documentation.

6. The reconciliation report will be reviewed, approved, dated, and initialed by the Executive Director.
XI. Property and Equipment

Property and equipment includes items such as:

1. Office furniture and equipment
2. Computer hardware
3. Computer software
4. Leasehold improvements

It is the organization’s policy to capitalize all items that have a unit cost greater than one thousand dollars ($2,500). Items purchased with a value or cost less than one thousand dollars ($1,000) will be expensed in the period purchased.

The depreciation period for capitalized assets is as follows:

<table>
<thead>
<tr>
<th>Asset Type</th>
<th>Depreciation Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer Hardware</td>
<td>36 months</td>
</tr>
<tr>
<td>Office Equipment</td>
<td>60 months</td>
</tr>
<tr>
<td>Office Furniture</td>
<td>60 months</td>
</tr>
<tr>
<td>Computer Software</td>
<td>36 months</td>
</tr>
<tr>
<td>Leasehold improvements</td>
<td>Length of lease</td>
</tr>
</tbody>
</table>

1. A Fixed Asset Log is maintained by the Bookkeeper including date of purchase, asset description, purchase/donation information, cost/fair market value, funding source, identification number, and life of asset.

2. The Executive Director will review the Log.

3. Annually, a physical inspection and inventory will be taken of all fixed assets and reconciled to the general ledger balances.

4. The Executive Director shall be informed in writing of any change in status or condition of any property or equipment.

5. Depreciation is recorded at least annually. Depreciation is computed using the straight-line method over the estimated useful lives of the related assets. Any impaired assets discovered during the inventory will be written down to their actual value.
XII. Personnel Records

In the event that the COHC employs staff directly instead of leasing employees, entering into secondment arrangements, or using a benefits service, the COHC will follow the following procedures regarding personnel records:

1. All personnel files contain the following documents: an application and/or resume, date of employment, position and pay rate, authorization of payroll deductions, W-4 withholding authorization, performance reviews, termination data where applicable, a signed confidentiality agreement, a signed acknowledgement of receipt of the employee handbook and policies, an emergency contact form, and other forms as deemed appropriate by the Executive Director.

2. All employees will fill out an I-9 form and submit the allowable forms of identification to the Executive Director.

3. The completed I-9 forms will be kept in a secure location separate from the personnel files.

4. All personnel files are to be kept in a secure, locked file cabinet or safe and accessed only by authorized personnel.
XIII. Payroll Processing

In the event that the COHC employs staff directly instead of leasing employees, entering into secondment arrangements, or using a benefits service, the COHC will follow the following procedures regarding payroll processing:

1. Timesheets are to be prepared by all staff on the approved form and submitted semi-monthly on the designated dates. If submission dates those months fall on a weekend or holiday, the timesheets are to be submitted the day prior to the weekend or holiday. Exceptions to the submittal date may occur and will be communicated accordingly.

2. Timesheets are to be kept on a daily basis and completed in ink – unless prepared electronically.

3. Any corrections to timesheets are to be made by making a single line through the error and writing in the correction. Correction fluid and/or tape are not allowable.

4. Timesheets are to be signed and dated by the employee and the employee’s supervisor for submission to the Executive Director.

5. Any changes to the standing information of the payroll register from the prior period including addition of new employees, deletion of employees, or changes in base pay rate must be accompanied by an Employment Information Form and signed by the Executive Director before the change can be made.

6. The Executive Director will process payroll in a timely manner and record vacation time, holiday hours, sick time, and any other information deemed necessary to properly reflect time worked.

7. The Executive Director will distribute paychecks on the designated dates each month. If the designated dates fall on a weekend or holiday the paychecks will be distributed the day before.

8. If the employee requests that his/her check be turned over to a third party, the request must be made in writing prior to distribution.

9. Employees may choose direct deposit to a designated bank account. Their paycheck is deposited directly into the designated account on the payroll date. The employee will receive a verification stub.

10. The Executive Director will review payroll expenditures and allocations monthly.

11. All quarterly federal and state payroll reports will be prepared and filed appropriately.

12. All W-2 statements are issued to employees prior to January 31st of the following year for the prior calendar year.
XIV. End of Month and Fiscal Year-End Close

1. At the end of each month and fiscal year end, the Executive Director will review all balance sheet accounts including verification of the following balances: cash accounts match the bank reconciliations, fixed assets accounts reflect all purchases, write-downs and retirements, accounts receivable and payable accounts match outstanding amounts due and owed.

2. The income and expense accounts review will include reconciliation to amounts received and expended and verification that payroll expenses match the payroll reports.

3. Once the final monthly and fiscal year-end financial statements are run, reviewed, and approved by the Executive Director, no more entries or adjustments will be made into that month or year’s ledgers.

4. At the end of the fiscal year, an outside CPA will prepare the annual Return for Organization Exempt from Income Tax (IRS Form 990) and any related state filings. The return will be presented to the Executive Director, the Board Finance Committee, and the Board pursuant to the COHC’s Form 990 Policy. The Executive Director will then file the return with the Internal Revenue Service by the annual deadline.

5. All other appropriate government filings including those required by the state tax board and attorney general’s office will be completed and filed with the appropriate agency.
XV. Financial Reports

The Bookkeeper will prepare the monthly and annual financial reports for distribution to the Executive Director. The reports will include: balance sheet, statement of income and expenses, budget versus actual report for each initiative, a budget versus actual report for the organization, accounts receivable aging, accounts payable register and aging, and any other requested reports.

Monthly and annual financial reports will be submitted to the Finance Committee and Board of Directors for review.
XVI. Fiscal Policy Statements

1. All cash accounts owned by the COHC will be held in financial institutions that are insured by the FDIC or NCUSIF.

2. All capital expenditures that exceed one thousand dollars ($2,500) will be capitalized.

3. No salary advances will be made under any circumstances.

4. No travel cash advances will be made except under special conditions and pre-approved by the Executive Director. Please refer to the Travel and Other Expense Policy, as applicable.

5. Reimbursements will be paid upon complete expense reporting and approval using the official COHC form. The Board Chair will authorize reimbursements to the Executive Director.

6. The Executive Director and the Board Chair are the signatories on the COHC’s bank accounts. Disbursements exceeding $2,500 require a second signature by an authorized board member, unless the checks are payment for 1) payroll reimbursement for a third party that manages or administers payroll for the COHC or 2) a contract that has previously been approved by the Board of Directors. Checks over $5,000 require approval from the Board of Directors, unless the checks are payment for 1) payroll reimbursement for a third party that manages or administers payroll for the COHC or 2) a contract that has previously been approved by the Board of Directors.

7. Bank statements will be reconciled monthly. All bank statements will be given unopened to the Executive Director for review or viewed by the Executive Director online.

8. Correction fluid and/or tape will never be used in preparing any accounting documents.

9. Accounting and personnel records will be kept in locked file cabinets in the office and only parties with financial and/or HR responsibility will have access to the keys.
Central Oregon Health Council

Financial Statements

For the Year Ended December 31, 2020
(With Comparative Totals for the Year Ended December 31, 2019)

DRAFT
Central Oregon Health Council
Financial Statements
For the Year Ended December 31, 2020
(With Comparative Totals for the Year Ended December 31, 2019)

Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Auditor's Report</td>
<td>1 - 2</td>
</tr>
<tr>
<td>Financial Statements:</td>
<td></td>
</tr>
<tr>
<td>Statement of Financial Position</td>
<td>3</td>
</tr>
<tr>
<td>Statement of Activities</td>
<td>4</td>
</tr>
<tr>
<td>Statement of Functional Expenses</td>
<td>5</td>
</tr>
<tr>
<td>Statement of Cash Flows</td>
<td>6</td>
</tr>
<tr>
<td>Notes to Financial Statements</td>
<td>7 - 11</td>
</tr>
</tbody>
</table>
Independent Auditor's Report

To the Board of Directors
Central Oregon Health Council
Bend, Oregon

I have audited the accompanying financial statements of Central Oregon Health Council (a nonprofit organization), which comprise the statement of financial position as of December 31, 2020, and the related statements of activities, functional expenses, and cash flows for the year then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these financial statements based on my audit. I conducted my audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that I plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor’s judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity’s preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant estimates made by management, as well as evaluating the overall presentation of the financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.
Opinion

In my opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Central Oregon Health Council as of December 31, 2020, and the changes in its net assets and its cash flow for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Summarized Comparative Information

I have previously audited the Central Oregon Health Council’s 2019 financial statements, and I expressed an unmodified audit opinion on those audited financial statements in my report dated June 11, 2020. In my opinion, the summarized comparative information presented herein as of and for the year ended December 31, 2019, is consistent, in all material respects, with the audited financial statements from which it has been derived.
Financial Statements

DRAFT
Central Oregon Health Council  
Statement of Financial Position  
December 31, 2020  
(With Comparative Totals for December 31, 2019)

<table>
<thead>
<tr>
<th></th>
<th>2020</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>$11,920,017</td>
<td>$13,226,223</td>
</tr>
<tr>
<td>Certificates of deposit</td>
<td>14,838,475</td>
<td>6,500,000</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>930,327</td>
<td>332,603</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>1,997</td>
<td>1,997</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td><strong>$27,690,816</strong></td>
<td><strong>$20,060,823</strong></td>
</tr>
<tr>
<td><strong>Liabilities and Net Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable</td>
<td>$1,870</td>
<td>$23,932</td>
</tr>
<tr>
<td>Payroll liabilities</td>
<td>23,980</td>
<td>30,278</td>
</tr>
<tr>
<td>QIM withhold payable</td>
<td>454,725</td>
<td>-</td>
</tr>
<tr>
<td>SDOH-E payable</td>
<td>61,682</td>
<td>-</td>
</tr>
<tr>
<td>JMA settlement payable</td>
<td>8,252,129</td>
<td>-</td>
</tr>
<tr>
<td>Grants payable</td>
<td>1,315,034</td>
<td>3,567,518</td>
</tr>
<tr>
<td><strong>Total liabilities</strong></td>
<td>10,109,420</td>
<td>3,621,728</td>
</tr>
<tr>
<td><strong>Net assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Without donor restrictions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undesignated</td>
<td>5,622,569</td>
<td>12,632,292</td>
</tr>
<tr>
<td>Board designated</td>
<td>11,740,049</td>
<td>3,806,803</td>
</tr>
<tr>
<td><strong>Total without donor restrictions</strong></td>
<td>17,362,618</td>
<td>16,439,095</td>
</tr>
<tr>
<td>With donor restrictions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temporarily restricted</td>
<td>218,778</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total net assets</strong></td>
<td>17,581,396</td>
<td>16,439,095</td>
</tr>
<tr>
<td><strong>Total liabilities and net assets</strong></td>
<td><strong>$27,690,816</strong></td>
<td><strong>$20,060,823</strong></td>
</tr>
</tbody>
</table>

The accompanying notes are an integral part of these statements.
Central Oregon Health Council  
Statement of Activities  
For the Year Ended December 31, 2020  
(With Comparative Totals for the Year Ended December 31, 2019)

<table>
<thead>
<tr>
<th></th>
<th>2020 Without Donor Restriction</th>
<th>2020 With Donor Restriction</th>
<th>2019 Total</th>
<th>2019 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Support and revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract revenue</td>
<td>$4,086,068</td>
<td>$</td>
<td>$4,086,068</td>
<td>$4,037,754</td>
</tr>
<tr>
<td>Shared savings benefit</td>
<td>8,335,481</td>
<td>-</td>
<td>8,335,481</td>
<td>7,535,282</td>
</tr>
<tr>
<td>Grant revenue</td>
<td>20,214</td>
<td>258,984</td>
<td>279,198</td>
<td>84,188</td>
</tr>
<tr>
<td>Interest income</td>
<td>181,655</td>
<td>-</td>
<td>181,655</td>
<td>204,507</td>
</tr>
<tr>
<td>JMA settlement</td>
<td>(8,252,129)</td>
<td>-</td>
<td>(8,252,129)</td>
<td>-</td>
</tr>
<tr>
<td>Total support and revenue</td>
<td>4,371,289</td>
<td>258,984</td>
<td>4,630,273</td>
<td>11,861,731</td>
</tr>
<tr>
<td><strong>Net assets released from restrictions</strong></td>
<td>40,206</td>
<td>(40,206)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program services</td>
<td>3,226,925</td>
<td>-</td>
<td>3,226,925</td>
<td>7,174,238</td>
</tr>
<tr>
<td>Management and general</td>
<td>261,047</td>
<td>-</td>
<td>261,047</td>
<td>287,936</td>
</tr>
<tr>
<td>Total expenses</td>
<td>3,487,972</td>
<td>-</td>
<td>3,487,972</td>
<td>7,462,174</td>
</tr>
<tr>
<td><strong>Change in net assets</strong></td>
<td>923,523</td>
<td>218,778</td>
<td>1,142,301</td>
<td>4,399,557</td>
</tr>
<tr>
<td>Net assets, beginning of year</td>
<td>16,439,095</td>
<td>-</td>
<td>16,439,095</td>
<td>12,039,538</td>
</tr>
<tr>
<td>Net assets, end of year</td>
<td>$17,362,618</td>
<td>$218,778</td>
<td>$17,581,396</td>
<td>$16,439,095</td>
</tr>
</tbody>
</table>

The accompanying notes are an integral part of these statements.
Central Oregon Health Council  
Statement of Functional Expenses  
For the Year Ended December 31, 2020  
(With Comparative Totals for the Year Ended December 31, 2019)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and benefits</td>
<td>$ 589,691</td>
<td>$ 196,564</td>
<td>$ 786,255</td>
<td>$ 619,483</td>
<td>$ 196,564</td>
<td>$ 816,047</td>
</tr>
<tr>
<td>Community impact funds</td>
<td>2,338,470</td>
<td>-</td>
<td>2,338,470</td>
<td>6,381,841</td>
<td>-</td>
<td>6,381,841</td>
</tr>
<tr>
<td>Professional fees</td>
<td>-</td>
<td>14,728</td>
<td>14,728</td>
<td>-</td>
<td>14,728</td>
<td>73,019</td>
</tr>
<tr>
<td>Program expenses</td>
<td>185,770</td>
<td>-</td>
<td>185,770</td>
<td>228,150</td>
<td>-</td>
<td>228,150</td>
</tr>
<tr>
<td>Office expenses</td>
<td>42,817</td>
<td>15,222</td>
<td>58,039</td>
<td>53,918</td>
<td>15,222</td>
<td>69,134</td>
</tr>
<tr>
<td>Occupancy</td>
<td>28,107</td>
<td>9,369</td>
<td>37,476</td>
<td>41,304</td>
<td>9,369</td>
<td>50,733</td>
</tr>
<tr>
<td>Insurance</td>
<td>-</td>
<td>18,329</td>
<td>18,329</td>
<td>-</td>
<td>18,329</td>
<td>15,359</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>-</td>
<td>3,644</td>
<td>3,644</td>
<td>-</td>
<td>-</td>
<td>3,644</td>
</tr>
<tr>
<td>Continuing education</td>
<td>24,240</td>
<td>375</td>
<td>24,615</td>
<td>11,081</td>
<td>375</td>
<td>11,456</td>
</tr>
<tr>
<td>Dues and subscriptions</td>
<td>12,417</td>
<td>2,290</td>
<td>14,707</td>
<td>17,087</td>
<td>2,290</td>
<td>19,377</td>
</tr>
<tr>
<td>Travel</td>
<td>1,579</td>
<td>526</td>
<td>2,105</td>
<td>18,617</td>
<td>526</td>
<td>23,143</td>
</tr>
<tr>
<td>Advertising</td>
<td>3,834</td>
<td>-</td>
<td>3,834</td>
<td>2,315</td>
<td>-</td>
<td>2,315</td>
</tr>
<tr>
<td><strong>Total functional expenses</strong></td>
<td><strong>$ 3,226,925</strong></td>
<td><strong>$ 261,047</strong></td>
<td><strong>$ 3,487,972</strong></td>
<td><strong>$ 7,462,174</strong></td>
<td><strong>$ 261,047</strong></td>
<td><strong>$ 8,723,221</strong></td>
</tr>
</tbody>
</table>
Central Oregon Health Council  
Statement of Cash Flows  
For the Year Ended December 31, 2020  
(With Comparative Totals for the Year Ended December 31, 2019)

<table>
<thead>
<tr>
<th></th>
<th>2020</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash flows from operating activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in net assets</td>
<td>$1,142,301</td>
<td>$4,399,557</td>
</tr>
<tr>
<td>Adjustments to reconcile change in net assets to net cash provided by operating activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest on certificates of deposit</td>
<td>(181,655)</td>
<td>(152,775)</td>
</tr>
<tr>
<td>(Increase) decrease in operating assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>(597,724)</td>
<td>(252,603)</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>-</td>
<td>8,747</td>
</tr>
<tr>
<td>Increase (decrease) in operating liabilities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable</td>
<td>(22,062)</td>
<td>19,400</td>
</tr>
<tr>
<td>Payroll liabilities</td>
<td>(6,298)</td>
<td>1,085</td>
</tr>
<tr>
<td>QIM withhold payable</td>
<td>454,725</td>
<td>-</td>
</tr>
<tr>
<td>SDOH-E payable</td>
<td>61,682</td>
<td>-</td>
</tr>
<tr>
<td>JMA settlement payable</td>
<td>8,252,129</td>
<td>-</td>
</tr>
<tr>
<td>Grants payable</td>
<td>(2,252,484)</td>
<td>(732,665)</td>
</tr>
<tr>
<td>Net cash provided by operating activities</td>
<td>6,850,614</td>
<td>3,290,746</td>
</tr>
<tr>
<td><strong>Cash flows from investing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proceeds from liquidation of certificates of deposit</td>
<td>31,750,848</td>
<td>37,078,739</td>
</tr>
<tr>
<td>Purchases of certificates of deposit</td>
<td>(39,907,668)</td>
<td>(29,781,545)</td>
</tr>
<tr>
<td>Net cash provided (used) by investing activities</td>
<td>(8,156,820)</td>
<td>7,297,194</td>
</tr>
<tr>
<td><strong>Net change in cash and cash equivalents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents, beginning of year</td>
<td>13,226,223</td>
<td>2,638,283</td>
</tr>
<tr>
<td>Cash and cash equivalents, end of year</td>
<td>$11,920,017</td>
<td>$13,226,223</td>
</tr>
</tbody>
</table>
1. **Summary of Significant Accounting Policies**

**Nature of Organization**

Central Oregon Health Council (COHC) is a not-for-profit, tax-exempt, public and private community governance entity. COHC’s mission is to improve the quality and efficiency of healthcare delivery for, and the health outcomes of, community members in the Central Oregon region. COHC achieves its purpose through its governance over the region’s Coordinated Care Organization (CCO), PacificSource Community Solutions and by awarding community impact grants to help fund community partner programs consistent with COHC’s mission.

COHC was officially created by Senate Bill 204 in 2011 to facilitate collaboration, regional planning, and community governance.

**Basis of Presentation**

COHC follows the accrual basis of accounting under accounting principles generally accepted in the United States of America (U.S. GAAP). Under professional standards, COHC is required to report information regarding its financial position and activities according to two classes of net assets: net assets without donor restriction, and net assets with donor restriction.

*Net assets without donor restriction* represent resources over which the Board of Directors has unlimited discretionary control to carry out the activities of COHC in accordance with the articles of incorporation and bylaws. *Net assets with donor restriction* represent resources whose use is limited by externally imposed restrictions that will be met either by actions of COHC or by the passage of time.

Resources that are restricted are reported as an increase in net assets without donor restriction if the restrictions expire (that is, when a stipulated time restriction ends or purpose restriction is accomplished) in the reporting period in which the revenue is recognized. All other restricted revenue is reported as increases in net assets with donor restriction, depending on the nature of the restrictions. When a restriction expires, net assets with donor restriction are reclassified to net assets without donor restriction and reported in the statements of activities as net assets released from restrictions.

**Liquidity and Reserves**

COHC has a policy to manage its liquidity and reserves in order to meet its needs to fund operating expenditures. At December 31, 2020, COHC’s financial assets, reduced by amounts not available for general expenditures within one year, are comprised of the following:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and cash equivalents</td>
<td>$11,920,017</td>
</tr>
<tr>
<td>Certificates of deposit</td>
<td>$14,838,475</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>930,327</td>
</tr>
<tr>
<td>Liquid assets available</td>
<td>27,688,819</td>
</tr>
<tr>
<td><strong>Less designated and restricted funds</strong></td>
<td>(11,958,827)</td>
</tr>
<tr>
<td><strong>Liquid assets available for general expenditure</strong></td>
<td>$15,729,992</td>
</tr>
</tbody>
</table>
1. **Summary of Significant Accounting Policies**, continued

**Board Designated Net Assets**

Annually COHC’s Board of Directors designates funding for 6 Regional Health Improvement Plan (RHIP) workgroups. The RHIP is informed by the Regional Health Assessment (RHA) and RHIP pillars are defined by COHC’s Board of Directors. COHC’s Board of Directors have designated this funding to be used in the following service areas: Addressing Poverty and Enhance Self-Sufficiency; Behavioral Health: Increase Access and Coordination, Promote Enhanced Physical Health Across Communities, Stable Housing and Supports, Substance and Alcohol Misuse; Prevention and Treatment, and Upstream Prevention: Promotion of Individual Well-Being. Following is the board designated activity for the year ended December 31, 2020:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning balance</td>
<td>$ 6,027,464</td>
</tr>
<tr>
<td>RHIP workgroups</td>
<td>5,972,536</td>
</tr>
<tr>
<td>Less expenditures of designated funds</td>
<td>(259,951)</td>
</tr>
<tr>
<td><strong>Ending balance</strong></td>
<td><strong>$ 11,740,049</strong></td>
</tr>
</tbody>
</table>

**Income Taxes**

COHC is an exempt organization under Section 501(c)(3) of the Internal Revenue Code (IRC) and therefore no provision for federal or state income taxes has been included in these financial statements.

**Use of Estimates**

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

**Cash and Cash Equivalents**

For purposes of the statement of cash flows, cash and cash equivalents consist of cash in interest and non-bearing interest depository accounts and certificates of deposits with original maturities of three months or less. COHC maintains cash and certificate of deposit balances at multiple financial institutions. From time to time throughout the year, part of the balances exceeded federal insurance limits. At December 31, 2020, cash and cash equivalent balances held in excess of federally insured limits was $4,718,677.

**Investments**

As of December 31, 2020, COHC held various investments in certificates of deposit. The certificates earned interest ranging from 0.15 percent to 1.28 percent. The certificates of deposit are reported at cost plus interest earned. All certificates of deposit are considered current due to maturity being within one year of the statement of financial position date.

**Property and Equipment**

All property and equipment acquisitions and renovations in excess of $2,500 and with an estimated useful life over one year are capitalized at cost. Donated property is recorded at its estimated fair market value on the date of donation.
1. **Summary of Significant Accounting Policies**, continued

**Accounts Receivable**

As of December 31, 2020, COHC had accounts receivable of $930,327 due from PacificSource for services rendered and grants awarded. PacificSource is a related party to COHC. Management did not record an allowance for doubtful accounts because receivables has been fully collected as of the date of the independent auditor’s report.

**Revenue Sources**

COHC holds an operating contract through a Joint Management Agreement (JMA) with PacificSource. This contract includes a 1.325 percent of the global budget provision that supports the priorities of the RHIP. The contract also includes separate monthly payments for COHC’s various responsibilities that include creating and implementing the RHA and RHIP as described in the PacificSource Coordinated Care Organization Contract.

**Functional Allocation of Expense**

The costs of providing various programs and other activities have been summarized on a functional basis in the accompanying statement of functional expenses. Accordingly, certain costs have been allocated among the programs and supporting services benefited. COHC utilizes a simplified cost allocation method whereby specifically identifiable costs are charged directly to the program or supporting services and indirect costs are allocated among program and supporting services through an allocation base. COHC uses its chart of accounts to track indirect costs for allocation in the functional expense categories.

2. **Grants Payable**

At December 31, 2020, COHC had grants payable as follows:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>BestCare Treatment Services</td>
<td>$ 800,000</td>
</tr>
<tr>
<td>Crook County</td>
<td>474,700</td>
</tr>
<tr>
<td>St. Charles Health System</td>
<td>40,334</td>
</tr>
<tr>
<td><strong>Total grants payable</strong></td>
<td><strong>$1,315,034</strong></td>
</tr>
</tbody>
</table>

The three providers above are all considered related parties to COHC.

3. **QIM Withhold Payable**

COHC acts as pass-through entity, assisting PacificSource Community Solutions, in the administration of Quality Incentive Measures (QIM) withholdings and payouts to local health care providers. On December 31, 2020, $454,725 was earmarked as due to local health care providers.

4. **SDOH-E Payable**

COHC acts as pass-through entity, assisting PacificSource Community Solutions, in the administration and awarding of Social Determinants of Health - Equity (SDOH-E) grant payouts as approved by the Community Advisory Council. On December 31, 2020, $61,682 was earmarked as due to local providers.
5. **JMA Settlement Payable**

Consistent with COHC’s operating contract through the JMA with PacificSource Community Solutions, $8,252,129 has been designated as payable from COHC to local Central Oregon health care providers as of December 31, 2020. The settlement amount was originally due back to PacificSource Community Solutions, however, PacificSource Community Solutions opted to waive the settlement. The COHC used the previously Board approved methodology to distribute the funds.

6. **Operating Leases**

COHC leases office space under an operating lease. For the year ended December 31, 2020, total expense related to this lease was $30,541. The current executed lease expires November 30, 2022.

Future minimum lease payments under non-cancelable operating leases are as follows:

<table>
<thead>
<tr>
<th>For the Year Ending December 31,</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>2021</td>
<td>31,403</td>
</tr>
<tr>
<td>2022</td>
<td>29,619</td>
</tr>
<tr>
<td>Total</td>
<td>61,022</td>
</tr>
</tbody>
</table>

7. **Related Party Transactions**

COHC provides grant awards to local organizations that employ members of the COHC Board in key positions at the grant recipient organization. Grants awarded to related party organizations during the year ended December 31, 2020, are as follows:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deschutes County</td>
<td>581,431</td>
</tr>
<tr>
<td>St. Charles Health System, Inc.</td>
<td>255,554</td>
</tr>
<tr>
<td>Central Oregon Intergovernmental Council</td>
<td>37,864</td>
</tr>
<tr>
<td>Total</td>
<td>874,849</td>
</tr>
</tbody>
</table>

8. **Concentration of Revenue**

COHC received approximately 95.3 percent of its ongoing revenue from one contract with PacificSource Community Solutions, for the year ended December 31, 2020.

9. **Prior Year Summarized Comparative Information**

The financial statements include certain prior year, summarized, comparative information in total, but not by net asset or functional classification. Such information does not include sufficient detail to constitute a full comparative presentation in conformity with accounting principles generally accepted in the United States of America. Accordingly, such information should be read in conjunction with COHC’s audited financial statements for the year ended December 31, 2019, from which the summarized information is derived.
10. Subsequent Events

Management evaluates events and transactions that occur after the statement of financial position date as potential subsequent events. Management has performed this evaluation through the date of the independent auditor’s report and noted the following:

COHC operations may be affected by the ongoing outbreak of the coronavirus (COVID-19) which was declared a pandemic by the World Health Organization in March 2020. Management is carefully monitoring the situation and evaluating its options during this time. No adjustments have been made to these financial statements as a result of this uncertainty. However, subsequent to December 31, 2020, the investment and credit markets have experienced significant volatility which may affect COHC assets. Management cannot currently quantify the financial impact COVID-19 will ultimately have on COHC, however it may result in a material decline of COHC’s financial position, activities and cash flows.
## Financial Dashboard

<table>
<thead>
<tr>
<th>Ratio</th>
<th>12/31/2020</th>
<th>12/31/2019</th>
<th>12/31/2018</th>
<th>Benchmark</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acid Test</td>
<td>2.74</td>
<td>5.54</td>
<td>3.78</td>
<td>2.00</td>
<td>Liquid assets to cover payables</td>
</tr>
<tr>
<td>Days cash on hand, without donor restriction</td>
<td>825</td>
<td>438</td>
<td>494</td>
<td>45+</td>
<td>Unrestricted cash in operational days available</td>
</tr>
<tr>
<td>Operating cash flow</td>
<td>6,850,614</td>
<td>3,290,746</td>
<td>(204,841)</td>
<td>0+</td>
<td>Cash provided (used) by organizational operations</td>
</tr>
<tr>
<td>Net cash reserve (burn) per day</td>
<td>18,769</td>
<td>9,016</td>
<td>(561)</td>
<td>0+</td>
<td>How much in net cash organization saved (used) each day</td>
</tr>
<tr>
<td>Working capital, without restriction</td>
<td>17,360,621</td>
<td>16,437,098</td>
<td>12,003,073</td>
<td>0+</td>
<td>Liquid assets available to leverage growth/strategic plan</td>
</tr>
<tr>
<td>Personnel % of total revenue</td>
<td>18.0%</td>
<td>5.2%</td>
<td>11.2%</td>
<td>&lt;70%</td>
<td>How much of your organizational revenue is spent on people</td>
</tr>
<tr>
<td>Advertising % of total revenue</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.5%</td>
<td>How much of your organizational revenue is spent telling your story</td>
</tr>
<tr>
<td>Program % of total expenses</td>
<td>92.5%</td>
<td>96.1%</td>
<td>97.0%</td>
<td>75%+</td>
<td>How much of your annual budget is spent on your mission</td>
</tr>
<tr>
<td>Annual budget</td>
<td>11,740,101</td>
<td>7,462,174</td>
<td>8,335,732</td>
<td>N/A</td>
<td>What your fiscal year cost</td>
</tr>
<tr>
<td>Operating margin</td>
<td>8.9%</td>
<td>37.1%</td>
<td>-51.6%</td>
<td>4%+</td>
<td>Profit per dollar of revenue</td>
</tr>
<tr>
<td>Revenue concentration of largest funder</td>
<td>95%</td>
<td>96%</td>
<td>90%</td>
<td>&lt;20%</td>
<td>Organizational reliance on support from single funder</td>
</tr>
</tbody>
</table>
Public Perception  |  Survey Results

73  7
responses  interviews

• Why did we do the survey?
• Who participated?
• What the quiz showed us
• The ultimate result!!
Why did we do the survey?

1. Identifying our value proposition aligns with our Strategic Plan

2. The COHC can be difficult to explain

3. Sustainability beyond investments
The last time you had to explain what the COHC is, how did it feel?

They didn’t get it

They “got it” enough

They totally got it

Hard

Neutral

Easy
### Sustainability Beyond Investments

**Why do we want to be known as more than just a funder? What is lost when people perceive us as primarily a funder?**

<table>
<thead>
<tr>
<th>In case the money runs out (years away)</th>
<th>We use $ as a means to achieve health outcomes, it doesn’t always take $</th>
<th>The goals is health outcomes, not $</th>
<th>We want to also connect others</th>
<th>Ppl’s expectations are ‘off’ and we can’t meet them</th>
</tr>
</thead>
<tbody>
<tr>
<td>We lose partnerships that could bring benefit to our region</td>
<td>Waste</td>
<td>Suppresses important conversations</td>
<td>Opportunities to collaborate in other ways</td>
<td>If we only fund we miss other opportunities to improve well-being</td>
</tr>
<tr>
<td>Time is lost trying to explain over and over how we are not just a funder</td>
<td>Transformation is not just a one and done</td>
<td>Collective Impact</td>
<td>Because regional health improvement takes more than just 1 org and $$</td>
<td>Only being a funder is limiting innovative opportunities</td>
</tr>
<tr>
<td>Understanding the value of a backbone org</td>
<td>We’re about health in all policies, not just about money</td>
<td>Our principles transcend our bank account</td>
<td>Greater impact</td>
<td>It takes more than $$ to do what needs to be done</td>
</tr>
</tbody>
</table>
What questions were we trying to answer?

Why are people showing up to our meetings?

What makes the COHC valuable to our partners?
How should we be introducing ourselves?

What is one thing that, if we stopped doing it, people would leave the COHC?
Who participated?

**General Survey:**
- 15 Community Members
- 58 Organization Reps
- 61 Workgroup Members
- 28 Committee Members
- 32 from Health Care
- 22 from non-profits
- 12 from Government

**Interviewees Included:**
- Community members
- Former grantees
- Organizations who have **not** received funding
- Healthcare, government & non-profit
The Quiz

What we asked:
• Where does the RHIP money come from?
• How are PacificSource & COHC connected?
• Why are workgroups making investments?
• Why does the COHC make investments at all?
• Does the COHC negotiate service provider contracts?
• Who is the “COHC” really?

Why we had a quiz:
• Get a baseline
• Identify knowledge gaps among volunteers
• Remind survey takers of some key facts prior to the perception questions
• 1 in 7 are un/misinformed about where the RHIP money comes from

• 2 in 5 do not understand the relationship the COHC has with PacificSource

• 2 in 3 do not know where the workgroup’s power to make investments comes from

• 2 in 5 do not realize there is a contract that enables the COHC make investment decisions

• 2 in 5 are not aware that the COHC does not negotiate service provider contracts

• Almost everyone knows the “COHC” really is all of us
So, why do people find value in the COHC?

What is in our "Secret Sauce"?
Inclusivity

We listen and offer low-barrier entry, understanding all communities have different needs

Shepherding

Professional & involved support staff, deliberate processes

Visionary

A broad spectrum of priorities

Strategic

Health is more than health care, we make data-driven decisions

Action-oriented

Effective opportunity to volunteer, concrete steps, not just wishing for change acting on it with resources

Cross-sectoral

Inclusive partnerships, unlikely partners, networking, learning from peers outside industry

Health-focused

Ensuring access to wellness, and action in aspects of wellbeing
So, if those 7 things are the ingredients, what does the label on the front of the bottle say?
We partner with our communities to guide and align vision, strategy, and activities across industries for a healthier Central Oregon.

Not a replacement for our vision, mission, or purpose statements.
We partner with professionals and community members from different backgrounds to shepherd collective intentions, efforts, and actions for a stronger Central Oregon.

Inclusivity  
Shepherd ing  
Visionary  
Strategic  
Action-oriented  
Cross-sectoral  
Health focused
We partner with our communities to guide and align vision, strategy, and activities across industries for a healthier Central Oregon.

**Value Statement**

**Framework**
- Inclusivity
- Shepherding
- Visionary
- Strategic
- Action-oriented
- Cross-sectoral
- Health focused
How will it be used?

Presentations
Communications Toolkit
Grant applications
As a checklist

Introductions
Website
Onboarding
Press Releases
Central Oregon Health Council
Executive Director’s Update
June 10, 2021

- Facilitate PEP meeting
- Facilitate Finance meeting
- Multiple stakeholder/community meetings
- Steering committee for TRACES work (United Way)
- EL Hub as ex-officio member
- El Hub Investment Steering Committee
- Central Oregon Suicide Prevention Alliance Leadership
- COHIE Board Officer – HIE
- Fiscal agent and Project Mgr for Social Services Steering UNITE US (CIE)
- System of Care Executive Team member
- Grant software management
- Managing OABHI contract (terminating 6.30.2021)
- CCO 2.0 alignment and support and training
- Board Governance Committee support
- Cost & Utilization Steering committee
- Maintain office closure and provide for minimal disruption to staff, committees, workgroups and community
- Manage Strategic Plan
- Manage SB741 in long session to amend sunset date of 1.2022
- Phase II of Unite Us CIE pilot (transition plan)
- 2020 financial audit process (field audit April-May 2021)
- Appointed to Local Public Safety Coordinating Council
- Participated in the Healthcare Congress/American College of Healthcare Executives (ACHE)
- Economic Recovery Plan/CEDS member
- Completed ED Succession/Transition Plan
- Start office move transition plan

Coming up:
- PTO 6.24 – 7.12
## Strategic Plan Report Card 2020-2024

### Accomplishments

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Who?</th>
<th>Success Looks Like:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Research Alternative Payment Methodology (APM) promising practices and models.</td>
<td>Staff</td>
<td>APMs align with contract deliverables</td>
</tr>
<tr>
<td>0</td>
<td>Discuss pros and cons of APM promising practices and models at Operations Council, the Provider Engagement Panel (PEP), Finance Committee, and Cost and Utilization Steering Committee (CUSC), and make a recommendation to the Board.</td>
<td>Committees, Board, Staff</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Pursue exploratory discussions with PacificSource Health Plans that shed light on the shared benefits/advantages and possible barriers of expanding community governance to additional revenue streams, such as Medicare and commercial lines.</td>
<td>PacificSource, Staff</td>
<td>Additional revenue stream</td>
</tr>
<tr>
<td>2</td>
<td>The COHC staff conducts grant research.</td>
<td>Staff</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Prepare to apply for a grant in 2022, COHC as the recipient</td>
<td>Staff</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Collaborate with two community provider organizations to launch a pilot Community Information Exchange (CIE).</td>
<td>Staff</td>
<td>Providers adopt Community Information Exchange (CIE)</td>
</tr>
<tr>
<td>5</td>
<td>Transition CIE project from the COHC to PCS</td>
<td>PacificSource, Staff</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>The Central Oregon CIE is established and utilized widely</td>
<td>Staff</td>
<td></td>
</tr>
</tbody>
</table>
### Strategic Plan Report Card (cont’d)

<table>
<thead>
<tr>
<th>Accomplishments</th>
<th>Who?</th>
<th>Success Looks Like:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- COHC staff gather and share tools/strategies to explore opportunities for workgroups.</td>
<td>Staff</td>
<td>Funded projects reflect multi-sector partnerships</td>
</tr>
<tr>
<td>- COHC RHIP Workgroups begin funding multi-sector projects.</td>
<td>Staff</td>
<td></td>
</tr>
<tr>
<td>- Create, finalize, and vote on the purpose (ends) statement, to guide our work alongside the approved COHC mission and vision.</td>
<td>Governance, Staff</td>
<td></td>
</tr>
<tr>
<td>- Develop simple and concise multi-level external communications plan for board member and partner use.</td>
<td>Staff</td>
<td></td>
</tr>
<tr>
<td><strong>Q4</strong> Include expectations in the COHC Board Policy Book of Board member organizations incorporating the COHC Strategic Plan &amp; RHIP priorities</td>
<td>Governance, Board, Staff</td>
<td>COHC strategic plan and RHIP priorities are formally prioritized within Board members’ organizations</td>
</tr>
<tr>
<td><strong>Q3</strong> Survey Board members for current state adoption of the COHC SP &amp; RHIP Priorities in their organizations</td>
<td>Board, Staff</td>
<td></td>
</tr>
<tr>
<td>- Impact regional health through the RHIP (participation, investments)</td>
<td>Staff</td>
<td></td>
</tr>
<tr>
<td>- Explore strategic planning processes tailored to our community coalition model.</td>
<td>Staff</td>
<td></td>
</tr>
<tr>
<td>- Develop a process and tools for annual COHC self-evaluation</td>
<td>Governance, Staff</td>
<td>Annual Board self-evaluations</td>
</tr>
<tr>
<td>- Board self-eval will be conducted in 2021 for the first time</td>
<td>Governance, Board, Staff</td>
<td></td>
</tr>
<tr>
<td>- The COHC Board can name the key cost drivers in the CCO.</td>
<td>CUSC, Board, Staff</td>
<td>CUSC enacts strategies to address key cost drivers that are adopted by the Board</td>
</tr>
<tr>
<td><strong>Q3</strong> Establish baseline data around key cost drivers.</td>
<td>Staff</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- **Not started**
- **Obstacles**
- **On Schedule**
- **Initial Successes**
- **Complete**

**Published:** 4.1.2021
### Engaging regulators for informed decision-making

<table>
<thead>
<tr>
<th>Accomplishments</th>
<th>Who?</th>
<th>Success Looks Like:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The COHC staff will engage key PacificSource Community Solutions staff in strategic discussions on bi-directional communications streams that currently exist between the CCO and OHA.</td>
<td>Staff</td>
<td>Bi-directional communication between OHA and the COHC</td>
</tr>
<tr>
<td>The COHC Board will develop a regular process to collaborate with PacificSource that identifies critical policy goals in the operation and funding of Coordinated Care Organization model (CCO) in Oregon.</td>
<td>Board, Staff</td>
<td>Inform future CCO policy decisions</td>
</tr>
<tr>
<td>The COHC staff will engage key PacificSource Community Solutions staff to map out various bi-directional communications streams that currently exist between the CCO and OHA across all relevant programs or departments.</td>
<td>Staff</td>
<td></td>
</tr>
<tr>
<td>Build consensus between COHC and the CCO to define bi-directional communication with OHA</td>
<td>Staff</td>
<td></td>
</tr>
<tr>
<td>The COHC Board, committees &amp; workgroups will receive advocacy training and education.</td>
<td>Board, Committees, Workgroups, Staff</td>
<td>Advocacy &amp; policy efforts</td>
</tr>
<tr>
<td>Assess legislative relationships and opportunities of individual Board members.</td>
<td>Board, Staff</td>
<td></td>
</tr>
<tr>
<td>Build an internal advocacy/lobbying process</td>
<td>Staff</td>
<td>Advocacy strategy</td>
</tr>
<tr>
<td>Invite Board members to bring legislative priorities forward which align with the RHIP to discuss advocacy opportunities</td>
<td>Board, Staff</td>
<td></td>
</tr>
<tr>
<td>Invite RHIP Workgroup members to bring legislative priorities forward which align with the RHIP to discuss advocacy opportunities</td>
<td>Workgroups, Staff</td>
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</table>

Q3 | Q2 | Q4 | Q4 | Q2  |

Not started | Obstacles | On Schedule | Initial Successes | Complete |
Strategic Plan Report Card (cont’d)

<table>
<thead>
<tr>
<th>Accomplishments</th>
<th>Who?</th>
<th>Success Looks Like:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish data subcommittee with clear objectives (Cost and Utilization Steering Committee (CUSC).)</td>
<td>CUSC, Staff</td>
<td>Cost driver reform commitment at Board member organizations</td>
</tr>
<tr>
<td>The CUSC will identify data points that are representative of drivers that contribute to increased healthcare costs.</td>
<td>CUSC, Staff</td>
<td></td>
</tr>
<tr>
<td>The subcommittees of CUSC will be supported to identify concrete actions that organizations can take by December 2021.</td>
<td>CUSC, Board, Staff</td>
<td></td>
</tr>
<tr>
<td>Obtain MOUs from the three pilot participants/data contributors.</td>
<td>CUSC, Staff</td>
<td>2% decrease in the cost of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Launch data infrastructure pilot</td>
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</tbody>
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Obstacles

- Not started
- Obstacles
- On Schedule
- Initial Successes
- Complete

table

Strategic Plan Report Card (cont’d)
### Identifying and addressing inequities

<table>
<thead>
<tr>
<th>Accomplishments</th>
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<th>Success Looks Like:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Governance Committee will review Board’s bylaws to ensure equity goals are met.</td>
<td>Governance, Staff</td>
<td>Board diversity (for “Directors-at-Large”)</td>
</tr>
<tr>
<td>Talk with a possible Warm Springs representative (leadership), find out if there is value for them in COHC Board participation.</td>
<td>Board, Staff</td>
<td></td>
</tr>
<tr>
<td>Survey current COHC Board members via REAL-D and current Board representative make-up.</td>
<td>Board, Staff</td>
<td></td>
</tr>
<tr>
<td>With the support of the Central Oregon Diversity, Equity, and Inclusion (CODEI) Committee, develop and begin collecting three COHC organizational DEI measures.</td>
<td>CODEI, Staff</td>
<td>Funded projects prioritize rural and marginalized communities</td>
</tr>
<tr>
<td>With the support of CODEI, develop and implement tools to support regular consideration and use of equity in all COHC committees and workgroups (to better respond to needs of rural and marginalized communities).</td>
<td>CODEI, Staff</td>
<td></td>
</tr>
<tr>
<td>Define what rural and marginalized communities are and how we will measure this.</td>
<td>Staff</td>
<td>Equity throughout the COHC</td>
</tr>
<tr>
<td>Define what “promote and ensure equity in roles” will contain.</td>
<td>CODEI, Staff</td>
<td></td>
</tr>
<tr>
<td>Develop a meaningful relationship between the Board &amp; the CAC</td>
<td>Board, CAC, Staff</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Status</th>
<th>Not started</th>
<th>Obstacles</th>
<th>On Schedule</th>
<th>Initial Successes</th>
<th>Complete</th>
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<tr>
<td>Column</td>
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<tr>
<td>Accomplishments</td>
<td>Who?</td>
<td>Success Looks Like:</td>
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</tr>
<tr>
<td><strong>Q3</strong> Design a disincentive for poor QIM performance.</td>
<td>Staff, Board</td>
<td>100% QIM Payouts</td>
<td></td>
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</tr>
<tr>
<td><strong>Q3</strong> Include outcomes based incentives regarding social determinants in RHIP workgroup investments which demonstrate cost-avoidance.</td>
<td>Workgroups, Staff</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Q4</strong> Develop ways to incentivize outcomes through at least one RHIP investment.</td>
<td>Staff</td>
<td>Demonstrate and incentivize cost-avoidance</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Q3</strong> Develop qualifications/criteria that outcomes-based incentivizing may work.</td>
<td>Staff</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Q3</strong> Internally develop standards of demonstrated cost-savings that qualify recommending a project for inclusion in contracting/the global budget.</td>
<td>Staff</td>
<td>Global budget absorbs projects proving cost-savings</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Q3</strong> Design a protocol with the CCO to determine minimum standards for projects in order to be considered for inclusion in the Global Budget.</td>
<td>PacificSource, Staff</td>
<td></td>
<td></td>
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</tbody>
</table>
### Rotating Quarterly Board Spotlight

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2</td>
<td><strong>Include expectations in the COHC Board Policy Book of Board member organizations incorporating the COHC Strategic Plan &amp; RHIP priorities</strong></td>
</tr>
</tbody>
</table>
|         | - The Governance Committee submitted the Board Policy Book for a vote at the April 2021 Board meeting and included placeholders for additional policies.  
- The Governance Committee and Staff will add language into the Board Policy Book about Board Member organization alignment with the COHC’s Strategic Plan and RHIP Priority Areas.  
- The Board will discuss and vote on this policy in Q2 2021.  
- The intent of this policy is to demonstrate Board Members’ ability to identify and commit to alignment between their own organization’s strategic plan and/or improvement plans, and that of the COHC. |
| Q3      | **Survey Board members for current state adoption of the COHC SP & RHIP Priorities in their organizations** |
|         | - Once expectations are defined in the policy book, Board members whose organizations are represented on the COHC Board (excludes at-large members and CAC Chair) will be surveyed in Q3 2021 for a baseline of current alignment.  
- We will conduct this survey annually to compare with baseline results.  
- Survey results will be shared publicly and discussed beginning with the second survey in 2022 for accountability. |
| Q2      | **Survey current COHC Board members via REAL-D and current Board representative make-up.** |
|         | - Race, Ethnicity, Language, and Disability (REAL-D) data is becoming the industry standard for demonstrating demographics and diversity.  
- In Q2 2021 the COHC Board will be surveyed for REAL-D for the first time. The CAC is already surveyed annually for REAL-D, as this is a requirement of OHA.  
- The REAL-D data will be used to demonstrate current Board representation compared to the demographics of Central Oregon. This is an important aspect of diversity, equity, and inclusion.  
- De-identified results will be shared with the Board in Q3 2021. |

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**Demonstrating effective governance**

**Identifying and addressing inequities**

Published 4.1.2021
CCO Director Report
Date: June 2021
To: The Central Oregon Health Council (COHC) Board of Directors
Prepared by: Leslie Neugebauer, Senior Director, Medicaid Governance

PACIFICSOURCE COMMUNITY SOLUTIONS CENTRAL OREGON CCO UPDATES:

Senate Bill (SB) 889/Voluntary Value-Based Payment (VBP) Compact
Passed in 2019, SB 889 mandates the alignment of VBP efforts across public and private health care initiatives and markets. Overall, VBP principles outlined in SB 889 align with CCO 2.0 VBP Roadmap requirements. However, SB 889 does push Oregon payers and providers to adopt advanced VBP models more quickly. As part of implementation, a voluntary compact of payers, providers and purchasers (the Sustainable Health Care Cost Growth Target Committee) has identified opportunities to: 1) lower costs, 2) improve quality of care, and 3) improve efficiency of the health care system using innovative payment models for all payers. PacificSource’s CEO, Ken Provencher, is a member of the Sustainable Health Care Cost Growth Committee. PacificSource has signed off on the Voluntary VBP Compact. This information was presented to the COHC Board in May.

Semi-Annual Care Management Report
As part of new CCO 2.0 requirements, CCOs must submit biannual care coordination data to OHA. The Central Oregon CCO’s Manager of Care Management will be presenting the first biannual report to the Provider Engagement Panel in June for discussion and feedback prior to submission to OHA in mid-August. Additionally, the report will be included the August CCO Directors report, as part of the consent agenda, for board approval.

1115 Waiver
OHA is working on the next iteration of the 1115 Medicaid Transformation Waiver, as the current waiver expires in June 2022. OHA has announced that the focus areas of this next waiver will center on: 1) Access to Coverage; 2) Equity Centered Systems of Health; 3) Smart, Flexible Spending through Global Budget; and 4) Reinvest Savings Across Systems. They are currently drafting concept papers for each of these topics and will likely open up the public comment process as early as July of 2021. We expect they will submit their final waiver application to CMS no later than December 2021.

COVID-19 Vaccine Measure
OHA is proposing a new COVID-19 vaccine metric to incentivize a high vaccination rate of the Oregon Health Plan population. The metric is similar to CCO Quality Incentive Metrics (QIMs), though it will not be part of the existing 2021 QIM set. Incentive funds for this new metric will come from existing CCO Quality Pools. OHA is using an Emergency Outcome Tracking process to develop the metric. Yet to be determined are improvement targets, the percentage of the Quality Pool at stake, and the official start date. PacificSource is already tracking CCO member COVID-19 vaccination rates and will share data with providers once the metric specifications are finalized. PacificSource has been engaging in targeted outreach strategies to assist members with receiving a COVID-19 vaccination. We will continue to keep the COHC and provider partners updated as we learn more from the OHA.
Q1 2020 Quality Pool
CCOs will receive Quality Pool dollars from regional performance in Q1 of 2020 on June 30, 2021. The Central Oregon CCO’s estimated maximum payout is $3,268,359. As recommended by the Finance Committee and endorsed by the COHC Board, 50% of these funds will be put back into the global budget and the other 50% have the following allocation: 35% to provider partners (distributed by COHC), 10% to SDOH-E partners (designated by the CAC), 5% to quality/population health initiatives (directed by the PEP and PCS partners).

Upcoming Provider Trainings
Shared Decision Making
Instructor: Mary Minniti, Senior Policy and Program Specialist at the Institute for Patient and Family Engagement
Date(s): June 8, 2021 and June 15, 2021
Time: 11:30AM to 1:00PM
Registration: https://PacificSource.myabsorb.com?KeyName=SharedDecisionMaking

GENERAL PACIFICSOURCE UPDATES:

New Vice President of Medicaid Programs
Erin Fair Taylor will be joining PacificSource on June 28, 2021 as the Vice President of Medicaid Programs. Erin comes to PacificSource from CareOregon, where she served most recently as the Chief Strategy Officer. Erin received her juris doctor degree from the University of Oregon Law School, a Master of Public Health degree from Tulane University School of Public Health & Tropical Medicine, and a bachelor’s degree in anthropology from the University of Florida, Gainesville.

New Director of Lane County CCO
Kellie DeVore will be joining PacificSource on June 28, 2021 as the Lane CCO Director. Kellie is currently the Executive Director of Habitat for Humanity of Central Lane. Kellie received her Master of Public Health Administration from the University of Oregon and a bachelor’s degree in political science and modern languages (Spanish).
COHC Community Advisory Council
Held virtually via Zoom
May 20, 2021

Present:
Brad Porterfield, Chair, Consumer Representative
Larry Kogosvek, Vice Chair, Consumer Representative
Mayra Benitez, Consumer Representative
Linda Johnson, Community Representative
Tom Kuhn, Deschutes County Health Services
Regina Sanchez, Crook County Health Department
Elizabeth Schmitt, Consumer Representative
Mandee Seeley, Consumer Representative
Ken Wilhelm, United Way of Central Oregon
Cris Woodard, Consumer Representative

Absent:
Natalie Chavez, Jefferson County Health
Elaine Knobbs-Seasholtz, Mosaic Medical
Lauren Kustudick, Consumer Representative
Theresa Olander, Consumer Representative
Jolene Greene, Consumer Representative
Jennifer Little, Klamath County Public Health

Others Present:
MaCayla Arsenault, Central Oregon Health Council
Rebeckah Berry, Central Oregon Health Council
Tania Curiel, Oregon Health Authority
Rebecca Donell, Oregon Health Authority
Buffy Hurtado, PacificSource
Gwen Jones, Central Oregon Health Council
Renee Markus Hodin, Center for Consumer Engagement in Health Innovation
Donna Mills, Central Oregon Health Council
Leslie Neugebauer, PacificSource
Kelsey Seymour, Central Oregon Health Council
Colleen Sinsky, FUSE
Kristen Tobias, PacificSource
Introductions

- Introductions were made and Brad Porterfield welcomed all attendees.

Public Comment

- Brad welcomed public comment.
- Cris Woodard noted the houseless population that has gathered outside of Bi-Mart in Bend. Larry Kogosvek shared the shelter there closed a month ago, which has left folks outside.
- Kristen Tobias shared NeighborImpact is encouraging anyone in need of rental assistance to apply early, as they anticipate the rent moratoriums and eviction freezes will lift soon.
- Tom Kuhn recognized Kelsey Seymour and the Central Oregon Health Council for partnering with Deschutes County to release videos debunking the COVID-19 vaccine fertility rumors.

Approval of the Consent Agenda, Minutes

- Ken Wilhelm motioned to approve the minutes; Larry Kogosvek seconded. All were in favor, the motion passed unanimously.

Oregon Health Authority Updates

- Rebecca Donell shared there is an innovator agent from OHA holding virtual office hours to answer questions about REALD data. Linda Johnson noted she and Brad will be attending the annual CAC conference. MaCayla Arsenault and Gwen Jones confirmed they will attend also. Rebecca confirmed the conference will be recorded for anyone unable to attend the live session.

Community Health Projects Process Development

- MaCayla shared the amount to be awarded this year will be $431,681.98.
- The group discussed the possibility of lowering the award floor below $5,000, considering removing the floor altogether and accepting requests, no matter how small. Time ran out before consensus could be reached. MaCayla asked the CAC to look out for correspondence about this and other decisions between now and the next meeting.

SHARE (Supporting Health for All through Reinvestment) Initiative

- Kristen Tobias explained the SHARE initiative is a Social Determinant of Health-Equity (SDOH-E) funding stream designated by the Oregon Health Authority (OHA). She noted part of the requirement is to have the CAC involved, and PacificSource has elected to have the CAC vet the program budget for their proposed project with FUSE. Colleen Sinsky presented the FUSE project which connects chronically homeless individuals with housing through the housing-first model. Kristen shared there will be a follow-up presentation in June when the CAC can review the budget.
Emerging Issues Process Update
- Brad asked CAC members if they are willing to participate in the process for developing an Emerging Issues Process offline. Linda and Larry volunteered.

CAC Recruitment Committee
- Gwen asked CAC members if they are willing to help with recruiting outside of regular meeting times. She introduced Renee Markus Hodin as the consultant supporting CAC recruiting. Larry volunteered.
COVID-19 Final Report for Brightways Counseling Group (RHIP)
“Access to Care - Telehealth”
Reviewed by the Behavioral Health: Increase Access & Coordination Workgroup

Summary of Results:

- This project was intended to be able to provide phones to individuals that did not have access to phones, Wi-Fi, or any device to be able to complete telehealth counseling appointments.
- The intent was to make sure that no one that was in need of counseling went without counseling due to lack of resources.
- If any individual was in need of a cell phone in order to be able to complete telehealth counseling sessions, we would work with the individual to provide them a phone that ran on data that they could use to meet over video with their clinician.
- Throughout the course of this project, we were able to provide cell phones for 22 individuals in need who would not have been able to get the help they needed without the phones provided.
- By getting the phones to the individuals they were able to meet over video with their clinicians for sessions weekly and receive the care they needed.
- Without the cell phones provided these clients would have had no way to receive the care they were seeking due to COVID restrictions and not being able to be in the office.

Story:

All 22 of the individuals that we have been able to provide cell phones to have been extremely grateful for the opportunity to receive counseling services even though they had a lack of resources. We would never want to turn someone away because they did not have a video capable device to do telehealth sessions on. This project in particular helped one individual be able to receive counseling, medication management, and group therapy services all from the cell phone provided via telehealth. Without this project they would have been struggling to find access to the care they urgently needed.
COVID-19 Final Report for Weeks Family Medicine (RHIP)
“Weeks Everywhere”
Reviewed by the Behavioral Health: Increase Access & Coordination Workgroup

Summary of Results:

- Initially this project started with the focus of being able to outreach to our Behavioral Health population in Deschutes County and rural areas, to increase appointment attendance, decrease our No Show rates, aid in the follow up of AOD treatment and add a convivence for our patients by being able to be seen from their home.
- This project has helped our practice on numerous levels, and we are happy to continue the growth and use of Telehealth.
- With the COVID-19 global pandemic, Telehealth was the only way patients had access to our BHC for almost a year.
- Patients continue to elect Behavioral Health Telehealth visits as this suits their lifestyle, Pandemic awareness, and personal needs best.
- The implementation of Telehealth was the only avenue for our behavioral health patient population to be seen during the onset, and majority of the duration of 2020, due to the global pandemic.
- Patients still elect to be seen via Telehealth as they can continue quarantine, reach out for help from home or work, and receive AOD follow up and assistance.
- Our PCP providers can connect patients in same day circumstances with the ease of a phone call to the BHC, or face to face visit via Telehealth with the BHC.
- The biggest challenge the practice, as well as the patients, encountered were navigating I.T. issues.
- A lot of time and configuration on the back end with our I.T. staff as well as appointing a clinic champion to assist patients and other staff members was very time consuming and expensive.
- A lot of possible face to face telehealth options were converted to phone conversations when needed, due to user error, poor patient internet connection, provider laptop configuration, and a list of ongoing issues.

Story:
This project has brought Telehealth services to our Behavioral Health population as well as our routine med checks, sick visits that can't be brought into the clinic, and many other PCP appointment opportunities. By allowing patients to stay in their homes, and not risk contracting or spreading the COVID-19 virus we have helped keep families in their homes and overall assisted in keeping positive cases down.

*Order of projects is by final report submission date  
Published June 2021
COVID-19 Final Report for Council on Aging for Central Oregon (RHIP)
“Addressing Urgent Food Needs for Seniors”
Reviewed by the Address Poverty and Enhance Self-Sufficiency

Summary of Results:

- This project focused on supporting the urgent food needs of the older population in Central Oregon via our organization’s meal programs.

- By providing additional food for the growth of our meal programs, Meals on Wheels and Congregate dining which we are now delivering via drive-through to-go meals, this grant has allowed us to serve more clients and reduce food insecurity.

- We are still handing out and delivering our meals in a safe, socially-distant manner to keep our clients, volunteers and staff safe.

- Thank you for contributing to our program's success and the growing number of meals served to older adults throughout Central Oregon.

- The generous funds provided covered the cost of food for 1,000 of these meals - approximately 8% of the total meals (12,900) provided in May 2020.

Story:

Our free meal services provides nutrition and an opportunity for connection for all. Providing meals and an chance to connect with a volunteer or other attendees in the drive through, allows our clients to feel seen which has an enormous impact on the well-being of our most vulnerable members of our community. One of our new clients in Sisters became very emotional when she discovered the drive through service. She shared with our team member that she usually just opens up a can of peaches or makes of bowl of oatmeal and that is all she has to eat. She was grateful to read about this through the Nugget (Sisters, OR newspaper) so she can pick up and eat these amazing meals and connect with others in the community throughout the week.
COVID-19 Final Report for Sunstone Recovery (NRHIP)
“Sunstone Recovery Connected”

Reviewed by:
Substance and Alcohol Misuse: Prevention and Treatment Workgroup

Summary of Results:

- Sunstone Recovery Connected has allowed for us to be able to offer clients telehealth direct care services during the COVID-19 crisis.
- Sunstone Recovery Connected has also allowed for us to smoothly transition from in person care to telehealth.
- We have also been able to secure a HIPAA compliant telehealth platform and train/hire staff so we’re able to continue to offer Telehealth services to the Central Oregon community.
- Sunstone Recovery Connected has allowed for current and new clients to receive telehealth direct care services during the COVID-19 pandemic.
- We have achieved our goal to be able to offer 100% of all of our clinical services via telehealth and have been able to hire and train staff to implement the new telehealth platform.

*Order of projects is by final report submission date

Published June 2021
COVID-19 Final Report for Parkinson’s Resources of Oregon (Non-RHIP)  
“Vulnerable Senior Outreach”

Summary of Results:

- With 142 households included, we are confident that together we improved lives. Without exception, the folks we spoke with were grateful for the outreach and quite eager for conversation.
- In some calls we learned of a recent (or unknown to us) death, which opened the door for possible grief support referrals.
- Everyone of course wanted to discuss covid and the prospect of a vaccine, but also the data support that at least a third wanted help to become engaged with zoom support groups and other Parkinson’s Disease-specific programs.
- The personal connection made the participation seem more possible.
- We also learned that for some, telephone truly is the lifeline for that home. Limited or no internet. No computer or broken computer at home, etc.
- We are working to leverage our existing programs and volunteers to continue support especially to these folks with technology barriers.
- We are actively making plans to continue some form of this initiative. We have had some success with key volunteers, including one just for Central Oregon.
- The challenge is that the needs are so varied, it is difficult to provide sufficient training for a volunteer.
- Even our highly experienced staff needed to lean upon our social worker for some cases. We will utilize the call log and topics discussed data to help inform the need for future education programs.

Learning:

Lessons learned for us was how eager our constituents are for the connection. Even post pandemic/quarantine we envision an ongoing need for some form of telephone outreach and connection. Too many folks aren't tech savvy, aren't driving, or don't have the initiative to reach out - yet without exception - people we reached were grateful and appreciative of the connection and open to learning about resources.
COVID-19 Final Report for La Pine Community Health Center (RHIP)
“The Behavioral Health COVID-19 Telehealth Project”
Reviewed by the Behavioral Health: Increase Access & Coordination Workgroup

Summary of Results:

- The Telehealth Project enabled La Pine Community Health Center’s (LCHC) Behavioral Health (BH) providers to work with their patients remotely keeping both the clients and staff safe from contracting the COVID-19 virus.
- Telehealth also allowed more flexibility as patients sequestered during the COVID-19 and following the Social Distancing requirements.
- Patients of LCHC are experiencing additional or new situations that are requiring consultation with the BH providers.
- By implementing this project during the beginning of the pandemic then continuing as the restrictions were relaxed, LCHC continued to serve the BH patients more easily, conveniently and in the patients’ preferred setting.

Quote:

“Because of the COVID-19 pandemic, many of my patients felt very uncomfortable coming to the clinic for our visits. Additionally, transportation is an ongoing issue. Telehealth provided, and continues to provide, a safe alternative to in-person visits. Patients who participated in a telehealth visit expressed satisfaction and gratitude that telehealth was and is an option for Behavioral Health consultations. After many months of isolation, it was important for me to be able to touch base with my patients and "see" how they were doing.” Beth - Behavioral Health provider

*Order of projects is by final report submission date  Published June 2021
COVID-19 Final Report for St. Charles Health System (Non-RHIP)
“Expansion of Continuous Glucose Monitor Services to All Patients”
Reviewed by the Promote Enhanced Physical Health Workgroup

Summary of Results:

- The results of this project showed an increase in time in target range (defined as blood glucose of 70-180 mg/dl) for patients who received a continuous glucose monitor (CGM).
- The mean baseline time in target range (TIR) prior to CGM was 50%, compared with 67% at the end of the CGM use period.
- Those who continued the CGM for at least 90 days, had an average A1c reduction of 1.1%, which is considered clinically significant.
- A study from Sweden showed an A1c reduction of 7.8% to 7% reduced the risk of cardiovascular death by 45%, as well as a reduction in fatal and nonfatal coronary heart events of 37%.
- CGM also increases patient satisfaction, by eliminating finger stick BG monitoring.
- Most patients become more engaged with getting their diabetes under control when they can see how their BG changes after certain meals or with exercise.
- Overall, using a CGM in managing diabetes can improve A1c control in patients with diabetes, improve long term outcomes, and increase patient satisfaction and engagement.

Story:

Many patients who live in remote areas of Central Oregon may experience barriers to access secondary to travel restrictions and cost. Quick treatment of hyperglycemia after diagnosis of diabetes is pertinent for improved health outcomes. CGM services allow for remote monitoring which helps to bridge this gap. One specific Type 2 Diabetic patient from La Pine who struggled with hyperglycemia for years (A1c of 11.4% in 2018, 10.6% in 2019 and 10.2% in 2020), despite being managed by endocrinology, was referred to PharmD clinic and had CGM placed in 10/2020. With consistent CGM use for 160 days, implementation of lifestyle changes and medication adjustments based off CGM data the patient's A1c significantly improved to 6.6% on 5/20/21.

*Order of projects is by final report submission date
Published June 2021
Summary of Results:

- ReVillage was able to open its doors to ten children on May 5.
- This was able to happen because we went through a thorough hiring process, guided by our partnership with a local diversity, equity & inclusion consultancy.
- We were also able to purchase supplies to ensure we are COVID19 compliant.
- We now are able to offer full-time, affordable care (approximately seven percent of median income in Bend) to four children and no-cost care to six children through our partnership with Baby Promise.
- We have the tools and quality of staff we need to expand our program into a second location later this year and expand our current location to offer care for an additional five children.
- Our staff and board will be trained in DEI and our hiring process was thorough and intentional.
- We are COVID-compliant and safe, able to operate as an emergency provider for ten children.
- We are breaking down barriers to care for families in Central Oregon as a nonprofit committed to quality care and replicating our program.

Quotes:

This quote comes from one of the parents of a child in our care:

"When you think of Bend, you think of the local catchphrase: living here is poverty with a view. And that has been so true for us. We're adults with a child but in a lot of ways we couldn't survive without our families stepping in. Which is not something either of us want but it is just the reality of what life has been like. This will be the first time since we've lived in Bend that we both have full-time jobs and childcare for [our son], so we're kind of like, 'There's a light at the end of the tunnel. Maybe things will be okay.'"
Summary of Results:

- As a Winter Shelter, we were not able to open as in years past due to COVID restrictions.
- Volunteers were not as readily available due to most of our help being retirees, who are a vulnerable population for COVID, as are the homeless.
- The difficulty of running a congregant shelter and trying to mix two vulnerable populations proved to be insurmountable for us.
- Despite this challenge, we did, however, distribute food boxes, winter clothing, camping gear and provided hotel stays to guests with emergency needs.
- It was a different Winter having to navigate a pandemic and even though our volunteers were down significantly, the community stepped up to offer coats and other supplies to give away.
- Although outside of the scope of this grant, we also distributed food in Sunriver with our limited volunteer pool.
- The Community knows that we help people in La Pine and Sunriver and it was much needed, especially this past year.
- While we weren't open for sleeping hours, we did purchase camping gear, including tents, tarps, sleeping bags and heaters for those sleeping in the woods and for those sleeping in their vehicles.
- We also distributed over 100 food boxes per month and a significant amount donated winter clothing.
- We also started two recovery meetings per week with an average attendance of about 20 each.

Story:

Two gentlemen who are working on sobriety were living in their vehicle. We were able to provide them with regular food, a source of heat and winter clothing. They came here from Florida and were not prepared at all for Winter. Additionally, we gave them place to shower and connected them with meetings. As a result, they were able to get jobs and stability in life.
AGE DEMOGRAPHICS
(From OHA Enrollment Files)

% of CCO Members by Age Group

Child 00-12: 27%
Child 13-18: 12%
Adult 19-35: 27%
Adult 36-45: 12%
Adult 46-55: 10%
Adult 56-64: 9%
Adult 65+: 4%

28.5 yrs
Average Age

LANGUAGE
(From REALD Data)

Interpretation Needs

1.96%
of Members Say they Need Spoken
and/or Sign Language Interpretation

0.15%
Sign Language
1.92%
Spoken

Top 5 Non-English Languages:

Spanish, 4.7%
Other, 1.5%
Vietnamese, 0.0%
Chinese - Traditional, 0.0%
Chinese - Simplified, 0.0%

READING LANGUAGE

Spanish, 4.9%
Other, 1.2%
Vietnamese, 0.0%
Cantonese, 0.0%
Mandarin, 0.0%

PRIMARY RACE / ETHNICITY
(From REALD Data)

White: 44.0%
Passive non-response: 26.1%
Active non-response: 21.5%
Hispanic or Latino/a: 5.7%
American Indian or Alaska Native: 1.5%
Asian: 0.6%
Black or African American: 0.5%
Native Hawaiian or Pacific Islander: 0.1%
Middle Eastern/Northern African: 0.0%

A passive non-response indicates that the member left the question blank or the data has not yet been provided. An active non-response means that the member responded “decline to answer” or selected “unknown.”

Data not provided: 1.6%
Declined to Answer: 10.2%
Did not Answer: 24.4%
Selected Unknown: 11.3%

DISABILITY
(From REALD Data)

7.3%
of Members say they are living
with a disability (of any kind)

% Members by Disability Type
(Members may select as many as apply)

Deaf: 1.0%
Blind: 1.2%
Difficulty with Dressing or Bathing: 1.0%
Difficulty Walking or Climbing Stairs: 2.1%
Difficulty with Performing Errands: 2.2%
Issues with Memory or Decisions: 3.6%
Limited Activity in Any Way: 4.9%
ENROLLMENT
(FROM OHA ENROLLMENT FILES)

63,994 May 2021
Avg Membership

<table>
<thead>
<tr>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child 0-18, 19%</td>
<td>Adult 19+, 33%</td>
</tr>
<tr>
<td>Child 0-18, 20%</td>
<td>Adult 19+, 28%</td>
</tr>
</tbody>
</table>

53% Female
47% Male

MEMBER MAP

TERMS & DEFINITIONS

RATE GROUP TERMS:
Rate Groups - OHA groups members into various rating categories of aid. These categories of aid are also used by actuaries to set premium rates for each CCO.
ABAD - Aid to the Blind/ Aid to the Disabled
ACA - Affordable Care Act (Medicaid Expansion)
CAF Children - Children in Adoptive, Substitute, or Foster Care
CHIP - Children’s Health Insurance Programs
OAA - Old Age Assistance
PLM - Poverty Level Medical
TANF - Temporary Assistance to Needy Families
w/ & w/o Medicare - With and without Medicare Coverage/Eligibility

OTHER TERMS:
Avg Membership - Average membership. In contrast to a count of unique members covered, this reflects the average number of members covered over a period of time. Due to the nature of how members can come on/off plans in Medicaid, average membership is nearly always lower than the count of unique members with coverage during a time period.
CCO - Coordinated Care Organization
REALD - Race, Ethnicity, Language and Disability Data. This data is optional for members to provide. It is collected by OHA and sent to CCOs in member eligibility data files.

MEMBER RATE GROUPS
(FROM OHA ENROLLMENT FILES)

<table>
<thead>
<tr>
<th>Rate Group</th>
<th>% of Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA Ages 19-44</td>
<td>28.1%</td>
</tr>
<tr>
<td>ACA Ages 45-54</td>
<td>7.2%</td>
</tr>
<tr>
<td>ACA Ages 55-64</td>
<td>7.2%</td>
</tr>
<tr>
<td>ABAD &amp; OAA* (w/ &amp; w/o Medicare)</td>
<td>9.9%</td>
</tr>
<tr>
<td>CAF Children</td>
<td>1.3%</td>
</tr>
<tr>
<td>PLM, TANF, and CHIP Children 0-18</td>
<td>36.8%</td>
</tr>
<tr>
<td>Poverty Level Medical Adults &amp; TANF (Adult)</td>
<td>8.9%</td>
</tr>
<tr>
<td>Breast/Cervical Cancer Program</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td>0.0%</td>
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</tbody>
</table>