

Accountable Community of Health Certification Process Medicaid Transformation Project Demonstration

The certification process will ensure each Accountable Community of Health (ACH) is capable of serving as the regional lead entity and single point of performance accountability to the state for transformation projects under the Medicaid Transformation Project demonstration (demonstration). Certification is a two-phase process that requires ACHs to provide information to demonstrate compliance with expectations set forth by the state and the Centers for Medicare and Medicaid Services (CMS). Through this process, the state will assess whether each ACH is qualified to fulfill the role as the regional lead and therefore eligible to receive Project Design funds. Specifically, through certification, the state will determine if each ACH meets expectations contained within the demonstration [Special Terms and Conditions](#) (STCs) including alignment with SIM contractual requirements, composition requirements, and organizational capacity expectations and development.

Certification criteria are established by the state in alignment with the demonstration STCs. Each ACH will submit both phases of certification information to the state within the required time frames. The state will review and approve certification prior to distribution of Project Design funds. Each ACH must complete both phases of certification and receive approval from the state before the state will consider its Project Plan application. Given the level of effort necessary to develop thorough Project Plan applications, ACHs will be expected to begin Project Plan development prior to completion of both certification phases.

The certification process, scoring criteria and Project Design funding awards are at the sole discretion of the Washington State Health Care Authority (HCA).

Certification Process Timeline



The certification materials submitted by the ACH will be posted on the HCA website for public review. Upon successful completion of the Phase I and Phase II certification, ACHs will earn Project Design funds. These funds will be paid directly to ACHs (as opposed to incentive payments, which will flow through the financial executer.) Project Design funds are intended for ACH use in development, submission, execution, and oversight of a successful Project Plan application.

To craft certification responses, ACHs should refer to the following key documents for important information outlining various obligations and requirements of ACHs and the state in implementing the Medicaid Transformation Project:

1. The Medicaid Transformation Project demonstration [Special Terms and Conditions](#) (STCs), which set forth in detail the nature, character, and extent of federal involvement in the demonstration,

the state's implementation of the expenditure authorities, and the state's obligations to CMS during the demonstration period. The STCs were approved on January 9, 2017.

2. The Medicaid Transformation Toolkit, and any finalized protocols that support the demonstration STCs.
3. Other key documents and resources as may be specified by HCA.

Phase II Certification Submission Instructions:

1. **Zip file.** ACHs must submit one zip file comprised of completed Phase II Certification Submission Template and attachment files. The overall zip file must be titled: "[ACH Name] - ACH Phase II Certification Submission."
 - a. The completed Phase II Certification Submission Template file must be in PDF format and titled: "[ACH Name] – Phase II Certification Submission Template." **All fields in the Phase II Certification Submission Template must be completed.**
 - b. Each required and recommended attachment to the Phase II Certification Submission Template must be a separate file in PDF format. The attachment must be named according to the ACH name, corresponding section, and attachment letter. For example, for the logic model, driver diagram, table, and/or theory of action illustration, "[ACH Name] – Theory of Action and Alignment Strategy – Attachment A." **All required attachments to the certification template must be included.**
 - c. **ACHs must clearly respond to questions in the Phase II Certification Submission Template response boxes.** If including additional attachments beyond those that are required and recommended to substantiate responses, label and make reference to these attachments in the responses. **Additional attachments may only substantiate, not substitute for, a response to a specific question. HCA reserves the right to not to review attachments beyond those that are required or recommended.**
 - d. **ACHs must adhere to the response word count limits per category.** The word count will be calculated as a total of the ACH-entered text in the response boxes by category. The word count limit is a not to exceed amount and ACHs are strongly encouraged to be responsive but concise.
2. **Upload.** Submissions must be uploaded to box.com. Instructions forthcoming.
3. **Deadline.** Submissions must be uploaded **no later than 3pm PT on August 14, 2017.** HCA will accept Phase II Certification submissions between July 17, 2017 and August 14, 2017 and ACHs are encouraged to submit earlier in the submission window. **Late submissions will not be accepted.**

Questions regarding the certification process must be directed to medicaidtransformation@hca.wa.gov.

Phase II Certification Overview

Phase II Certification is intended to ensure that each ACH meets state expectations regarding progress and milestones necessary to serve as the regional lead entity and single point of performance accountability to the state for transformation projects under the demonstration. Through Phase II Certification, each ACH will demonstrate that it is well qualified to submit a transformation Project Plan application to the state and show that it is ready to launch selected projects. ACH should ensure that its Phase II Certification response addresses specific areas for improvement identified in its Phase I Certification scoring. In addition to recent developments and capacities, significant changes in direction and structure that have occurred since completion of Phase I Certification should be clearly explained and documented as part of Phase II Certification.

The ACHs must respond to a series of questions in the Phase II Certification submission template to demonstrate achievement of expectations in the following categories:

- Theory of Action and Alignment Strategy
- Governance and Organizational Structure
- Tribal Engagement and Collaboration
- Community and Stakeholder Engagement
- Budget and Funds Flow
- Clinical Capacity
- Data and Analytic Capacity
- Transformation Project Planning

Submission Deadline: August 14, 2017, 3:00 PM PT

Baseline Review Requirements: The Phase II Certification submission must meet the baseline review requirements to proceed to HCA review and scoring. Not meeting these baseline review requirements will result in the ACH not passing Phase II Certification. The baseline review requirements consist of ACH foundational and Phase II Certification submission requirements. The foundational requirements are critical for an ACH's success at serving as the regional lead entity and single point of performance accountability to HCA for transformation projects under the demonstration. The submission requirements are intended to create consistency in response submissions and to aid in a more efficient review and scoring process.

Baseline Review Requirements
Foundational Requirements
<p>ACH has:</p> <ul style="list-style-type: none"> ✓ Secured an ACH Executive Director; ✓ Been established as a legal entity with an active contract with HCA to serve as the regional lead entity and single point of performance accountability for Delivery System Reform Incentive Payment (DSRIP) transformation projects; ✓ Secured the ACH’s primary decision-making body approval of detailed budget plan for Project Design funds awarded under Phase I Certification; ✓ Secured the ACH’s primary decision-making body approval of the approach for projecting and budgeting for the Project Design funds anticipated to be awarded under Phase II Certification; and ✓ Convened and will continue to convene open and transparent public meetings of ACH decision-making body for discussions and decisions that pertain to the Medicaid Transformation demonstration.
Submission Requirements
<p>Phase II Certification submission:</p> <ul style="list-style-type: none"> ✓ Designates point of contact ✓ Includes responses for all fields in the template ✓ Each category complies with word count parameters ✓ Includes all required attachments submitted (see Attachment Checklist) ✓ Uploaded by August 14, 3pm PT

Scoring Process: At least two HCA reviewers will each independently review an ACH’s entire certification submission. A few additional HCA Subject-Matter Experts (SMEs) will also independently review and provide scoring input on specific categories, so ACHs should not assume reviewers will have read other sections, and should craft answers in each category to stand alone. Additionally, reviewers will be familiar with ACH scores from Phase I, but will not review Phase I submissions in advance or in parallel to reviewing Phase II submissions. For those questions that request “updates since Phase I” ACHs should therefore provide a very brief recap of the status at Phase I to provide context for the updates (For instance, “In Phase I, we stated that we would Since then, we have done . . .”). This approach will help the ACH prepare for the Project Plan Submission, which will be reviewed and scored by an Independent Assessor, who will not be familiar with the ACH, prior Certification submissions, or other background documents. ACHs that received a score of 1 or 3 in any category in Phase I Certification are particularly encouraged to focus on these updates.

When conducting the qualitative review and scoring for Phase II Certification submissions, HCA reviewers will evaluate the following:

- **Completeness** – Responds to all parts of the question, and required attachments provide all information requested and support narrative responses
- **Clarity** – Articulates clear answers to the question
- **Specificity and Detail** – Provides a level of depth in information that conveys thoughtful and meaningful efforts and evolving capacity, e.g., articulates key steps, considerations, timing, accountability; cites examples of progress/achievements

- **Logic** – Provides rationale between the strategy/process/mechanism and the intended impact

Scoring Criteria: Phase II Certification submissions will be scored based on a 100-point scale. ACHs must receive an overall score of 60 or higher to achieve Phase II Certification. Specific point values are assigned to each category in the table below. Within each category, ACHs must receive 60% of the total possible points to pass. At its sole discretion, HCA will conduct the qualitative review and scoring of Phase II Certification submissions.

Category	Maximum Points Available
Theory of Action and Alignment Strategy	10
Governance and Organizational Structure	10
Tribal Engagement and Collaboration	10
Community and Stakeholder Engagement	10
Budget and Funds Flow	15
Clinical Capacity and Engagement	15
Data and Analytic Capacity	15
Transformation Project Planning	15

Each ACH is eligible to receive up to \$5 million in Project Design funds for successful demonstration of meeting Phase II requirements and expectations. Specific Project Design fund amounts are designated for each scoring tier below. Funding¹ will be distributed if certification criteria are met, and the ACH and HCA have executed a contract for receipt of demonstration funds.

Phase II Certification Project Design Funds	
Score	Amount
60-69	\$3.5 million
70-79	\$4 million
80-89	\$4.5 million
90-100	\$5 million

¹ Timing and amount of funding is contingent on CMS approval of all related protocols.

Phase II Certification Submission Template

ACH Phase II Certification: Submission Contact	
ACH	Better Health Together
Name	Hadley Morrow
Phone Number	509-954-0831
E-mail	hadley@betterhealthtogether.org

Theory of Action and Alignment Strategy – 10 points

Description

Provide a narrative describing the ACH’s regional priorities and how the ACH plans to respond to regional and community priorities, both for the Medicaid and non-Medicaid population. Describe how the ACH will consider health disparities across populations (including tribal populations), including how the ACH plans to leverage the opportunity of Medicaid Transformation within the context of regional priorities and existing efforts. Identify and address any updates/improvements to the ACH’s Theory of Action and Alignment Strategy since Phase I Certification. Provide optional visuals if helpful to informing the narrative; visuals will not count toward the total word count.

Instructions

Provide a response to each question. Total narrative word count for the category is up to 1,250 words.

ACH Strategic Vision and Alignment with Healthier Washington Priorities and Existing Initiatives

1. Define a clear and succinct region-wide vision.

In our region, every person, regardless of background, life experience or environment, will live a productive, high quality life, with access to stable housing, nutritious food, transportation, education, meaningful employment that pays the bills with some left over for savings, and social support networks that foster emotional and psychological wellbeing. Each person will be supported by an integrated community health system, accountable to improving health through delivering culturally competent, whole person care.

2. Summarize the health care needs, health disparities, and social risk factors that affect the health of the ACH’s local community.

Spanning 12,273 square miles, much of our region consists of isolated, rural communities that are miles away from consistently available health services. Provider shortages, especially in Behavioral and Oral Health, further constrict access, especially for rural health providers who struggle to fill positions. Severe disparities exist even in resource-heavy urban center Spokane, where the life expectancy between neighborhoods varies by up to 18 years.²

Our jail and emergency system are over and inappropriately utilized by behavioral health patients without access to stable social and health supports. Youth enter foster care at nearly double the state average in Spokane County.³ A severe housing shortage further increases the risk of homelessness for vulnerable people. These social risk factors connect to a high presence of Adverse Childhood Experiences (ACEs), increasing risk for chronic disease and contributing to our high prevalence rates of asthma and diabetes, varying from county between 14.4%-28.4% and 9%-11% respectively (HYS &

² www.srhd.org/documents/PublicHealthData/HealthInequities-2012.pdf&usg=AFQjCNHOYW_8lulcWiwi7SF_nOpS_pVzNg

³ 2013 Foster Placement rate per 1000. Spokane County = 10.2, state average = 5.7. (<http://datacenter.kidscount.org/data/>)

RWJF).

3. Define your strategies to support regional healthcare needs and priorities.

In an integrated regional community health system, Behavioral, Oral, and Physical health systems are delivered in a whole person, culturally competent way. Providers take a team approach to care which recognizes the body, mind, spirit and environment as interconnected, and health care delivery systems are supported by linkages to community support services to improve overall health.

As the community health hub, the ACH will maintain a network of community based referrals and care coordination resources, ensuring best fit care at the right time. The ACH will track population health across multiple systems to measure the overall effectiveness of the care network in improving access and outcomes. Baseline data will define the current status, and help identify bright spot interventions to scale as well as gaps or widening health disparities. This data will inform recommendations for policy change. Committed to furthering our work past DSRIP, BHT will position the use of the Pathways Hub and a Community Dashboard as long-term community infrastructure.

Success in a value based payment system will require shared savings that reflect shared responsibility across the multiple sectors that support population health. Health system providers will rely on social service delivery systems to assist patients in overcoming barriers to improve their health. The five potential target populations on our Theory of Action graphic were selected based on community data and momentum around interrupting the negative cycle of ACEs by addressing social and health access needs. Our work with potential target populations will focus on addressing risk factors related to ACEs, including incarceration, opioid use, and foster care as well as opportunities to disrupt intergenerational risk factors, and promote upstream prevention with a focus on pregnant mothers and management of chronic disease. Multiple local health, social, governmental and philanthropic initiatives are currently aligning around this issue, furthering our regional impact beyond demonstration.

4. Describe how your project selection approach addresses the region-wide needs and priorities.

Community conversations have driven this work since the beginning through Community Strategy Map focus groups, our Leadership Council, and strong connections to Rural Health Coalitions and Spokane based initiatives exploring and guiding the best local solutions. We have positioned care coordination as an anchor strategy due to the centrally identified need to “coordinate the coordinators,” been identified over and over again when engaging with community partners.

In launching Health System and Community Care Coordination Inventories, which surveyed partners for their vision, capacity, engagement of clinicians and patients, workforce and data needs for Medicaid transformation, we are keeping community infrastructure needs and perspective as the main driver of this work and project selection. Our five regional priorities⁴ have stayed constant and speak to community desire to see stronger linkages between health and social determinants systems to support whole person, community based care with a focus on prevention. These inventories serves

⁴ See BHT - Theory of Action and Alignment Strategy - Attachment B

as an initial environmental scan of system partners and will inform alignment of Community Health Transformation Collaboratives, which will assemble in September to further solidify those needed linkages and drive project design and implementation.

5. Explain how you will align existing and planned resources and activities into a region-wide strategy, including complementary projects, community resources and other investments.

A central part of whole person care for our region is disrupting the intergenerational cycle of ACEs. Many concurrent regional activities are addressing these risk factors, including rallying of multisector organizations such as Priority Spokane, Invest Health, the A Way Home Washington 100 Day Challenge around ending youth homelessness, and Empire Health Foundation's region wide ACEs initiative. Spokane County recently earned a \$1.75 million dollar MacArthur Foundation grant to address overcrowded and racially disproportionate jail usage which will align with our Jail Transition Pathways Pilot efforts, and Providence is preparing to expand number of beds for psychiatric patients and adding child psychiatric residency slots which will increase access to behavioral health supports. BHT has actively engaged in design efforts with these partners to ensure proactive connection to demonstration, and specifically care coordination, efforts. We see BHT playing a connector role in linking organizations towards regional success, and intend to expand care coordination as the mechanism for ensuring smooth continuum of care for high risk populations.

BHT originally formed to seize on the opportunity provided by the Health Benefit Exchange contract for Navigator insurance enrollment. Recognizing the need to sustain historically low uninsured rates both for patient access to care and as a provider payment mechanism, we will align these efforts through both our health system transformations and our community based care coordination to retain and expand our 95% uninsured rate. Increased medical and dental residency slots coming online in Spokane will expand the pipeline of providers training and practicing in our region, and create new opportunities to train the next generation of care providers in an integrated, whole person model.

6. Describe the interventions and infrastructure investments that will potentially be shared or reused across multiple projects.

BHT expects shared infrastructure and interventions, including the Pathways Hub and Community Dashboard, throughout the Collaborative model, and ACH project management will be shared across projects and counties to maximize impact.

Expanding care coordination efforts will be an anchor strategy for the BHT region in connecting disparate systems. The BHT Pathfinder Hub will support best practice Care Coordination and information sharing across the region's community based organizations and health systems. The Pathways technology platform provides real-time data to identify resource gaps and monitors the effectiveness of best practice interventions as well as the quality of Care Coordination Agencies that will implement them. This will be a powerful tool to support a data-driven case for alignment of community investments, especially around major resource gaps in safe and affordable housing, jobs in rural counties and transportation throughout the region. We plan to work with CORE to develop a community dashboard to monitor key metrics identified in the waiver and our community priorities. This will be a multi-functional dashboard extending beyond the waiver to allow ongoing community

tracking and prioritization.

BHT will withhold 10% of all demonstration dollars to invest in a Community Resiliency Fund, aligned with ACH community priorities with data supported by the ACH Community Dashboard. It is the intent of BHT to leverage these dollars to influence increased targeted investment in Population and Community Health Improvement, including aligning nonprofit Hospital Community Benefit dollars, Philanthropic funders, and other shared savings investment models.

Attachment(s) Recommended

A. Logic model(s), driver diagrams, tables, and/or theory of action illustrations that visually communicate the region-wide strategy and the relationships, linkages and interdependencies between priorities, key partners, populations, regional activities (including workforce and population health management systems), projects, and outcomes.

Note: These documents are intended to reflect the thought process that the ACH went through to define a vision for transformation that is grounded in community needs and tied to the broader Healthier Washington objectives, and to define how it will align its activities and resources to advance this vision in an efficient manner.

Governance and Organizational Structure – 10 points	
<u>Description</u>	Provide a description on the evolution of the governance and organizational structure of the ACH. Identify and address any updates/improvements to the ACH’s Governance and Organizational Structure since Phase I Certification. Visuals can be used in this section to inform the narrative and will not count toward the total word count.
<u>Instructions</u>	Complete the attestations and provide a response to each question. Total narrative word count for the category is up to 1,000 words.
ACH Attestation(s)	
ACH has secured an ACH Executive Director.	<input checked="" type="checkbox"/> YES
ACH has been established as a legal entity with an active contract with HCA to serve as the regional lead entity and single point of performance accountability for DSRIP transformation projects.	<input checked="" type="checkbox"/> YES
ACH Structure	
1. Describe the ACH’s sector representation approach in its governance structure. Describe how the ACH is interacting with particular sectors across the region (e.g., primary care, behavioral health, etc.), and how those sectors are engaging with the decision-making body.	
<p>Better Health Together has a multi-tiered governance structure with distributed decision-making, joint ownership and mutual accountability that drives innovation and fosters co-investment that leads to impact.</p> <p>BHT was formed prior to the establishment of ACHs. Board members were recruited based on individuals and organizations poised to have the greatest impact on improving the health of our region. This structure aimed to foster and support regional stakeholder readiness to adopt an amplified “evidence-based, health in all policies” approach. As BHT took on the ACH role of regional convener and backbone, we further developed our three chamber governance structures⁵ to include the representative body of the Leadership Council, serving as the strategic synthesizer, and the Health Champions, operating as “mini-ACHs” convened by county to purposefully construct and ensure broad multi-sector, geographical and cross-organization collaboration. The combination of strategic alliances and engagement strategies ensures focus on the health status and priorities of the whole community so that no single entity, sector or person dominates the decision-making or activities of the ACH.</p> <p>Upon guidance from HCA in July of 2017, BHT’s Board has expanded the expectations of board level sector representation to also include:</p>	

⁵ See Attachment H for Decision Making & Accountability visual

- Provide strategic guidance on issues critical to improving health in our region based on their experience, expertise and perspective.
- Approve ACH decisions, seeking feedback from Leadership Council, Rural Coalitions, Tribal Partner Leadership Council and other sector representing entities.
- Serve on the ACH Leadership Council and at least one other BHT Board Committee including: Finance, Executive, Governance and Audit and actively participate in other ACH related community engagement activities.
- Communicate with other members of their sector or Native American Health partners to ensure effective information flow and strong engagement on matters related to the ACH.
- Proactively solicit input, seek feedback and update other organizations within their sector. Disclose differences of opinion or disagreements within their sector on decisions to the Board of Directors.
- Disclose any substantive or perceived Conflicts of Interest as they relate to sector effecting decisions and/or the ACH.

Starting in June 2017, BHT now hosts a monthly community comment period inviting sector representatives to share feedback directly to the Board. All BHT Board meetings are open to the public to observe deliberation, in-person or by call-in. Starting in August, BHT will support Board members in establishing regular communications tools to support ongoing feedback to their sector. The Leadership Council, Rural Health Coalitions, and Tribal Partners Leadership Council will continue to serve as the primary mechanism to solicit feedback on pending action under consideration by BHT’s board for Demonstration purposes.

2. If applicable, provide a summary of any significant changes that have occurred within the governance structure (e.g., composition, committee structures, decision-making approach) since Phase I Certification, including rationale for those changes. (Enter “not applicable” if no changes)

Since Phase 1 Certification, BHT has implemented the following items:

- Declared Board meetings open to the public and invited community members to provide feedback.
- Appointed a Regional Integration Planning Team to support FIMC and Bi-Directional project planning, insuring cross sector information sharing to meet state mandated 2020 deadline. This team is comprised of County Commissioners, 3 MCO representatives, 1 rural health system leader, 1 urban health system leader, 2 clinical providers, 2 Medicaid behavioral health providers, a representative identified by the Tribal Partner Leaders, and a BHO director.

Once our Community Health Transformation Collaboratives launch in early September, we anticipate convening representatives from each to serve on one of three learning teams focused on:

- Clinical Integration
- Financials
- Data

3. Discuss how personal and organization conflict of interest concerns are addressed within the ACH, including considerations regarding the balanced and accountable nature of the ACH decision-making body to directly address identified conflicts.

In July 2017, the BHT Board approved a more comprehensive personal and organizational Conflict of Interest policy to ensure that conflicts are personally disclosed, and to allow the Board Chair to identify perceived conflicts of interest. At the beginning of each Board meeting, the Board Chair will review the agenda and ask board members to disclose any conflict. This will be recorded in the minutes. If a board member does not disclose a conflict, it is at the discretion of the Board Chair to identify it. Board members will abstain from voting on conflicted items. The chair reserves the right to allow conflicted board members the right to provide a non-binding vote.

Staffing and Capacities

4. Provide a summary of staff positions that have been hired or will be hired, including current recruitment plans and anticipated timelines.

BHT is fully staffed with:

- Alison Carl White, Executive Director - oversees the governance, strategy, and day to day operations for the ACH.
- Jenny Slagle, Associate Director: Health System Transformation - oversees the strategy and development of Tribal Partners Leaders Council, regional planning for Health System Transformation and Community Care Coordination, and serves as the Pathways Hub lead.
- Hadley Morrow, Associate Director: Community Transformation - oversees the strategy development for Community Engagement, Communications and Data efforts for the ACH.
- Justin Botejue, ACH Project Manager: serves as project level support for Pathways Hub and as lead for the Ferry, Stevens and Pend Oreille rural health coalitions as well as the lead project manager for Community Strategy Maps for Social Determinants of Health and Population Health.
- Devon Wilson, ACH Project Manager: serves as project level support for Data, Workforce development and as lead for Adams and Lincoln County rural health coalitions.
- Ginger Joseph, Executive Assistant

Additionally, BHT is provided back office support services for finance, accounting and human resources management via Empire Health Family with support from:

- Sarah Lyman, Vice President for Shared Services
- Jill Angelo, CFO for Shared Services
- Dani Doss, Accounting Manager for Shared Services
- Daphne Williams, Human Resources Director for Shared Services

- Kiana McKenna, Communications Coordinator for Shared Services

Finally, BHT has hired Uncommon Solutions to assist in the strategic development of the Health System Collaborative model, Providence CORE to assist in data collection and analysis, KPMG to assist in the development of our funds for Demonstration Projects, Foundation for Healthy Generations to support the development of the Pathways Hub for national certification and Applied Insight for focus group and meaningful engagement strategy development.

We plan to regularly evaluate our staffing structure to ensure appropriate staffing capacity throughout the Demonstration. It is expected our Community Health Transformation Collaboratives will need funding to support project management as well as technical assessment and assistance, and we expect to fund this through Certification and Project dollars. We will provide details of this support in our regional project portfolio.

Attachment(s) Required

- A. Copies of charters for committees and workgroups that outline purpose, members, responsibilities, and scope.**
- B. Conflict of interest policy.**
- C. Draft or final job descriptions for all identified positions or summary of job functions.**
- D. Short bios for all staff hired.**

Attachment(s) Recommended

- E. Sector representation policy describing any agreements or expectations for decision-making body members to communicate with and engage partners within a defined sector.**
- F. Revised visual/chart of the governance structure, if there have been significant changes since Phase I Certification.**
- G. Revised organizational chart that outlines current and anticipated staff roles to support the ACH, if there have been significant changes since Phase I Certification.**

Tribal Engagement and Collaboration – 10 points

Description

Provide a narrative describing specific activities and events that further the relationship and collaboration between the ACH and Indian Health Service, tribally operated, or urban Indian health program (ITUs), including progress on implementing the requirements of the previously adopted Model ACH Tribal Collaboration and Communication Policy or other unanimously agreed-upon written policy. Identify and address any updates/improvements to the ACH’s Tribal Engagement and Collaboration since Phase I Certification.

Instructions

Provide a response to each question. Total narrative word count for the category is up to 1,000 words.

Collaboration

1. Provide an update on the ACH efforts described in Phase I Certification, particularly for any next steps identified.

Better Health Together (BHT) continued specific efforts of relationship building and collaboration with Indian Health Service providers, Tribal Organizations, and Urban Indian Health Centers, (I/T/U) in our region. Identified tribal partners include The Confederated Tribes of the Colville Reservation, Spokane Tribe of Indians, Kalispel Tribe of Indians, The Healing Lodge of the Seven Nations, The NATIVE Project, and Lake Roosevelt Community Health Centers. Leaders from these health systems are invited designees of the Tribal Partners Leadership Council.

The Tribal Partners Leadership Council (TPLC), co-chaired by Jessica Pakootas (representing the Kalispel Tribe) and Alison Ball (representing the Colville Tribe), has established a re-occurring meeting the last Tuesday of each month. BHT Executive Director and Associate Director/Tribal Sr. Project Manager provide support and technical assistance toward the Medicaid transformation planning and project implementation.

The first TPLC meeting was held in Spokane on May 25. Leaders from the Kalispel Tribe of Indians Camas Clinic, Spokane Tribe of Indians Health & Human Services department, and Lake Roosevelt Community Health Center were present. Attendees acknowledged previous communication and engagement difficulties, however expressed positive interest in working with BHT to learn about ACH efforts, specifically engagement in regional efforts and/or the statewide tribal efforts. Looking for other partnerships needed, the group identified that the American Indian Community Center (AICC) is used by the Urban Indian populations and that the AICC should a part of the discussion going forward. Attendees suggested that BHT visit I/T/U locations for a tour and individual review of Medicaid demonstration, with each facility’s key staff and leadership.

BHT Executive Director and Tribal Sr. Project Manager held Medicaid Demonstration informational and feedback sessions through the month of June, visiting the Spokane Tribe of Indians, Lake Roosevelt Community Health Center, American Indian Community Center, Kalispel Tribe of Indians and the Colville Tribe.

On June 19, BHT hosted a six-hour work session for the TPLC. The Spokane Tribe and AICC were scheduled to attend, however both encountered scheduling conflicts. Tribal partners shared health systems updates and challenges. One common theme identified between the health systems is of lack of workforce available in their rural areas, along with retention and ongoing provider development opportunities. BHT reviewed Medicaid demonstration funding overview and provided an update on health system transformation planning activities, all of which work to address the issues identified by the tribal partners. Attendees committed to working collaboratively and continue to stay engaged in planning. Meeting materials and notes were emailed to all I/T/U partners.

The July 25 TPLC meeting was held at the Camas Community Center for Wellness in Usk, WA. The group discussed the Medicaid Transformation Demonstration Tribal Protocol for the DSRIP Program, and Phase I and II Certification processes. This included briefings and a feedback session on all BHT board policies to be adopted at the July board meeting. Attendees concluded that they would like to further discuss collaboration for an opioid prevention and treatment project.

In addition to the above activities, we have included tribal representatives in comprehensive community and provider engagement strategy planning by conducting interviews with tribal and urban Indian health and human service leaders and tribal members to elicit their guidance for effective meaningful engagement in ACH activities and Medicaid transformation. The TLPC appointed two members to our Regional Integration Planning team. We are also working with our partners to conduct a tribal member focus group in the coming month.

**2. If applicable, describe any opportunities for improvement that have been identified regarding the Model ACH Tribal Collaboration and Communication Policy and how the ACH intends to address these opportunities.
(Enter “not applicable” if no changes)**

The BHT Board of Directors adopted the region’s Tribal Collaboration and Communication Policy in May 2017 and added suggested wording from The Healing Lodge of Seven Nations to include “Tribal Organizations” along with Tribes, IHS, and Urban Indian partners. The Tribal Partners Leadership Council also identified another Tribal Organization, the American Indian Community Center.

Ongoing attempts to engage both The NATIVE Project and The Healing Lodge of Seven Nations via email, telephone, and meeting requests have been unanswered. However, as an FQHC, The NATIVE Project been engaged within meetings held with the other major FQHCs in the area. BHT will continue to include both organizations in all tribal partner meeting correspondence and planning communication, with a standing invitation to participate.

3. Demonstrate how ITUs have helped inform the ACH’s regional priorities and project selection process to date.

Better Health Together has conducted a region wide health systems transformation and care coordination planning inventory, which is being used to further refine regional priorities and assist in project development and planning. Recognizing the need to include culturally competent evidence based care models, we included specific identified models that the I/T/U partners may reference in their efforts of health system transformation. Wherever possible, BHT will provide technical and project support to I/T/U partners as planning and project selection is developed.

Board Training
<p>4. Demonstrate the steps the ACH has taken since Phase I Certification to ensure the ACH decision-making body receives ongoing training on the Indian health care delivery system, with a focus on the local ITUs and on the needs of both tribal and urban Indian populations. Identify at least one goal in providing ongoing training in the next six months, the steps the ACH is taking to achieve this goal and the timing of these steps.</p>
<p>The BHT staff Leadership Team participated in a Tribal Client Relations training May 18, reviewing Native American history and historical trauma, along with communication protocols and tribal cultural awareness.</p> <p>On May 23, a joint BHT and EHF Board meeting was held at the Kalispel Tribe Camas Center for Community Wellness. Colville, Kalispel and Spokane tribal representatives gave presentations of their respective tribe’s history, and overview of their current health systems. One common circumstance between the tribes is that their health systems, providing service to their combined 15,000 tribal members, have continually been federally underfunded. This is one reason that the tribes have expressed interest in the ACH Medicaid transformation, learning and gauging how it may align with their tribal strategic goals and plans. At the conclusion of the joint meeting, each BHT Board member reflected on the information shared with varying degrees of shock and outrage of the disproportionate health inequity for Indian health care systems.</p> <p>On August 29, 2017, BHT will host a joint BHT Board, ACH Leadership Council, TPLC learning session. Our TPLC identified content to be included (history of health care delivery system changes and the implication on Native American/Alaskan Natives in Washington state) and facilitated agreement from former Colville Tribal Council member, Mel Tonasket, to conduct the session. As we develop our Community Health Transformation Collaboratives, we expect to continue education and technical training as it relates to tribal engagement and collaboration.</p>
Attachment(s) Required
<p>A. Demonstration of adoption of the Model ACH Tribal Collaboration and Communication Policy, either through bylaws, meeting minutes, or other evidence. Highlight any modifications that were agreed to by all required parties.</p> <p>B. Bio(s) for the representative(s) of ITUs seated on the ACH governing board.</p> <p><i>If you do not have an ITU representative on the governing board, please attach a description of the efforts made to fill the seat.</i></p>
Attachment(s) Recommended
<p>C. Statements of support for ACH certification from every ITU in the ACH region.</p>

Community and Stakeholder Engagement – 10 points
<p><u>Description</u></p> <p>Provide a narrative that describes current and future efforts regarding community and stakeholder engagement and how these actions demonstrate inclusion of and responsiveness to the community. Identify and address any updates/improvements to the Community and Stakeholder Engagement category since Phase I Certification.</p>
<p><u>Instructions</u></p> <p>Complete the attestations and provide a response to each question. Total narrative word count for the category is up to 2,000 words.</p>
ACH Attestation(s)
<p>ACH has convened and continue to convene open and transparent public meetings of ACH decision-making body for discussions and decisions that pertain to the Medicaid Transformation demonstration.</p> <p style="text-align: right;"><input checked="" type="checkbox"/> YES</p>
Meaningful Community Engagement
<p>1. What strategies or processes have been implemented to address the barriers and challenges for engagement with community members, including Medicaid beneficiaries, identified in Phase I Certification? What are the next steps the ACH will undertake to continue to address remaining barriers and challenges? If applicable, discuss any new barriers or challenges to engagement that have been identified since Phase I Certification and the strategies or processes that have been implemented to address them.</p> <p>BHT has not identified any new barriers since Phase 1, and has focused efforts on strengthening new policy to improve communication and engagement.</p> <p>May 1st, the Board approved an updated Leadership Council Engagement Policy where BHT staff follow an outline of engagement policies for new or potential members as well as a policy for keeping “disengaged” members up to speed on the fast-paced developments of the Demonstration.</p> <p>BHT began hosting Public Comment periods before Board meetings June, creating an opportunity for multi-sector representatives and Medicaid beneficiaries to share their thoughts and ideas to the governing body and ACH staff. 5 community partners have commented to date.</p> <p>BHT initiated the first quarterly Cross-Coalition Conference Call with rural county coalition representatives from 5 counties. This opened up new lines of communication and collaboration and served as another vehicle for providing the rural perspective to the Leadership Council (LC).</p> <p>Since adding 3 more staff in May 2017, we have greatly increased our capacity to be available to engage and seek feedback from community members. Central to our strategy is offering ACH staff time for local capacity building, such as staffing rural health coalitions or facilitating program design</p>

for Tribal Health partners. Embedding staff to support local community efforts has increasingly positioned them as trusted leaders and messengers for this work.

2. Describe any success the ACH has achieved regarding meaningful community engagement.

We've witnessed success in engagement through regular participation from a high number of diverse partners, who participate freely in conversation contributing to the ACH's region wide vision and strategy.

- Over 75 community members participated on a Community Strategy Action team.
- 80 Optional Project Letters of Interest (LOI)
- 94 community members attended our Project Showcase in Spokane with representation from all six counties

This participation signals an enormous level of commitment, especially when community members gave feedback on project ideas. To support regional participation, BHT offered to compensate mileage and lodging for rural partners to attend the showcase.

We have solidified our internal engagement process for recruiting new LC members and keeping current members engaged. Our staff are quick to conduct outreach with any new organizations that attend our open LC or Board meetings. We now track attendance at each LC meeting and request member organizations be in attendance for 2 out of every 3 meetings. If attendance drops below expectation, ACH staff reach out to check in and bring them up to speed. Moreover, we have instituted the practice of always including a feedback activity for LC meetings, to always include a mechanism for input and feedback on ACH progress. This has led to our LC list to grow by seven organizations since Phase 1, and regular engagement has fostered richer participation in LC meetings.

Our monthly ACH update through MailChimp maintains a 40% readership rate, nearly two times higher than the non-profit industry average, telling us we deliver useful, accessible and timely content.

3. In the Project Plan, the ACH will be required to provide evidence of how it solicited robust public input into project selection and planning, including providing examples of at least three key elements of the Project Plan that were informed by community input. Demonstrate how community member/Medicaid beneficiary input has informed the project selection process to date. How does the ACH plan to continue to incorporate community member/Medicaid beneficiary input meaningfully on an ongoing basis and meet the Project Plan requirement?

BHT has relied on community input to guide our process, with our regional priorities generated from community conversations across all counties and unanimously agreed to by our LC. We conducted over 40 meetings to build our Community Action Strategy maps, anchoring our ACH efforts to leverage and work beyond DSRIP funded projects. Washington CAN assisted in recruiting community

members to participate in these work groups, including Medicaid beneficiaries who spoke to their experiences⁶. Regardless of topic, participants described our region with a wealth of passionate people and effective programs, but an inability to meet large scale population improvements due to a lack of high-level, outcomes based coordination. This need to “coordinate the coordinators” is what lead us to explore the Pathways Model for our SIM project, and now as an anchor strategy for our DSRIP efforts. Over 50% of LOIs submitted to BHT included an intent to use the Pathways model, validating that this model is considered by the majority of our community partners as the right fit to address the barriers and gaps to care that was voiced in those early feedback groups.

BHT contracted with Applied Insight, LLC to build a comprehensive, meaningful consumer and provider engagement plan. To date, Applied Insight has completed 18 key informant interviews of 25 invitations extended, with interviewees representatives of diverse health systems. One focus group has been completed in partnership with Rural Resources in Colville, and two others (one FQHC, one I/T/U) are in development. At least five consumer input groups will be conducted between August and October, representing geographic and demographic diversity. This input will inform the Rules of Engagement for our Collaboratives and overall project selection. Applied Insight has also begun on-site observations and consumer discussion opportunities in clinical settings, shadowing Patient Services Coordinators as they work with patients. Feedback continues to validate and deepen the consumer and partner-driven priorities identified in the original strategy map sessions and community showcase.

BHT recently closed our Health System (HSI) and Care Coordination Inventories (CCI), seeking partnering provider perspective vision for transformation. Synthesis is underway to summarize key partners’ current state and intent to participate in Demonstration. This comprehensive inventory will be utilized to inform decisions on how we structure our Demonstration planning efforts. Based on early feedback, we expect to adopt a Community Health Transformation Collaborative Model (Collaboratives) that will match aligned partners together to meet the Demonstration metrics and goals. Providers were asked to share how they currently seek consumer and beneficiary feedback in their internal planning, so the ACH can work to align with those engagement opportunities.

Partnering Provider Engagement

4. What strategies or processes have been implemented to address the barriers and challenges for engagement with providers (clinicians, social service providers, community based organizations and other people and organizations who serve Medicaid beneficiaries) identified in Phase I Certification? What are the next steps the ACH will undertake to continue to address remaining barriers and challenges? Discuss any new barriers or challenges to engagement that have identified since Phase I Certification and the strategies or processes that have been implemented to address them.

Early provider engagement themes gleaned from Applied Insight interviews include: significant challenges in care coordination and care transitions; policy restrictions that impede the ability to coordinate care for complex patients; inadequate time with patients; and the need for training and

⁶ Evidence of Medicaid beneficiary status/attendance was not recorded at this meeting to respect anonymity in our Strategy Maps.

models that support the new integrated care team and its resulting systems changes both within clinical settings and between clinical and community providers. Provider “change fatigue” is a significant issue, and interviewees suggested thoughtful approaches for gathering provider input at the right time, in the right way, and toward the right outcomes so as to not further overwhelm them and to set the stage for real and lasting health and health system change.

Building upon input from key informant and provider interviews, we will establish a calendar of additional engagement activities to secure meaningful provider engagement throughout the project planning and selection period to inform the long-term meaningful provider engagement strategy, which will include new strategies defined by the providers themselves.

One of the challenges we will be addressing in the coming month is the need to engage in different ways with providers in larger health systems and with those in smaller, rural or independent practices. We have received candid feedback that what works for providers who have a variety of supports and administrative layers setting the stage for success, will not necessarily work for providers in other settings. We will continue to work with our provider champions from these various settings to help determine the right types of engagement, communication and supports to allow us to effectively partner with one another.

5. Describe any success the ACH has achieved regarding partnering provider engagement.

Consistent progress on our comprehensive meaningful provider engagement strategy described in #4 is our most significant success. Early provider input regarding challenges and ideas for effective engagement has been valuable and consistent with our working assumptions about provider perspective. Input from varying levels of providers (front line, medical officers, society/association representatives) and types of providers, has given a comprehensive lens from which to examine project selection and planning. We are integrating feedback for the most effective ways to garner input and collaboration as we move forward, including: utilizing already trusted and established groups and; seeking provider input through trusted messengers and information vehicles; and creating “plain talk” documents and electronic resources that clearly outline the value proposition for early and ongoing provider engagement in this work.

6. Demonstrate how provider input has informed the project planning and selection process to date, beyond those provider organizations included directly in the ACH governance structure. (Note: In the Project Plan, the ACH will be required to identify partnering organizations and describe how it secured the commitment of partnering providers who: cover a significant portion of the Medicaid population, are critical to the success to the project, and represent a broad spectrum of care and related social services.)

Our HSI surveyed providers on their vision for transformation, and provided valuable information on what providers will need to be successful in a transformed system. Seventeen⁷ physical and behavioral health providers returned the inventory. These organizations self-reported a total of

⁷ 4 of 17 organizations completed the Health Systems Inventory are represented on BHT Board, as well as shorter Care Coordination Inventory Attachment

219,344 Medicaid patients served in 2016, confirming these partners represent a significant majority of Medicaid care providers. Our CCI was returned by sixteen⁸ organizations representing social service, prevention, and Tribal partners who offer care coordination services. Nine of the Health Systems who completed the HSI also submitted a shorted Care Coordination attachment which detailed their site base care coordination efforts.

While inventories are not a binding commitment, they demonstrate partner willingness to participate in project planning efforts. When synthesis is completed, feedback will be used to inform the formation of Collaboratives responsible for project design and implementation planning. Teams will have access to these inventories and complete LOIs to help with recruitment for creating supportive linkages and to drive project selection. We expect these teams to begin meeting in September to finalize a project plan for board approval on November 2nd.

Our Regional Integration Team launched August 10th with multi sector participation including provider champions attending. This group will explore the best fit for regional integration and developing a plan for transitioning to FIMC.

Transparency and Communications

7. Demonstrate how ACH is fulfilling the requirement for open and transparent decision-making body meetings. When and where does the ACH hold its decision-making body meetings (for decisions that concern the demonstration)?

The BHT Board hosts a public comment hour and open board meetings once a month, generally in Spokane at the Philanthropy Center, access is also available by call in. Public Comment takes place one hour before the board meeting, for community members to address board members directly. When the board meeting begins, community members are invited to attend but listen only. BHT was established as a nonprofit prior to serving the ACH backbone, and therefore the Board also governs non-ACH related decisions. Summaries of the public comments are included in board minutes, and any decisions made at the Board meetings are provided at the monthly LC meeting to keep our partners up to date.

8. What steps has the ACH taken to ensure participation at decision-making meeting? (i.e., rotating locations, evening meetings for key decisions, video conference/webinar technology, etc.) Are meeting materials (e.g. agenda and other handouts) posted online and/or e-mailed in advance?

Public comment periods are held during the lunch hour, 12-1 pm, with the Board Meeting commencing at 1 pm. A webinar option is always available. BHT posts the dates and location of upcoming board meetings on our website with the agenda in advance. Once approved, minutes from each meeting are [posted on our site](#). The public may listen to the ACH portion of the agenda in listen-only mode via webinar, or in-person. If any person wants to make additional comments, BHT staff are always available to contact and pass along comments to the board.

⁸ 3 of 16 organization completed the Care Coordination Inventory are represented on the BHT Board

9. Discuss how transparency has been handled if decisions are needed between public meetings.

According to our bylaws, the BHT Board may vote electronically when decisions are needed between meetings. Should this be the case, the decision will be included in the next board agenda so the vote is reflected in the public minutes, which BHT will post on our website. The Board intends to use this practice sparingly.

10. Describe the ACH’s communications strategy and process. What communication tools does the ACH use? Provide a summary of what the ACH has developed regarding its web presence, including but not limited to: website, social media and, if applicable, any mobile application development.

Over the past three years, we have developed a process for shared planning through dynamic communication and robust information management. This has aided in our ability to inspire a new way of collaborating while building common strategies to improve the health of our region.

BHT invests heavily in a robust website which includes the LC and Board meeting schedules for the whole year, as well as notes, documents and recordings from meetings. We regularly post synthesized content on our blog in easy to digest formats to support shared knowledge. We are especially proud of our [Pathways videos](#) which were incredibly well received by partners. Additionally, all new information is synthesized into a monthly ACH eNews update through MailChimp, which has increased from ~200 to ~300 subscribers since we submitted our Phase 1 designation. We are active Twitter users, and attempt to tweet each meeting or discussions with partners to increase transparency.

Attachment(s) Required

- A. Meeting minutes or meeting summaries for the last three decision-making body meetings and screenshot capturing distribution of meeting minutes/summaries (e.g., email distribution, website post).**
- B. List of all public ACH-related engagements or forums for the last three months.**
- C. List of all public ACH-related engagements or forums scheduled for the next three months.**
- D. Evidence of meaningful participation by community members. Examples include: attestation of meaningful participation by at least one Medicaid beneficiary, meeting minutes that memorialize community member attendance and comments, and solicitation for public comment and ACH response to public comments.**
- E. Attestation of meaningful participation from at least three partners from multiple sectors (e.g., managed care organizations, Federally Qualified Health Centers, the public health community, hospitals, primary care, and behavioral health) not participating directly on the decision-making body.**

Budget and Funds Flow – 15 points

Description

Design funding is designed to ensure ACHs have the resources necessary to serve as the regional lead for Medicaid Transformation. Provide a description of how design funding has been used to date to address capacity and staffing needs and ensure successful Project Plan development. Through required Attachment C, provide a projected Phase II Project Design fund budget over the course of the demonstration.

ACH oversight of project incentive payments will be essential to the success of the demonstration. Summarize preliminary plans for funds flow and incentive payment distribution to partnering providers.

Identify and address any updates/improvements to the ACH’s Budget and Funds Flow since Phase I Certification.

Instructions

Complete the attestations and provide a response to each question. Total narrative word count for the category is up to 1,500 words.

ACH Attestation(s)

ACH has secured the primary decision-making body’s approval of detailed budget plan for Project Design funds awarded under Phase I Certification

YES

Date of Approval: 7/26/2017

ACH has secured the primary decision-making body’s approval of approach for projecting and budgeting for the Project Design funds anticipated to be awarded under Phase II Certification

YES

Date of Approval: 7/26/2017

Project Design Funds

1. Discuss how the ACH has used Phase I Project Design funds. Provide percent allotments in the following categories: ACH Project Plan Development, Engagement, ACH Administration/Project Management, Information Technology, Health Systems and Community Capacity Building, and Other.

BHT has focused our Phase 1 Design dollars on building the capacity of our internal and community teams to prepare for project planning. We have expended \$20,794.11 since receiving Phase 1 in June, and expect to allocate dollars per our board approved budget in the following ways:

- **ACH Project Plan:** 19% utilized to hire KPMG, CORE and Uncommon Solutions to support financial, data and collaborative project development. Since Phase 1, we have hosted five work sessions plus weekly check-ins with the consulting team to develop our plan.

- **Engagement:** 4% to contract with Applied Insight to inform and support authentic engagement activities with both Consumers and Clinicians. We have conducted 18 key informant interviews, hosted a Consumer Focus Group in partnership with Rural Resources and NEW Health, and front line job shadowing with CHAS Patient Service Coordinators. We provided funding to support partners for time and space provided, and to community member stipends for participation in the focus groups.
- **ACH Administration Project Management:** 24% utilized went to staff and administering the Demonstration efforts.
 - 2.5 FTE staff positions, the balance of the 4.75 FTE ACH staff roles are funded out of the SIM and other BHT contracted work.
 - 9.5% of Phase 1 dollars were allocated to Administration of the ACH including rent, finance, HR, and communications support.
- **Information Technology:** 5% to support the continued launch of the Pathways Pilots in Spokane County. Dollars have been utilized to purchase tablets to run the Pathways technology, consulting, and development of appropriate technology interfaces to support pilot.
- **Health Systems & Community Capacity Building:** 23% to support the region’s first Performance Payments for successful completion of the Health System and Care Coordination Inventories.
- **Other:** 25% were held back and designated per Board policy to support a Community Resiliency Fund (10%) and Reserves (15%) to be spent by the end of the demonstration period.

2. Describe how the ACH plans to use Phase II Project Design funds to support successful Project Plan development.

At our July Board meeting, Phase 2 Design allocations were approved on the expectation we earn the full \$5 million. Please note the Board approval was for calendar year 2017 allocations. We intend to allocate the remaining 42% (\$2.1 million), in addition to our allocated reserve funds, once we have finalized our Collaboratives and assessed Partner needs. Calendar year 2017 allocations of Phase 2 funds include:

ACH Project Plan: 2% will continue to fund KPMG, CORE and Uncommon Solutions contracts to support financial, data and collaborative project development. We will also enter into a contract with Foundation for Healthy Generations to support and develop statewide training for the Pathways Hub.

Engagement: 2% will continue our focused efforts with consumers and clinicians and will be woven together with the expectations of the Collaboratives. We will continue to provide community member stipends for participation in focus groups

ACH Administration Project Management: 9% to staff in 2017 the Demonstration efforts:

- 2.5 FTE staff positions, the balance of the 4.75 FTE ACH staff roles are funded out of the SIM and other BHT contracted work.
- 6% of Phase 2 dollars were allocated to Administration of the ACH including rent, finance, HR, and communications support.
- An additional 18% is expected to be budgeted for leadership and staff support for the duration of demonstration.

Information Technology: 3% to support the continued launch of the Pathways Hub model in the region. We expect this to be a future area of investment to support project plans.

Health Systems & Community Capacity Building: 16% to support the region’s first performance payments for successful completion of the Health System and Care Coordination Inventories.

Other: 50% to be held back and designated per Board Policy to support a Community Resiliency Fund and reserves to be spent by the end of the demonstration period.

3. Describe what investments have been made or will be made through Project Design funds in the following capacities: data, clinical, financial, community and program management, and strategic development.

At this time, the Board has not adopted a budget for Project Design funds for the above-named capacities. We are utilizing a thoughtful, engaged process to establish a powerful Collaborative Model that will align healthcare systems and social determinants of health systems together to maximize impact and achieve our regional goals. Based on Board discussions to date and advice from our consulting team, it would be premature to allocate these dollars until the Collaborative Model is adopted and a formal assessment on the strengths and weaknesses of each model has been completed. We will be providing a detailed plan with the Project Plan Application.

4. Describe the process for managing and overseeing Project Design fund expenditures.

Phase 1 and Phase 2 project design dollars are allocated by board policy and managed by the BHT Executive Director. The BHT Board Finance Committee meets monthly to review financials including a projected year-end spending plan.

In August, we expect the Board to appoint a Finance Transformation Project Team to workshop and recommend the funding models for Collaboratives that will include both infrastructure investments and incentive payments to the board. This team will be comprised of BHT finance committee board members, key financial expertise partners, and a required designee from each Collaborative.

Incentive Fund Distribution Planning

5. Describe the ACH’s Project Incentive fund planning process to date, including any preliminary decisions, and how it will meet the Project Plan requirement. (Note: In the Project Plan, the ACH will be required to describe how Project Incentive funds will be distributed to providers.)

We expect to launch an informational feedback session in late-August for interested partners and community members to give feedback on the proposed models under development by KPMG. Our Transformation Finance Committee team will use this information to further flesh out a recommended set of policies for Board approval in September. This policy will be integrated into Project Plans due to BHT in late October. We expect Year 1 design dollars to be focused on

infrastructure investments for the Collaborative project design efforts.

Yet to be formally adopted by the BHT board, ACH staff will recommended a high-level funds flow framework that consists of the following four elements:

- Funds used by the ACH for DSRIP project management and ACH-wide investments and supports for the benefit of all Collaboratives, subdivided into projects such as HIT/HIE, workforce and community engagement.
- Fixed funds to support Collaboratives with DSRIP project management and project costs
- Performance based funds to help align Collaborative incentives with those the ACH is held accountable to during the DSRIP program, such as engagement criteria, outcomes, and reporting requirements.

Relationship to Other Funds and Support

6. Describe any state or federal funding provided to the ACH and how this does or does not align with the demonstration activities and funding (e.g., state and federal funds from SIM, DOH, CDC, HRSA).

BHT is under contract with the Health Benefit Exchange to administer our region’s Navigator Network. This contract was renewed in July 2017 for five years and allows us to continue our efforts to ensure that people in our region have access to health insurance. These efforts are an effective leverage point to support our health system partners who benefit when more of their patients are insured. We have leveraged investments from SIM and the Empire Health Foundation to support the development of our Pathways pilots in Ferry and Spokane Counties, as well as needed infrastructure to grow our and support broad health transformation efforts including the continued support of the Community Strategy Maps, Rural Health Coalitions and other community based efforts.

7. Describe what investments (e.g., convening space, volunteer positions, etc.) have been made or will be made for the demonstration through in-kind support from decision-making body/community members in the following capacities: data, clinical, financial, community and program management, and strategic development.

Our Health Systems Inventory (HSI) surveyed partners willingness to donate in-kind in the above categories, and BHT intends to closely track all interested partners and donations. To summarize those results as well as outside contributions:

Data: Spokane Regional Health District (SRHD) donated in-kind staff time to build our [Community Linkage Map](#), which will serve as a vital tool for assessing and connecting impactful partnerships in an integrated community health system. They’ve offered additional in-kind support in data and analysis to support Community Strategy Maps.

Through our HSI the majority of our potential partners identified a willingness to share their data to support project planning and evaluation.

Clinical: Six organizations surveyed in our HSI noted clinical provider champions within their practices willing to donate time and expertise to project planning Collaboratives. Most potential care coordination agencies noted their intention to donate staff time to training new workflows and

models to meet Pathways requirements in kind.

Financial: Empire Health committed \$240,000 to ACH efforts in 2017. Our region benefits from two large non-profit hospital systems with a history of generous community benefit giving.

Community: The most effective recruitment to our Leadership Council and other partnerships has always been word of mouth, and our partners are generous in donating their time to be spokespeople and make connections on behalf of the ACH. Empire Health Foundation offers in-kind convening space to our partners as part of our shared services, and our rural partners have been generous in donating space for meetings outside of Spokane, not to mention the many miles driven to come to attend meeting in person. We expect sufficient in-kind support in meeting spaces, recruitment, and volunteering throughout demonstration based on the strength of our relationships.

Program Management: Partners are understanding that they will be responsible for some level of in-kind program management of projects taken on in partnership with the ACH. Partners have also expressed willingness to donate staff time to necessary supervisor trainings to advance transformations.

Strategic Development: SRHD has offered in-kind training to BHT staff in Results Based Accountability and Lean Six Sigma to support internal ACH program design, evaluation, and quality improvement efforts. Multiple partners have offered staff and leadership time and expertise to support strategy development and we expect sufficient in-kind support in this category.

Attachment(s) Required

- A. **Bio or resume for the Chief Financial Officer (CFO) or equivalent person responsible for ACH financial functions.**
- B. **Financial Statements for the previous four quarters. Audited statements preferred. If an ACH does not have four quarters of financial statements available, provide as many as possible.**
- C. **Completed Phase II Project Design Funds Budget Template, which includes Projected Project Design fund budget over the course of the demonstration, additional funding sources, and in-kind resources that the ACH expects to leverage to prepare their Project Plans and build the capacity and tools required to implement the Medicaid Transformation Project demonstration.**

Clinical Capacity – 15 points

Description

Provide a summary of current work the ACH is undertaking to secure expertise and input from clinical providers. The ACH should describe strategies that identify and address gaps and make progress toward a redesigned system using statewide and regional education, workforce, and clinical systems partners. Identify and address any updates/improvements to the ACH’s Clinical Capacity and Engagement since Phase I Certification.

Instructions

Provide a response to each question. Total narrative word count for the category is up to 1,250 words.

Clinical Expertise

1. Demonstrate how clinical expertise and leadership are being used to inform project selection and planning to date.

Provider input from 15 key informant interviews⁹ conducted by Applied Insights reaffirm ACH and Demonstration activities will benefit from increased provider expertise at the planning tables for Demonstration projects and activities of the ACH as a whole. Early provider engagement themes include: significant challenges in care coordination and care transitions; Health Information Exchange challenges; policy restrictions that impede the ability to coordinate care for complex patients; inadequate time with patients; need for training and models that support the new integrated care team and provider “change fatigue”.

Our Health System Inventory¹⁰ (HSI) captured input from 17¹¹ Health Systems partners¹² to help inform project planning. Inventories asked systems to assess current state, desired future state, and identified gaps in areas of value-based contracting, bi-directional integration, various option project models, workforce, engagement of clinical providers and patients and FIMC. We specifically requested information about each system’s approach to engaging clinical providers, as well as identification of provider champions to share in planning moving forward.

Since Phase 1, BHT staff have hosted 5 feedback sessions on Health System Transformation and Community Care Coordination Inventory tailored for FQHCs, Tribal Partners, Rural Health Centers and

⁹ With input from: Behavioral Health Providers and Organizations, Consumer Advocacy and Equity-focused Organizations, County Government (Elected and Administrative Representatives), Federally Qualified Health Centers, Health System Providers, Major Health Systems (hospital, primary care, behavioral health, specialty, oral health, etc.), Managed Care Organizations, Nonprofit Health Providers, Provider Associations (Hospital Association, State Medical Association, Local Medical Society, Rural Health Association), Public Health, Rural Health and Human Service Providers, Social Determinants Service Providers (e.g., Housing, Energy, Basic Needs), Tribal and Urban Indian Organization Representatives

¹⁰ Blank Copy of inventory included in BHT – Clinical Capacity – Attachment B

¹¹ 4 of 17 organizations who completed the Health Systems Inventory are represented on BHT Board.

¹² Including Providence, MultiCare/Rockwood, NEWACS, Adams County Integrated Health System, American Indian Community Center, CHAS, East Adams Rural Health Care, Ferry County Hospital, Frontier Behavioral Health, Lake Roosevelt CHC, Lincoln Hospital, NATIVE project, Newport Hospital, Odessa Memorial, Planned Parenthood, SRHD, and YVFWC

Care Coordinating partners. These individual sessions included clinical staff leadership whose time we greatly appreciated knowing that connecting the work to the providers delivering the service will be essential to managing the change process and securing buy in for clinical transformation. Not wanting to take away from care of patients, we will continue to take guidance from Health Systems leaders on when in the process is appropriate to engage service delivering provider. We will continue to refine our provider engagement strategies based off recommendations from these interviews.

2. Discuss the role of provider champions for each project under consideration.

Expecting BHT board approval in August, in September we will launch Community Health Transformation Collaboratives (Collaboratives), comprised of key partners, expertise and experiences that required to implement demonstration projects. In our HSI, seven systems, including FQHCs, I/T/U, Community Health Centers, and Medicaid behavioral health providers, identified provider champions who will be invited to join Collaboratives and give feedback to our Regional Project Portfolio submission to HCA.

We expect the Board to approve “rules of engagement” for participation in each Collaborative, including at minimum, required representation from one primary care, behavioral health and social determinant of health provider to be engaged in the development of the Transformation Projects.

Clinical Input

3. Demonstrate that input was received from clinical providers, including rural and urban providers. Demonstrate that prospective clinical partnering providers are participating in project planning, including providers not serving on the decision-making body.

The HSIs received covered all six of our BHT ACH counties, serving a self-reported 209,582 Medicaid Beneficiaries in 2016. Eight were from rural partners, three public hospital districts that include rural clinics, all Medicaid Behavioral health providers in the rural community and largest provider in Spokane County, and three from I/T/U partners, four FQHCs, and both Providence and Rockwood/Multicare. BHT staff are connecting with the five rural providers who did not respond to complete the survey, and expect to have responses by the end of the month. We have relied on health system partners to appropriately engage clinical providers in the completion of the Inventory and expect to strengthen the requirement for clinical providers to engage in the project implementation plan via the Collaboratives.

Our Regional Integration Team met on August 10th. This team is comprised of County Commissioners, three MCO representatives, one rural health system leader, one FQHC, one urban health system leader, two clinical providers, two Medicaid behavioral health providers, a representative identified by the Tribal Partner Leaders Council and the BHO director.¹³ 17 organizations were invited to participate in this team’s first meeting August 10th, 2017. Clinical providers invited include:

- Dr. McCarthy UW School of Medicine, Board Chair of Spokane Medical Society and practicing physician

¹³ See BHT - Governance and Organizational Structure - Attachment A Regional Integration Planning Team Charter

- Dr. Matt Layton WSU School of Medicine and SRHD Methadone Clinic Director and practicing psychiatrist
- Dr. Samuel J. Huber, Chief Medical Officer for Behavioral Health MultiCare
- Brian Sandavol, practicing mental health profession and clinical director for Unify Community Health
- Rick Weaver, retiring executive Comprehensive Health Care

As we develop our Pathways Hub, we have received regular guidance from co-founder of the model, Dr. Sarah Redding. Additionally, we engaged with Medical Directors at United Health Care and Coordinated Care here and in Ohio, plus Clinical Managers from Molina, and a registered nurse. Additionally, several leaders in our community health sector who volunteered information to our Community Strategy Maps are former nurses, psychologists and behavioral health specialists.

Additional providers who have offered expertise in support of overall regional health transformation through the Leadership Council or other planning opportunities are included in the attached bios.

4. Demonstrate process for assessing regional clinical capacity to implement selected projects and meet project requirements. Describe any clinical capacity gaps and how they will be addressed.

Our initial assessment of clinical capacity was conducted through self-reported information collected from 17 Health Systems in our HSI, disclosing a narrative of their current and future capacity needs and plans. This scan will inform project planning and baseline assessment, and we intend to cross reference findings with data and analytic support from Providence CORE using relevant available data.

Creative solutions, such as telehealth, mobile and co-located services, will be needed to overcome challenges isolated rural providers face in recruitment, as well as concurrent efforts to address social barriers to care such as transportation.

There are exciting plans to expand workforce through Spokane based education programs such as CHAS's forthcoming Nurse Practitioner Residency Program, Providence's dental and child/adolescent psych residency programs slated for 2019 and a Dental Residency programs that will expand the provider pipeline.

5. Demonstrate how the ACH is partnering with local and state clinical provider organization in project selection and planning (e.g., local medical societies, statewide associations, and prospective partnering providers).

Since our inception we have worked with Washington State Medical Association, Washington State Hospital Association, and Spokane County Medical Society to build partnerships with the providers they represent, and to gain insight into the best ways to capitalize on provider expertise during the planning process. BHT staff are in regular discussions with WSHA representatives to continue to align efforts across the ACHs and the state specifically on Opioid, Data and workforce strategies. Additionally, BHT is working to build a productive relationship with the Spokane County Dental Society, the Washington State Academy of Family Physicians and Washington Association of Community and Migrant Health Centers to strengthen our clinical provider efforts.

By design, our ACH has focused on leadership engagement in the ACH. Our intent was to ensure broad representation and relationships from our Board to our Leadership Council to our Health Champions comprised of rural partners. This engagement has not always connected to the clinical providers in the region. We recognize that many providers don't yet know what the ACH is or how they fit into the value proposition, and need timely and tailored information. We heard from provider focus groups suggestions to work through administrative levels of organizations and trusted associations to secure delivery staff input at the right stage.

One of the largest challenges our region has is access to care due to significant provider shortages. We work closely with the Spokane Teaching Health Clinic (a consortium comprised of WSU, Providence and Empire Health Foundation) to inform our broad strategy around provider shortage, the role Teaching Health Centers can play in closing the access gap and a mechanism to train our future workforce for an integrated, whole person strategy. The BHT region's number one economy is health care. There are many efforts that BHT aligns with to further the region's goal of the growing health care economy related to innovation, specialty medical care and medical education that includes the region's Vision 2030 efforts lead by Greater Spokane Incorporated.

Attachment(s) Required

A. Current bios or resumes for identified clinical and workforce development subject matter experts or provider champions.

Re-attach bio or resume even if previously provided in Phase I Certification. ACHs should also include any additional bios or resumes, if applicable.

Data and Analytic Capacity – 15 points

Description

The ability to utilize regional data will be foundational to ACHs’ success as part of the Washington Medicaid Transformation demonstration. From understanding regional health needs to project selection to project planning, ACHs will be expected to access, interpret, and apply data to inform their decisions and actions.

The HCA has supplemented previously existing public data (e.g. Healthier Washington Dashboard, the Washington Tracking Network, and RDA data resources) with releases of regional population health and provider utilization data for ACH use. ACHs must identify additional, supplementary, data needs and determine, in consultation with HCA, which of those needs can be met by HCA within the timeline. ACHs will then need to detail plans to leverage data and analytics capabilities from their partner organizations (providers, CBOs, MCOs, other regional stakeholders) to further inform their decision-making.

Provide a summary of how the ACH is using this data in its assessment of regional health needs, project selection, and project planning efforts.

Instructions

Provide a response to each question. Total narrative word count for the category is up to 1,750 words.

ACH Data and Analytic Capacity

1. List the datasets and data sources that the ACH is using to identify its regional health needs and to inform its project selection and planning process.

BHT used the following data sources:

- HCA “RHNI Starter Set”
- [Healthier Washington Dashboard](#)
- DSHS ACH Profile
- [HCA Medicaid Enrollment Reports](#)
- [HCA Provider Report](#)
- HCA/RDA Measure Decomposition
- [Community Checkup](#)
- [UW Center for Health Workforce Studies](#) Reports
- [Indian Health Service](#) Government Performance and Results
- Health Systems and Care Coordination Planning Inventories
- Community Action Strategy Workgroup Findings
- [Odds Against Tomorrow: Health Inequities in Spokane County Report](#)
- Community Linkage Mapping General and Technical Reports
- Provider Partner LOI
- [Spokane Community Indicators](#) by Dr. Patrick Jones of EWU

2. Describe how the ACH is using these data to inform its decision-making, from identifying the

region's greatest health needs, to project selection and planning.

Data sets are being used by the to inform Theory of Action, identify health care needs, gaps, and disparities; select projects and estimate potential for project impact; identify target populations for projects; identify partnering providers and organizations; understand community needs; engage stakeholders; design and plan projects; and assess workforce capacity and gaps.

We first used in-depth local reports to facilitate community engagement discussions about local needs and priority populations, referenced in our Community Strategy Map conversations, which have formed the basis of our regional integration strategy. We are now looking at how additional data sets align with feedback from those sessions. This includes reviewing data provided by HCA, public sources, or from partners to identify health disparities, regional variation, and any driving or underlying causes for current performance or outcomes. We will visualize key information for sharing with our Leadership Council, Community Health Transformation Collaboratives, and stakeholders to show how community findings and the data fit together to inform our overall theory of action and future data driven decision discussions.

3. Identify any data and analytic gaps in project selection and planning efforts, and what steps the ACH has taken to overcome those barriers.

BHT has identified several data and analytic gaps:

- Lack of direct access to data sources to answer questions in a timely manner, including key Demonstration measures, detailed information on Medicaid population by health care system/provider, and social determinant of health metrics needed to evaluate whole person community health.
- BHT has identified five potential priority populations through a community engagement feedback process, but does not have access to information about the size and characteristics of this population such as their top health care and social determinant of health needs. Significant data acquisition and analysis will be required to make informed decisions about the impact of targeting these populations.
- For project selection, BHT would like to model the community impact of implementing different projects with different populations. We lack both a framework for this model and data to feed into the model.

BHT has taken the following steps to address data gaps and barriers:

- BHT has contracted with Providence CORE to provide data and analytic support; has executed a shared services contract with KPMG to assist with modeling funds flow and project impact; and has contracted with CCS to develop and implement a data platform to support community care coordination. CORE completed our RHNI data set and has expanded capacity to collect and analyze data from available sources.
- BHT has used publically available and proxy data sources to assist with project and target population selection as well as the most up-to-date rates available for publically reported Demonstration measure in the Healthier WA Dashboards.

- BHT has submitted data requests to HCA for data on target populations, providers, and utilization, and has worked collaboratively with other ACHs to identify data request priorities.

BHT has administered a Health Systems Planning Inventory (HSI) to get counts of Medicaid lives by health care system along with demographic and health information, as well as a Care Coordination Inventory to identify client demographic information to validate with Medicaid information and cross reference social determinants and health care information. This information will be cross referenced with data supplied by the state as well as available public data to lend multiple perspectives as well as potential identify discrepancies where possible.

Data-related Collaborations

4. Describe if the ACH is collaborating, or plans to collaborate, with other ACHs around data-related activities.

BHT collaborates closely with Pierce County and Southwest ACH on data-related activities. The three ACHs have contracted individually with Providence CORE to provide data & analytics support, and collectively with KPMG to support project planning efforts.

The ACHs have collaborated on identifying data needs, measures of interest, and data requests to HCA. They held a joint planning session focused on data needs and are aligning regional data collection and monitoring efforts, assessment tools, and reporting. They also plan to share best practices in a shared learning collaborative. This collaborative will serve to facilitate best practices and share relevant information related to data, governance, strategy, and the spread of those learnings, especially where one region may be high performing on a measure/project. Our final data collaboration is with CORE who we are using as a third party to obtain data and ensure that it is secure to reduce liability.

5. Describe to what extent to date the ACH is collaborating with community partners (e.g. providers, CBOs, MCOs) to collect data or leverage existing analytic infrastructure for project planning purposes.

One major community partnership has been with the Spokane Regional Health District, who we have utilized to help digest the raw data we have compiled at different points throughout this process. A major example of this effort is our community linkage map, a survey-based report that tracked referral patterns, education and data exchanges, financial support and general collaboration between organizations throughout the region in the Health, Education, Business, and Social Service Sectors. SRHD took the survey results and created a network analysis of our regional health system, baselining current state of community linkages and work silos. This linkage map will help planning teams assess major gaps or duplications in service to inform creation of linkages that support a transformed system.

We are also collaborating with Providence CORE to increase our data analytics capacity and are considering utilizing a resource developed by Providence's Population Health Informatics division, the Community Pathways to Health Platform, a predictive analytics platform that uses various data sources to provide insight on what's happening within a given area and what's happening with health

care spending and service utilization based on the social determinants of health.

BHT is completing security assessments for Molina, Coordinated Care, Amerigroup, Community Health Plans and United HealthCare to allow data share and better integration for Pathways Care Coordination Systems platform.

Collaborative relationships have also been developed with our partners for our Ferry County and Spokane County Pathways Care Coordination Pilots. We've established data share agreements with the Ferry County Jail, Hospital, and Healthy Ferry County Coalition. These partnerships were essential in tracking inmate information and tracking health-cost savings, and we are in the process of developing a similar set of partnerships for our Spokane County Jail Project.

Provider Data and Analytic Capacity

6. Demonstrate the ACH's engagement process to identify provider data or data system requirements needed to implement demonstration project goals.

BHT's approach has been centered on understanding provider capability and capacity-building interests. At a provider level, we received Health System and Care Coordination Inventories from identified health and social service providers. These inventories allow our health system partners to share different data points related to their patient population (coverage type, # of patients receiving service by service type, demographics, health status including target populations, social risk factors, and diagnoses). This included questions regarding their current use of EHR or other systems relevant to bi-directional data sharing, clinical community linkages, timeline communication among care team members, care coordination and management processes to enable population health management and quality improvement processes. We also asked about their ability to produce and share baseline information, to describe what additional investments that will be needed to meet the data needs, and what investments they are willing to make towards expanding data, clinical, programmatic, and financial capabilities.

At a project partner level, we requested all potential optional project participants to submit letters of interest (LOI). In these LOIs they were asked to indicate whether they would be willing to share data (none, some, or all). All submitters expressed a willingness to share at least some of their data related to the project, although many identified technical barrier where they would need ACH assistance to overcome. In short, by understanding where our region's health systems are, where they want to go, and what they need to get there - we are confident we will be able to identify and provide the support needed to achieve transformation.

7. Demonstrate the ACH's process to identify data or data system requirements needed to oversee and monitor demonstration project goals.

It is imperative that we have timely, accurate data for this demonstration to be successful in our region.

- BHT fielded initial Health System and Care Coordination Inventories, including questions related to current and planned provider data, data system capacity, and needs to implement Demonstration projects.
- BHT has begun developing a framework for self-monitoring and continuous improvement,

including identifying supplemental process and outcomes measures for regional incentive structures, processes for data collection, and frequency and granularity of reporting. We are collaborating with CORE to create a data collection and evaluation plan for how we will track our goals. This plan will set BHT down the path of identifying the necessary sources of data, ensuring we have the appropriate data share agreements and contracts in place to receive the data, developing a schedule for when that data will be reported and ensuring a secure infrastructure is used for accessing the data.

- BHT is working closely with Care Coordination Systems to explore use of the platform both for implementation of the Pathways model, and to develop a Community Dashboard to monitor key metrics identified in the waiver and our community priorities. Data collected from clients working through Pathways will help us monitor effectiveness of best practice interventions and the care coordinators employing them, and flag resource scarcities preventing Pathways from closing and contributing to lower health outcomes.
- BHT will leverage available information from the HCA Value Based Payment (VBP) survey, particularly any questions related to barriers and enablers to VBP, including interoperable data systems, data sharing, and quality measurement.

8. Identify the ACH’s process to complete a workforce capacity assessment to identify local, regional, or statewide barriers or gaps in capacity and training.

Through our Health Systems Inventory we asked providers to describe their current and future workforce needs and how they plan to address provider shortages during the 5-year demonstration period. We will use this information to identify any assistance needed or gaps so that we can build into a plan to support workforce development.

We are hopeful that the Pathways technology will increase capacity for our care coordination partners to track and share data, as well as support providers across sectors in taking a team approach to care with real time patient data. This will rest heavily on the ability for this technology to link systems already in place, which will be further analyzed in the environmental capacity scan we will conduct as part of Pathways Hub certification. We expect the ACH will need to support training of partners on this new technology system, as well as tracking and evaluation standards.

Attachment(s) Required

None

Transformation Project Planning - 15 points

Description

Provide a summary of current transformation project selection efforts including the projects the ACH anticipates selecting.

Instructions

Provide a response to each question. Total narrative word count for the category is up to 2,000 words.

Anticipated Projects

1. Provide a summary of the anticipated projects and how the ACH is approaching alignment or intersections across anticipated projects in support of a portfolio approach.

We launched our project selection process with an all-call for Optional Project Letters of Interest (LOI) due May 15th, yielding a strong showing of community interest across the region in all project areas. Over 80 LOIs submitted from 45+ organizations from all counties.

We concurrently launched our Health System (HSI) and Care Coordination Inventories (CCI). The HSI asked our major Medicaid health systems to define their vision for delivery system transformation, current utilization and interest in Toolkit project models, assessment of current workforce, value based contracts and technology. We have identified 23 health systems and received inventories from 17 systems on July 31. 21 Organizations submitted CCIs which asked for a similar scan for potential agencies.

The LOIs, HSI and CCIs inform the emerging Collaborative model that we expect to finalize for project selection. BHT expects to support between 3-8 Community Health Transformation Collaboratives (Collaboratives). These Collaboratives will be reflected in our Regional Project Portfolio. While the Board has not approved the final model, BHT staff will recommend that each Collaborative be required to develop a plan to address Bi-Directional Integration, Community Based Care Coordination, Transition, Diversion, Opioid and Chronic Disease Self-Management models reflected in the Toolkit. It is still to be determined whether or not Maternal and Child Health and Oral Health projects will be required. The final decision will be based on community interest, funds flow model and baseline data to meet the metrics at the November 2 Board meeting.

BHT is collecting feedback from partners and stakeholders on the Collaborative model and expects to approve the model at the August 22 Board meeting. Before we finalize the model, we will infuse funds flow and data analysis work to ensure that we are strategically ensuring maximization of regional earning potential and health impact.

We expect to launch our Collaboratives in September with intensive work sessions throughout the month of October. "Project plans" will be due to BHT in October to provide opportunity for Board approval prior to submission on November 16.

2. Describe any efforts to support cross-ACH project development and alignment. Include reasoning for why the ACH has, or has not, decided to undertake projects in partnership with other ACHs.

Recognizing a need for focused collaboration between regions with aligned philosophy, BHT has formed a learning collaborative with Pierce and Southwest ACHs to leverage strengths, share best practices and troubleshoot potential obstacles relating to the transformation process. Recognizing significant structural similarities between our ACHs, we have hired Uncommon Solutions, Inc. to facilitate this learning collaborative. Additionally, the three ACHs are working with the Foundation for Healthy Generations and Dr. Sarah Redding to develop our care coordination project through the Pathways Model. Recognizing the important need for expertise in data and finance, we each have hired Providence Center for Outcomes Research and Education (CORE) to assist in synthesizing data, and KPMG US, LLC to develop a funds flow model.

BHT has served as a leader in the early adoption of the Pathways Model and has committed to sharing learned experiences. Executive Director, Alison Carl White, convened and participated in learning sessions across ACHs throughout the previous Spring. BHT Associate Director/ACH Senior Tribal Project Manager Jenny Slagle, has also provided support and information to North Central ACH regarding the shared Colville Tribe connection. Furthermore, BHT partnered with North Sound ACH and shared a tax consultant to advise on the B&O tax issue as it related to Demonstration revenue. BHT staff regularly share learnings in our weekly cross-ACH staff calls and respond to requests from fellow ACH colleagues.

BHT seeks to ensure ongoing collaboration with our Greater Columbia and North Central ACH neighbors where porous borders lend shared partners such as the Colville Tribe, Providence Health Care, Rural Resources, NW Rural Health Network, and Aging and Long-Term Care of Eastern Washington. Once there is clarity on project selection, it is our intent to identify and coordinate our efforts to maximize investment across our shared partners, expecting collaboration around Bi-Directional Integration and Community Based Care Coordination.

3. Demonstrate how the ACH is working with managed care organizations to inform the development of project selection and implementation.

Managed Care Organizations (MCOs) have a substantial voice in the project selection process, although our approach has primarily focused on the needs of the health and social determinants of health delivery systems for Medicaid patients. Our 17-member Board serves as the governing body and primary decision-making authority of our ACH with two MCO representatives: Peter Adler¹⁴, and Dr. Jay Fathi¹⁵. All five MCOs are voting members of our Leadership Council and send staff regularly to participate in meetings and one-on-one sessions with BHT team.

Our HSI, process specifically solicited feedback from MCOs. Furthermore, we have requested that each MCO complete the CCI. These requests followed with individual MCO meetings focusing on their feedback and needs regarding the Collaborative model, role of the MCOs in moving to an integrated care delivery system, what can the ACH do to support the goal of reaching 90% VBP contracts for 2021, and what are opportunities for direct data sharing with MCOs.

¹⁴ President of Molina Health Care of Washington

¹⁵ President and CEO of Coordinated Care of Washington.

Additionally, BHT has leveraged its SIM funding to support the development of two Pathways Model pilots for jail transition populations in Spokane and Ferry Counties. We are actively engaging MCOs in contract development to support this work, demonstrating their commitment to the care coordination project selection.

Project Plan Submission

4. What risks and mitigation strategies have been identified regarding successful Project Plan submission?

BHT views the transition to Fully Integrated Managed Care (FIMC) as a requirement to successfully transform the health and social determinants of health systems in addition to successfully shifting to a Value Based Payment and Care model. Key county commissioners and Medicaid behavioral health leaders have been outspokenly opposed to the 2020 FIMC mandate. To mitigate this risk and encourage the region to consider the implications of passing up the \$8.7 million dollar integration incentive, BHT adopted a policy in April, to encourage regional movement to mid-adopter by appointing a work team to focus on developing a Regional Integration Planning team¹⁶. This short-term work team will identify a high-level plan for meeting the 2020 FIMC mandate, evaluating the mid-adopter option, and ensuring alignment of county health and criminal justice system with our regional project portfolio.

Like many of our ACH colleagues, BHT is very concerned that the data currently available is insufficient to effectively determine a funds flow model to maximize the incentives tied to each project. We are also concerned about negative partner perception as we attempt to set transformation vision and goals without provider/system/county baseline data. To mitigate this risk, we have contracted with Providence CORE to support the analysis of the current data available, provide data counsel and translation for data requests to HCA, and to assist in building a data and self-monitoring strategy to support the Demonstration goals and community-driven goals for earning incentive dollars.

BHT has worked hard to build relationships with community partners whose work represents the heart of this region. Our open Optional Project Letter of Interest process received 80+ submissions, which indicates a great breadth of organizations ready to be involved in this work. Many of these partners have been at the table since the ACH's inception and have seen several evolutions of the expected role of the ACH in the Demonstration. We see a significant risk of losing community momentum for work that is not aligned with the Demonstration toolkit. To mitigate this, we have a Board-approved policy to hold back 10% of all Demonstration earned incentives to support a Community Resiliency Fund to align and leverage additional resources throughout the community including shared savings models, local philanthropic investments, and community benefit to fund likely social determinant of health investments to keep up to pace with the rapidly changing healthcare delivery system.

BHT has worked incredibly hard to engage tribal health leaders throughout the region, understanding that Tribes have faced generational disenfranchisement from systems. We created a Board co-chaired

¹⁶ Please see BHT-Governance and Organizational Structure - Attachment A Regional Integration Planning Team Charter for full list of members

Tribal Partners Leadership Council and hired an ACH Senior Tribal Project Manager. While we have made progress on Tribal engagement, we continue to face tense relations with The NATIVE Project and find the fragile Indian Health System a challenge for leaders to carve out the time to prioritize ACH efforts. These challenges are exacerbated by the slow flow of information from HCA on the Tribal Coordinating Entity, Terms and Conditions, and time needed for Tribal partners to weigh where the greatest impact to their population will come from. We continue to proactively support added capacity for Tribal partners, in addition to increased coordination with the Empire Health Foundation’s Native American Health Leaders who are funding significant work in all three regional Tribes to support care coordination in chronic disease and medication management.

5. Demonstrate how the ACH is identifying partnering providers who cover a significant portion of Medicaid beneficiaries.

Our HSI asked providers to share demographic info on their Medicaid population served and assigned.¹⁷ We will cross-reference those self-reported numbers with HCA data with assistance from Providence CORE to ensure we capture enough of the market in our health systems partnerships. We are concerned that the significant growth of Medicaid beneficiaries since the ACA will show that a large portion of the Medicaid population does not have adequate access to healthcare, despite a majority of our partnering providers delivering Medicaid services in the region.

6. What strategies are being considered to obtain commitments from interested partnering providers? What is the timeline for obtaining these commitments?

Partners who successfully fill out our inventory forms will be given a \$2,000 performance payment for the CCI and \$5,000 for the HSI. These documents are not legally binding commitments, but combined with our open LOI process, will allow us to gauge organization commitment. The HSI was due July 31st and the CCI was due August 4th. Our next step will be to invite partners to participate in our Collaborative planning process.

7. Demonstrate how the ACH is ensuring partnering providers represent a broad spectrum of care and related social services that are critical to improving how care is delivered and paid for.

We ensure a broad range of representation through vigorous community engagement:

Our Leadership Council is comprised of 60 organizations, representing all of the core sectors needed to improve how care is delivered and paid for. This group serves as the strategic synthesizer for the region.

BHT Board is comprised of 17 geographically diverse organizations and leaders representing Physical and Behavioral Health Systems, Native American Health Leaders, Social Determinant and Public Health sectors.

Health Champions/Rural Health Coalitions each are comprised of at least 10 local organizations reflective of at least one partner representing Physical and Behavioral Health, Social Determinants,

¹⁷ Please see BHT - Transformation Project Planning - Attachment A for a list of participating providers.

and Public Health.

Our broad engagement efforts have resulted in over 80 Optional Project Letters of Interest submissions from dental, physical health, behavioral health, public health, and social service providers demonstrating a broad spectrum of partners.

We expect our Collaboratives will have requirements to include: Physical, Mental and SUD providers, representation of Native American Health partners, Social Determinants and Care Coordinating providers, Public Health, EMS and County representation.

8. Demonstrate how the ACH is considering project sustainability when designing project plans. Projects are intended to support system-wide transformation of the state's delivery system and ensure the sustainability of the reforms beyond the demonstration period.

We are developing our Community Health Transformation Collaboratives with a focus on moving the region to value based purchasing and whole person care. VBP is the cornerstone of our sustainability plan recognizing the need to transition how we pay for care and linking social determinant of health services. We are working to align data, funds flow, and model development to maximize the opportunity to integrate selected projects into a value based model and weave together local resources and investment to reach this goal. For instance, it is expected that the Board's funds flow policy will include directed investments for startup costs, infrastructure and technical assistance emphasizing DSRIP funding for transition, not an ongoing payment stream.

The Pathways Model rests as an anchor strategy for all of our Demonstration Transformation work. Pathways offers an opportunity to better leverage an outcomes payment model to sustain care coordination beyond typical philanthropic/government contracts. We see this as a way to disrupt the cycle of fragile funding many social determinant of health partners face as government and philanthropic partners rotate through grant periods. We expect that Pathways can and will be funded through payers, though not exclusively Medicaid MCOs, but in addition to innovative partnerships through the region with philanthropic organizations and city and county governments. This will result in improved community capacity that will last beyond the Demonstration.

Attachment(s) Required

A. Initial list of partnering providers or categories of partnering organizations interested in or committed to implementing projects.

Attachments Checklist

Instructions: Check off each required attachment in the list below, ensuring the required attachment is labeled correctly and placed in the zip file. To pass Phase II Certification, all required attachments must be submitted. Check off any recommended attachments in the list below that are being submitted, ensuring the recommended attachment is labeled correctly and placed in the zip file.

Required Attachments	
Theory of Action and Alignment Strategy	
None	
Governance and Organizational Structure	
<input checked="" type="checkbox"/>	A. Copies of charters for committees and workgroups that outline purpose, members, responsibilities, and scope.
<input checked="" type="checkbox"/>	B. Conflict of interest policy.
<input checked="" type="checkbox"/>	C. Draft or final job descriptions for all identified positions or summary of job functions.
<input checked="" type="checkbox"/>	D. Short bios for all staff hired.
Tribal Engagement and Collaboration	
<input checked="" type="checkbox"/>	A. Demonstration of adoption of the Model ACH Tribal Collaboration and Communication Policy, either through bylaws, meeting minutes, or other evidence. Highlight any modifications that were agreed to by all required parties.
<input checked="" type="checkbox"/>	B. Bio(s) for the representative(s) of ITUs seated on the ACH governing board. <i>If you do not have an ITU representative on the governing board, please attach a description of the efforts made to fill the seat.</i>
Community and Stakeholder Engagement	
<input checked="" type="checkbox"/>	A. Meeting minutes or meeting summaries for the last three decision-making body meetings and screenshot capturing distribution of meeting minutes/summaries (e.g., email distribution, website post).
<input checked="" type="checkbox"/>	B. List of all public ACH-related engagements or forums for the last three months.
<input checked="" type="checkbox"/>	C. List of all public ACH-related engagements or forums scheduled for the next three months.
<input checked="" type="checkbox"/>	D. Evidence of meaningful participation by community members. Examples include: attestation of meaningful participation by at least one Medicaid beneficiary, meeting minutes that memorialize community member attendance and comments, and solicitation for public comment and ACH response to public comments.
<input checked="" type="checkbox"/>	E. Attestation of meaningful participation from at least three partners from multiple sectors (e.g., managed care organizations, Federally Qualified Health centers, the public health community, hospitals, primary care, and behavioral health) not participating directly on the decision-making body.
Budget and Funds Flow	
<input checked="" type="checkbox"/>	A. Bio or resume for the Chief Financial Officer (CFO) or equivalent person responsible for ACH financial functions.
<input checked="" type="checkbox"/>	B. Financial Statements for the previous four quarters. Audited statements are preferred. If an ACH does not have four quarters of financial statements available, provide as many as possible.
<input checked="" type="checkbox"/>	C. Completed Phase II Project Design Funds Budget Template, which includes Projected Project Design fund budget over the course of the demonstration, additional funding sources, and in-kind resources that the ACH expects to leverage to prepare their Project Plans and build the capacity and tools required to implement the Medicaid Transformation Project demonstration.

Clinical Capacity	
<input checked="" type="checkbox"/>	A. Current bios or resumes for identified clinical and workforce subject matter experts or provider champions. <i>Re-attach bio or resume even if previously provided in Phase I Certification. ACHs should also include any additional bios or resumes, if applicable.</i>
Data and Analytic Capacity	
None	
Transformation Project Planning	
<input checked="" type="checkbox"/>	A. Initial list of partnering providers or categories of partnering organizations interested in or committed to implementing projects.

Recommended Attachments	
Theory of Action and Alignment Strategy	
<input checked="" type="checkbox"/>	A. Logic model(s), driver diagrams, tables, and/or theory of action illustrations that visually communicate the region-wide strategy and the relationships, linkages and interdependencies between priorities, key partners, populations, regional activities (including workforce and population health management systems), projects, and outcomes. <i>Note: These documents are intended to reflect the thought process that the ACH went through to define a vision for transformation that is grounded in community needs and tied to the broader Healthier Washington objectives, and to define how it will align its activities and resources to advance the vision in an efficient manner.</i>
Governance and Organizational Structure	
<input type="checkbox"/>	E. Sector representation policy describing any agreements or expectations for decision-making body members to communicate with and engage partners within a defined sector.
<input type="checkbox"/>	F. Revised visual/chart of the governance structure, if there have been significant changes since Phase I Certification.
<input checked="" type="checkbox"/>	G. Revised organizational chart that outlines current and anticipated staff roles to support the ACH, if there have been significant changes since Phase I Certification.
Tribal Engagement and Collaboration	
<input checked="" type="checkbox"/>	C. Statements of support for ACH certification from every ITU in the ACH region.
Community and Stakeholder Engagement	
None	
Budget and Funds Flow	
None	
Clinical Capacity	
None	
Data and Analytic Capacity	
None	
Transformation Project Planning	
None	