

## 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 limit of up to 1,000 words 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](mailto: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
<b>Foundational Requirements</b>
<p><b>ACH has:</b></p> <ul style="list-style-type: none"> <li>✓ Secured an ACH Executive Director;</li> <li>✓ 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;</li> <li>✓ Secured the ACH’s primary decision-making body approval of detailed budget plan for Project Design funds awarded under Phase I Certification;</li> <li>✓ 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</li> <li>✓ 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.</li> </ul>
<b>Submission Requirements</b>
<p><b>Phase II Certification submission:</b></p> <ul style="list-style-type: none"> <li>✓ Designates point of contact</li> <li>✓ Includes responses for all fields in the template</li> <li>✓ Complies with word count parameters (up to 1,000 words per section)</li> <li>✓ Includes all required attachments submitted (see Attachment Checklist)</li> <li>✓ Uploaded by August 14, 3pm PT</li> </ul>

**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. Funding<sup>1</sup> 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

<sup>1</sup> 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	
<b>ACH</b>	Cascade Pacific Action Alliance
<b>Name</b>	Winfried Danke
<b>Phone Number</b>	360.539.7576 ext. 125
<b>E-mail</b>	<a href="mailto:Dankew@crhn.org">Dankew@crhn.org</a>

## 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.

The purpose of the Cascade Pacific Action Alliance (CPAA), an Accountable Community of Health (ACH), is to improve community health and safety through cross-sector, region-wide collaboration. CPAA has identified three overarching goals that align closely with Healthier Washington’s priorities and the Triple Aim:

Regional Health Improvement Plan “Meta” Goals		
Improve Health	Whole Person Care	Smarter Spending
Improve health equity and health outcomes for all residents in our communities, with a focus on addressing the social determinants of health.	Keep residents healthy as long as possible and address all health needs with a focus on prevention and early interventions.	Reduce per-capita health care costs while improving the quality of care provided to residents in our communities.

Shared Regional Health Priorities				
Priority areas to achieve goals including specific activities, programs, policies, and system change strategies to bring about change.				
				
Improve Healthcare Access	Improve Care Coordination & Integration	Prevent & Manage Chronic Disease	Prevent and Mitigate Adverse Childhood Experiences (ACES)	Enhance Economic & Educational Opportunities

By addressing these five priority areas through high-impact strategies detailed in the CPAA’s Regional Health Improvement Plan (RHIP), CPAA will achieve its overarching goals. CPAA is deeply rooted in the collective impact framework and builds on many years of regional cross-sector collaboration, predating the formation of the Alliance. While CPAA looks to the Medicaid Demonstration as an opportunity to accelerate health system transformation through targeted investments, we are well aware that realizing our region’s vision will require sustained collective action across the region for many years to come. Early on, as one of two Pilot ACHs, CPAA emphasized aligned cross-sector action,

and we remain committed to regional collaboration and health improvement that extends beyond the Medicaid population and the Demonstration. The attached value proposition summarizes key functions of CPAA that transcend the Demonstration.

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

Improving health equity by focusing on the social determinants of health is an overarching goal for CPAA that serves as a lens for all its work. The CPAA region covers 7 counties that include both rural and urban communities with approximately 600,000 residents and nearly 190,000 Medicaid beneficiaries. According to the Robert Wood Johnson Foundation (RWJF) County Health Rankings, six out of these seven counties rank below the 50<sup>th</sup> percentile of all counties surveyed. While our rural communities are particularly affected, health disparities and poor health outcomes extend across the region. The following summarizes key health care needs, health disparities, and social risk factors in the CPAA region:

**Health Care Needs, Health Disparities, and Social Risk Factors**

- Adult and adolescent smoking and obesity rates for the overall population are higher than the state average; residents have less access to exercise opportunities and healthy foods.
- Heart disease is the second largest leading cause of death in our region across all counties. The management of chronic diseases, including obesity and heart conditions, places a huge burden on our health care system.
- Mental health is also a concern, with adults and adolescents reporting higher rates of poor mental health than statewide. Adolescent depression is of particular concern, with 35-41% of adolescents within CPAA’s counties reporting depression symptoms within the past year.
- Adequate health care access is a problem throughout our region, but is particularly severe in our rural communities where the number of health care providers is well below the Washington State average.
- Dental utilization is lower for the overall and Medicaid population of all ages.
- Emergency department utilization is also higher than statewide, potentially reflecting challenges for or with members who have no other access to care, (approximately 16% of ED visits are potentially avoidable, higher than the statewide rate).
- Our health care system is highly fragmented, resulting in poor transitions of care and reduced health outcomes as patients struggle to navigate a confusing health system. Care for individuals with complex health needs, who require assistance from multiple service systems (medical, behavioral health, and social services), is a significant challenge in this fragmented system. Service providers often do not know of each other, share relevant information, or work together to improve health outcomes. This is of particular concern for individuals suffering from mental health and chemical dependency issues who require cross-sector assistance.
- Our region has a high burden of ACEs, which are likely contributing to the prevalence of chronic disease and other poor health outcomes.
- Teen pregnancy and unintended pregnancy rates are higher than statewide, and the percent of CPAA’s population using LARC is lower than statewide.
- Lack of education and high rates of unemployment are contributing to poor health. Five of the seven counties rank in the top ten worst counties for unemployment rates in Washington State (RWJF, County Health Rankings).
- The median household income for our rural communities is nearly a third lower than the Washington State average.

Please see attached RHNI and data summary for more information.

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

CPAA went through a yearlong planning process to identify strategies that are in alignment with the priorities and healthcare needs of our region. By implementing these strategies, we expect to improve health outcomes for the residents in our region. The following summarizes these key strategies for each shared health priority area:

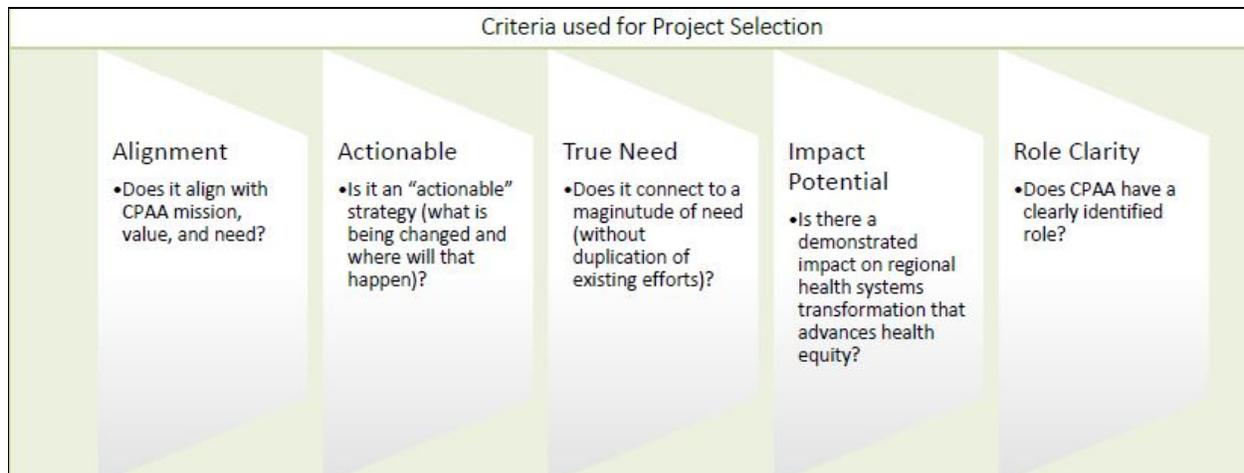
Improve Healthcare Access	Improve Care Coordination & Integration	Prevent & Manage Chronic Disease	Prevent and Mitigate Adverse Childhood Experiences (ACES)	Enhance Economic & Educational Opportunities
Top Identified Strategies "Prior to the Demonstration"				
<ul style="list-style-type: none"> <li>Activity: Joint regional recruitment plan</li> <li>Program: Develop ARNP residency program</li> <li>Systems: Develop Tele-medicine network</li> </ul>	<ul style="list-style-type: none"> <li>System: Care Traffic Control</li> <li>System: Behavioral Health Integration</li> <li>Program: Community Care Center</li> <li>Program: Wellness Center</li> <li>System: Community Based Paramedicine</li> <li>System: Community Health Workers</li> </ul>	<ul style="list-style-type: none"> <li>Systems: Improve access to chronic disease self-management programs</li> </ul>	<ul style="list-style-type: none"> <li>Activity: Coordinate NEAR Speakers bureau</li> <li>Systems: Increase access to home visiting programs</li> <li>Systems: Expand Kinship Care Program</li> <li>Systems: Develop Trauma Informed Communities</li> </ul>	<ul style="list-style-type: none"> <li>Systems: Support individuals in obtaining &amp; maintaining employment and livable income</li> </ul>
Current Implemented Strategies Align with RHIP				
	<ul style="list-style-type: none"> <li>Youth Behavioral Health Coordination Pilot</li> </ul>	<ul style="list-style-type: none"> <li>Youth Marijuana Prevention and Education Program</li> </ul>		
Medicaid Transformation Demonstration Project Areas Align with RHIP				
<ul style="list-style-type: none"> <li>Access to Oral Health Services</li> </ul>	<ul style="list-style-type: none"> <li>Bi-Directional Integration of Care and Primary Care</li> <li>Community Based Care Coordination</li> <li>Transitional Care</li> <li>Diversion Interventions</li> </ul>	<ul style="list-style-type: none"> <li>Chronic Disease Prevention &amp; Control</li> <li>Addressing the Opioid Health Crisis</li> </ul>	<ul style="list-style-type: none"> <li>Reproductive and Maternal/Child Health</li> </ul>	

CPAA has begun addressing these priorities through two starter projects:

- Since 2015, the *Youth Behavioral Health Coordination Pilot* addresses care coordination, access improvement, ACEs prevention and mitigation, educational opportunities enhancement, and chronic disease prevention.
- Since 2016, the *Youth Marijuana Prevention and Education Program* addresses ACEs and chronic disease prevention. See attachment.

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

Once CPAA had identified its shared health priorities and key strategies, the next step was to select high-impact projects to improve health through cross-sector collaboration and shared action. In selecting these projects, several criteria were considered:



CPAA used this same set of criteria to select Medicaid Demonstration projects, albeit with slight modifications. For instance, *Impact* was directly linked to whether the project has the potential to improve the health of large numbers of Medicaid beneficiaries and *Actionable* requires that the project can start up and achieve results quickly. CPAA augmented its project selection process with updated regional health needs data, conducted a public online survey that showed that community members are greatly interested in a more coordinated care system, and received project selection recommendations from its work groups. After review of all this information, CPAA has chosen to pursue all 8 Demonstration projects.

**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.**

From the beginning, CPAA has applied a portfolio approach to health system transformation; i.e., CPAA has selected projects that build upon and complement each other. To implement this approach, each work group is conducting an environmental scan to identify existing community resources in each project area. Information collected includes current activities, lead partners, and funding streams. This asset mapping process uses online surveys that are publically available. The information is then reviewed by each work group to identify gaps and to develop strategies that leverage existing resources. Our work groups began this work in June and are expected to complete their assessments in August. The results of the project specific assessments are reviewed by the CPAA Support Team, which includes the work group chairs. The Support Team, which comes together monthly, is tasked with integrating this information to ensure that the work groups complement each other and their strategies are aligned across the region. The following is a summary of the current status of Demonstration project planning for the CPAA region:

Medicaid Transformation Demonstration Project Areas and Activities Identified 8/1/2017

<b>Bi-Directional of Care &amp; Primary Care</b> <ul style="list-style-type: none"> <li>•Use collaborative care model to integrate behavioral health into primary care and primary care into behavioral health</li> </ul>	<b>Community Based Care Coordination</b> <ul style="list-style-type: none"> <li>•Develop Regional Pathways Hub</li> </ul>	<b>Transitional Care</b> <ul style="list-style-type: none"> <li>•INTERACT 4.0</li> <li>•Transitional Care Model</li> <li>•The Care Transitions Intervention</li> </ul>	<b>Diversion Interventions</b> <ul style="list-style-type: none"> <li>•Community Paramedicine</li> </ul>
<b>Opioid Response</b> <ul style="list-style-type: none"> <li>•Prevention: Prevent Opioid Use and Misuse</li> <li>•Treatment: Link Individuals with OUD with Treatment Services</li> <li>•Overdose Prevention: Intervene in Opioid Overdoses to Prevent Death</li> <li>•Recovery: Promote Long-Term Stabilization &amp; Whole Person Care</li> </ul>	<b>Reproductive and Maternal/Child Health</b> <ul style="list-style-type: none"> <li>•10 Recommendations to improve womens health before conception</li> <li>•Home Visiting Programs for pregnant high risk first time mothers.</li> <li>•Bright Futures or EMHI</li> </ul>	<b>Access to Oral Health</b> <ul style="list-style-type: none"> <li>•Oral Health in Primary Care</li> <li>•Mobile/Portable Dental Care</li> </ul>	<b>Chronic Disease Prevention &amp; Control</b> <ul style="list-style-type: none"> <li>•Chronic Care Model</li> </ul>

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

In order to achieve synergies between selected projects and create sustainability, it is vital for CPAA to invest in shared infrastructure, resources, and systems across projects to the greatest extent possible. Three key investment areas stand out: financing, workforce, and health information technology and exchange capabilities. The following summarizes strategic investments that CPAA will potentially make to establish shared infrastructure across projects.

Medicaid Transformation Demonstration Supports & Investments	
Health & Community Systems Capacity Building	
<b>Financial Sustainability through Value Based Payment</b>	Invest in provider readiness so that providers are able to enter into value-based contracts. Work with Qualis and the Practice Transformation Hub to prepare providers and leverage the work of the Clinical Provider Advisory Committee to meet state goals.
<b>Workforce</b>	Connect with state workforce resources, providers, MCOs, the Practice Transformation Hub, CPAA Consumer Advisory Committee, and the Enhancing Education and Economic Opportunities Work Group to address workforce implications for the Demonstration. Potential investments include implementing telehealth, training and expanding the number of community health workers, and training providers in trauma informed practices, cultural competency, tribal affairs, and health equity.
<b>Systems for Population Health Management</b>	Invest in the interoperability of existing systems to enhance data sharing. Potential alignment areas include One Health Port, Clinical Data Repository, and connecting partners to EDIE/PreManage systems, EPIC, and HIT/HIE systems to support streamlined data sharing and improved efficiencies for providers.

CPAA is actively exploring collaborating with other ACHs and statewide partners to leverage these strategic investments beyond the region.

**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

#### Description

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.

#### Instructions

**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.**

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.**

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.**

CPAA is rooted in a distributed leadership model that includes cascading levels of governance. At the local level, CPAA includes 7 community forums -- broad-based coalitions of multi-sector stakeholders that are county based. Each of these local community forums sends representatives to a regional coordinating council (Council) that also includes other regional and statewide stakeholders. The CPAA Council is supported by the Support Team, which includes a subset of Council members, and prepares Council meeting agendas and other preparatory work for the Council. Several project specific work groups report to the Council. In early 2017, when the CPAA incorporated as a single-member Limited Liability Corporation with CHOICE Regional Health Network (CHOICE) being the sole member, a CPAA Board (Board) was formed which has final decision-making authority for the CPAA, and the Council now serves in an advisory role to the Board.

The composition of the Board mirrors the deliberate cross-sector composition of the Council, albeit with a reduced number of directors. Instead of more than 40 Council members, the Board has 19

director seats that reflect the diversity of community sectors, partners, and geographic areas within the region. More than half the director seats are non-clinical.

As the sole member of the LLC, CHOICE appoints 51 percent of director seats including: behavioral health provider, community hospital/critical access hospital, federally qualified health center/community health center, health system, provider network/PCP, and public health. The Council appoints the remaining seats: at large, behavioral health organization, consumer or Medicaid beneficiary, criminal justice, education, managed care organization, and social services. The tribes appoint a Tribal Government Services Director.

Using an online application form, Council members and other community members were encouraged to apply for Board positions through an open nomination process. During the March Council meeting, Council members reviewed the nominations and voted for Board Directors. During the June Council meeting, the Consumer Board seat was filled and a consumer representative appointed to the Council. To date, all Board seats have been filled with the exception of the Tribal Government Services Director position, which remains open until filled.

Board directors are encouraged to engage with others in their sector, and they have the opportunity to caucus with their sector before participating in decision-making. However, they have a fiduciary responsibility and a duty of loyalty to the organization, not to the sector or the organization that employs the director. One way Board directors engage with others in their sector is through council meetings that immediately precede board meetings and include additional sector representatives. All directors are required to attend at least 50% of council meetings so they hear the broader cross-sector discussions. More than 50 people have attended the last three council meetings, and attendance continues to grow with the use of teleconferencing.

Directors are also encouraged to reach out to their sector between board meetings, and they work with other members of their sector in work groups and local forums. This has proven to be an effective sector engagement strategy. For instance, behavioral health providers throughout the region recently met in between board meetings to discuss their sector approach to financial integration of managed care and articulated their consensus position at a board meeting. Likewise, MCOs regularly caucus in between monthly CPAA meetings, and our tribal partners, some of whom actively participate in the Council, regularly get together to coordinate their perspective.

**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)**

Not Applicable.

**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 April 2017, the CPAA Board adopted a detailed conflict of interest policy and implemented an annual disclosure of board directors’ conflicts of interest. The policy is intended to address personal and organizational level conflicts that may arise while serving as a board director. In particular, the policy seeks to mitigate conflicts that may arise from a director (1) being affiliated with another organization with which CPAA may have an actual or potential financial relationship (e.g., as a trustee, board member, officer, advisory committee member, volunteer, or employee of the business

partner), or (2) having a close relationship with organizations with which CPAA may have an actual or potential financial relationship (e.g., through a family member or close companion).

The policy prohibits self-dealing transactions unless a number of very specific conditions are met, the directors with a conflict of interest have fully disclosed the nature of the conflict and, at the request of the board, withdrawn from voting on the matter. Any transaction or vote involving a potential conflict of interest may only be approved when a majority of disinterested directors determines that it is in the best interest of the corporation to do so. The policy details requirements to record conflicts of interest and specifies a process for handling violations of this policy.

Additionally, during board meetings, a conflict of interest check is performed for each agenda item. If a director has a known conflict of interest but does not declare the conflict, it is the Chair's responsibility to raise the conflict. If the Chair neglects to do so or is not aware of the conflict, any other member of the board is encouraged to raise the issue. Please see the attached conflict of interest policy.

## 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.

In February 2017, CPAA executed an administrative services agreement with CHOICE to provide staffing to fulfill required capacities. As part of the Phase I ACH certification process, CPAA approved a staffing structure that combines core in-house personnel with specialized contracted labor.

#### In-house Personnel :

- The CEO works with the council and board to develop strategic direction and provides strategic leadership.
- Reporting to the CEO, two Program Directors are responsible for oversight of the Demonstration projects. The Clinical Director must have appropriate expertise to develop strategies for monitoring activities of clinical providers, which will reflect both large and small providers and urban and rural providers.
- Several Program Managers, reporting to the Program Directors, are responsible for supporting the planning and implementation of Demonstration projects.
- Several Support Personnel assist the managers and directors in their respective roles (e.g., Administrative Support Specialist, Communications Specialist, etc.).
- A Community and Tribal Liaison, reporting to the CEO, is responsible for assisting the CEO in effective community and Tribal engagement.
- An Operations Director, reporting to the CEO, is responsible for all internal agency operations, including HR and finance.
- A Data Analytics and IT Manager, reporting to the Operations Director, supervises a data team including a Data Analyst and IT Administrator, responsible for population health management modeling, development and management of clinical data collection and reporting systems, and performing root cause analyses for quality metrics to recommend quality improvement strategies.

#### Specialized Contracted Labor:

- *Financial:* Wittenberg, LLC is providing bookkeeping and accounting services and assisting with budgeting and funds flow development.
- *Clinical:* A Chief Medical Officer will provide oversight to the Clinical Director and assistance with the clinical provider advisory committee.
- *Data:* Providence CORE is providing specialized data analytics services (e.g., project-level measures) and is advising CPAA on setting up an effective data strategy and data infrastructure.
- *Planning:* Health Management Associates is supporting CPAA in Demonstration project and implementation planning.

### Current and Future Recruitment

In developing its staff team, CPAA is drawing on a core of existing, experienced CHOICE personnel. The following CPAA positions have been filled with current CHOICE staff: CEO, Program Director, Operations Director, Data Analytics & IT Manager, Communications Specialist, Program Support Specialist, and a Community and Tribal Liaison.

The following is an overview of current job openings. Recruitment is managed by the Operations Director, using Indeed, the CHOICE website, social media, and newsletters to advertise open positions:

Function	Position	Status	Due Date
Data Analytics	Data Analyst	Recruiting	9/1/2017
Data Analytics/Clinical	Healthcare Quality Analyst	Inactive	12/1/2017
Information Technology	IT Administrator	Recruiting	9/1/2017
Clinical Oversight	Chief Medical Officer (Contracted)	In Negotiation	9/1/2017
Clinical Oversight	Clinical Director	Recruiting	10/1/2017
Administrative Support	Program Specialists	Completed	09/1/2017
Program Management	Program Manager Bi-Directional Integration	Completed	09/1/2017
Program Management	Program Manager Opioid Response Manager	Recruiting	09/1/2017
Program Management	Program Manager Pathways Hub	Recruiting	10/1/2017
Program Management	Program Manager Diversions	Inactive	12/1/2017
Program Management	Program Manager Transitional Care	Inactive	12/1/2017
Program Management	Program Manager ACEs & Chronic Disease	Inactive	12/1/2017
Program Management	Program Manager Oral Health	Inactive	12/1/2017

#### 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.**

CPAA has continued to emphasize tribal engagement since Phase I Certification. Leading up to Phase I Certification, with the help of the Skokomish Tribal Health Director, CPAA established a legal entity governing board structure that reserves one of 19 seats for a Tribal Government Services Director. In March 2017, the CPAA Board approved the Model ACH Tribal Collaboration and Engagement Policy. CPAA intends to go beyond this policy to achieve authentic and meaningful engagement of tribes.

In keeping with the policy, since Phase I Certification, CPAA has focused on establishing a Committee of Tribes. In June 2017, CPAA contacted, per letter and email, the chairpersons and health directors of all seven federally recognized tribes in the region with a request that each tribe name a representative to serve on the committee.

In response to this request, the Cowlitz Indian Tribe affirmed, in recognition of the sovereign status of Indian nations, that each tribe be represented with a separated director seat on the Board. In July, the Board heard directly from the Cowlitz Indian Tribe Health Director on the issue. The Board plans to contact all tribes, beginning with the Cowlitz Indian Tribe, to request an in-person visit with the Tribal Council to discuss tribal representation.

While CPAA has been unable to fill the Tribal Government Services board director seat, CPAA has continued to build relations with tribal partners and engage tribal health leaders in its work. This includes visiting tribal health facilities to learn about Indian health services, attending tribal events, and working with tribal health leaders to shape the selection and design of the Demonstration projects. In May 2017, the Board visited the wellness center of the Confederated Tribes of the Chehalis. The Health Director of the Confederated Tribes of the Chehalis attended CPAA community events, and she and the health directors of the Cowlitz Indian Tribe and the Skokomish Tribe attended the June Council meeting when Demonstration project areas were selected. Since Phase I Certification, all three directors have remained engaged by attending Council meetings. Most recently, with the help of one of our clinical Provider Champions, we met with a physician from the Nisqually Indian Tribe and a visit to the Tribal Health Center is pending. Statements of support for ACH certification from two tribes in the CPAA region are attached. Moreover, on August 10, the Council expanded membership to all seven Tribes.

**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)*

In addition to engaging all 7 federally recognized tribes in the CPAA region in work groups and Demonstration project design, forming a Committee of Tribes is a priority. We plan to follow up our written request for participation in the committee with personalized outreach to each tribe to understand any concerns about participating in the committee.

Engaging with tribes appropriately and respectfully requires an understanding of each tribe’s unique circumstances, needs, and interests. CPAA is committed to meeting each tribe on their own terms. CPAA is cognizant that successful tribal engagement requires time and deliberate effort. In order to create greater capacity for a customized, individualized approach, CPAA has recruited a Community and Tribal Affairs Liaison.

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

Since its inception, CPAA has sought to include ITUs in its planning and development process.

Following a regional workshop by the American Indian Health Commission at the Chehalis Confederated Tribes in June 2016, CPAA has seen improved tribal engagement. In particular, the Skokomish Tribal Health Director began attending Council meetings and advised CPAA on effective tribal engagement, including guidance with the development of the legal entity structure.

Following site visits to the Skokomish Tribal Health Center and the Wellness Center of the Confederated Tribes of the Chehalis, the health directors of both tribes have regularly participated in Council meetings. Over the last few months, the health director of the Cowlitz Indian Tribe has also attended Council meetings regularly. All three health directors attended Council deliberations about regional priorities and project selection, culminating in the June Council meeting when the CPAA reviewed a host of different data points and selected all eight Medicaid Demonstration projects for its Medicaid Demonstration project portfolio.

Leading up to this decision, the Health Director of the Confederated Tribes of the Chehalis participated in a community event in Grays Harbor County in May 2017 that explored the different Medicaid Demonstration project areas and resulted in a recommendation of priority projects for the CPAA Council’s consideration.

Additionally, tribal health leaders have begun to engage in work groups. For instance, the Tribal Health Director of the Confederated Tribes of the Chehalis has attended work sessions of the Opioid Response Work Group. In an effort to incorporate tribal health priorities into the Medicaid Demonstration planning more systematically, CPAA recently contacted the health directors of all seven federally recognized tribes with a request to share their top health priorities for consideration by work groups in project design.

**Board Training**

**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.**

Since Phase I Certification, the Board has continued its exploration of the Indian health care delivery system. The Board visited the Wellness Center of the Confederated Tribes of the Chehalis in May. During the visit, board members had the opportunity to tour the health facility and learned about the Indian health care delivery system with a focus on the needs of tribal Indian populations.

CPAA is now setting up visits to other tribes in the region. The Cowlitz Indian Tribe Health Director invited the Board to visit her health facility. A visit to the Nisqually Indian Tribe Health Center is pending. We plan to visit with at least two tribes during the next six months.

Goals of Visits and Training			
1. Gain a better understanding of existing health care capabilities of our tribal partners and explore partnership opportunities	2. Gain a better understanding of each tribe's specific health needs, challenges, and priorities so we can better incorporate this knowledge into our project planning	3. Expand the board's knowledge of the Indian health care delivery system in general to improve decision making and raise greater awareness to tribal implications of CPAA activities	4. Deepen our relationships with tribes to facilitate meaningful and authentic engagement in order to improve the health of our interrelated communities

Particular emphasis is placed on inviting tribal partners to participate actively in Demonstration project planning.

**Attachment(s) Required**

**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.**

**B. Bio(s) for the representative(s) of ITUs seated on the ACH governing board.**

*If you do not have an ITU representative on the governing board, please attach a description of the efforts made to fill the seat.*

**Attachment(s) Recommended**

**C. Statements of support for ACH certification from every ITU in the ACH region.**

**Community and Stakeholder Engagement – 10 points**

Description

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.

Instructions

**Complete the attestations and provide a response to each question. Total narrative word-count for the category is up to 2,000 words.**

**ACH Attestation(s)**

**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.**

YES

**Meaningful Community Engagement**

**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.**

In Phase 1 of ACH certification, three main challenges around community engagement were identified: (1) engaging with consumers, including Medicaid beneficiaries; (2) filling the consumer seat on the Board; and (3) needing additional capacity to engage our communities more broadly and deeply. Since then, we have worked hard to overcome these challenges.

To date, we have engaged consumers through local focus groups in five of seven counties covered by CPAA. These conversations have provided an opportunity to learn what is working well for consumers and what needs improvement to help consumers and their families be healthy. CPAA partners who work with Medicaid beneficiaries were instrumental in recruiting participants. We worked with our technical assistance consultants on the development of a moderator guide, selection of interview questions, and identification of best practices for conducting consumer focus groups.

At the May and June 2017 Council meetings, we heard from two consumers interested in serving on the Board. Both have many years of experience with our health care system and a solid understanding of the challenges Medicaid beneficiaries face. In June, the Council appointed one of the two applicants as a director to the Board, filling the Consumer seat. The other applicant was asked to serve on the Council to strengthen the consumer voice. We are working with our consumer representatives between meetings to make sure they are supported and able to engage meaningfully.

A Community and Tribal Liaison was hired to expand capacity to engage our communities more broadly and deeply through public forums, town hall meetings, our website, and social media, and to provide more support to our local community forums.

In addition, we are seeking to establish other bi-directional means of communication with consumers. We are working with our partners to recruit consumers to project work groups, and we are establishing a Consumer Advisory Committee. The committee will ensure that clinical considerations are balanced with the needs, interests, and perspectives of stakeholders with a lived experience of health disparities. Consumer champions will come from throughout the region.

We are exploring offering stipends and other financial incentives to support consumer engagement. Consumer focus group participants received a \$25 gift card, food was provided, and the meetings were held after regular business hours. A challenge, however, is that state funding does not cover

these expenses, and we have to find other sources of funding for stipends, food, etc. We are approaching local community foundations to help support these expenses.

To CPAA, successful community engagement is achieved when diverse community members, including Medicaid beneficiaries, and organizations representing different community perspectives actively participate in collaborative regional health improvement and when the community voice meaningfully informs the work of the Alliance. Indicators of success include the number of community members and organizations representing diverse community perspectives that actively participate in CPAA meetings, broad representation of community members and community organizations from across the region, and sustained, consistent participation. Another key indicator is the degree to which CPAA decisions and actions reflect the needs and interests of the community.

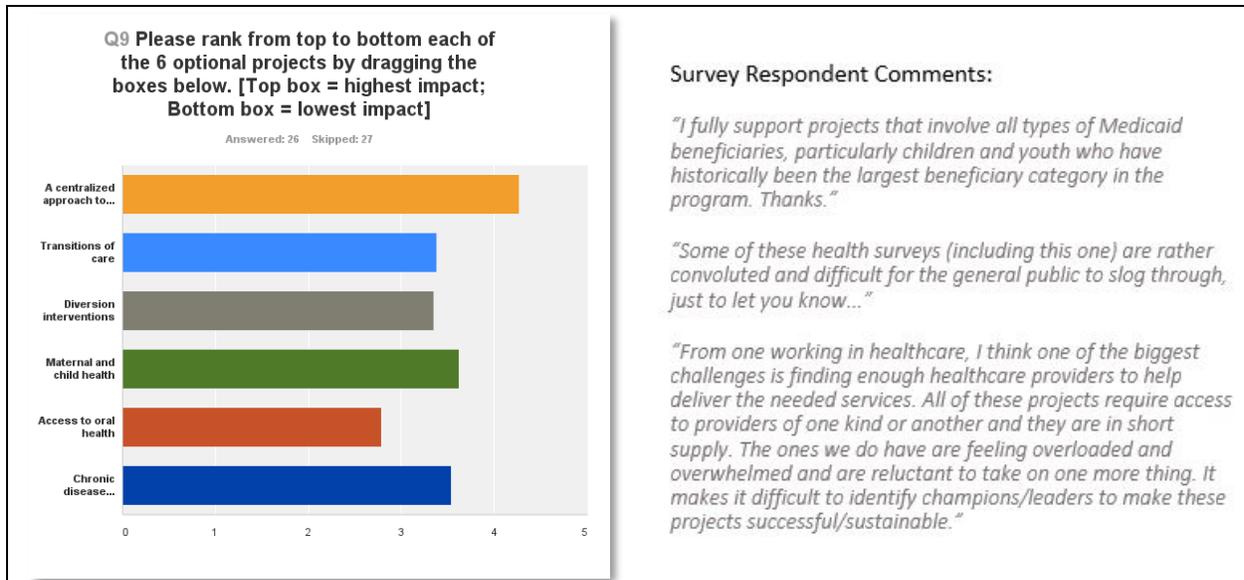
**2. Describe any success the ACH has achieved regarding meaningful community engagement.**

CPAA has successfully engaged diverse community members and community organizations in a number of different ways. There are local community forums in all 7 counties covered by CPAA that bring together a broad range of community members and organizations, often monthly, to learn about CPAA and inform CPAA decision making. Some of these community forums have hundreds of participants. All of the forums are cross-sectoral. CPAA has seen attendance at its council meetings increase consistently to well over 50 individuals at monthly meetings, including a number of guests from throughout the region. CPAA has held consumer focus groups in most of the 7 counties, meeting 23 community members in their home communities and hearing directly from Medicaid beneficiaries. Their testimonials now inform project planning. **We plan to hold more consumer focus groups in the fall to receive feedback on preliminary project designs before implementation planning.** In addition, CPAA has appointed two consumer representatives to its Board and Council, while adding 7 seats to the Council, ensuring enhanced community and consumer voice in decision-making, and we are recruiting at least 9 community members to serve as consumer champions on our Consumer Advisory Committee. Community members are welcome to attend CPAA meetings at all levels, and public comments are solicited at board meetings for agenda items. Public comments and responses are recorded in meeting minutes.

**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?**

CPAA is using cascading levels of community engagement to ensure community member/Medicaid beneficiary input into project selection and planning. Community members/consumers/Medicaid beneficiaries are engaged at the local (community forums) and regional decision-making level (Council and Board) and we are working on their engagement in project work groups. To date, community member/consumer/Medicaid beneficiary input into project selection has occurred primarily through surveys, focus groups, local community forums, and Council/Board participation.

A community/consumer survey was promoted through the CPAA newsletter, community partner newsletters targeting consumers, social media feeds, and word of mouth. Survey respondents prioritized the following Demonstration projects: community care coordination; maternal and child health/chronic disease management; transitional care/diversion interventions; and oral health.



**Survey Respondent Comments:**

*"I fully support projects that involve all types of Medicaid beneficiaries, particularly children and youth who have historically been the largest beneficiary category in the program. Thanks."*

*"Some of these health surveys (including this one) are rather convoluted and difficult for the general public to slog through, just to let you know..."*

*"From one working in healthcare, I think one of the biggest challenges is finding enough healthcare providers to help deliver the needed services. All of these projects require access to providers of one kind or another and they are in short supply. The ones we do have are feeling overloaded and overwhelmed and are reluctant to take on one more thing. It makes it difficult to identify champions/leaders to make these projects successful/sustainable."*

These insights informed the Council and Board during project selection and led to the decision to pursue all 8 Demonstration projects, provided our region has the capacity to develop 8 successful project plans.

Community members/Medicaid beneficiaries also expressed their preferences in consumer focus groups, and organizations serving vulnerable community members participated in community meetings that were held in all 7 counties to prioritize Demonstration projects leading up to formal project selection by the Council/Board. Lastly, two Medicaid beneficiaries participated in the formal project selection process by the Council/Board.

**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.**

In Phase I certification, a lack of clarity for providers on the Medicaid Demonstration and accommodating providers' busy schedules for community meetings were identified as primary challenges. We have worked hard to overcome these barriers. We have shared and reviewed a host of resources with providers, including the final DSRIP Planning Protocol and project plan template. We are also working with providers to help them understand likely funds flows so they can determine their level of commitment to a project area. In addition, we have consulted with providers to determine the best days and times to hold meetings. Many providers prefer Tuesday and Thursday meetings, so we are holding meetings on those days whenever we can. We are also hosting meetings with clinical partners during breakfast and lunch hours to accommodate busy schedules. Additionally, we are making call-in options available for all meetings so partners can participate in meetings without the added cost and time of travel throughout our large region.

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

To CPAA, successful provider engagement is achieved when diverse providers actively participate in collaborative regional health improvement and when the provider voice meaningfully informs the work of the Alliance. Indicators of success include the number of providers that actively participate in CPAA meetings, broad representation of providers from across the region, and sustained, consistent participation. Another key indicator is the degree to which CPAA decisions and actions reflect the needs and interests of providers.

From the very beginning, a broad range of providers from throughout the region has consistently engaged in CPAA’s work. This includes clinical providers (hospitals, clinics, community health centers, behavioral health providers, etc.), as well as social service providers (housing, long-term services, etc.) and public health. Provider engagement occurs at both the local and regional level through participation in local community forums and regional work groups, committees, and Council/Board meetings. At the regional level, more than 30 providers have consistently engaged in CPAA work groups for the last four months, shaping Demonstration project designs.

**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.)**

Recognizing the importance of provider input into project selection and project planning, given their key role as project implementers, CPAA has established a multi-pronged strategy to ensure broad provider participation in both project selection and planning. First, CPAA is using its local community forums in all seven communities to inform decision-making. These forums include a broad range of providers, clinical and otherwise, and all seven forums identified their respective project priorities prior to CPAA project selection. CPAA augmented this information with special meetings with providers in different parts of the region to ascertain project priorities. For instance, in Grays Harbor County, CPAA convened the clinical leaders of two hospitals, including CEOs and Chief Medical Officers, to discuss and prioritize Demonstration projects. At another meeting in Grays Harbor, CPAA discussed the Demonstration projects with behavioral health providers, public health, community health centers, and a tribal health director. The CPAA Council and Board considered this information in their formal project selection.

Second, providers are well represented in CPAA work groups. This includes community health centers, behavioral health providers, family clinics, large and small hospitals, community action agencies, social service providers, public health, and many more. We are undertaking targeted outreach to providers serving large Medicaid populations to ensure their active participation, and all work groups are open to new members at any time. Through these work groups, providers can directly shape project designs.

Finally, providers are able – and encouraged – to provide input through the CPAA website (comment section) and special surveys. CPAA recently released a Request for Qualifications to providers that asks providers to identify preferred projects.

**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)?**

All CPAA meetings, including board meetings, are open to the public unless the board meets in executive session (e.g., to discuss personnel matters). Meeting dates and times are published in advance on the CPAA website. Meeting reminders, including call-in options, are sent by email a week in advance, and again one day in advance, of meetings. Meeting summaries are developed for all CPAA meetings, including board meeting minutes, and distributed within one week. The summaries are shared with a large distribution list (over 300 recipients) and posted on the CPAA website. Council and Board meetings are held the second Thursday of the month in Elma, WA, a central location. Once per quarter, the meeting location rotates to other parts of the region.

**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?**

As detailed above, to maximize meeting participation, CPAA widely announces meeting times and locations, makes meeting materials available at least one week in advance online (CPAA website) and through email, and sends meeting reminder emails. CPAA also rotates council and board meeting locations throughout the region once a quarter and holds board meetings immediately after council meetings on the same day to make it easy for council members to participate and ensure accountability. Council meetings use webinar technology, and board meetings include a call-in option.

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

CPAA follows the same meeting notification standards and practices for special meetings of the board or executive committee (if the board delegates decision making authority to the committee) as for regular meetings. This includes publishing special meeting dates and times on the CPAA website in advance of the meeting, sending electronic meeting reminders a week in advance and one day in advance of the meeting, and making a call-in option available. As with all CPAA meetings, meeting summaries of special meetings are compiled within one week and distributed to our large email distribution list as well as posted on the CPAA website to ensure transparency and accountability. All meetings, including special meetings, are open to the public unless an Executive Session is required.

**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.**

The communication strategy and process for CPAA is centered on communication tools that meaningfully engage communities and partners. This includes a website with bi-directional communication options and broad social media presence.

Bi-Directional Communication Tools	
Enhanced Website	Pertinent Information and Calendar Tool
Monthly eNewsletter	Community Information and Feedback
Facebook	Broad Community Engagement
LinkedIn	Engagement of Professionals
Twitter	Rapid Information Sharing

CPAA is transitioning its website from CHOICE to a standalone website, [www.cpaawa.org](http://www.cpaawa.org). The design of the new website has been completed and provides a more user-friendly experience. The website includes the organization’s purpose, information

on how to get involved and how to provide feedback, and meeting information and materials. A soft launch of the new website is scheduled for mid-August; it will be fully operational by September.

**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
<p><u>Description</u></p> <p>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.</p> <p>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.</p> <p>Identify and address any updates/improvements to the ACH’s Budget and Funds Flow since Phase I Certification.</p>
<p><u>Instructions</u></p> <p><b>Complete the attestations and provide a response to each question. Total narrative word-count for the category is up to 1,500 words.</b></p>
ACH Attestation(s)
<p><b>ACH has secured the primary decision-making body’s approval of detailed budget plan for Project Design funds awarded under Phase I Certification</b></p> <p style="text-align: right;"><input checked="" type="checkbox"/> <b>YES</b> <b>Date of Approval: <u>May 11, 2017</u></b></p>
<p><b>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</b></p> <p style="text-align: right;"><input checked="" type="checkbox"/> <b>YES</b> <b>Date of Approval: <u>July 31, 2017</u></b></p>
Project Design Funds
<p><b>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.</b></p> <p>CPAA’s approach to using Phase I Project Design Funds (P1 Funds) has remained unchanged. In keeping with our application during Phase I certification, we have used P1 Funds as follows:</p> <ul style="list-style-type: none"> <li>• <b>Project Planning and Development:</b> 22% – Salary and Fringe of Executive Director, Program Director, Program Support Specialists, and Operations Management to oversee project planning and development.</li> <li>• <b>Engagement:</b> 15% – Meeting space and personnel expense of Executive Director, Program Director, Program Support Specialists, and Community and Tribal Liaison to engage with community stakeholders and partners including providers, consumers, and tribal officials.</li> </ul>

- **ACH Administration/Project Management:** 11% – Salary and Fringe of Executive Director, Program Director, Program Support Specialists, and Operations Management to oversee the administration of Phase II certification and provide logistical support for meetings.
- **Information Technology:** 17% – Purchase of five new computer workstations and installation of additional wiring in expanded office space.
- **Health Systems & Community Capacity Building:** 9% – Salary and Fringe of Executive Director and Program Director to facilitate work groups that assess capacity gaps within the region.
- **Other:** 25% - Utilities, lease, supplies, travel, office furniture, and minor space improvements.

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

CPAA estimates the cost of administering the Demonstration to total \$7.15 million, excluding \$1 million in expenses covered through P1 Funds. This assumes CPAA engaging in 8 Demonstration projects. CPAA will use larger amounts of Phase II Project Design Funds (P2 Funds) in DY 2, when we anticipate the greatest need for increased administrative capacity to support project planning and implementation. We will use progressively fewer P2 Funds over the subsequent years of the Demonstration. This approach is in line with our commitment to achieve long-term sustainability.

In order to fund the estimated budget gap of \$2.15 million for administrative expenses, CPAA will allocate a small portion of project incentive funds in DY 1 and DY 2 to augment Project Design funds. This will leave 100% of project incentive funds available for distribution to participating providers in DY 3-5.

The attached budget, which the Board approved on July 31, 2017, shows the total estimated cost of the Demonstration, as well as how much will be funded by either P2 Funds or DY 1-2 project incentive funds.

**ACH Project Plan Development** in DY 1 is completely funded by P1 Funds.

**Engagement** throughout the demonstration project will cost approximately \$304,736, of which \$188,320 will be funded with P2 Funds. The funds will pay for a portion of the Community and Tribal Liaison (\$110,623), convening and training of community stakeholders and tribal partners (\$37,200), and outreach and travel throughout the region (\$40,497).

**ACH Administration and Project Management** is expected to cost approximately \$4,336,403 throughout the Demonstration. A total of \$3,097,448 will be funded by P2 Funds. P2 Funds will fund 3.05 FTE of executive and administrative staff, and 8.65 FTE of project management staff to run eight projects. Total personnel cost funded by P2 Funds is \$2,016,015. P2 Funds to administer the Demonstration also include consulting support of \$483,000, technical and clinical training of \$10,000, travel throughout the region to support project partners at \$48,000, legal fees of \$10,000, and contracted administrative services of \$530,433.

**Information Technology** is estimated to cost \$1,138,444, of which \$744,138 will be funded by P2 Funds. This includes 2.8 FTE of analytical and technical staff at \$500,958, improvements in administrative systems for project management and data analysis at \$36,000, and \$207,180 in costs associated with the increase in data capacity for CPAA.

**Health Systems and Community Capacity Building** is expected to cost approximately \$919,407, of which \$600,716 will be funded through P2 Funds. These costs are related primarily to project

management staff engaging with contracted providers to assess capacity gaps throughout the region and develop mitigation strategies.

**Other** expenses include the cost to operate an expanded facility during the Demonstration. Such costs include anticipated utilities and lease expense of \$226,382, Business and Occupation (B&O) taxes on P2 Funds of \$75,000, equipment purchases of \$37,300, and other expenses including insurance, fees, and licenses at \$30,696. P2 Funds will pay for \$369,378 of the total estimated expenses of \$454,808.

**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.**

**Data** investments to date include a contract with Providence CORE to provide enhanced data analysis to inform Phase II certification and project design. CPAA hired a Data Analytics Manager and opened the IT Administrator and Data Analyst positions in July 2017 to establish a CPAA data team.

**Clinical capacity** investments include engaging with clinical subject matter experts and contracting with Health Management Associates to facilitate the project planning process, culminating in the CPAA project plan to be submitted in the Fall of 2017.

**Financial** investments made to date include enhanced accounting capabilities by upgrading the existing accounting system, hiring an Administrative Support Specialist to strengthen existing financial controls, and increased engagement of the Operations Director and contracted accounting firm of Wittenberg, CPA to assist with budget methodology and development. Also, CPAA will be working closely with Manatt and Health Management Associates to develop a payment methodology to pay participating providers.

**Community Engagement & Program Management** investments include the hiring of a Community and Tribal Liaison in July 2017, a Bi-Directional Care Integration Program Manager in August 2017, and an Opioid Response Program Manager who will start in September 2017. The remaining project managers are expected to be hired by October 1, 2017.

**Strategic Development** investments to date include engaging Health Management Associates for project planning and facilitation. CPAA has also expanded office space to accommodate new staff.

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

Finance Committee worked with management to develop both Phase I and II budgets. The committee then recommended to the Board approval of the proposed budgets prior to submission of Phase I and II applications. The Board approved the budgets after discussion.

Management reviews monthly financial statements to track expenses against the budget. Each quarter, Finance Committee reviews quarterly financial statements against the budget. Expenditures over set thresholds as defined in the authorization matrix receive the appropriate levels of approval, i.e., expenditures not included in the budget and expenses over \$5,000.

Day-to-day expenses are approved by the program/project manager prior to purchasing goods or services. Invoices and receipts are coded to the correct funding source and project, and later entered into the agency's accounting system, MIP. Monthly reconciliations are performed.

**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.)**

CPAA began exploring funds flow structures and methodologies in May 2017, when Oregon Health Science University (OHSU) presented an overview of Demonstration funding mechanics and funds flow to the Council. Following this introduction, the Council learned about different options to structure partnering provider payments in July during a webinar by KPMG. Since then, management and a member of the Finance Committee participated in a follow-up conversation with OHSU. The Council held a shared learning session on funds flow design in August, which set the stage for a deeper exploration of Project Incentive fund planning. CPAA will work with Manatt and Health Management Associates to develop a proposed funding and allocation methodology for review and approval by the Council and Board prior to project plan submission this fall.

**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).**

CPAA receives annual funding of \$262,880 from the Washington State Department of Health to administer the regional Youth Marijuana Prevention and Education Program. The project aligns well with the Demonstration -- the Opioid response project in particular will be able to build on the solid partner relationships established through this program.

CPAA receives \$220,000 in SIM funds annually from the Washington State Health Care Authority. These funds support CPAA operations as well as CPAA programming, in particular, the Youth Behavioral Health Care Coordination pilot project. SIM funding is leveraged with \$87,000 in pilot project support from the Cambia Health Foundation. SIM funding aligns well with the Demonstration. Pilot project funding aligns well with the community-based care coordination project under the Demonstration.

**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.**

CPAA has attracted a broad range of in-kind support:

**Data:** Key stakeholders and partners have shared service data during project planning. For instance, Sea Mar shared medical utilization data, Cowlitz has shown top 911 calls, and the Adverse Childhood Experiences Mitigation work group has catalogued current home visiting programs in the region.

**Clinical:** Clinical partners have provided guidance on clinical job descriptions, provider engagement strategies, and project plan design.

**Financial:** Members of the Finance Committee have provided guidance on budgeting, financial modeling, and expenditure approval. KPMG provided a training to the Council at no cost that focused on provider funds allocation methodologies. The value of this training is estimated at \$840.

**Community and Program Management:** Work groups, committees, and community forums across 7 counties meet, often monthly, to advise on decision-making and project planning. To support these meetings, various partners in the region donate meeting space. The value of donated in-kind space is approximately \$6,140 per year. Additionally, Healthy Living Collaborative, Mason General Hospital, Sea Mar, Mason Matters, Cowlitz Family Health, and Thurston Thrives have each assisted with recruitment of Medicaid beneficiaries.

**Strategic Development:** Community forums, committees, and work groups also support this strategic area. The CHOICE Board approved the spending of approximately \$30,000 to provide legal expertise to establish the CPAA ACH LLC. Additionally, CHOICE executive leadership has provided hundreds of hours in-kind to support CPAA development.

#### 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.**

<b>Clinical Capacity – 15 points</b>	
<u>Description</u>	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.
<u>Instructions</u>	<b>Provide a response to each question. Total narrative word-count for the category is up to 1,250 words.</b>
<b>Clinical Expertise</b>	
	<b>1. Demonstrate how clinical expertise and leadership are being used to inform project selection and planning to date.</b>
	<p>CPAA has adopted a multi-pronged strategy to engaging clinical providers and ensuring that clinical expertise and leadership is being used to inform project selection and planning. First, clinical providers are engaged at all levels of “cascading” governance, i.e., at the local level (county-based community forums), in project work groups and committees, and at the regional decision-making level (Council and Board). Second, CPAA is establishing a Clinical Provider Advisory Committee composed of clinical providers from throughout the 7-county region and different provider types (urban/rural; small, mid-sized, and large facilities; administrators and frontline providers; primary care providers and specialists; etc.). This committee is tasked with the following:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <div style="background-color: #005596; color: white; padding: 5px; border-radius: 10px; margin-bottom: 10px;"> <b>Clinical Provider Advisory Committee</b> </div> <ul style="list-style-type: none"> <li>Providing advice and clinical oversight for specific projects;</li> <li>Assessing clinical implications and feasibility of work group products;</li> <li>Ensuring alignment, coordination and integration of clinical strategies across work groups;</li> <li>Providing input on project design;</li> <li>Overseeing provider engagement activities;</li> <li>Assessing workforce and value-based purchasing implications of project plans;</li> <li>Serving as liaison with local and state clinical provider organizations.</li> </ul> </div> <div style="width: 35%; padding-left: 20px;"> <p>Third, CPAA is using Provider Champions to ensure clinical expertise is included in all work groups during project planning and implementation. Fourth, CPAA is engaging frontline</p> </div> </div> <p>providers in project selection and planning using Provider Champions, the lead administrators, and chief medical staff of clinical provider organizations (CEOs, CMOs, COOs, and CQOs) as a conduit to reach these providers. See Question 3 for details.</p>
	<b>2. Discuss the role of provider champions for each project under consideration.</b>
	<p>CPAA is using Provider Champions to ensure clinical expertise is included in all work groups during project planning and implementation. In our region, these champions come from a variety of clinical backgrounds and include frontline clinical providers (e.g., physicians and nurses), executive leaders (CMOs, CQOs, etc.), and allied health professionals. Provider Champions are forming the core of CPAA’s Clinical Provider Advisory Committee.</p> <p>Our Provider Champions are playing a crucial role in project design. They ensure that projects are feasible from a clinical perspective, integrate well with existing workflows and leverage existing clinical infrastructure, improve care delivery, and are patient-centered. They also play an important</p>

bridging function between CPAA and the broader clinical provider community. Through their professional networks, Provider Champions are able to confirm project designs with peers and help with the recruitment of providers into work groups.

In recruiting Provider Champions, CPAA is guided by the following principles: (1) subject matter expertise relevant to project area; (2) willing and able to work in a team environment; (3) diversity of perspectives (rural/urban; large or mid-sized clinic/independent provider; administrator/mid-level/frontline provider; primary care/specialty care/oral health/behavioral health; traditional clinical provider/allied health professional); (4) experience working with Medicaid beneficiaries; and (5) geographic diversity (representation from all 7 counties).

### 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.**

A broad range of clinical providers has helped with both project selection and project planning. This includes providers serving on the decision-making body and many others who do not serve in this capacity. For instance, CPAA brought together clinical providers in Grays Harbor County, including administrative and clinical leaders (CEOs and CMOs/CQOs) from Grays Harbor Community Hospital and Summit Pacific Medical Center, to assess and prioritize Demonstration projects. Similarly, the leaders of eight rural and urban hospitals in the CPAA region, along with the CEOs of two Community Health Centers, Providence Medical Group, Behavioral Health Resources, and five public health departments, have provided ongoing advice on project selection and planning, including provider engagement. All are committed to help with project planning; several of these leaders are participating in project work groups. Additionally, Phyllis Cavens, MD, a pediatrician with Child and Adolescent Clinic of Longview and lead pediatrician of the CMS grant Pediatric Transforming Clinical Practice Initiative, has provided advice on project selection and design, especially around care coordination and maternal and child health. Tammy Moore, Doctor of Nursing Practice and CCO at Summit Pacific Medical Center, has helped with selecting the target population for Pathways and ensuring alignment with value-based purchasing. Kevin Haughton, MD, a family physician with Providence Medical Group, has led care coordination planning and is now assuming a lead role in our bi-directional integration project planning which is bringing together key clinical providers in the CPAA region. These are just a few examples of a long list of clinical providers who are providing input in CPAA project selection and planning, some in the capacity of work group provider champions.

#### **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.**

CPAA is using several different strategies to assess the regional clinical capacity to implement selected projects: (1) We have issued a Request for Qualifications (RFQ) to providers in our region. The RFQ asks providers to identify which selected projects they are interested in, what existing infrastructure can be leveraged, and what additional capacity is needed to successfully implement selected projects. (2) We are partnering with the VBP Task Force and the DOH Practice Transformation Hub to assess provider readiness, e.g., through provider surveys. (3) We are using the work of the Sentinel Network to identify likely clinical capacity gaps. (4) We are using the CHOICE Board, which combines key providers across a 5-county region, to identify clinical capacity gaps. Gaps identified to date include workforce challenges, such as recent allied health graduates not being trained to perform accurate coding in quickly evolving EMRs, and workflow changes tied to team-based medicine that challenge clinical staff who have historically practiced in more segregated domains. A broader clinical capacity gap is linked to low Medicaid rates that prevent adding RNs and MSWs to the clinical care team.

Strategies to address these gaps include on the job training and management making time for busy frontline staff to reorganize themselves in teams. Increasing Medicaid rates will require policy changes.

**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).**

CPAA is working closely with local and state clinical provider associations. Our Provider Champions provide an effective link to their respective organizations and associations. At the state level, CPAA has actively and consistently engaged with both WSHA and WSMA, as well as the HILN, to understand provider needs and explore cross-ACH approaches to key project areas, such as care coordination, bi-directional integration, and opioid response. We are using project-planning templates developed by WSHA as a starting point for CPAA project planning for bi-directional integration and opioid response, and we are exploring WSHA's QBS system as a potential project reporting tool. We are working with WSMA to recruit WSMA sentinel network members in our region as core clinical partners for our project work groups.

**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.

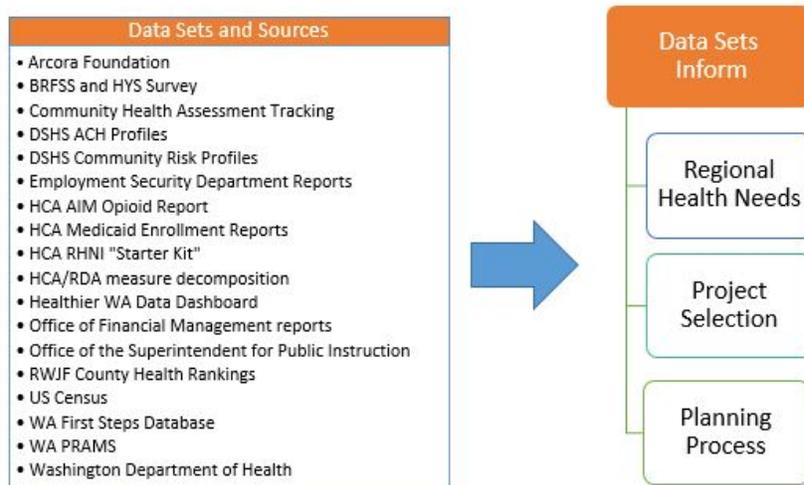
### Instructions

**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.

CPAA has used a wide range of datasets and data sources to identify regional health needs and inform project selection and planning:



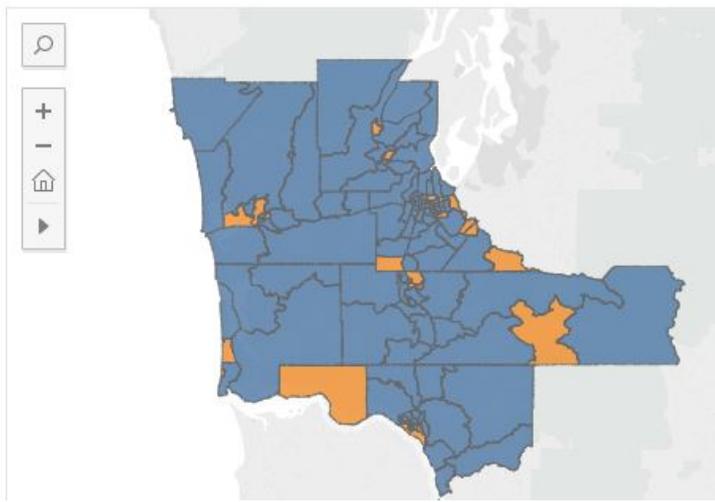
To aid with project selection, CPAA also gathered primary data through community surveys, provider focus groups, and local community meetings in all 7 counties.

### 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.

CPAA used these data initially to identify and then focus aligned action (e.g., Youth Behavioral Health Care Coordination Pilot) on 5 regional health priorities: Increase Healthcare Access, Integration and Coordination of Care, Chronic Disease Prevention and Management, Prevention and Mitigation of Adverse Childhood Experiences, and Enhancing Economic and Educational Opportunities. More recently, we have been using the data to help develop strategies under the Demonstration that align with these regional priorities.

This data, along with recommendations from work groups, community meetings, and a community survey, then informed the selection of Demonstration projects. The data confirmed the need for the CPAA’s focus on youth as a primary target population, given the vast room for improvement for many child health indicators (immunizations, dental care, obesity, teen pregnancy, etc.).

Mortality CPAA by Census Tract 2006 - 2015



*Areas in orange represent highest rate of mortality by county.*

The data also informs our project work groups (WGs) in the selection of target populations and sub-regions. For instance, while initially leaning toward focusing care coordination on individuals with diabetes as a precursor for more severe and costly conditions and in line with CPAA’s early intervention focus, after analysis of the data, the Care Coordination WG selected pregnant women and individuals with cardiac disease as the highest need population in the region. All WGs are using mortality data by US Census Tract (and other data) as a proxy for identifying health disparities and identifying sub-regions for focused interventions. To guide our

WGs, we also use tools generated by CORE that crosswalk project outcome measures, data sources, and interventions. This will ensure that designs for chosen projects will meet outcome goals.

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

While HCA is providing access to claims data, significant gaps persist. Following is a summary of data and analytic gaps identified to date and steps taken or planned to address these gaps:

Gap Identified	Steps Taken	Next Steps
Access to cost data to perform cost-benefit analyses for different interventions and target populations, and determine financial implications for providers.	Requested cost data from both state and MCO partners.	Review funds flow calculator to understand potential funding available for partners.
Inventory of existing community assets to leverage in project design.	Work groups performing project specific asset mapping (e.g., Care Coordination, Opioid Response, and Diversion WGs).	All work groups to perform asset mapping; update regional health asset inventory.
Provider readiness assessment for project implementation.	Request for Qualifications sent to providers asking about readiness to implement projects and distribution of VBP provider survey.	Review RFQ responses to assess provider capabilities and gaps; work with Qualis Health/ Practice Transformation Hub to assess provider readiness; review VBP survey results.
Granular data broken out by age/gender/income/geography specially for: <ul style="list-style-type: none"> <li>• Teen pregnancy</li> <li>• Obesity</li> <li>• Mental Health</li> <li>• Chemical dependency</li> </ul>	Working with CORE and potential partnering providers to fill data gaps.	Teen pregnancy: Explore whether local health department partners can fill data gaps.
Internal data analytics capacity	Hired Data Manager, and contracted with CORE for strategic data support.	Build internal capacity to help overcome data and analytics gaps; exploring data partnerships with other ACHs (see Questions 4 and 6).

### Data-related Collaborations

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

CPAA is exploring partnership opportunities with other ACHs around data-related activities. CPAA has entered into a contract with CORE to augment existing CPAA data capabilities and advise on the development of an effective, sustainable data strategy. CORE is assisting other ACHs with meeting their data needs as well, and the ACHs have shared with each other data products developed by CORE, such as a crosswalk of Demonstration outcome measures and project areas.

CPAA has taken the lead on exploring whether the Quality Benchmarking System (QBS) that the Washington State Hospital Association (WSHA) has developed could serve as a tool for ACHs to track clinical provider performance data. We have participated in multiple conversations with WSHA and a number of ACHs to explore this option.

Additionally, we are exploring a data partnership with King County. We had an initial conversation with the King County Public Health Department to assess what data analytics capabilities King County could make available to augment CPAA's capacity around local performance measurement. We are now preparing a more in-depth discussion with both King County and CORE to determine how we can best work together to ensure data investments are aligned across ACH regions and maximize sustainability.

This dovetails with CPAA's participation in a cross-ACH partnership around aligning performance measures, data interoperability, and data governance for data products provided by the state, led by Olympic ACH (OCH). CPAA is committed to working with other ACHs to align data investments to the

greatest extent possible in order to ensure consistent data protocols that allow comparison across ACH boundaries and maximize long-term sustainability of our data infrastructure.

**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.**

CPAA has extensively used its partnerships with a broad range of community partners in preparing the selection of Demonstration projects. This has included obtaining data from clinical and social service providers to assess the different project options. For instance, CPAA held a series of meetings in all 7 counties, bringing together clinical and social service providers and other stakeholders, to assess local health needs and priorities.

CPAA is also reaching out to community partners to collect data and leverage existing analytical infrastructure for project planning. For instance, we have asked MCOs to provide cost data that would assist CPAA in selecting the preferred target population/s for community-based care coordination. Similarly, we have asked a wide range of other community partners to share their data on available services in an effort to map our region’s assets in different project areas. We are either in the process of gathering this data from our community partners or have already obtained such information for the following project areas: care coordination services, paramedic services, opioid response and substance use disorder services, and services aimed at mitigating the effects of ACEs. We are preparing similar asset mapping activities for all other project areas. The response of our community partners has been very positive to our requests for data sharing and assistance with data analytics, and we plan to make data sharing and engaging with the regional data team a requirement for participating providers.

**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.**

With Phase I Design Funds now being available, CPAA is making strategic investments to expand its data capabilities. This includes hiring a Data Analytics Manager (completed) and Data Analyst (pending). Identifying data or data system requirements needed to implement Demonstration project goals is a primary responsibility of these positions. CPAA is working closely with key provider partners, including statewide partners, such as the WA State Hospital Association (WSHA), and major health systems (e.g., Providence), community health centers, and other clinical and social service providers that are likely to partner with CPAA in the Demonstration. A first step is assessing what data systems are currently being used by these community partners and what, if any, interoperability exists between these systems. This assessment will begin September 1, 2017, and will be ongoing. Data sharing capabilities are vital to the success of the Medicaid Demonstration, especially for Domain 2 activities. We plan to continue working closely with the state’s AIM Team and other ACHs to facilitate interoperability and consistent data gathering and analysis. We also plan to leverage existing data collection and exchange initiatives and tools to the greatest extent possible, such as the Clinical Data Repository, One Health Port, Pre-Manage/EDIE, etc. It is vital for CPAA to define provider data and data system requirements early on to determine the feasibility of Demonstration projects, to guide our partners’ investments in data systems, and to direct the CPAA’s investments in the region’s data infrastructure. While CPAA has only begun to discuss potential funds flows to participating providers, one idea under consideration is to incentivize infrastructure investments that would maximize long-term sustainability of Demonstration projects.

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

CPAA will need to put systems into place to effectively and efficiently oversee and monitor the performance of individual participating providers and the achievement of Demonstration project goals overall. We have begun to look into different Customer Relationship Management (CRM) tools in partnership with other ACHs, most notably OCH. One such system under consideration is Salesforce. We are also assessing to what degree the Quality Benchmarking System that WSHA has pioneered may be useful for this purpose. Essential to our choice of a CRM tool will be ease of use and the ability to verify provider performance independently. We are exploring if efficiencies can be gained by aligning data and data systems across ACHs (see Question 4).

CPAA plans to establish a planning group to assess which data or data systems are required to oversee and monitor demonstration project goals. The group will be supported by the Data Analytics Manager and Data Analyst and include external strategic data partners (CORE, WSHA, key participating providers, and possibly King County). The group will begin its work in September 2017.

A key consideration will be the ease with which data can be entered and shared between providers and CPAA. Our provider partners consistently articulate concerns about costly administrative requirements for performance reporting and monitoring. CPAA will build upon existing data reporting infrastructures and processes to the greatest extent possible. For instance, this could include leveraging EDIE/Pre-Manage to share care information across a continuum of providers. Again, aligning reporting requirements across ACHs will be crucial to gain efficiencies.

**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.**

In designing Demonstration projects, a key consideration will be to what extent there is a sufficient workforce in the region to implement the projects. Based on community conversations to date, a number of projects will require additional workforce capacity, e.g., for behavioral health integration and care coordination. In their project planning, each work group is assessing existing capacities (asset mapping) and identifying capacity gaps, including workforce needs. Each work group is identifying strategies to close existing gaps, and the identified gaps and strategies are synthesized by the CPAA Support Team to arrive at a set of mutually reinforcing strategies.

Given the complex, systemic nature of workforce development and the considerable investment required, many workforce development strategies (e.g., training of new professionals, credentialing or certification, or workforce extension through technology/telehealth) will require coordination between ACHs and with statewide workforce development initiatives. As a first step, we are entering into a partnership with Greater Columbia and OCH to assess shared workforce capacity gaps and establish cross-ACH workforce development strategies. A corresponding cross-ACH work group is being formed now.

In this work, we are seeking to leverage existing workforce development infrastructure and programs to the greatest extent possible. CPAA will begin with an assessment of available statewide resources partnering with HCA’s Healthier WA workforce expert Suzanne Swadener. We will also contact key partnering providers (e.g., large health systems) to determine what workforce development support they can provide in furtherance of Demonstration projects. We anticipate that CPAA will have completed a comprehensive assessment of workforce development resources and identified priority workforce development strategies in support of all chosen Demonstration projects by June 2018.

**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 1,000 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.**

At their June 2017 meeting, using extensive data from multiple sources and recommendations from local community forums, work groups, its support team, and community surveys, the Council and Board decided to pursue all 8 Demonstration projects not only because they meet our region’s health needs, but also because the projects are highly interconnected. CPAA has received consistent feedback from providers that Domain 2 activities in particular are logically connected and synergies could be gained by addressing these projects in an integrated way.

To ensure the development of an aligned project portfolio, CPAA is employing several strategies:

Strategies for Alignment
<ul style="list-style-type: none"> <li>• We are using the CPAA Support Team to coordinate the work of our project work groups. The Support Team includes the Chairs of all work groups, thus serving an integrative function.</li> <li>• CPAA is establishing a Clinical Provider Advisory Committee. This committee is charged with providing clinical oversight over all project work groups and ensures that the project approaches are both feasible and coordinated across projects.</li> <li>• CPAA is establishing a Consumer Advisory Committee, to ensure that all project approaches are responsive to consumer needs and building off each other from a consumer perspective.</li> <li>• Both the broad-based Council and Board will have ultimate responsibility for ensuring alignments of projects into an integrated portfolio.</li> </ul>

**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.**

CPAA is working with other ACHs to coordinate project development and alignment.

Rationale for Cross-ACH Collaboration for Project Design and Implementation		
CPAA shares clinical services areas with neighboring ACHs	CPAA has much in common with other rural ACHs	ACHs can potentially increase impact and leverage limited resources through joint investments

Examples of the latter include investments in Domain 1 activities, especially workforce development and strategic data partnerships. Aligned data infrastructures and data analysis capabilities are

<p>essential to compare outcomes across regions and crucial to the long-term sustainability of the Demonstration. Similarly, all ACHs share workforce shortages, which require a coordinated approach across ACHs to resolve. Aside from Domain 1 activities, to date, CPAA has partnered with other ACHs, primarily in the development of community-based care coordination (Pathways) and opioid response. For Pathways, we have partnered with BHT and the Pierce ACH to learn from their project development efforts. On opioids, we have worked with OCH to assess potential strategies. We anticipate increasing our partnerships with other ACHs in project development as other regions finalize their project portfolio.</p>
<p><b>3. Demonstrate how the ACH is working with managed care organizations to inform the development of project selection and implementation.</b></p>
<p>MCOs participate at all levels of CPAA’s cascading governance, including the Council and Board, support team, and work groups. A MCO representative chairs the ACEs Work Group, and MCO representatives are active in all work groups. We anticipate that MCOs will remain actively engaged at all levels of governance during project implementation, including the monitoring of CPAA performance. This will be vital, given their role as payers. Understanding the needs and interests of our MCO partners and keeping them engaged – similar to our participating providers – is crucial to ensure the long-term sustainability of our projects. We intend to deepen our partnership with MCOs by inviting clinical representatives from MCOs to serve on the Clinical Provider Advisory Committee and engaging MCOs in project implementation as appropriate.</p>
<p><b>Project Plan Submission</b></p>
<p><b>4. What risks and mitigation strategies have been identified regarding successful Project Plan submission?</b></p>
<p>There are a number of risks associated with successful project plan submission, mainly the short timeline to complete project planning. While we cannot extend the time available for project planning, we have devised creative strategies to maximize the efficiency of the project planning process. For instance, we are grouping most of Domain 2 project planning; i.e., work groups convene on the same day so stakeholders can attend multiple work groups without excessive travel times. This will also support aligning planning across project areas.</p> <p>Another area of risk centers on adequate project planning support. Staffing 8 work groups is labor intensive. With Design Funds now available, CPAA is staffing up as quickly as possible. However, finding qualified staff takes time. CPAA is mitigating this risk by engaging assistance from consultants to extend internal capacity.</p>
<p><b>5. Demonstrate how the ACH is identifying partnering providers who cover a significant portion of Medicaid beneficiaries.</b></p>
<p>CPAA is working with both the AIM team and CORE to identify providers that serve large numbers of Medicaid beneficiaries in the CPAA region.</p>
<p><b>6. What strategies are being considered to obtain commitments from interested partnering providers? What is the timeline for obtaining these commitments?</b></p>
<p>In August, CPAA issued a <i>Request for Qualifications</i> (RFQ) for interested providers in the region, which outlines project requirements. We anticipate that many of the providers responding to the RFQ will commit to becoming partnering providers by November; we will immediately engage interested providers in our project planning.</p> <p>For providers to make this commitment, CPAA needs to develop a preliminary partnering provider compensation model. At the July Council meeting, KPMG presented on different funds flow design</p>

options. This webinar was followed in late July by a meeting with Dan Vizzini from Manatt, who presented on funds flow design to the Council in May, and the CPA firm that is advising CPAA on finances, to begin framing out potential partnering provider payment models. CPAA plans to partner with OCH and Greater Columbia ACH to develop a more robust funds flow design this fall, in time for partnering provider commitments for the project plan application in November.

**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 anticipate a broad range of providers will respond to the RFQ. However, if responses to the RFQ are limited to particular provider types, CPAA will actively reach out to missing provider types to ensure a well-rounded partnering provider pool that includes a broad spectrum of care and related social services. We will use our Clinical Provider Committee and Support Team to first identify the right mix of providers and then, in the event of missing provider types, assist with targeted outreach to those missing organizations. The CHOICE Board, which is composed of many different provider types, may also be a good avenue to effectively engage missing providers. Emphasis will be placed on providers that serve large numbers of Medicaid beneficiaries.

**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.**

Project sustainability is a key consideration in the design of CPAA project plans. CPAA has adopted a portfolio approach to its project design activities by establishing mutually reinforcing and complementary project designs within and across project domains. Consequently, we are looking to focus investments on aligned interventions, shared resources, and shared infrastructure across projects. For instance, it will be crucial to make investments in *shared* HIT/HIE capabilities and *strategically aligned* investments in workforce development across projects to meet the workforce demands of all projects.

Similarly, it will be important to not only align performance metrics across projects to the greatest extent possible, but to establish a regional performance measurement infrastructure that builds on existing resources. To this end, we plan to convene our key stakeholders and partners to assess what existing data gathering and analysis capabilities in our region could be enhanced through strategic investments by CPAA to meet the region’s information needs.

Additionally, we plan to pay close attention in our project design to alignment with the needs and the existing infrastructure and workflows of payers (especially MCOs) and provider systems. Financial sustainability will only be achieved if both payers and providers integrate the projects into their respective organizations.

**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	
<b>Theory of Action and Alignment Strategy</b>	
None	
<b>Governance and Organizational Structure</b>	
<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.
<b>Tribal Engagement and Collaboration</b>	
<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>
<b>Community and Stakeholder Engagement</b>	
<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.
<b>Budget and Funds Flow</b>	
<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.
<b>Clinical Capacity</b>	
<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>
<b>Data and Analytic Capacity</b>	
None	
<b>Transformation Project Planning</b>	
<input checked="" type="checkbox"/>	A. Initial list of partnering providers or categories of partnering organizations interested in or committed to implementing projects.

<b>Recommended Attachments</b>	
<b>Theory of Action and Alignment Strategy</b>	
<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>
<b>Governance and Organizational Structure</b>	
<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 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.
<b>Tribal Engagement and Collaboration</b>	
<input checked="" type="checkbox"/>	C. Statements of support for ACH certification from every ITU in the ACH region.
<b>Community and Stakeholder Engagement</b>	
None	
<b>Budget and Funds Flow</b>	
None	
<b>Clinical Capacity</b>	
None	
<b>Data and Analytic Capacity</b>	
None	
<b>Transformation Project Planning</b>	
None	