

Phase II Certification Submission Template

ACH Phase II Certification: Submission Contact	
ACH	Greater Columbia Accountable Community of Health (GCACH)
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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.

GCACH's regional vision is that we become a vibrant, healthy community in which all individuals, regardless of their circumstances, can achieve their highest potential. To reach this vision, GCACH's mission is to advance the health of our population by decreasing health disparities, improving efficiency of health care delivery, and empowering individuals and communities through collaboration, innovation, and engagement.

With funding from the Demonstration, GCACH is engaging community-led, cross-sector and region-wide collaboration to design transformation projects that promote prevention, build health system capacity to deliver care more effectively, focus on person-centered whole person approaches, support clinical-community linkages, and are accountable through measurable health outcomes. With up to \$119 million in incentive payments tied to ACH projects, GCACH recognizes the imperative to design and implement a portfolio of projects that will collectively achieve measurable improved health outcomes and contribute to the cost-savings necessary to support a sustainable health system transformation. If our efforts are successful, the GCACH region will see measurable improved health outcomes, decreased health care spending, and advancement toward the Quadruple Aim.

Beyond the five-year Demonstration, GCACH envisions our role continuing as a backbone organization supporting cross-sector and region-wide collaboration around regional health priorities. This role may also include continued support in areas such as data analytics, performance monitoring, broad community engagement, and region-wide communications.

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

The GCACH region is a largely rural community that covers nine counties and the Yakama Nation, 15,000 square miles, and has a population of approximately 703,000 people. Compared with the rest of the state, the population is more rural (23%), has higher rates of poverty (19.5%), has a higher percentage of its population enrolled in Medicaid (35%), and a higher percentage of its population that is uninsured (18%). The region is culturally and racially diverse, with a higher proportion of Hispanic (26%) and Native American (14%) populations than the statewide average, as well as a large migrant seasonal farmworker population (20%).

To evaluate regional health needs, we reviewed national, state, and local data sources, and identified significant health needs across all eight project areas outlined in the Healthier Washington Toolkit. GCACH has found significant variation in health indicators across the nine counties in the region, as well as health disparities experienced by Native American and Hispanic populations. This points to the need for projects with the flexibility to target unique local community needs as well as the importance of bi-directional communication with Native American and Hispanic communities to ensure that together we design effective programs.

As an overall region, key health indicators related to diabetes, obesity and teen pregnancy suggest areas for improvement. Our data also indicate other areas for region-wide improvement including emergency department usage, well-child visits, anti-depressant medication management, and adult immunizations.

Greater Columbia ACH Differentiations		
Characteristics	Statewide	GCACH
Rural	18%	23.3%
Hispanic/Latino	11.2%	26.4%
American Indian/Alaska Native	1.2%	14.3%
Less than high school graduate	10%	19.2%
Non-Citizen	7.1%	10.0%
Limited English proficient	7.9%	13.5%
Migrant Seasonal Farmworker	4.1%	19.6%
Uninsured	13.5%	18.2%
Medicaid Insured	26%	34.7%
Below Poverty	12.9%	19.5%

Social, Economic and Health Risk Factors - GCACH

	Asotin	Benton	Columbia	Franklin	Garfield	Kittitas	Walla Walla	Whitman	Yakima	WA State	Graph
County Demographics											
Population	22,105	190,209	3,944	88,807	2,219	43,269	60,338	48,177	248,830	7,170,351	
% below 18 years of age	20.7%	26.7%	18.5%	33.1%	19.8%	17.8%	21.4%	15.0%	29.8%	23%	
% 65 and older	21.2%	13.8%	27.4%	8.3%	25.1%	15.1%	16.9%	10.0%	13.1%	14%	
% American Indian and Alaskan Native	1.6%	1.2%	1.6%	1.5%	0.5%	1.2%	1.4%	0.8%	6.2%	2%	
% Hispanic	3.8%	21.0%	6.9%	52.4%	5.2%	8.9%	21.6%	5.9%	48.3%	12%	
% Non-Hispanic white	91.0%	71.5%	87.9%	41.5%	91.3%	84.1%	72.1%	79.6%	44.3%	70%	
% not proficient in English	0.3%	4.0%	0.9%	14.1%	0.2%	1.3%	4.3%	1.3%	11.1%	4%	
% Females	51.5%	49.8%	50.3%	48.1%	50.6%	49.7%	48.8%	49.1%	50.0%	50%	
% Rural	6.7%	10.6%	34.3%	13.3%	100.0%	40.1%	17.1%	27.5%	23.5%	16%	
Social & Economic Factors											
Median household income	\$ 46,573	\$ 62,698	\$ 40,209	\$ 58,246	\$ 47,087	\$ 47,378	\$ 50,120	\$ 43,817	\$ 46,891	\$ 64,100	
Income inequality	4.4	4.5	4.3	3.9	3.9	5.4	4.7	7.2	4.0	4.5	
Unemployment	5%	7%	6%	8%	6%	6%	6%	5%	8%	6%	
High school graduation	67%	79%	N/A	75%	N/A	82%	80%	87%	73%	81%	
Children in poverty	24%	20%	25%	21%	22%	16%	21%	14%	27%	16%	
Children: free or reduced price lunch	54%	52%	56%	74%	47%	44%	57%	35%	76%	46%	
Children in single-parent households	34%	31%	20%	34%	23%	25%	32%	25%	39%	29%	
Social associations	11.3	9.0	15.1	6.7	13.5	9.6	9.0	10.5	8.5	9.0	
Violent crime	235	214	81	237	177	116	215	148	298	290	
Injury deaths	75	54	80	38	N/A	65	71	43	63	61	
Health Behaviors											
Adult smoking	16%	14%	17%	16%	16%	16%	15%	16%	17%	15%	
Adult obesity	33%	32%	30%	30%	33%	29%	28%	23%	30%	27%	
Food environment index	7.4	7.9	6.8	7.7	4.4	6.4	7.5	5.9	8.1	7.6	
Physical inactivity	22%	19%	22%	17%	28%	17%	20%	16%	24%	17%	
Access to exercise opportunities	73%	82%	66%	55%	74%	72%	76%	78%	69%	88%	
Excessive drinking	18%	20%	15%	19%	18%	19%	20%	21%	17%	18%	
Alcohol-impaired driving deaths	60%	24%	100%	28%	0%	31%	16%	27%	50%	35%	
Sexually transmitted infections	325.6	358.8	223.2	496.3	221.6	399.9	324.2	672.1	613.7	381.2	
Teen births	40	36	25	60	N/A	9	28	4	59	26	
Food insecurity	19%	12%	19%	9%	13%	17%	13%	20%	12%	14%	
Limited access to healthy foods	5%	4%	10%	12%	36%	10%	7%	8%	5%	5%	
Drug overdose deaths	N/A	14	N/A	7	N/A	11	19	8	9	14	
Clinical Care											
Uninsured	11%	11%	12%	18%	9%	12%	14%	10%	18%	11%	
Primary care physicians ratio	1,057	1,413	996	3,252	2,215	1,575	798	1,511	1,432	1,190	
Dentists ratio	2,211	1,475	1,315	2,537	2,219	2,704	1,341	2,834	1,595	1,270	
Mental health providers ratio	381	570	563	925	2,219	709	434	753	431	360	
Preventable hospital stays	33	47	38	41	37	47	25	43	45	33	
Diabetes monitoring	84%	86%	86%	87%	86%	90%	88%	88%	88%	86%	
Mammography screening	66%	65%	43%	61%	77%	62%	63%	60%	59%	61%	
Outcomes											
Premature death	6,714	5,239	8,170	4,898	N/A	5,106	6,530	4,868	7,106	5,500	
Poor or fair health	16%	14%	16%	21%	14%	15%	16%	16%	24%	14%	
Poor physical health days	4.1	3.5	4.0	4.0	3.7	3.7	3.9	4.1	4.5	3.6	
Poor mental health days	3.8	3.5	3.9	3.9	3.7	3.8	3.6	4.1	4.1	3.7	
Diabetes prevalence	13%	10%	12%	7%	14%	8%	10%	7%	10%	9%	

Source: 2017 RWJF County Health Rankings

2017 Master County Tables B Present

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

Since 2014, GCACH has employed a two-pronged strategy to support regional health needs: 1) data-driven evaluation of regional and county-level health needs, and 2) broad cross-sector, region-wide collaboration and engagement to develop solutions addressing these needs. Prior to the Demonstration, GCACH engaged an 18-month regional, community-based process to evaluate local, state, and national data sources examining key health indicators in our region. This work resulted in the formation of five Priority Work Groups (PWGs) to address the region's most pressing health priorities: Care Coordination, Diabetes/Obesity, Behavioral Health, Healthy Youth & Equitable Communities, and Oral Health.

With the approval of Washington's Medicaid 1115 waiver, the original five PWGs evolved into eight Project Teams (PTs) aligned with our identified regional needs and the Healthier Washington Toolkit.

GCACH Priority Work Group	MTD Project Team
Behavioral Health	Bi-Direction Integration of Care & Primary Care Transformation
	Addressing Opioid Use Public Health Crisis (NEW TEAM)
Care Coordination	Community-Based Care Coordination
	Transitional Care (NEW TEAM)
	Diversion Interventions
Healthy Youth & Equitable Communities	Reproductive and Maternal/Child Health
Oral Health	Access to Oral Health Services
Diabetes/Obesity	Chronic Disease Prevention and Control

Each PT formed out of the GCACH Leadership Council (LC), a multi-sector, representative group of subject matter experts brought together to advise the GCACH Board and that is now comprised of over 350 individuals representing a range of sectors throughout the region. Since early May 2017, each PT has further evaluated regional health data and engaged in a collaborative process to develop a proposed project plan in each of the eight project areas, with a focus on evidence-based models and achieving measurable improvements in health outcomes. Each of the PTs has been led by one or two members of the team designated as Project Facilitators. The Project Facilitators from each PT participate on the Project Advisory Committee (PAC), formed to identify areas of alignment and synergy across the projects. (See attached, Project Development Approach, and Project Team Report Template.)

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

At the August Board meeting, the GCACH Board will make a formal project selection decision based review of the project plans presented by each PT, recommendations by an independent Technical Advisory Committee (TAC), recommendations by the GCACH LC, community and stakeholder input, and based on strategic considerations under the DSRIP project application scoring framework and the project funds calculator. Our project selection approach ensures that the Board’s decision is based on a data-driven regional health needs identified assessment, and incorporates broad cross-sector and community input.

The independent TAC is comprised of five clinical and subject matter experts, and is charged with making recommendations to inform the Board’s project selection decision at our August board meeting. The TAC will evaluate the eight project plans based on 10 criteria aligned with the Healthier Washington priorities (see attached):

1. Community support for the project
2. Linkages to local organizations
3. Impact/synergy with other projects
4. Sustainability
5. Likelihood of return on investment
6. Health equity
7. Alignment with community needs
8. Measurement infrastructure
9. Workforce
10. Adoption of Toolkit/evidence-based models

TAC members include former Oregon Governor John Kitzhaber, MD, Dr. Hugh Straley (President, Bree Collaborative), Dr. Lee Ostler, DDS (past President of the American Academy of Oral System Health), Bob Burden (former Administrator for Group Health), and Mike Bonetto (GCACH Regional Coordinator).

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.

GCACH is building a portfolio of projects that leverages existing community resources and aligns project efforts to maximize our impact on health outcomes. In July, GCACH engaged preliminary discussions around project alignment with the LC, PAC and Project Teams. Following the Board’s project selection decision in August, GCACH will support a series of facilitated discussions with the PAC and PTs focused on an in-depth evaluation of project intersection and alignment around core areas, such as Domain 1 strategies, target populations, and metrics.

In addition, with input from PTs and the LC, GCACH will develop a Letter of Interest (LOI) for each Project Area to identify potential participating providers to be released in September. This LOI will provide an opportunity for providers and agencies to describe how they will build upon and align their existing resources and complementary projects with opportunities in each project area. GCACH will work with PTs, the LC and partners such as Local Health Improvement Coalitions (LHIC) to gather local input regarding existing programs and services that align or complement with the project areas.

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

GCACH’s initial assessment of project alignment has identified potential shared interventions and infrastructure needs across projects. These include:

- *Region-wide Pathways HUB and data sharing infrastructure* will serve as shared regional resource to align and optimize care coordination and outreach to target populations. Phase 1 Project Design Budget: \$75,000
- *Workforce - Community Health Workers and Registered Nurses* are identified by several project areas as key workforce needs. Phase 1 Project Design Budget: \$50,000 (workforce assessment)
- *Performance measurement and Health Information Exchange (HIE) infrastructure* will be critical to track provider performance and provide timely performance feedback. Phase 1 Project Design Phase Budget: \$106,000 (HIE for rural providers), \$50,000 (GCACH data capacity).
- *Community engagements* efforts will be shared across projects to gather community input and engage collective action. Phase 1 Project Design Budget: \$150,000 (LIHCs), \$54,000 (GCACH capacity), \$12,000 (website).

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																																		
<p><u>Description</u></p> <p>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.</p>																																		
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ACH Attestation(s)																																		
<p>ACH has secured an ACH Executive Director.</p> <p style="text-align: right;"><input checked="" type="checkbox"/> YES</p>																																		
<p>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.</p> <p style="text-align: right;"><input checked="" type="checkbox"/> YES</p>																																		
ACH Structure																																		
<p>1. Describe the ACH’s sector representation approach in its governance structure. Describe how the ACH is interacting with particular sectors across the region (e.g., primary care, behavioral health, etc.), and how those sectors are engaging with the decision-making body.</p>																																		
<p>GCACH is a 501(c)3 organization governed by a Board of Directors representing 17 sectors, as illustrated below.</p> <div style="text-align: center;"> <p>BOARD OF DIRECTORS</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="background-color: #f4a460; text-align: center; padding: 5px;">Public Health</td> <td style="background-color: #f4a460; text-align: center; padding: 5px;">Hospital</td> <td style="background-color: #f4a460; text-align: center; padding: 5px;">FQHC</td> <td style="background-color: #f4a460; text-align: center; padding: 5px;">Healthcare Provider</td> <td style="background-color: #f4a460; text-align: center; padding: 5px;">Mental Health Provider</td> <td style="background-color: #f4a460; text-align: center; padding: 5px;">CBO/FBO</td> <td style="background-color: #f4a460; text-align: center; padding: 5px;">Social Services</td> <td style="background-color: #f4a460; text-align: center; padding: 5px;">Local Government</td> </tr> <tr> <td style="padding: 5px;">Walla Walla County Department of Community Health Meghan Debolt</td> <td style="padding: 5px;">Yakima Memorial Hospital Eddie Miles</td> <td style="padding: 5px;">Tri-Cities Community Health Martin Valadez, President</td> <td style="padding: 5px;">Sunnyside Community Hospital Brian Gibbons, Treasurer</td> <td style="padding: 5px;">Comprehensive Mental Health Ed Thornbrugh</td> <td style="padding: 5px;">Catholic Family and Child Services Darlene Darnell</td> <td style="padding: 5px;">SE WA Aging and Long Term Care Lori Brown</td> <td style="padding: 5px;">No Director at this time</td> </tr> <tr> <td style="background-color: #f4a460; text-align: center; padding: 5px;">Education</td> <td style="background-color: #f4a460; text-align: center; padding: 5px;">Philanthropy</td> <td style="background-color: #f4a460; text-align: center; padding: 5px;">Managed Care Organizations</td> <td style="background-color: #f4a460; text-align: center; padding: 5px;">Housing</td> <td style="background-color: #f4a460; text-align: center; padding: 5px;">Workforce Development</td> <td style="background-color: #f4a460; text-align: center; padding: 5px;">Tribes</td> <td style="background-color: #f4a460; text-align: center; padding: 5px;">Public Safety</td> <td style="background-color: #f4a460; text-align: center; padding: 5px;">Consumer</td> <td style="background-color: #f4a460; text-align: center; padding: 5px;">Transportation</td> </tr> <tr> <td style="padding: 5px;">Educational Service District 123 Les Stahlnecker</td> <td style="padding: 5px;">Three Rivers Community Foundation Carrie Green</td> <td style="padding: 5px;">United Healthcare Amina Suchoski</td> <td style="padding: 5px;">Yakima Neighborhood Health Rhonda Hauff, Vice-President</td> <td style="padding: 5px;">Washington State Allied Health Center of Excellence Dan Ferguson</td> <td style="padding: 5px;">Yakama Nation Frank Mesplie</td> <td style="padding: 5px;">Kittitas Valley Fire and Rescue John Sinclair, Secretary</td> <td style="padding: 5px;">No Director at this time</td> <td style="padding: 5px;">People for People Madelyn Carlson</td> </tr> </table> </div>	Public Health	Hospital	FQHC	Healthcare Provider	Mental Health Provider	CBO/FBO	Social Services	Local Government	Walla Walla County Department of Community Health Meghan Debolt	Yakima Memorial Hospital Eddie Miles	Tri-Cities Community Health Martin Valadez, President	Sunnyside Community Hospital Brian Gibbons, Treasurer	Comprehensive Mental Health Ed Thornbrugh	Catholic Family and Child Services Darlene Darnell	SE WA Aging and Long Term Care Lori Brown	No Director at this time	Education	Philanthropy	Managed Care Organizations	Housing	Workforce Development	Tribes	Public Safety	Consumer	Transportation	Educational Service District 123 Les Stahlnecker	Three Rivers Community Foundation Carrie Green	United Healthcare Amina Suchoski	Yakima Neighborhood Health Rhonda Hauff, Vice-President	Washington State Allied Health Center of Excellence Dan Ferguson	Yakama Nation Frank Mesplie	Kittitas Valley Fire and Rescue John Sinclair, Secretary	No Director at this time	People for People Madelyn Carlson
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To deepen engagement with each sector represented on the Board, GCACH formed a Leadership Council (LC) to serve as an advisory body to the Board. The LC has an open-membership structure, and a current roster of over 350 members providing further representation of each sector designated on our Board. Membership in the LC is open to all individuals residing in our regional service area with interest in collaboration to improve health. Leadership Council members must designate one sector to represent, and members play a key role in deepening GCACH engagement with each sector represented on our Board as there is an explicit expectation that they communicate and engage with their respective constituencies.

GCACH engaged an inclusive and transparent process to form the sector representation structure of our Board and LC. In December 2014, we held a ten-county retreat to determine a process for choosing our Board and LC. The retreat resulted in the formation of a governance subcommittee to further evaluate and recommend a governance model. The subcommittee recommended that we form a single Board and single LC, with a distributive model of governance reflecting broad geographic and cross-sector representation. The subcommittee identified 16 sectors to be represented, with an additional sector representing FQHCs identified at the first board meeting. For ongoing decisions regarding represented sectors, the Board may vote to add or modify sectors at any time. Leadership Council members may also request that a sector be added.

The GCACH LC and the governance subcommittee then engaged in an intensive, six-month Board recruitment and interview process to recommend sector representatives to serve on the GCACH Board. New Board member candidates are nominated by the LC based on sector representation, and reviewed by the Board nominating committee and recommended for Board approval.

Each sector represented may have a maximum of one member serving on the Board, and each member has one vote. With a board seat designated for each sector, this model ensures:

- Representation by all sectors playing essential roles in improving health and health system transformation efforts in our region.
- Majority of members are non-health system stakeholders, placing emphasis on members providing perspectives on social determinant of health.
- Representation by major healthcare stakeholders.
- Distributive model where none of the sectors can dominate.

Board Member Engagement with their Sectors

GCACH has communicated regularly with Board members during and outside of board meetings with the expectation that they communicate with agencies, organizations and individuals within their sectors regarding GCACH efforts. At our August board meeting, the Board will review a written Sector Representation Policy to formalize and document these expectations.

Examples of board member engagement with their sectors include: Board President, Martin Valadez, (FQHCs) is helping facilitate outreach to other FQHCs and social service organizations to support a consumer focus group. Meghan DeBolt, (Public Health) has played an instrumental role in engaging participation by all Local Health Jurisdictions in the region. Dan Ferguson, (Workforce Development) has connected GCACH with workforce organizations and efforts across the state. Vice-President, Rhonda Huff, (Housing) is a conduit for innovative housing initiatives at all levels of government that she shares with the Board and LC.

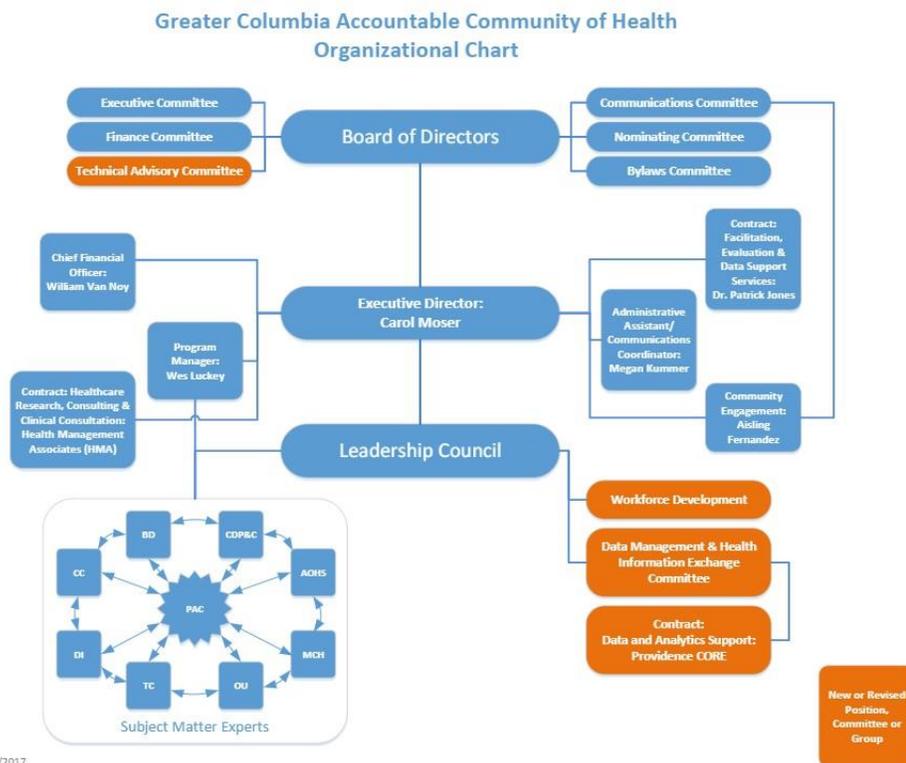
Leadership Council and Sector Engagement

As described earlier, the LC was established to help deepen sector engagement in the GCACH. As such, the Leadership Council plays a key role in facilitating ongoing broad sector engagement with the GCACH Board. The LC now includes a roster of over 350 individuals and we regularly have between 60 and 90 LC members attending our monthly LC meeting (by phone or in person). These meetings occur directly prior to and at the same location as our monthly GCACH Board meeting, allowing the Leadership Council to inform Board deliberations and decisions, and to attend and provide public comment at Board Meetings as desired.

Currently, we have over 80 LC members also serving on one of eight Project Teams to inform the development of Demonstration project proposals. The Project Teams and the LC will provide recommendations to the Board on key regional health needs and proposed projects to move forward in the ACH demonstration project plan application.

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)

GCACH continues to operate as a 501(c)3 organization governed by a Board of Directors representing 17 sectors, and to work with a LC that brings together a broad base of sector representatives and serves as an advisory body to the Board.



Since Phase 1 Certification, GCACH received Board approval to form a Technical Advisory Committee (TAC) to serve as an independent advisory body to the Board. The TAC will bring subject matter expertise (especially clinical) in the form of recommendations to the Board on Project Selection and

will score letters of interest and qualifications. Additionally, the Chief Financial Officer, hired June 22, now meets regularly with the Finance Committee to review all financial data.

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

The GCACH Board serves as the primary decision-making body for selecting project areas to submit in the Project Plan application and to determine project participants. At the same time, GCACH Board Members may represent organizations with significant financial interests in advancing certain projects or participation of entities in the project. The GCACH conflict of interest policy defines conflicts of interests and outlines expectations for Board members to take appropriate action on matters in which they are conflicted. All GCACH board members have signed the GCACH conflict of interest policy. In addition, all board meetings begin with an attestation of conflicts of interest, and a written reference defining conflict of interest is included in board meeting agendas.

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.

GCACH has created a staffing structure to facilitate alignment of resources and efforts across projects, rather than a structure with staff working in siloes. This summer GCACH completed recruitment for two new positions, and has now hired staff in the following positions:

- Executive Director (hired June 2014)
- Chief Financial Officer (hired June 2017)
- Program/Data Manager (hired March 2017)
- Director of Community Engagement (staff reclassified June 2017)
- Communications Coordinator/Administrative Assistance (hired June 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.

Greater Columbia ACH covers a broad geographic area that encompasses Washington's largest federally recognized Tribe: The Yakama Nation. The Yakama Nation covers more than 1.1 million acres and provides services to more than 11,000 AI/AN individuals. They are an essential community provider for the AI/AN population in the GCACH region. Since Phase I Certification, GCACH has undertaken several key actions to deepen our engagement with the Yakama Nation:

- **Adoption of the Model ACH Tribal Collaboration and Communication Policy:** On May 18, 2017, the GCACH Board of Directors adopted the Model ACH Tribal Collaboration and Communication Policy. The policy was signed by Tribal Council member, Frank Mesplie, on August 4th 2017 during an in-person meeting with GCACH staff (Executive Director, Carol Moser, Chief Financial Officer, William Van Noy, and Program Manager, Wes Luckey) and Yakama Nation representatives (Human Services Administrator E. Arlen Washines, Deputy Director, and Tonya Kreis, Behavioral Health Services). GCACH is also actively seeking and has requested a formal statement of support from the Yakama Nation. We currently have Frank Mesplie serving on our Board and Yakama Nation representatives attending GCACH meetings as demonstration of support.
- **Areas for Collaboration:** During the August 4th meeting, GCACH staff and Yakama Nation representatives discussed what collaboration would look like to the Yakamas. Yakama Nation representatives articulated that they would like support from GCACH in developing their project selections and planning documents. Importantly, they noted the need to strike a balance between collaborating and ensuring that there is support and space for traditional Native American approaches to addressing important health problems. While GCACH and the Yakama Nation have many health issues in common, especially in behavioral health, substance abuse, chronic disease, and obesity, our approaches to addressing them may differ. For example, the Yakamas are very concerned with suicide rates, anger management, and addictions issues, but also have many programs uniquely designed to address these issues with culturally appropriate best practices.

<p>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)</p>
<p>The Tribal Collaboration and Communication Policy has been adopted and signed by GCACH President Martin Valadez and Yakama Tribal Council member, and GCACH Board member, Frank Mesplie (attached).</p>
<p>3. Demonstrate how ITUs have helped inform the ACH's regional priorities and project selection process to date.</p>
<p>As described in the Phase 1 certification, members of the GCACH LC and Board participated in an American Indian Health Commission (AIHC) meeting in August of 2016 to begin a dialogue to identify health-related concerns of the Yakama Nation specifically. At the time, a number of areas for collaboration between GCACH and the Tribes were identified including access to culturally competent care, oral health, integration of behavioral health, diabetes, and whole person care. Another meeting with Tonya Kreis, with the Yakama Nation Behavioral Health Program in April, provided GCACH staff with a keener understanding of the barriers for participation in ACH-related activities. GCACH is actively working to provide support to overcome these barriers and facilitate engagement in ACH activities, such as support travel cost to ACH-related activities.</p>
<p>Our primary strategy for ensuring that ITUs are informing our regional priorities and project selection is our strong partnership and connection to the Yakama Nation. Our Tribal Board representative, Frank Mesplie, is a member of the Yakama Tribal Council, providing GCACH with a strong connection to the Tribal Council and opportunity for open communication.</p>
<p>Besides having Tribal representation on our Board and on project teams, we are scheduling a meeting with the Tribe to determine projects specific to the Yakama Nation, and have discussed with Tribal representatives the need to augment the Yakamas' HIT infrastructure. As a result, design funding in the amount of \$50,000 has been identified from Phase I certification funds to support Tribal HIT Infrastructure.</p>
<p>GCACH staff have also committed to working with the Yakama Tribe to support a Committee to start the process of selecting and developing a Medicaid Demonstration project plan. One area of common interest that was discussed on August 4th was emergency department utilization. Mr. Washines indicated that because their on-site medical clinic was only open between 8am-5pm, Tribal members end up at the emergency department during off-hours. Also, because the Behavioral Health staff lacks adequate IT infrastructure and reliable internet and phone service, they cannot respond to crisis calls in a timely fashion. This is an area of great concern to both GCACH and the Yakamas that we would like to address in the project plan.</p>
<p>Board Training</p>
<p>4. Demonstrate the steps the ACH has taken since Phase I Certification to ensure the ACH decision-making body receives ongoing training on the Indian health care delivery system, with a focus on the local ITUs and on the needs of both tribal and urban Indian populations. Identify at least one goal in providing ongoing training in the next six months, the steps the ACH is taking to achieve this goal and the timing of these steps.</p>

The Yakama Nation is the largest Indian Tribe in the State of Washington. For the GCACH to be successful in achieving its vision, it is critical to ensure that Board members are trained in the Indian health care delivery system and understand the unique challenges facing tribal members and the strengths tribes offer in addressing health disparities and improving health outcomes with culturally appropriate approaches.

The Greater Columbia ACH Leadership Council attended a Tribal Workshop sponsored by the American Indian Health Commission (AIHC) in August 2016 that covered the history of the health care law and Tribal issues concerning Indian Health Services. The presentation also highlighted health concerns of the Yakama Tribe. GCACH members noted that the region and Yakama Tribe share common health issues of diabetes, obesity, oral health, behavioral health, and health equity. This training is foundational and we want to ensure that all Board members receive this training. As such, we are working with AIHC and with the HCA Tribal Liaison, Jessie Dean to schedule another Board training in October 2017. Additionally, we will continue to work with the AIHC, the Yakama Nation and the HCA Tribal Liaison to systemically provide an annual training about tribal health needs as well as training for new Board members as part of the onboarding process.

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.

GCACH is deeply committed to community engagement and elevating the voices of Medicaid beneficiaries. Despite our successes, important challenges exist.

- Engaging Medicaid beneficiaries is difficult and has been an ongoing challenge. Beneficiaries lack the time and resources to participate, may face language and/or cultural barriers, and often struggle to feel heard amidst the voices of professionals. We have not yet filled the consumer seat on our governing board despite active efforts.
- The size of our region also poses another challenge for community engagement. GCACH covers over 15,000 square miles, including many rural areas.
- Limited staff capacity to do manage time-intensive outreach and engagement work.

Our strategies to mitigate these challenges are:

- **Created a Director of Community Engagement Position:** To prioritize this work we created a position with the sole focus on leading community and consumer engagement; it has been filled by Aisling Fernandez, a competent Spanish-speaker.
- **Leveraging expertise and networks of partners serving Medicaid consumers:** We are actively working to incorporate advice and recommendations from partners serving Medicaid consumers. These include engagement with MCOs, community-based organizations, social service agencies, Local Health Improvement Coalitions, and providers, particularly FQHCs and

Community Health Workers, in every part of our region. These partners have established relationships and lines of communication with beneficiaries and can help us recruit consumers for focus groups, a Consumer Council and other engagement activities.

- **Focus Group(s) with Medicaid Consumers:** GCACH is planning to hold focus groups with Medicaid beneficiaries to gather input on the demonstration projects. We are partnering with the FQHC Tri-Cities Community Health (TCCH) and Community Action Connections (CAC) in Pasco, organizations that primarily serve the Medicaid population. We are currently exploring strategies to design focus groups in a manner that best supports engagement by beneficiaries, with a goal of holding 3-4 focus groups this Fall, and will be gathering input from beneficiaries during FQHC week.
- **Form a Consumer Council (CC):** GCACH will form a CC the first quarter of 2018. The CC will be comprised of 6-8 current and former Medicaid consumers and/or their family members, as well as Medicare, VA, private insurance beneficiaries and uninsured. A committee of consumers will empower participants to speak out, rather than relying on one consumer seat on a board. To facilitate involvement, we are identifying what is needed to support participation in the CC (e.g., food and child care during meetings, online / phone meetings and mileage reimbursement for travel to meetings).

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

Leadership Council meetings: Due to the overwhelming interest from community members and stakeholders, GCACH has had to relocate Leadership Council (LC) meetings four times to accommodate participation. Nearly 100 people attended the June 22nd meeting held at Columbia Basin College to hear the Project Team (PT) reports by the Team Facilitators and provide oral and written feedback on the projects. In addition to physical space, this venue offers audio/visual capacity which allows people to participate via phone or computer.



June 22nd Leadership Council Meeting

Project Plan Meetings:

We have supported approximately 60 meetings by PTs and the LC in 2017 to develop the project plans presented in June, hosted by GoToMeetings.

Local Health Improvement Coalitions (LHICs):

Several LC members have requested that the GCACH Board formalize partnerships with LHICs in sub-regions of our service area on which they also actively participate. The Board has allocated \$150,000

from Design Funds to support five LHICs, and GCACH staff is working on an agreement for Board

approval in September. GCACH’s Executive Director has also been asked to sit on two of the LHIC Boards. Members of the Benton-Franklin Community Health Alliance and two of their subcommittees, the Oral Health Coalition and the Tri-Cities Diabetes Coalition have provided helpful feedback to all project categories.

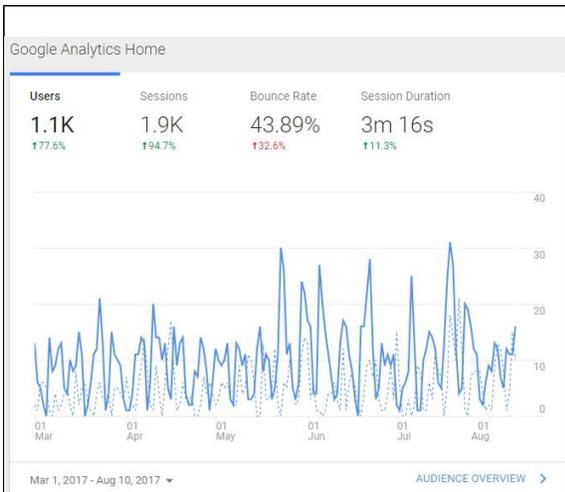
Planned Use of Phase II Certification Project Design Funds - Distribution by Category and Timeframe

Example Budget Category	Example Budget Items	DY 1 - 2017					
		Q1 - Q2	Q3-Q4	DY2 - 2018	DY3 - 2019	DY 4 -2020	DY 5 - 2021
Engagement	Convening			\$ 12,000	\$ 12,000	\$ 11,000	\$ 11,000
	Education and training			\$ 38,000	\$ 33,000	\$ 28,000	\$ 28,000
	Tribal consultation			\$ 30,000	\$ 30,000	\$ 30,000	\$ 30,000
	Marketing and outreach			\$ 15,000	\$ 15,000	\$ 13,000	\$ 13,000
	Travel			\$ 10,000	\$ 10,000	\$ 9,000	\$ 9,000
	Performance Reporting			\$ 20,000	\$ 20,000	\$ 15,000	\$ 15,000
	Other: Local Health Improvement Coalitions			\$ 150,000	\$ 150,000	\$ 150,000	\$ 150,000
Total Engagement:		\$ -	\$ -	\$ 275,000	\$ 270,000	\$ 256,000	\$ 256,000

Engagement with Yakama Tribe: The GCACH-Yakama Tribe Collaboration policy was signed by Councilmember Frank Mesplie on August 4th and GCACH has committed commitment \$30,000 to support tribal engagement efforts.

Meetings with Community Partners: GCACH staff have met with MCOs, the Greater Columbia Behavioral Health Organization, the Yakama Tribe, Federally Qualified Health Clinics (FQHCs), social service providers, LHICs, public health systems, clinicians, SE WA ALTC Governing Board, League of Women Voters (Benton and Franklin Counties), and stakeholder groups to consult with them on GCACH’s demonstration project plan. Examples of one-on-one meetings held include the Yakama Nation, Benton-Franklin Health District, Virginia Mason Memorial, SE WA Rural Health Coalition, Sunnyside Community Hospital, Department of Social and Human Service (DSHS) Community Service Offices (CSOs) and the Benton-Franklin Community Health Alliance.

Conversations with MCOs and FQHCs have been instrumental in developing a community engagement strategy based on data and community needs. They have advised on what projects and activities appear sustainable beyond the Demonstration period, and on community engagement strategies that meet beneficiaries in places or events they are attending rather than GCACH-centered events. As such, the Director of Community Engagement will be participating in the National Health Center week by attending the “Festival in the Parking Lot and Health Fair” at the Yakima Neighborhood Health Services FQHC in Yakima.



Electronic communications: GCACH sends out regular updates via our electronic email list of 400 community members as well as through our website, which provides extensive information on our ACH and demonstration project activities. The website has experienced significant growth over the past six months.

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?

GCACH has gathered community member feedback on projects through LC meetings, one-on-one meetings with partners and stakeholders across the region, including clinicians and social service providers, an online regional survey, and PT meetings.

At the June LC meeting, PTs presented their project ideas and over 100 participants completed and returned feedback forms. The feedback received has been compiled and shared with PTs, LC and the Board. Feedback will continue to be gathered through November and shared. The teams have been asked to address the feedback in their project drafts. GCACH staff will track community feedback that is incorporated into Project Plans.

To ensure Medicaid beneficiary input, GCACH staff will go to events, centers and residential areas and meet beneficiaries where they are at. We will also work to engage beneficiary input through focus groups and on the Consumer Council. We also plan to include family members of hard-to-reach consumers on the Consumer Council (CC) and in focus groups as one way of addressing barriers beneficiaries may face in engagement.

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.

The formation of PTs has led to greater engagement among providers in recent months. Each team has one to two project facilitator(s); six of the PTs are led by clinicians. Each of the teams also have 3-4 providers engaged in their project development work. These clinicians have helped to spread the

message about GCACH and the demonstration projects and have been effective “provider-to-provider” messengers.

The hospitals and FQHCs employ the majority of providers in the GCACH service area, so engaging these systems has been critical to linking with provider champions. GCACH staff and Board members have spent significant time making personal contact with the hospital CEOs, making presentations to their Boards, retreats, personal visits, communicating via emails, attending Washington State Hospital Association (WSHA), and regional stakeholder meetings. The Executive Director and Program Manager have been working with WSHA and the Northwest Rural Health Network to find areas for collaboration within the hospital system. The Yakima Valley Farm Workers Clinic has been highly engaged on PTs, as has Yakima Neighborhood Health Services, Benton-Franklin Health District, Kittitas Valley Healthcare, Signal Health, Virginia Mason Memorial, and Walla Walla County Health Department.

GCACH will send letters of interest to potential partnering providers and request for qualifications once the final project areas have been determined. This action is expected to increase communication opportunities between providers and GCACH staff, and is intended to get direct feedback on the project areas.

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

Provider engagement in demonstration project development is a key success for GCACH. There are currently over forty (40) licensed providers and clinicians serving on PTs. Six of the eight teams are led by provider champions.

Four conversations have been held with supervisors at Community Service Offices (DSHS) between Cert. Phases I & II. GCACH is gathering input on hurdles their clients experience navigating social service and health service systems in the context of the Demonstration Projects and what solutions they “dream” of. We have received feedback from these conversations about which evidence-based initiatives they think will be helpful (especially if strengthened or enhanced), which already exist and do not need to be duplicated, and which would not be practical for their clients who struggle with having their health and social service needs met.

Conversations with MCOs and FQHCs have been instrumental in developing a community engagement strategy based on data and community needs. Between Certification Phase I and Phase II, there have been two conference calls with MCO partners and one conference call with FQHC partners. These conversations have been inclusive of all five MCOs and all six FQHCs in our region, and invitations were sent out to all MCO and FQHC partners in our 400-person Master Contact List for GCACH.

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.)

GCACH has actively engaged provider input through Project Teams and our LC, as described above. Through this process, providers are directly engaging in the development of project plans and the Board selection process.

GCACH is also reaching out through one-on-one meetings with providers and in capturing provider input in a matrix with each type of stakeholder and consumer/community group cross-tabulated with the Demonstration Project Categories in Domains 2 and 3. This feedback will be incorporated into the Project Plan Application due to the HCA in November.

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)?

GCACH actively encourages and enables community participation in open and transparent Board and LC meetings. Board and LC meeting minutes and materials are posted publicly on our website, and links are included in our monthly newsletter. LC materials are emailed to our list of 400 community members and partners. Our website includes a calendar of meetings, all past and current Board and LC meeting minutes, materials, and other resources.

Columbia Basin College provides a public forum for monthly LC and Board meetings which have increased in attendance ranging from 60 to nearly 100 people. GCACH allows for phone and online participation in our LC and Board meetings, including opportunities for discussion breakout groups for phone and web participants.

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?

In order to maximize participation, Board and LC meetings are held back to back to minimize transportation barriers for members. All meeting materials and minutes are posted publicly on our website in advance of meetings, and LC materials are emailed to our list of 400 community members and partners. LC and Board meetings use GoToMeeting webinar technology so that participants unable to attend in person are still able to see materials being presented and engage in discussions.

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

When Board decisions must be made between public meetings, this information is shared both on our website and emailed through our Director's report to our list of 400 partners and community members. We also ask our partnering organization to share GCACH news and announcements through their lists.

If a decision is needed between public meetings, the description of that action is also recorded in the minutes along with the electronic vote taken by each Board member. All meeting minutes are posted to our website.

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.

GCACH uses a wide array of communication tools and has just created and filled a Communications Coordinator position to manage this work. We have a robust website with a meetings calendar, meeting agendas and minutes, resources and all the materials shared in meetings or in-between meetings posted on the website. We are in process of upgrading and redesigning our site. Our Communications Coordinator has developed a communications matrix identifying a range of communication tools that GCACH uses based on The International Association for Public Participation.

We have created an email list of 400 community members and partners across the region, which we manage using MailChimp. Through this list we send a monthly newsletter, a weekly Director's report, and meeting and other announcements.

Attachment(s) Required

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

Budget and Funds Flow – 15 points

Description

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

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

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

Instructions

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

ACH Attestation(s)

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

YES

Date of Approval: July 20, 2017

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

YES

Date of Approval: July 20, 2017

Project Design Funds

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

On July 20, 2017, the Board of Directors approved the Finance Committee's recommendation to accept the Phase I budget with the following allotments to budget categories including proposed use of funds

- 17% -ACH Project Plan Development - Consultants, Meetings and Travel. To date, GCACH has used \$ 159,000 of Phase I Project Design ACH Project Plan Development funds for consultants to support the eight community-based project teams in developing proposed project plans.

- 21% - Community Engagement- Meetings, Education and Training, Marketing and Outreach, Travel and Local Health Improvement Coalitions. GCACH leadership and staff organized Medicaid beneficiary focus group, conducted presentations to obtain feedback from community partners and hospitals, and other community engagement efforts.
- 3% - Tribal Consultation. GCACH leadership has met with Yakama Nation representatives to discuss opportunities for collaboration. GCACH is actively working to provide support for Tribal engagement in ACH activities, such as support travel cost to ACH-related activities.
- 8% - ACH Administration/Project Management – Clinical Consultant, Legal, Website. We note that in year 1 the SIM grant fully funded GCACH administrative expense. This funding has supported activities identified in allotments to Phase 1 budget categories.
- 40% - Information Technology – HIT Consultant, ACH, Provider and Tribal Data Capacity, Internal Support and Administrative Systems and Investment in Pathways HUB. Funding supports efforts to address data infrastructure and capacity across provider organizations.
- 10% - Health Systems & Community Capacity Building – Workforce Recruitment, Training and Retention, Capacity Development for Health System Transformation.
- 1% - Other – Insurance

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

On July 20, 2017, the Board of Directors approved the Finance Committee’s recommendation to accept a preliminary budget based on anticipated funds to be awarded under Phase II Certification. The approach identified the following allotments to budget categories, including proposed use of funds.

- 8% -ACH Project Plan Development - Consultants, Meetings and Travel: During the funding period, GCACH staff will continue to work with consultants in developing, monitoring, evaluating and facilitating the advancement of the project plans. The budget assumes project plan development will ramp down in years 2 and 3 eventually ending in year 4.
- 18% - Community Engagement- Meetings, Education and Training, Marketing and Outreach, Travel, Performance Reporting, and Local Health Improvement Coalitions: Partner organizations are projected to organize into Local Health Improvement Coalitions designed to collaborate on planning, developing, implementing, monitoring and improving performance at the micro-system level. \$30,000 per year per identified partner organization is budgeted for participation of leadership and staff on project plan development work teams, Board or Leadership Council.
- 3% - Tribal Consultation: GCACH recognizes the value of Tribal engagement and participation. We are collaborating with the Yakama Nation as a partner to determine their project selection process. Funds have been allocated to support their participation in GCACH and HCA sponsored activities.
- 29% - ACH Administration/Project Management – Leadership and Support Staff, Backbone Operations, Clinical Consultant, Legal, Website: ACH Administration and Project Management is projected to increase significantly with the end of the State Innovation Model (SIM) funding. In year 1 the SIM grant fully funded GCACH administrative expense, however, with this funding source coming to an end in early 2018, GCACH will need to rely on Design funding to support administration.

- 28% - Information Technology – HIT Consultant, ACH, Provider and Tribal Data Capacity, Internal Support and Administrative Systems and Investment in Pathways HUB: The Phase II budget places more focus on Electronic Health Systems (EHR) assessment and evaluation to ensure data is readily available and is easily convertible to useful data required for meaningful analyses and reporting. Project design funds will be used to contract with a Healthcare IT expert to perform a network and community based capability assessment as part of implementation plan of selected projects.
- 13% - Health Systems & Community Capacity Building – Workforce Recruitment, Training and Retention, Capacity Development for Health System Transformation, Consultation for Monitoring and Evaluation of Project Development: Workforce is the key component to transforming the way care is delivered. Funding will be used to develop and implement a multi-pronged approach that includes recruitment, education and training, monitoring and evaluation of retention for direct care of services.
- 1% - Other – Insurance

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.

Phase I and Phase II Project Design Fund investments will be made in GCACH backbone leadership and staff and consultants for project plan development and program management.

- The Executive Director has worked closely with the Leadership Council and Board of Directors to develop organizational capacity and governance **strategies** to move GCACH forward. Phase II funding will be used to fund the backbone staffing structure with functions serving across projects including **program management, data, finance, communication and community engagement**. Backbone staff will work with HMA to support Project Teams.
- GCACH will continue to contract with HMA and Eastern Washington University to provide **program and fiscal management** support and to provide **strategic guidance** to the Leadership Council and Board of Directors. HMA will provide program management and subject matter expertise to support Project Teams to develop project plans.
- GCACH will contract with a consultant who has a deep understanding of emerging **clinical** developments in healthcare transformation and experienced in implementing innovative and evidence-based approaches to providing value-based health care.

Transparency with the **community** stakeholders and targeted consumers will be one of the keys to GCACH success. Project Design Fund investments will be made in communication, engagement and coalition building strategies.:

- Communication and openness with the regions stakeholders and targeted consumers will be one of the keys to GCACH success. A marketing and outreach strategy will include web-based methods along with social media to enable our partners to participate in two-way communications with the ACH.
- GCACH will hire a consultant to assess provider organizations information technology capacity and **data** analytics capabilities. Investments will be made to identify and support IT infrastructure needs on the Yakama Indian Reservation as well as other partner

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

GCACH hired an experienced CFO with a background in health care finance. The CFO position responsibilities include developing policies and procedures to bring to the Finance Committee for oversight and accountability of the accounting function such as budget development and execution, receivables, payables, payroll, financial analysis and internal controls.

The Finance Committee and Board have approved a detailed budget for Certification I and II Project Design Funds. Provisions exist for monitoring and modifying Design Fund expenditures. The CFO has authority to modify budget items within budget categories. The Finance Committee has been chartered and is charged with recommendations to the GCACH Board of Directors for approval. The committee meets monthly to review monthly financial statements and report on Project Design funds.

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.)

To guide the project incentive fund planning process, the CFO has been closely monitoring the release of fund flow design material being disseminated by Manatt.

The Finance Committee formed a Budget and Funds Flow Workgroup. The workgroup consists of governance members as well as partnering provider members and will convene on a bi-weekly basis to develop and present an effective methodology for distributing Program Incentive Funds This structure will determine how to assess the impact of selected DSRIP projects and recommend a funds flow approach and distribution plan to the Finance Committee, project teams and Leadership Council for review and recommendation to the Board for approval. The workgroup serves as an arm of the Finance Committee to develop provisions for monitoring and modifying funds flow based on changes needed to meet DSRIP goals.

GCACH leadership have been traveling to various locations within ACH’s catchment area to train partner organizations on the new DSRIP calculation tool and how best to utilize this information during the project selection and development phase. The DSRIP calculator will inform project selection to ensure a viable system and stabilize health care delivery in the Greater Columbia region.

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).

Funding from Health Care Authority SIM grant support the administration and program oversight of aligned activities until January 2018 and include:

- Salary of the Executive Director, CFO, Program Manager, Communication Coordinator, Administrative Assistant and Director of Community Engagement
- Space costs at Community Action Connections at \$1,200/month

Yakima Valley Community Foundation awarded \$ 125,000 which we used to develop our Regional Health Improvement Plan, and will use to leverage project areas.

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.

GCACH has developed strong partnerships in the community to provide meeting spaces, financial support for monthly meetings and retreats. There have been 59 meetings to date. Columbia Basin College provides a public forum for monthly Leadership Council and Board meetings which have increased in attendance ranging from 60 to nearly 100 people. Community Action Connections provides meeting and training space for GCACH activities, and offered their Day Shelter Space for childcare for the Medicaid focus group. Greater Columbia Behavioral Health sponsored LC and Board meeting space and WebEx support for almost two years. GCACH partners have volunteered key leaders and staff to devote time and effort to participate in Project Team, Leadership Council and Board meetings.

GCACH understands that our partners will need to make organizational and strategic investments in addition to DSRIP funding to align their business model with the GCACH strategy for health systems transformation.

Attachment(s) Required

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

Clinical Capacity – 15 points

Description

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

Instructions

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

Clinical Expertise

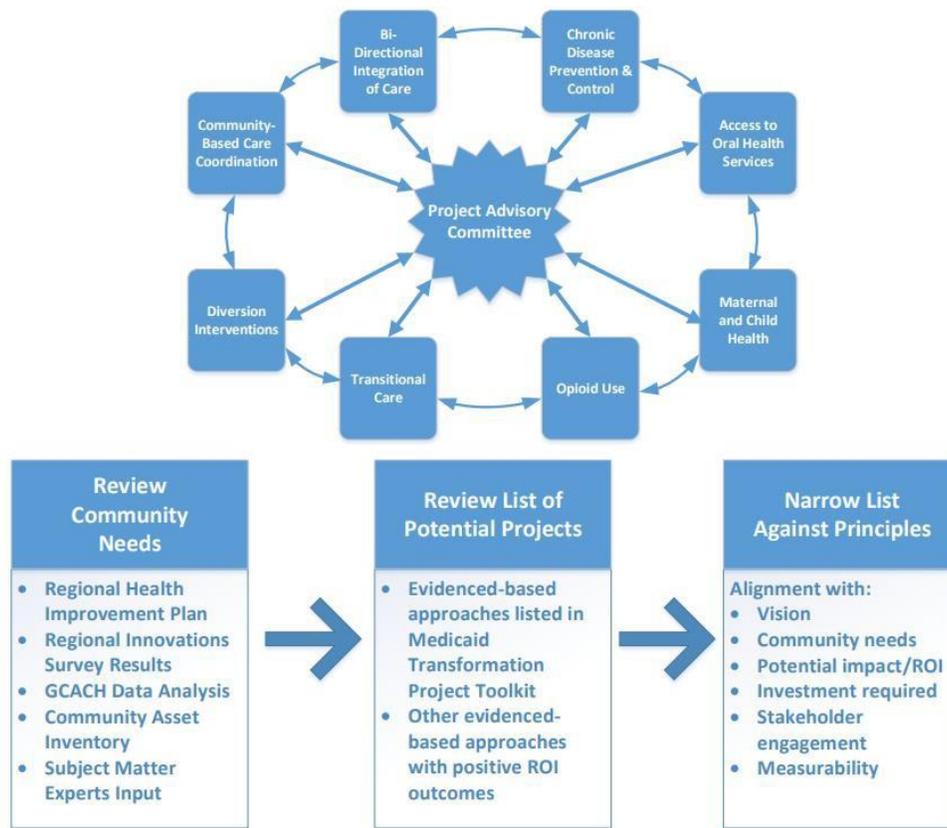
1. Demonstrate how clinical expertise and leadership are being used to inform project selection and planning to date.

GCACH is incorporating clinical expertise and leadership to inform project selection and planning through multiple avenues:

- *Project Teams and the PAC formation:* In April 2017, GCACH formed eight Project Teams (PT) to evaluate regional health needs data and develop project plans for each of the eight Healthier Washington Toolkit project areas. There are currently over 40 licensed providers and clinicians serving on PTs. Six of the eight teams are led by provider champions. (See Attachment A. Clinical expert bios, and visual diagram detailing participation on Project Teams)
- *Technical Advisory Committee:* At our July board meeting, the GCACH Board approved the formation of a Technical Advisory Committee (TAC). The TAC will serve as an independent advisory body to the Board, and will bring clinical subject matter expertise and recommendations to the Board for Project Selection and the Project Plan Application. The following are members of the TAC: Dr. John Kitzhaber, former Governor of Oregon, Dr. Hugh Straley, President of the Bree Collaborative, and Chair of the HILN Clinical Engagement Subcommittee, and Dr. Lee Ostler, DDS. Dr. Ostler was the former Chair of AAOSH, the American Academy for the Oral Systemic Link. The TAC will score each project, and provide commentary as to the feasibility and synergy with the other projects. In this way, the PTs and Board will receive independent feedback on their project plans from distinguished high-level expertise.

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

Each PF was given a Project Team Charter to guide the work of the PTs. The Charter detailed the steps necessary to develop the project plan including a root cause analysis, data review, reviewing evidence based practices being delivered within the region, return on investment, and synergy with the other teams. The PFs organized their respective PT teams with the support of the GCACH staff, and guided their PT discussions. In many cases, they brought in new committee members. The PFs formed a sub-committee called the project advisory committee who met with staff and consultants to further develop their projects, and find areas of synergy. On June 22, the PF presented their project plans to the Leadership Council, and are presenting their final reports to the Board of Directors on August 17th.



All Project Teams have relied heavily on the leadership from provider champions participating on the teams to inform development of their projects. Providers have provided critical insight into current system gaps and key considerations in the application of evidence-based strategies to address these needs. The following project teams were led by these provider champions:

- Bi-directional Integration of Physical and Behavioral Health: Brian Sandoval, Psy.D.
- Community-Based Care Coordination: Jorge Rivera, MBA, Molina Healthcare
- Transitional Care: Dr. Kevin Martin, Mandy McCollum, RN
- Diversion Interventions: Dr. Darin Neven, Karla Greene, RN BSN, Stein Karspeck, EMT-P
- Addressing the Opioid Use Public Health Crisis: Becky Grohs, RN, BSN, CCM; Everett Maroon
- Reproductive and Maternal and Child Health: Carla Prock, RN, Stan Ledington, Dr.PH
- Access to Oral Health Services: Dr. Mark Koday, DDS, Heidi Desmarais, RDH, BA, MSDH
- Chronic Disease Prevention and Control: Bertha López, Senior Director, Virginia Mason Memorial, Dr. Donald Ashley, Fenice Ferguso, Molina Healthcare

Clinical Input

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

The GCACH Leadership Council and Project Teams includes representation from a range of clinical providers, including school nurses, pediatricians, counselors, dentists, hygienists, emergency medicine physicians, licensed social workers, primary care physicians, a psychologist, paramedics, certified

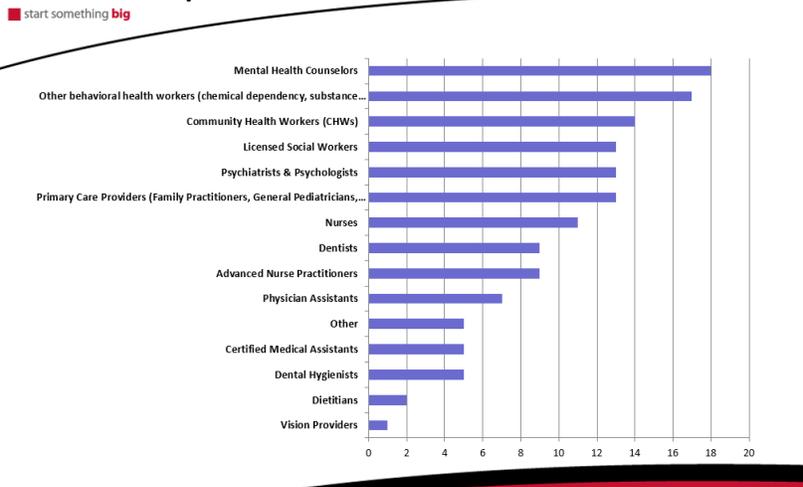
addiction medicine physicians, chemical dependency professionals, and behavioral health specialists. (See Attachment A. Clinical Expert bios and visual diagrams detailing participation on Project Teams.)

In addition, GCACH will develop a Letter of Interest (LOI) for each Project Area to be released in September to identify potential participating providers. This LOI will provide an opportunity for providers and agencies to provide input and actively engage in the project planning process.

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.

GCACH Project Teams have engaged in initial assessment of regional clinical capacity and gaps when developing their project reports. These reports were informed by a Regional Health needs survey (May 2017) which included a workforce section broken out by occupations in highest demand, and supported by the project report template that asked each team to identify staffing needs related to their projects.

Workforce questions: occupations in highest demand to be able to respond to Waiver



WORKFORCE REQUIREMENTS	<p><i>Will your project approach require any special workforce requirements not already in place, such as the addition of Community Health Workers? What might these requirements be?</i></p> <p>Project is likely to use extensive workforce of Community Health Workers, which are in existence in most sub regions of the ACH, but currently lacking a coordinated approach to training, certification and deployment to priority target populations; this will allow for geographically focused and culturally competent outreach of members requiring coordination of their health and also of social services provided for them, and it will also allow for coordination of services to whole families and not only to specific individuals within a family, reducing duplication of resources and overall cost</p> <p>The Pathways Hub will also require participation of the traditional clinical workforce, and of community navigators and specialists that will provide connection to social services</p>
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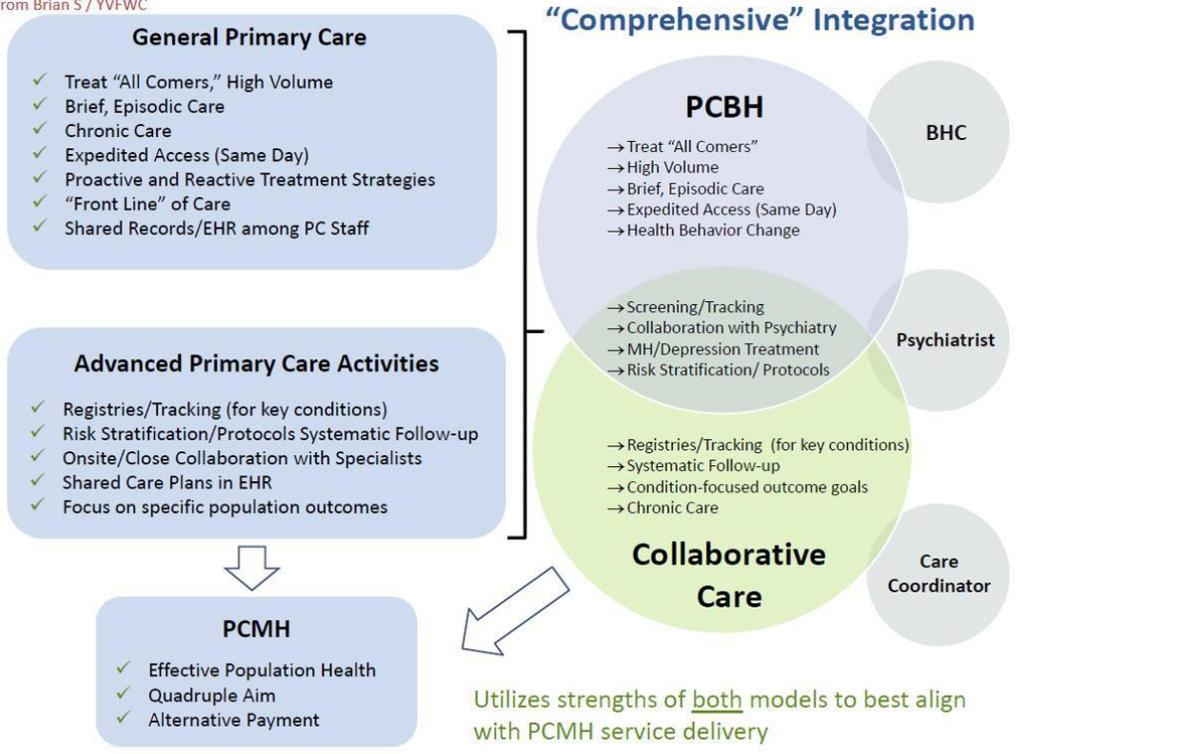
For project areas selected by the Board, GCACH will further evaluate clinical capacity gaps identified by the project teams in the matrix below which will be addressed by a Workforce Committee under the chairmanship of Dan Ferguson, GCACH Board member, and Director of the Washington State Allied Health Center of Excellence.

Toolkit Metrics	2A BH Integration	2B Care Coord	2C: Transitional Care	2D: Diversion	3A: Opioid Use	3B: MCH	3C: Oral Health	3D: Chronic Disease	TOTALS
CHWs									6
Cultural Compt training									5
Health Homes/ PCPs									5
Screen for SDOHs									4
Care Coordination/ Case Mngmnt									4
Hospitals									4
BH Providers									3
RNs									3
Provider/Clinician Training									3
Social Workers									2
Community Paramedicine									2
Needs Gap Assessment									1
Workforce development									1
VBP									1
Health promotion									1
Marketing / outreach									1
Dental hygenists									1

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).

The ED and PM have actively participated in WSHA meetings, support the Practice Transformation Hub efforts, presented information at hospitals, health departments, health symposiums, the Greater Columbia Behavioral Health organization, and local health improvement coalitions. Members of the project teams serve on statewide task forces such as the Bree Collaborative, the Opioid Task Force, the WA Dental Service Foundation, the Adult Dental Advisory Board, the Washington Academy of Family Physicians, and on local and regional medical societies. The State Innovation Model project was a partnership between WSU Tri-Cities College of Nursing, Trios, and Kadlec hospitals. We are working with the Benton-Franklin Workforce Development Council, and Pacific NW University of Health Sciences on workforce development and training.

From Brian S / YVFWC



Project Teams are connected to state-level project development efforts for bi-directional integration, opioid, and chronic disease. The Washington State Hospital Association (WSHA) and ACH leaders have been sharing their work on behavioral health, opioids, care integration, data needs, emergency department utilization and workforce. WSHA created a guidance document that indicates the clinical transformation steps required for primary care providers that was passed onto our Bi-Directional Integration team on 7/19, and six strategies offering promising interventions that can be implemented as part of the Medicaid demonstration opioid project on 8/3.

GCACH's Executive Director and Program Manager have made presentations to: Kittitas Valley Healthcare, 10/26, Virginia Mason Memorial and Signal Health, 6/1, Kadlec & St. Mary's, 8/15, Northwest Rural Health Network and Community Health Association of Spokane (CHAS), 4/28, SE WA ALTC Council of Governments Board, 4/6, Benton-Franklin Board of Health, 7/26, Qualis and Washington Health Alliance, 2/13 which have included clinicians. These presentations have served to validate the data on clinical and social measures, and to get feedback on project initiatives and measures. Additionally, GCACH has consulted with the Tri-Cities Diabetes Coalition which is comprised of diabetes specialists from the area hospitals, and the BFCHA Oral Health Coalition, comprised of dentists and hygienists.

Outreach to prospective partnering providers: GCACH will use recently released HCA Medicaid professional services claims data to identify total number of claims and beneficiaries by provider, general service category, and diagnostic condition. These data will be used to identify the providers serving the largest number of Medicaid beneficiaries. GCACH will reach out to ensure we are engaging these providers and consulting with them on project design, metrics, and the achievability of performance measures.

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.

- HCA/AIM RHNI "Starter Kit" datasets (Phase 1, 2, 3)
- HCA/AIM Hospital ER Utilization by ACH dataset
- HCA Apple Health Reports, Medicaid Enrollment by Eligibility Category, February 2017
- HCA Apple Health Reports, Medicaid Enrollment by MCO, April 2017
- DSHS/RDA Healthier Washington Dashboard
- DSHS/RDA Cross-system Outcome Measures, 2015
- DSHS/RDA demographic and health indicator maps
- DOH health indicator maps
- Washington State Department of Health – Health of Washington State Report 2014, 2016
- RWJF County Health Rankings, 2015, 2016, 2017
- RWJF Culture of Health Framework
- Washington Health Alliance Community Checkup, 2015, 2016
- Washington State Department of Health Data and Statistical Reports
- GCACH, Regional Health Improvement Plan, 2016
- Table 3. Data and Assessments – synthesis of national, state, and local data sources
- Table 5. Community Supports and Assets
- GCACH, Community Assets Inventory by Toolkit Project Area, 2017
- GCACH, Bi-directional Integration Models Inventory, 2017
- Community Commons maps

- 2012 Garfield Community Health Assessment
- 2012, 2013 Kittitas County Community Health Profile
- 2013 CHNA Report, Tri-State Memorial – Asotin
- 2016 Community Needs Assessment – Health, Education & Income, Lewiston Asotin
- 2016 CHA – Final - Lewiston Asotin
- 2017 HDC-Yakima Community Forum – Summary
- 2017 Local Health Jurisdictions in WA State CHA-CHIP-CHNA table-1
- 2017-0526 CHIP Update 5 DRAFT for Benton-Franklin Community Health Alliance Member review
- 2012 Benton-Franklin Community Health Needs Assessment
- CAN – 2015 Full-Asotin and central ID
- Columbia CHIP 11-14
- Columbia County Health Assessment 2009
- Final Report – Columbia County
- Kittitas County Community Health Improvement Plan
- Sunnyside Community Hospital and clinics CHNA report
- TriState-CHNA-2016-Final
- Walla Walla 11.12.22 CHIP final
- Walla Walla County Health Report 2015
- Whitman County Needs Assessment 2016 final
- Yakima Community HNA 2016

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.

“It is only through clear presentation of data that health policy can be developed.” State of Reform

GCACH has a strong history in using data to evaluate regional health needs and inform decision-making around project selection and planning. Dr. Patrick Jones, Executive Director of Eastern WA University’s Institute for Public Policy and Economic Analysis, was hired in June of 2014 to facilitate the fledgling GCACH given his expertise in data, research and policy development. During the next eighteen months, Dr. Jones led the Leadership Council through an intensive process to evaluate national, state and local data which resulted in five common priority areas: Care Coordination, Diabetes/Obesity, Behavioral Health, Healthy Youth & Equitable Communities, and Oral Health. Five Priority Committees were formed to review data, resources and initiatives in the region, and to start collaborating across disciplines.

The GCACH Regional Health Improvement Plan (RHIP) which was developed in the Spring of 2016 by a cross-sector, cross-county committee called the Strategic Issues Committee, and guided by a consultant, Deb Gauck, strengthened the work of the committees with additional data sources, including evidence-based practices and programs within the priority areas, and highlighting areas of health inequity. The RHIP incorporated five guiding principles:

- Promote a culture of health and health equity
- Facilitate a regional population health approach
- Engage the community
- Focus on prevention and early intervention

- Ensure strategies are data-informed, aligned, culturally competent, and sustainable.

With the approval of the Demonstration, the five priority areas evolved into the eight demonstration project areas given the natural alignment with our regional health priorities. In April 2017, GCACH launched eight Project Teams to engage an in-depth review of regional health data and develop project plans in each of the Demonstration project areas. GCACH staff presented an overview of key regional health needs to our Board, and separately to each Project Team (data socialization) based on our earlier RHIP evaluation as well as updated datasets provided by HCA and other sources listed above.

GCACH Priority Work Group	MTD Project Team
Behavioral Health	Bi-Direction Integration of Care & Primary Care Transformation
	Addressing Opioid Use Public Health Crisis (NEW TEAM)
Care Coordination	Community-Based Care Coordination
	Transitional Care (NEW TEAM)
	Diversion Interventions
Healthy Youth & Equitable Communities	Reproductive and Maternal/Child Health
Oral Health	Access to Oral Health Services
Diabetes/Obesity	Chronic Disease Prevention and Control

Accompanying this presentation, GCACH internal staff prepared a master data file synthesizing data sources reviewed, and presenting data in a digestible manner that compares GCACH to statewide performance, highlights variation by the nine counties in the region, and allows ready identification of health indicators with worse outcomes.

The GCACH tasked Project Teams with objectives to evaluate the regional health needs data in each project area and to develop proposed projects targeting these needs consistent with the Healthier Washington Toolkit. GCACH shared the master data file with each Project Team, and provided ongoing staff support to address data-related questions and other issues. Project Teams met weekly between May and June to develop a Project Team Report based on a standardized template (see attached). At our June 22, 2017 Leadership Council meeting, the Project Teams presented their reports, and received feedback from the broader Leadership Council and Board regarding the proposed projects.

At the GCACH August board meeting, the Board will select projects to move forward in the Project Plan application. This decision will be based on core selection criteria, including whether the project addresses a key regional health needs based on evaluation of data. If a project area moves forward, we expect to continue to engage in further data analysis to target populations and further inform project planning efforts.

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

In anticipation of the pivotal role that data will play in project selection, planning, implementation and ongoing monitoring of the projects, GCACH has hired internal staff (Program Manager, Wes Luckey) with dedicated job responsibilities and senior-level data analytic skills to support data-informed decision-making by our Board, Leadership Council, and Project Teams. In addition, we have

identified key contractors to support our internal staff capacities. Currently we have a contract with Eastern Washington University to provide this support as needed.

GCACH is actively engaged with Project Teams and addressing data gaps that arise. Because many of the team members work within clinical settings, they can access EDIE, PRISM, and disease registries. We have communicated key gaps in data to HCA and initiated requests. For example, given the high ER utilization rates in our region, we requested data detailing ER utilization by facility and diagnosis codes. HCA recently provided this data to all ACHs, addressing our request.

Data-related Collaborations

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

Cross-ACH collaboration is taking place between GCACH, Pierce County, Better Health Together and Southwest WA around joint implementation of the Pathways Community Hub model.

GCACH has engaged with multiple ACHs to share our approach for analyzing and synthesizing various datasets to identify and target our priority regional health needs. Given our mutual interests with other ACHs to use data throughout the Demonstration, we see collaboration on data-related activities as a key opportunity to share best practices and leverage resources needed to develop and support a regional health data infrastructure that helps us to effectively identify priority needs, target strategies to meet these needs, and monitor our success. A cross-ACH infrastructure and common data strategy also better serve our partnerships with MCOs, which provide Medicaid services across multiple ACHs. GCACH is actively exploring opportunities to collaborate with other ACHs to address common data-related needs through Providence Center for Outcomes Research and Education (CORE), an organization that currently provides data support to four other ACHs.

We plan to further collaborate with other ACHs to explore a cross-ACH data infrastructure and support system for Domain 1 activities (VBP, HIT, and workforce).

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.

GCACH has engaged with county health authorities in each of the counties throughout the region to evaluate and leverage local jurisdiction community health needs assessments and community health improvement plans. Representatives from each of these local authorities participate in our Leadership Council and are actively engaged in our project planning efforts. These existing evaluations provide critical information to inform our evaluation of regional health needs and clarify our understanding of priority needs.

GCACH is also closely engaged with and has developed strong relationships with MCO and provider representatives on our Leadership Council and participating in our Project Teams. We currently have representatives from all MCOs in our region participating on the Leadership Council, as well as representation from major health system providers (hospital, primary care, behavioral health, oral health). As we continue with project planning efforts, we will build on these relationships and further explore opportunities to leverage MCO and provider analytic infrastructure for purposes of project planning.

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.

GCACH is re-forming the Data Committee into the Data Management and Health Information Exchange (DMHIE) Committee to facilitate information sharing and coordination among GCACH member organizations on data related matters, including data system requirements and standardization. The DMHIE will also be charged with developing a coherent strategy for organizing, governing, analyzing, and deploying health information. Data management and HIE experts from various health systems, the GCACH Practice Transformation Support Hub coach, and chief information officers will be asked to serve on the committee. GCACH will also be contracting with external consultants and organizations.

In late August, following the Board's selection decision, GCACH will release a request for Letters of Interest (LOI) for each project area. GCACH will develop the request for LOIs with input from the Project Teams and the Data/HIE Committee. The LOI process will outline minimum participating provider qualifications, and provide an opportunity to gather information from potential partnering providers regarding their data or data system requirements needed to implement the demonstration projects. This will include, for example, information regarding electronic health record systems and capacity.

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

GCACH recognizes the critical need for data systems and infrastructure needed to monitor and oversee demonstration projects. The GCACH staff and the LC Data/HIE Committee will play a critical role in identifying GCACH data systems needed to oversee these projects. Important issues to consider include:

- Systems that leverage existing data
- Timely performance reporting and feedback to providers
- Interoperability of data system
- Data governance and information sharing arrangements
- Partnerships with MCOs

Another role of the DMHIE will be to identify data and information gaps and data integration needs to support the Participating Provider organizations, and the reporting requirements of the Demonstration. To ensure Participating Provider compliance with sharing performance data, conformance language will be embedded within the Letters of Interest/Requests for Qualifications to be released to interested agencies at the end of August. Compliance with sharing data will also be part of GCACH contracting language with Participating Providers.

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.

Using the advice of the Benton-Franklin Workforce Development Council, (BFWDC) GCACH developed a regional survey in March of 2017 to identify local and regional gaps in workforce capacity. The survey was distributed to 700 members across the GCACH area, and returned 113 responses. A Workforce Development Committee is being formed in response to the survey, and through the workforce needs identified in the project plans. The committee is being chaired by the Director of the Washington State Allied Health Center of Excellence, Dan Ferguson who is a GCACH Board member.

GCACH staff and the Chairman have since met with the BFWDC Executive Director and Board Chair to start developing an action plan.

Attachment(s) Required

None

Transformation Project Planning - 15 points

Description

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

Instructions

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

Anticipated Projects

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

The eight Project Teams (PTs) have developed eight potential projects described below. GCACH is actively pursuing strong linkages across projects for maximum impact in our region. The project teams began their work grounded in regional health data. Once projects were developed, teams presented them to the Leadership Council, at which point many important linkages were either identified or suggested.

We are working with our consultants (HMA) to conduct a deeper analysis of linkages across the projects in target populations, outcome metrics, strategies and provider types. The Leadership Council (LC) engaged in an exercise discussing how to strengthen the project portfolio through greater alignment and linkages. Analysis to “reverse engineer” from the performance metrics are currently underway, with the goal of aligning the practical need to consider performance metrics with the vision of regional health system transformation. Team facilitators will be active participants in these efforts by working with each other across projects, and with GCACH staff and the consultants. A Technical Advisory Committee will review the projects using criteria approved by the board, which includes linkages to other projects. The Board will also consider linkages across projects in its final review and approval of project selection.

MTD Toolkit: P4P Reporting Metrics



GCACH Demonstration Project Concepts	
2A	<p>This project will support providers in the region to adopt a continuum of complementary evidence-based care integration models. These models will optimize delivery system resources, tailor services based on patient complexity levels, and increase access to behavioral health services. Regional health needs assessments and capacity inventories have underscored significant population behavioral health needs and a lack of mental health providers. Key components of this project include:</p> <ul style="list-style-type: none"> • Analysis of current system integration resources and gaps • Development of data sharing systems to support integrated care • Hiring, training and supporting providers to adopt integration models targeting regional needs
2B	<p>This project will support development of a regional Pathways HUB to coordinate and support Community Health Workers (CHWs) to address a range of social and health-related issues using standard “pathways”. Members will receive a comprehensive assessment to identify needs impacting their health, and local CHWs will work with members in a range community and healthcare settings to address these needs using one or more “pathways” defining key steps for achieving targeted outcomes. Key components include:</p> <ul style="list-style-type: none"> • Determining and launching Pathways Hub entity • Training CHWs • Creating infrastructure to monitor and improve quality metrics
2C	<p>This project will improve support for at-risk enrollees transitioning from acute to less intensive care settings. The project will build upon several existing programs within the region with demonstrated success. The project will implement proven tools to support management of acute changes in condition without transport to the hospital. The project encompasses care transitions from hospital to home, home health agency, skilled nursing facility or other settings, as well as transitions to less intensive care levels. Key components:</p> <ul style="list-style-type: none"> • Adoption of Interventions to Reduce Acute Care Transfers (INTERACT) • Expansion of collaborative community para-medicine efforts • Expand use of field-based nurse care coordinators, CHWs, and community paramedics
2D	<p>This project area strengthens and expands community-based care coordination, outreach and education for Medicaid populations identified as high to moderate/low emergency department users. The project would use a centralized referral center to allow intake of referrals from emergency departments, emergency medical service agencies, urgent care, behavioral health and substance use providers, primary care providers, and other communities agencies. The referral center would serve as a single entity for identifying patient needs and managing and coordinating a full range of medical and community-based resources to prevent avoidable emergency department use. The project builds upon an existing care coordination model operating in several counties in the region that has demonstrated success in reducing emergency department utilization. Key components of the project include:</p>

	<ul style="list-style-type: none"> • Uses team of RN case managers and CHWs to provide medical care coordination and community-based outreach to connect individuals with needed services. • Classifies patients in to super-user or moderate/low-user groups, and services tailored to address patient needs. • Leverages the statewide Emergency Department Information Exchange to communicate and implement care plans for emergency department super-users.
3A	<p>This project engages a multi-pronged strategy to address the opioid crisis including: prevention, treatment, overdose prevention, and recovery. The project uses a harm reduction model to comprehensively assist patients to with an opioid use disorder. In many locations throughout the GCACH, programs exclude opioid users either formally through policy (all housing programs require sobriety, for example), or informally (physician groups telling patients they can't work with them or treat them until they stop using). This project area would support and encourage providers to open services to these patients, or to begin new or pilot programs. The project seeks to leverage existing provider services across the social service and health care infrastructure, and incentivize new services to fill in the gaps. Key project components include:</p> <ul style="list-style-type: none"> • Harm reduction model to increase support for individuals with opioid use disorders • Develop opioid case management hubs in strategic locations across the region to coordinate comprehensive services
3B	<p>This project expands the use of evidence-based home visiting programs for low-income families and children. The project would allow local communities to identify one of two evidence-based models (Nurse Family Partnership or Parents as Teachers) best addressing local needs. These efforts would build upon the experience of existing programs in the region implementing these evidence-based models. Yakima and Benton-Franklin counties currently operate successful Nurse Family Partnership programs, and the Parents as Teachers model has current affiliates in Yakima and Walla Walla counties. In addition, this project would support efforts to increase provider and consumer awareness, education and accessibility of long acting reversible contraception (LARC) in the region. Key components of the project include:</p> <ul style="list-style-type: none"> • Expands evidence-based home visiting programs for low-income mothers and families focusing on the Nurse Family Partnership and the Parents as Teachers models
3C	<p>This project aims to increase access to oral health services by expanding dental hygienists providing oral health services to adults in community settings and medical offices, embedding dental hygienists in medical primary care teams, and providing oral health case management services. Regional health needs assessments and capacity inventories have underscored low rates of access to oral health services among Medicaid adults and children, and a lack of dental health providers. Key components of the project include:</p> <ul style="list-style-type: none"> • Supporting dental hygienists to provide community-based preventive dental services for adults • Expand dental hygienist services in primary care clinics and schools • Train CHWs to provide oral health case management services to ensure access to needed social, clinical and oral health services.

3D	<p>This project increases prevention and treatment for chronic disease in relation to individuals with diabetes and obesity. The project focuses on expanding adoption of evidence-based diabetes and obesity chronic disease prevention and treatment models across the region. This effort would build upon the experience and success of Yakima County in implementing the Diabetes Prevention Program and Chronic Disease Self-Management Program. Key components of the project include:</p> <ul style="list-style-type: none"> • Develop regional project management and resources to support local implementation. • Hot spotting and GIS mapping to identify areas of greatest need, and gaps in services and resources. • Strategies to implement models in rural areas with smaller population size
<p>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.</p>	
<p>GCACH is exploring forming a Pathways Hub collaborative with Pierce, North Central, Better Health Together, Cascade and North Sound (as well as other potential ACHs). Through our consultant, HMA, we are also in discussions with CPAA and KCACH about shared learning and/or collaboration on project development and data and analytics. GCACH is also actively exploring opportunities to collaborate with other ACHs to address common data-related needs through Providence CORE.</p> <p>The ACHs have created a learning collaborative and meet on a weekly basis to share insights, expertise, and best practices. Specifically, GCACH is aligning with other ACHs in the following project areas:</p> <ul style="list-style-type: none"> ▪ CHW Workforce Coalition (Olympic, Cascade) ▪ Demonstration incentive allocation strategy and design (Olympic, Cascade) ▪ Engagement and alignment with MCOs around sustainability beyond the Demonstration (Olympic, Cascade) ▪ Identification of common platforms for customer relationship management, data warehouse, reporting, analysis, cybersecurity, survey management, and contract and compliance management (Olympic, Cascade) ▪ Exploration of a shared audit firm for economies of scale (Olympic, Cascade) ▪ Tribal training and engagement (Olympic, Cascade) ▪ Addressing Opioid Use - All ▪ Pathways Hub (Cascade, Pierce, BHT, N Central) ▪ Community Para-medicine (BHT) ▪ Bi-directional – All ▪ HIE exploration (SW ACH, Olympic) 	
<p>3. Demonstrate how the ACH is working with managed care organizations to inform the development of project selection and implementation.</p>	

All MCOs have been involved in project development and participate in PTs, as well as the LC. Amina Suchoski of United Healthcare is the MCO representative on our governing board. The Care Coordination project team is led by Jorge Rivera, and Fenice Fregoso co-chairs the Chronic Disease team, both work for Molina Healthcare. Kat Latet from CHPW has used her experience in value-based purchasing and care strategies to outline a strategy for bi-directional integration. In addition, GCACH staff have reached out to all MCOs in the region to discuss vision, community engagement, sustainability, and the projects being developed.

Several MCOs are taking leadership roles to facilitate or co-facilitate the teams. Twenty-five MCO representatives receive all GCACH meeting notices and materials, newsletters. Several MCO representatives have been actively engaged in helping advance implementation of fully-integrated managed care to our behavioral health organization, Greater Columbia Behavioral Health.

Project Plan Submission

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

GCACH has taken steps to mitigate risk through various strategies:

- The Project Selection Process was “reverse engineered” and built with the end in mind: a successful project plan.
- Wide engagement of potential participating providers.
- Clear communications of expectations, timelines, workflow, and planning steps.
- Hired consultants with DSRIP experience to work with staff, PTs, LC, and Board members to develop project portfolio.
- Providing the Board with an in-depth understanding of the Delivery System Reform Incentive Payments, and the achievability of pay for reporting and pay for performance metrics to mitigate risk for the project plan.
- Frequent engagement with Tribal partners to explain project planning processes.
- Presentations to hospital systems, local health improvement coalitions, Tribes, social services organizations, and stakeholders to get feedback on draft project plan.
- Input from Medicaid beneficiaries to ensure projects are practical and meet their needs.
- Creation of an independent Technical Advisory Committee comprised of high-level expertise in public policy, managed care, research, medical and dental.

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

GCACH will use recently released HCA Medicaid professional services claims data to identify total number of claims and beneficiaries by provider, general service category, and diagnostic condition. These data will be used to identify the providers serving the largest number of Medicaid beneficiaries. GCACH will reach out to ensure we are engaging these providers and consulting with them on project design, metrics, and the achievability of performance measures. (Attachment B: Professional Services Summary Report)

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

GCACH intends to identify interested partnering providers through a Letter of Interest (LOI) and/or Request for Qualifications (RFQ) process. The request for LOIs /RFQs will be issued at the end of August and due back in early October.

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.

COLLECTIVE IMPACT is a framework to tackle deeply entrenched and complex social problems. It is an innovative and structured approach to making collaboration work across health care, government, business, philanthropy, non-profit organizations and citizens to achieve significant and lasting social change. At its core, the GCACH is comprised of hundreds of organizations coming together to transform health care.

Greater Columbia Accountable Community of Health

GCACH has a wide array of partners engaged in the Leadership Council and our Board, which has led to projects that incorporate social determinants and recognize the value of providers outside health care delivery.

At its core, GCACH represents hundreds of organizations coming together using the Collective Impact Model. GCACH will notify a wide array of provider types and partners of project funding opportunities and encourage collaboration among partners in the submission of LOIs and RFQs.

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.

The PTs have been asked to consider and speak to sustainability in their project reports, including which entities will benefit from a project’s projected savings and which are likely to experience a revenue loss. This information informs how we need to work with the health care delivery system

providers in our region, and how to approach shared savings strategies. In addition, GCACH has actively reached out to and engaged the MCOs in our region. Already conversations are underway with one MCO (Molina) about the possibility of long-term funding for certain pathways within the Pathways Hub model. We have also utilized our consultants who have provided a recommended strategy for approaching other MCOs about sustainability.

Attachment(s) Required

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

Attachments Checklist

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

Required Attachments	
Theory of Action and Alignment Strategy	
None	
Governance and Organizational Structure	
X	A. Copies of charters for committees and workgroups that outline purpose, members, responsibilities, and scope.
X	B. Conflict of interest policy.
X	C. Draft or final job descriptions for all identified positions or summary of job functions.
X	D. Short bios for all staff hired.
Tribal Engagement and Collaboration	
X	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.
X	B. Bio(s) for the representative(s) of ITUs seated on the ACH governing board. <i>If you do not have an ITU representative on the governing board, please attach a description of the efforts made to fill the seat.</i>
Community and Stakeholder Engagement	
X	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).
X	B. List of all public ACH-related engagements or forums for the last three months.
X	C. List of all public ACH-related engagements or forums scheduled for the next three months.
X	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.
X	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	
X	A. Bio or resume for the Chief Financial Officer (CFO) or equivalent person responsible for ACH financial functions.
X	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.
X	C. Completed Phase II Project Design Funds Budget Template, which includes Projected Project Design fund budget over the course of the demonstration, additional funding sources, and in-kind resources that the ACH expects to leverage to prepare their Project Plans and build

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

Recommended Attachments	
Theory of Action and Alignment Strategy	
X	A. Logic model(s), driver diagrams, tables, and/or theory of action illustrations that visually communicate the region-wide strategy and the relationships, linkages and interdependencies between priorities, key partners, populations, regional activities (including workforce and population health management systems), projects, and outcomes. <i>Note: These documents are intended to reflect the thought process that the ACH went through to define a vision for transformation that is grounded in community needs and tied to the broader Healthier Washington objectives, and to define how it will align its activities and resources to advance the vision in an efficient manner.</i>
Governance and Organizational Structure	
X	E. Sector representation policy describing any agreements or expectations for decision-making body members to communicate with and engage partners within a defined sector.
X	F. Revised visual/chart of the governance structure, if there have been significant changes since Phase I Certification.
X	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	
X	C. Statements of support for ACH certification from every ITU in the ACH region.
Community and Stakeholder Engagement	
See Attachments	
Budget and Funds Flow	
See Attachments	
Clinical Capacity	
See Attachments	
Data and Analytic Capacity	
See Attachments	
Transformation Project Planning	
See Attachments	