Phase II Certification Submission Template

ACH Phase II Certification: Submission Contact	
ACH	King County
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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.

The King County Accountable Community of Health (KCACH)'s vision is that "by 2020, the people of King County will experience significant gains in health and well-being because our community worked collectively to make the shift from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities."

To advance this vision, the KCACH works to "build healthier communities through a collaborative regional approach focusing on social determinants of health, clinical community linkages, and whole person care."

The Demonstration funds will strengthen the region's ability to collaborate and align the efforts of providers, payers, local government, consumers, tribes and community based organizations. The KCACH intends to provide support for delivery system transformation and practice improvement and serve as the long-term structure for continued, authentic community and consumer engagement.

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

The KCACH adopted a Regional Health Improvement Plan (RHIP) framework in 2016 (see Attachment A, Figure 1), which identifies health needs and priorities. The RHIP framework prioritizes these needs:

- Addressing race and social justice through the social determinants of health,
- Care coordination,
- Chronic disease prevention,
- Maternal and child health, and
- Physical and behavioral health integration.

Our Regional Health Needs Inventory (RHNI) documents widespread health disparities in King County. For example, while 10% of the population reports mental distress on a frequent basis, 21% of low-

income residents do. Across-the-board inequities in virtually every health and well-being measure are pronounced by place and race, including tribal populations in our county. A social risk factor affecting many county residents is lack of affordable housing, experienced by 39% of the population, and identified as a significant priority in many of the 54 community health needs assessments conducted in the last five years. High levels of need are also concentrated in the southern part of King County.

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

The RHIP framework is founded on five principles to use as strategies to address priorities:

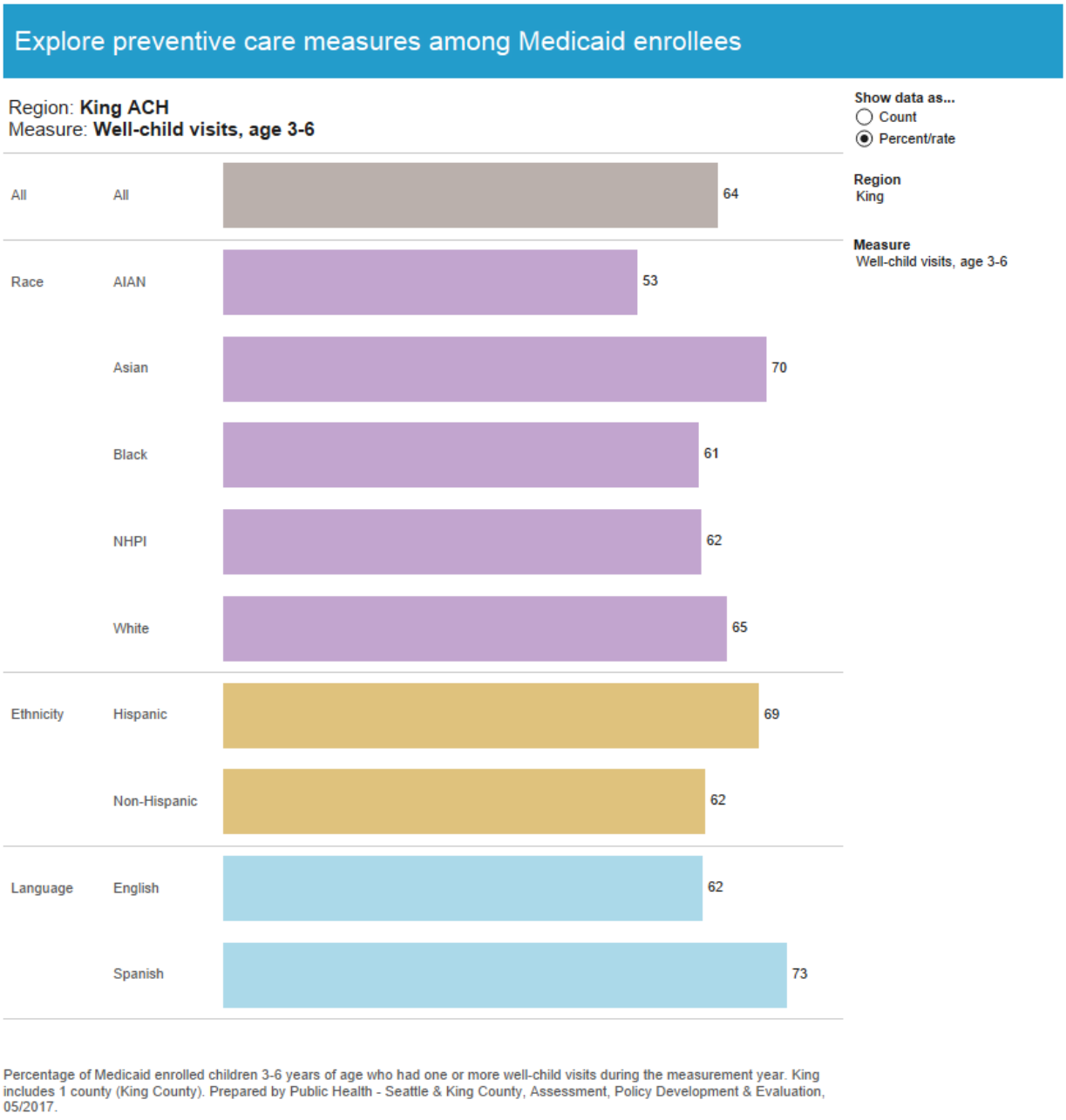
a. Use culturally and linguistically relevant and responsive services,
b. Focus on assets more than deficits,
c. Have on-going partnerships with community, not one-time interactions,
d. Embrace community-driven solutions, and
e. Use person-centered, team-based approaches that include community health workers, peer support specialists, navigators, and other non-traditional health workers.

The KCACH's strategies to address the region's needs and priorities will be accomplished by incubating, aligning and accelerating initiatives to strengthen communities and improve overall population health. The KCACH will work to align DSRIP projects with related efforts and investment flows to maximize impact and achieve results.

The KCACH project portfolio will then be designed around communities with the greatest health disparities and largest opportunity for improvement. Including the voices of people who are affected by inequities in the development, implementation and evaluation of innovative strategies to apply evidence-based and promising practices will be a more effective way to address health disparities. The KCACH will look to identify ways to engage communities more robustly in the planning and implementation. By reviewing our RHNI and other data, together with communities, we will better understand what the data are saying and what some of the challenges and solutions to improving overall health are for each community.

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

King County is characterized by relatively good overall population health that masks disparities by income, geography, race/ethnicity and language. Our theory of change responds to these needs by calling for more culturally-, geographically- and linguistically-specific strategies among the Medicaid population and informed by those with lived experiences. For example, the variations in well-child visits become apparent when we compare populations. While 76% of commercially insured children aged 3-6 years in King County receive well-child visits on time, only 56% of children the same ages with Medicaid do (Source: 2016 Community Checkup). Disparities by race and ethnicity are seen among Medicaid children as well. See table below.



In order to address project selection, the KCACH has assembled eight Project Design teams with cross-sector representation, including community health and behavioral health centers, managed care plans, hospitals, community partners, consumer perspectives and community-based organizations. These design teams are charged with developing projects that will lead to a portfolio with the greatest potential to address the region's priority health needs, meet performance targets and contribute to system transformation. Guidance to these teams is provided by the Demonstration Project Committee (DPC) of the Governing Board. Grounded in the RHIP, the DPC is tasked with designing overall Demonstration project strategy and recommending a portfolio of projects for review and approval by the Governing Board, and includes leaders from community organizations and delivery systems with deep subject matter expertise and hands-on experience in the region.

In doing the initial project plan template scoping, the design teams utilized the regional needs data to evaluate both the feasibility of and regional interest in project strategies. The DPC has also provided design teams with specific guidance and criteria to guide project development, such as addressing inequities, obtaining input from affected people, demonstrating sufficient reach to move countywide Medicaid metrics, and balancing being evidence-based and innovative. Design teams will solicit public comment on their draft project plans in late August. Final project plan templates are due to the DPC in September with a draft recommended portfolio going to the Board in October.

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.

The Governing Board will take a strategic approach to selecting a portfolio of projects by November 2017, seeking to connect the KCACH efforts to other regional initiatives. The DPC, with support from Health Management Associates (HMA), our recently retained DSRIP consultants, will carefully consider the Domain 1 investments needed across the projects and make recommendations to the Board. Design teams comprised of participants from multiple sectors will work on alignment and dissemination plans to build coordinated, region-wide strategies. They focus on breaking down siloes between sectors.

The KCACH Governing Board is structured to align regional activities, and its leadership reflects that multi-sector approach—the KCACH is chaired by an affordable housing leader and a Native American physical/behavioral health expert. In addition, several Board members and staff are participating in ReThink Health Ventures, a national cohort of six sites reforming health and well-being systems. As referenced in Figures 2 and 3 (Attachment A), the KCACH sees the value in aligning initiatives across several sectors.

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

The KCACH is excited about the opportunity to invest in interventions and infrastructure that will be valuable regional leave-behinds. Incentive payments likely will be used to fund one-time costs associated with the KCACH's theory of change, such as infrastructure improvements, practice transformation, data systems and the dissemination of evidence-based approaches.

Initial assessment of project plans suggest that shared infrastructure could be valuable to several projects. For example, there is recognition that despite having up to eight distinct projects, the KCACH should not build eight separate data and analytic platforms, but instead use a multi-stakeholder process to identify a minimum number of data investments to support cross-cutting and project-specific needs. Examples include a technology infrastructure to share care plans across multiple providers, a systematic way to connect primary care providers to community organizations, and new or re-purposed "no wrong door" physical locations that can meet patients' needs in flexible ways. Practice transformation infrastructure investments are being explored to support whole-person care that encompasses physical, behavioral, chronic condition and oral health care. The KCACH will also build on the work on Behavioral Health (BH) and value-based purchasing (VBP) currently underway. The county is working with stakeholders to develop a proposed VBP program to drive the VBP transition

and ensure the effective provision of integrated, whole-person BH services.

Attachment(s) Recommended

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

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

Governance and Organizational Structure – 10 points

Description

Provide a description on the evolution of the governance and organizational structure of the ACH. Identify and address any updates/improvements to the ACH's Governance and Organizational Structure since Phase I Certification. Visuals can be used in this section to inform the narrative and will not count toward the total word count.

Instructions

Complete the attestations and provide a response to each question. *Total narrative word-count for the category is up to 1,000 words.*

ACH Attestation(s)

ACH has secured an ACH Executive Director.

☒ **YES**

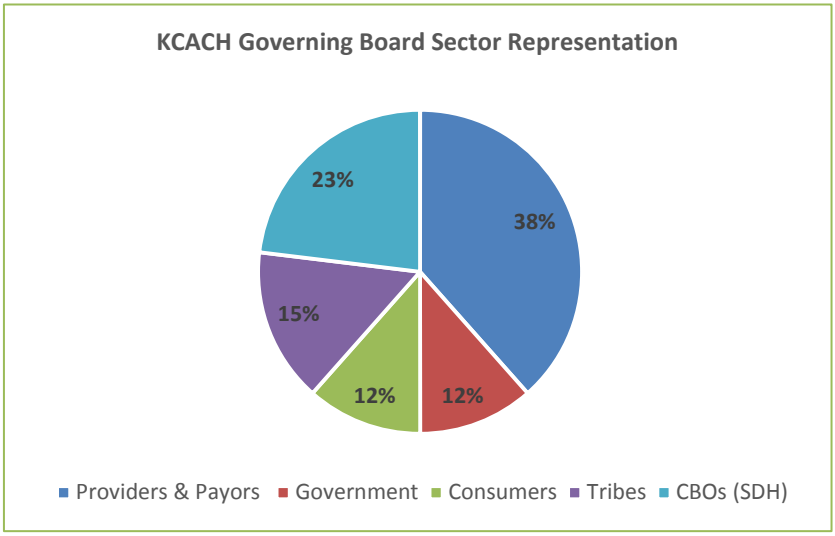
ACH has been established as a legal entity with an active contract with HCA to serve as the regional lead entity and single point of performance accountability for DSRIP transformation projects.

☒ **YES**

ACH Structure

1. Describe the ACH's sector representation approach in its governance structure. Describe how the ACH is interacting with particular sectors across the region (e.g., primary care, behavioral health, etc.), and how those sectors are engaging with the decision-making body.

In December 2016, the King County ACH (KCACH) Interim Leadership Council (ILC) approved a 25-member Governing Board (now 26 members, see below) that ensured balanced participation across sectors:



Since Phase I Certification, the Board has *added 1 tribal seat* to make for a 26-member Board:

Sector	Representative (# seats)
Providers / Payers	Primary care provider (1 seat) Federally qualified health center (1) Hospital, health systems (3) Behavioral health providers, including at least one substance abuse provider (3) Managed care organization (1) Local public health (1)
Government	King County (1 seat) City of Seattle (1) Suburban area (1)
Community/Consumer	Community based equity networks, coalitions and/or consumer advocate organizations, including grassroots consumers affiliated with these entities (3 seats)
Tribes	Federally recognized tribes in King County – Cowlitz, Muckleshoot and Snoqualmie (3 seats) Urban Indian Health Board (1)
Community Based Organizations (social determinants of health)	Housing (1 seat) Long-term care services/supports (1) Non-profit social service organizations (2) Philanthropy (1) At-large member (1)

To ensure sector representation, Board members committed during their orientation to community engagement responsibilities, including outreach to specific organizations/groups (see Attachment E).

Below are illustrative examples of communication between the Board and sectors:

1) At the July Governing Board meeting, one of the Board's hospital representatives shared feedback from the Washington State Hospital Association regarding how Medicaid beneficiaries would be counted who reside in one ACH-catchment area but receive services in another.

2) Likewise, the Board's community representatives bring recommendations from the Community/Consumer Voice (CCV) committee. At its June meeting, the Board adopted the CCV's equity impact assessment tool to guide project selection. The CCV is also charged with developing a community engagement plan and recruiting stakeholders to serve on various committees. Each committee of the ACH must also proactively facilitate community engagement; this responsibility

is not delegated to the CCV alone.

Finally, all Governing Board meetings are open to the public and ensure time for public comment. This allows organizations/individuals who may/may not be on a committee to engage in the decision-making process.

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)

As of Phase I Certification, the KCACH was established as a separate limited liability company (LLC) within the Seattle Foundation and under the direction of an independent Governing Board. The KCACH also created a committee structure to support its many activities (see Attachment F).
Since Phase I, several significant changes have been made to finalize and improve the governance structure. The KCACH has:

- **Hired an Executive Director (ED)**. Susan McLaughlin started on July 24, 2017.
- **Selected Governing Board Co-Chairs**. Two community-based representatives lead the Board: Betsy Lieberman, the housing sector representative, and Esther Lucero, of the Seattle Indian Health Board.
- **Added one tribal seat** to the Board to include all three King County federally-recognized tribes (Cowlitz, Muckleshoot, Snoqualmie).
- **Approved the backbone services contract** with Public Health Seattle-King County (PHSKC) to formalize data analysis, project management and other services (see Attachment G for details).
- **Adopted new policies and decision-making guidelines**, including conflict of interest and tribal policies. Since Phase I, the Board also updated its decision-making policy to include guidance on decisions that can be made by the Board, the Executive Committee and the Executive Director (see Attachment H).
- **Launched/expanded several committees**, including the Executive and Finance Committees. All Executive Committee members are tasked with being in leadership roles on each ACH committee to ensure effective coordination (see Attachment A, Executive Committee charter). A new Clinical Committee is under development.

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 Governing Board adopted a conflict of interest (COI) policy that is both robust and tailored to the ACH's central tenant of deliberately engaging sector experts. The following provisions were developed to address, among other things, the unique circumstance where some Demonstration projects may include many organizations represented on the Board:

- The policy applies to any member of the Governing Board, its Executive Director and Senior Management, and Executive and Finance Committees and includes personal financial interest, (e.g., ownership, investment) or organizational interest, (e.g., being employed by an agency).

- Members have a duty to disclose conflicts of interest and may recuse themselves at any time.
- If a conflict exists, a member can inform the discussion to lend his/her expertise as a sector representative (again, a central tenet of ACHs) but s/he must leave the meeting for the vote, cannot be counted for the purposes of determining quorum, and cannot improperly influence voting (i.e., only *dis*interested members can count towards quorum and vote).
- In the unusual circumstance where a quorum of disinterested members alone is not possible (e.g., a majority of members may have a conflict on the integration project), interested members *can* be counted for quorum (so that the vote can proceed) but cannot vote on the measure.
- In adopting this policy, the Board understood that conflicts do not apply to a sector, only to personal or organizational gain (e.g., if one project is favorable to the housing sector and another to the managed care organization (MCO) sector, members representing housing/MCOs would *not* have to recuse themselves). However, they *would* have a conflict if they or their organization stands to benefit.

The Board felt these provisions adequately address conflicts while taking into account the unique, and more complicated nature of ACHs. Outside legal counsel confirmed that these provisions meet IRS standards and do not compromise the KCACH's tax-exempt status.

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.

The KCACH is relying on a combination of internal staff and external contracts with deep content expertise. See Attachment G for a detailed overview.

Internal Staffing

The KCACH has or is filling the following high/medium priority positions:

POSITION	ACTION STEPS / TIMELINE
HIGHEST PRIORITY HIRES (July – September 2017)	
Executive Director	**Hiring complete** (started July 24, 2017)
Program Director	**Hiring complete** (effective September 25, 2017) Existing backbone staff is moving from Public Health-Seattle King County (PHSKC) to the KCACH
Program Manager	**Hiring complete** (effective September 25, 2017) Existing backbone staff is moving from PHSKC to the KCACH
Chief Financial Officer	**Action Steps / Timeline:** • Posted job announcement – July 31, 2017 • Applicant submissions due – August 21 • Interview candidates – August 28 - September 15 • Select & hire – October 1 **Lead:** Executive Director with consultant support **Interim Solution:** In the interim, the KCACH has several resources to draw upon: a) the

	Seattle Foundation serves as its fiscal agent and provides financial/infrastructure services (e.g., payroll, human resources); b) ongoing capacity from PHSKC as its contracted backbone partner; c) financial modeling assistance through consulting contract with HMA; and d) leadership from the Board's Finance Committee to develop the KCACH budget and support the Executive Director in financial planning.
Administrative Specialist	**Action Steps / Timeline:** • Posted job announcement – July 31, 2017 • Applicant submissions due – August 21 • Interview candidates – August 28 - September 15 • Select & hire – October 1 **Lead:** Executive Director with consultant support **Interim Solution:** PHSKC is providing administrative services as part of its backbone support contract. The KCACH is also considering contracting with a temp agency and/or 501 Commons for additional support if needed.
MEDIUM PRIORITY HIRES (October 2017 – January 2018)	
Community & Tribal Engagement Liaison	**Action Steps / Timeline:** • Evaluate specific roles/functions needed to support engagement – September 2017 • Post job announcement – September 2017 • Interview candidates – October 2017 • Select & hire – November 2017 **Lead:** Program Director **Interim Solution:** The KCACH is relying on its contracts with both Healthy King County Coalition and PHSKC to support community engagement and backbone services.
MEDIUM PRIORITY HIRES (October 2017 – January 2018) - CONTINUED	
Clinical Director	**Action Steps / Timeline:** • Determine if a Clinical Director function is needed and, if so, with what content expertise – October 2017 • Post job announcement – October 2017 • Interview candidates – November 2017 • Select & hire – December 2017 **Lead:** Executive Director **Interim Solution:** The KCACH Governing Board is in the process of launching a Clinical Committee to both increase provider engagement and bring the necessary clinical expertise to the table. In addition, numerous providers/clinicians serve on the KCACH Project Design teams. The KCACH will rely on this external capacity and Board member expertise to support these functions.
Additional Program Managers (as needed)	**Action Steps / Timeline:** • Determine if additional program manager(s) are necessary to support the Demonstration Project Committee and design teams; if so, with what content expertise (e.g., integration, care coordination) – October 2017 • Develop job description(s) – October 2017 • Post job announcement – November 2017 • Interview candidates – December 2017 • Select & hire – January 2018 **Lead:** Program Director

	Interim Solution: As mentioned above, PHSKC is providing program management support and can cover these functions in the interim (see Attachment G for details).
Communications Specialist	**Action Steps / Timeline:** • Determine if a separate communications specialist is necessary or if these functions are adequately covered with existing staff/contracts (e.g., community and tribal engagement liaison staff, engagement contract with the Healthy King County Coalition, backbone support contract with PHSKC) – October 2017 • Develop job description – October 2017 • Post job announcement – November 2017 • Interview candidates – December 2017 • Select & hire – January 2018 **Lead:** Program Director **Interim Solution:** Program Director, Program Manager and Administrative Specialist will cover immediate communication needs.

External Consultant & Service Capacity

The KCACH is contracting with organizations with deep expertise in DSRIP, data/analytics, community engagement, project management and other services. Specifically:

- **Backbone services contract** with PHSKC to provide project planning, design team support, data systems/analytics, performance monitoring, regional health needs inventory, and certification support (see Attachment G with staffing detail).
- **DSRIP consultant contract** with Health Management Associates (HMA) to provide project planning and financial modeling.
- **Community engagement contract** with Healthy King County Coalition to lead the CCV Committee and related work.
- **Operating agreement** with the Seattle Foundation to serve as fiscal sponsor (e.g., payroll, financial services).
- **Governance/facilitation contract** with Christina Hulet Consulting to support governance, structural, and decision-making practices.

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.
H. *SUPPLEMENTAL:* KCACH decision-making guidelines

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.

Before Phase I Certification, the King County ACH (KCACH) benefitted from active participation by Governing Board members representing Urban Indian Health Programs (Seattle Indian Health Board) and the Cowlitz tribe. A third Governing Board seat was being held for another Federally-recognized tribe in King County (Muckleshoot or Snoqualmie). The King County ACH Interim Leadership Council (the decision-making body of the KCACH until April 2017) had received Board training by leadership council member Esther Lucero, CEO of the Seattle Indian Health Board, in July 2016. The Model ACH Tribal Collaboration and Communication Policy had yet to be discussed and adopted as the new ACH Governing Board was seated in mid-April 2017.

Since Phase I Certification, the KCACH has continued to move forward with tribal engagement. New invitation letters to join the Governing Board have been sent to the Tribal Councils of Muckleshoot and Snoqualmie from the new KCACH Executive Director (see Attachment D). Additional Board training was provided by the American Indian Health Commission (AIHC) and HCA tribal liaison on July 20, 2017 for the new KCACH Governing Board. This training was believed to be so beneficial to those that attended that the KCACH is arranging for a follow-up training for additional members at a future 2017 Board meeting.

At its May 18 meeting, the KCACH Governing Board elected a tribal member, Seattle Indian Health Board CEO, Esther Lucero, as one of its Board Co-Chairs. At its June 28 meeting, the Board added a third tribal seat so that all Federally-recognized tribes in King County would have a seat at its table.

On May 26 and May 30, staff reached out to contacts provided by HCA's tribal liaison at Muckleshoot and Snoqualmie to share the Model ACH Tribal Collaboration and Communication Policy and request feedback on the policy. The KCACH offered to meet in person to answer any questions about the KCACH and the policy. A Snoqualmie tribe representative informed the KCACH of a change in contact at the tribe and the KCACH contact lists were updated. The KCACH followed up with both tribes on June 21 and again on August 3, but have received no additional response to-date. At the Board training on July 20, the KCACH was encouraged to continue reaching out to these tribes.

The Model ACH Tribal Collaboration and Communication Policy was adopted by the KCACH Governing

Board at its June 28 meeting. The Board made improvements to the policy (see next question). Furthermore, at the same meeting, the Board adopted an equity impact assessment tool (shared at the June 28 Statewide ACH convening in Chelan, WA), which will be required of Project Design teams before submission of project plan templates to the Governing Board. Tribes have been added to the tool as a distinct population to assess project impacts. In this way, the KCACH will be able to operationalize the requirement in the policy to determine if ACH actions and projects will have impacts on tribal populations.

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)

At its June 28 meeting, the Governing Board decided to improve upon the model policy by designating the Governing Board itself as the body responsible for assessing tribal concerns and issues (and not establishing a separate ACH tribal committee). The Board felt this would reflect that the tribes are a partner, not a stakeholder, and thus appropriately recognize the tribal perspective and more effectively incorporate that perspective into the KCACH's decision making process.

In addition, the Board added language to the policy about continuing to invite the tribes to the KCACH table who have not yet been involved. KCACH staff have been doing this proactively; the additional language was intended to signal this as an ongoing priority.

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

Through participation of the Cowlitz tribe and Seattle Indian Health Board (SIHB) on the KCACH Governing Board, currently active ITUs will be important decision makers in project selection. Through SIHB's Interim Leadership Council membership (between December 2015 and April 2017), ITUs helped inform the development and approval of the KCACH's Regional Health Improvement Plan framework.

Engagement of non-active ITUs in King County continues. On June 21 and August 3, staff reached out to contacts at Muckleshoot and Snoqualmie to inquire as to health priorities identified by the respective tribes as well as to share the Model ACH Tribal Collaboration and Communication Policy. Receiving no response, staff reached out to contacts at other tribes to inquire as to whether there had been an update to the Northwest Portland Area Indian Health Board compilation of health profiles since 2014, or whether there are other resources for identifying health priorities. KCACH staff were directed to, and will follow up with, the AIHC.

At the AIHC Tribal Workshop on July 19, tribes were invited to identify representatives to join the KCACH's eight Project Design teams, be listed as interested providers, and contribute to the public comment period for the draft project portfolio (anticipated in late August). Tribes will also be invited to participate in the planning phase of project implementation and/or community project planning sessions in early 2018.

Board Training

4. Demonstrate the steps the ACH has taken since Phase I Certification to ensure the ACH decision-making body receives ongoing training on the Indian health care delivery system, with a focus on the local ITUs and on the needs of both tribal and urban Indian populations. Identify

at least one goal in providing ongoing training in the next six months, the steps the ACH is taking to achieve this goal and the timing of these steps.

The KCACH Interim Leadership Council received Board training in July 2016 by council member Esther Lucero, CEO of the Seattle Indian Health Board, on the Federal trust responsibility and urban Indians. The Governing Board (which was officially seated in April 2017) participated in a tribal workshop with AIHC and the HCA tribal liaison on July 20, 2017. At the July 20 workshop, the Board members in attendance discussed how AIHC's training was foundational, and they felt all KCACH Board members would benefit. We discussed the logistics of a repeat training, and made plans with AIHC and the HCA tribal liaison to offer the training as a webinar to the KCACH Governing Board in the next six months. Staff will reach out to the HCA and AIHC in the Fall of 2017 to plan dates for this webinar and/or extend an invitation to a future Governing Board meeting.

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.

D. *SUPPLEMENTAL:* Tribal invitation letters

Community and Stakeholder Engagement – 10 points

Description

Provide a narrative that describes current and future efforts regarding community and stakeholder engagement and how these actions demonstrate inclusion of and responsiveness to the community. Identify and address any updates/improvements to the Community and Stakeholder Engagement category since Phase I Certification.

Instructions

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

ACH Attestation(s)

ACH has convened and continue to convene open and transparent public meetings of ACH decision-making body for discussions and decisions that pertain to the Medicaid Transformation demonstration.

☒ **YES**

Meaningful Community Engagement

1. **What strategies or processes have been implemented to address the barriers and challenges for engagement with community members, including Medicaid beneficiaries, identified in Phase I Certification? What are the next steps the ACH will undertake to continue to address remaining barriers and challenges? If applicable, discuss any new barriers or challenges to engagement that have been identified since Phase I Certification and the strategies or processes that have been implemented to address them.**

In Phase I Certification, the King County ACH (KCACH) identified challenges in authentic engagement due to limited time, budget, and capacity given the large numbers of perspectives in a region as populous as King County.

Strategies implemented to help address these challenges include:

- **Leveraging existing community expertise:** The KCACH executed a contract with the 45-member Healthy King County Coalition (HKCC) to broaden its reach and facilitate the Community/ Consumer Voice (CCV) committee, dedicated to consumer engagement. Next steps include dedicated outreach to Medicaid recipients through existing consumer organizations and groups such as Voices of Recovery, the Recovery Café, the Familiar Faces Advisory Group and members of the MCO and FQHC Community Advisory Committees.
- **Prioritizing inclusion in decision-making:** Consumer voices are present at multiple levels of the KCACH, including three seats on the Governing Board; three on the Demonstration Project Committee (DPC); and five on Project Design teams. Additionally, the CCV's chair is a member of the Executive Committee. The CCV meets monthly and will start holding evening meetings once per quarter to further expand participation.
- **Increasing capacity to support community engagement:** The KCACH will invest a portion of Phase II design funds to increase the capacity to support community engagement through expanded and/or additional contracts with community organizations such as HKCC and by adding KCACH staff capacity to ensure communities and consumers have what they need to actively engage in this work.

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

- The KCACH held 10 Community Learning Sessions (CLS) averaging 40 attendees each from multiple sectors. These sessions were open to the public, included robust discussion, and enabled all attendees to provide input into project planning.
- Our partnership with HKCC (mentioned above) to facilitate consumer engagement through the CCV is a key success for our region. The CCV has developed recommendations for authentic community/consumer engagement strategies, are implementing small grants to support community based organizations (CBOs) in engaging consumers and providing stipends to CBOs and consumers to decrease their barriers for participating in ACH meetings.
- Another success is our Familiar Faces Advisory Group – a group of individuals with lived experience (behavioral health and involvement in criminal justice) who meet monthly and have been advisors to the Familiar Faces Steering Committee informing them on ways to improve the system; helping with design of Familiar Face strategies (such as the VITAL team – a multidisciplinary intensive care management/treatment team). A subset of the advisors also sits on the Steering Committee.
- The KCACH has solicited and received feedback from the Behavioral Health Advisory Board, which is 51% consumers/family members of consumers of the behavioral health system. The KCACH has gone to their board meetings and solicited input regarding both the 2A and opiate projects.
- The KCACH has three community seats on the board and five community members participating on Project Design teams. The board adopted the CCV's equity impact assessment tool (see Attachment F), which prioritizes the need for consumer input, to guide the work of the KCACH and design teams.
- Consumer input has been an important value in the pre-work leading up to project development. In our early efforts, King County held 6 facilitated consumer focus groups that included individuals enrolled in community behavioral health and/or had past or current lived experience with mental health and substance use conditions to discuss the importance of system improvements and integrated care delivery. Their responses were incorporated into Integrated Design Committee recommendations that set the foundation for 2A project design.

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?

The KCACH hosted 10 Community Learning Sessions (CLSs) for potential Demonstration projects at the start of project planning to obtain input about the projects and community priorities within each domain. Information gathered at the CLSs was shared with the appropriate design team to guide and shape the formation of project planning.

Two specific community input examples:

July's chronic disease follow-up CLS confirmed the design team's direction, endorsing:

- Cardiovascular (including diabetes) and respiratory (including asthma) focus
- The pivotal role of community health workers representing diverse and underserved communities in King County
- Plans to continue presentations for partners such as the King County *Promotores* Network and their general membership

Similarly, the project proposal for reproductive and maternal/child health emerged directly from CLS priorities of:

- Care coordination and collaboration
- Culturally relevant approaches

All design teams will post draft project plans on the KCACH website for a two-week public comment period in late August. Design teams will partner with CCV to reach out to existing community and consumer forums for input. Feedback will be summarized and reflected back out to those who provided input as well as through standard communication channels.

Lastly, the design teams will utilize the CCV's equity impact assessment tool as project planning moves forward to ensure ongoing and bi-directional community and consumer communication.

Partnering Provider Engagement

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

In Phase I Certification, the KCACH reported challenges in engagement with partners due to limited time, budget, and capacity and large numbers of potential partners. Progress to address challenges include:

Provider engagement

- The full King County network of Medicaid Behavioral Health (BH) providers, contracted by the King County Behavioral Health Organization (BHO), has been engaged in the design and planning via participation in the CLSs.
- Having 3 seats on the ACH Governing Board, BH members provide monthly updates and receive feedback and input through the BH Provider Association.
- Physical health providers hold 4 seats on the Governing Board. CHC representatives provide regular updates through the Community Health Council of King County. Hospital/health system representatives provide regular updates through meetings of WSHA and King County Hospitals for a Healthier Community.
- Multiple health and behavioral health clinicians have lead roles on the Governing Board and DPC, and participate in all eight design teams. Hospital sector representatives, WSHA and Qualis Health, as well as the King County BHO actively recruited clinicians to participate in the design teams.
- Representatives from social services providers and CBOs (e.g. WithinReach, United Way,

South King Council of Human Services) are also participating on design teams.

Next steps

- Utilize the Governing Board's sector representatives, associations, conferences, and ACH newsletters to engage new providers.
- Leverage HCA data to reach out to providers that work with large numbers of Medicaid members.
- Scan ACH networks to identify social service and CBOs working with low-income residents.
- Develop a provider engagement committee to develop provider champions and implement provider engagement strategies.
- Co-host a forum with medical associations, MCOs, the BHO and others in the community and region about the Medicaid demonstration.
- Consider the broad array of provider types to engage, including those serving the developmentally disabled and long-term services and supports populations (based on project target populations).
- Solicit interest through an online letter of interest in the Fall of 2017 for project plan templates and 2018 planning work.

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

- There is strong representation of clinical and social service providers on the design teams. One notable success is our engagement with the criminal justice system through the Familiar Faces initiative. This has led to correctional staff participating in multiple design teams.
- Another success is the partnership with the low-income housing sector. This partnership has expanded health care providers' networks in the housing sector—a key social determinant of health resulting in at least one MCO hiring a Housing Specialist who has joined KCACH meetings and forums.

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.)***

Providers, beyond those represented in our governance structure, have played a significant role in the development of projects. A benefit of the participation of a wide array of provider types is that social services agencies and CBOs have held design teams accountable for addressing social determinants and expanding strategy design beyond medical delivery. For example, when the Transitional Care Design Team discussed whether to scale health care institutional inpatient discharge planning or explore jail transition work, it was invaluable to have correctional staff offer perspectives outside of the view of the traditional medical system.

The table below shows each design team's size and the number of participants representing health care and social service providers.

Design Team	Total	Clinical Providers	Social services/ CBOs
2A Bi-Directional	27	13	1
2B Care Coordination	62	11	10
2C Transitional Care	68	17	10
2D Diversion Interventions	19	7	5
3A Opioid Crisis	22	12	2
3B Reproductive and Maternal/Child Health	13	4	3
3C Oral Health	5	2	0
3D Chronic Disease	15	6	3

Transparency and Communications

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

The KCACH holds open, public meetings of its Governing Board every three to four weeks. Meeting schedules, agendas and meeting minutes are posted online here at least three days in advance and distributed to a stakeholder list of over 250 individuals. Meeting summaries are posted afterwards. Agendas include specific time for public comment. Approximately 40 members of the public attend on average. Meetings are held in several rotating locations in south Seattle and south King County to enable participation by a variety of stakeholders and increase access for those from south King County. Meeting locations include free parking and access to public transportation.

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?

The KCACH provides advance notification of meetings. Anyone can receive meeting notifications by clicking on the "Join our ACH stakeholder list" on the KCACH homepage. The website is updated frequently. Since Phase I, the KCACH has added a calendar to the homepage. The ACH has a stated value of transparency. Opportunities for input are announced via the HHS Transformation newsletter (with over 1000 subscribers). The ACH has CCV representation on the Board; the CCV meets monthly and will start to hold evening meetings once per quarter to further expand participation.

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

Governing Board decisions are bolded in meeting materials to promote transparency of decisions and timing. On occasion (but rarely), decisions are made via email, and announced at the subsequent Board meeting.

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

The KCACH's communications strategy aims to increase awareness and engagement through targeted communications to specific audiences.

- **Board Members** receive direct emails with meeting materials. These are also posted on the KCACH website.
- **The HHS Transformation e-Newsletter** (1013 subscribers, open rate of ~45%) distributes timely information to stakeholders (sent about once per month, or to share important announcements).
- **For the public,** the ACH uses the Public Health Insider blog and promotes posts via social media. (A recent post resulted in 321 views and 4,000 people reached via Facebook.) Posts are coordinated with the Seattle Foundation.

The KCACH is developing provider and consumer communication plans for 2018 that will utilize existing networks and incorporate use of social media, particularly for consumers. Consumer outreach will also be conducted through community meetings, as well as partnerships with community based organizations and key service providers. The provider engagement strategy will target providers through key messengers from the provider community who can serve as "champions of change," as well as communications through medical associations and MCOs.

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.
F. *SUPPLEMENTAL: KCACH Equity Impact Assessment Tool*

Budget and Funds Flow – 15 points

Description

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

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

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

Instructions

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

ACH Attestation(s)

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

☒ **YES**

Date of Approval: 7/17/17

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: 8/8/17

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.**

Phase I Design funds will be dedicated to ACH Administration (50%) and Project Plan Development (50%).

ACH Administration costs include: staffing – beginning with the Executive Director in July and expanding to six full time staff by the end of 2017; temporary staff and consulting contracts; office space rent and fiscal sponsorship. (Funding for backbone staff is not included in this distribution.)

Project Plan Development costs include a contract with DSRIP consultants, Health Management Associates (HMA). Project planning does not include funding for King County backbone staff, who are playing a significant role. Payment on the contract with King County for this work is deferred to the end of 2017 and will be covered with Phase II Design funds.

Beyond these expenditures, it is not anticipated that additional Phase I dollars will be available for investments in the other areas. Work related to the other categories is occurring during this timeframe, but will be supported retroactively with Phase II funding. This work includes community engagement planning by the Community/Consumer Voice (CCV) committee; research and information gathering related to technology platforms in the Care Coordination and other Project Design teams and Health Systems and Community Capacity assessments supported by King County data and analytics staff.

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

Fifty-one percent (51%) of Phase II Project Design funds will be dedicated to Project Plan development. These costs include King County ACH (KCACH) staff time, a contract with Public Health – Seattle & King County (PHSKC) to support project planning, convening and community engagement from Q2 2017 through Q2 2018, as well as an extension of the HMA contract in Q1-Q2 2018.

Furthermore, approximately 27% of Phase II funds will be used to cover the cost of KCACH Administration for Q1 – Q2 2018, including the growing direct staff costs of the KCACH and fixed operational expenditures such as rent and fiscal sponsorship.

After these two major areas of investment, approximately 10% of Phase II funds will be available for enhanced community engagement in Q4 2017 and Q1-Q2 2018. The KCACH Governing Board is awaiting a proposal from the CCV committee for robust engagement activities in the planning phase of project implementation in early 2018. It is anticipated that during this time, the KCACH will convene consumer and community meetings and feedback sessions to inform project implementation planning, and will engage in education and training with CBOs and other potential partners. Efforts to engage tribes in the region will also continue.

Finally, 12% of Phase II funds will be available for early investments in health information technology in Q3 – Q4 2018. Examples might include the expansion or enhancement of existing tools to a broader group of providers or development of new technologies for some providers to conduct population health management or clinical decision making tools.

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.

Project Design funds will support ongoing work in all of the areas listed above, primarily through the Backbone 2.0 contract with King County.

Backbone staff are supporting the Performance Measurement Workgroup (PMW), building the Regional Health Needs Inventory (RHNI) and providing data support to the design teams.

Backbone staff are also staffing and convening the design teams, engaging clinical and social service providers in project planning, and supporting strategic development of project plans. Finally,

backbone staff will provide support to the executive management of the KCACH through onboarding the new Executive Director and with tasks such as developing budgets for design funds and contracting with consultants for support with governance, community engagement and DSRIP expertise.

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

The Governing Board is responsible for overseeing the Project Design fund expenditures. They have approved a detailed budget for Certification Phase I funds and the proposed planned use of Certification Phase II funds. The Board has formed a Finance Committee tasked with financial planning and oversight, including planning related to the use of Project Design funds. The KCACH Executive Director, with interim support from backbone staff and incoming support from the CFO, will manage day-to-day budgets. The Seattle Foundation, the KCACH fiscal sponsor, will play an assurance role related to financial management.

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.)*

Project Incentive fund planning has focused on the development of the project portfolio, including the design of eight project plans that will meet target outcomes and maximize incentive payments. A Demonstration Project Committee (DPC) is overseeing the portfolio planning strategy and issuing guidance to design teams. The DPC is planning for Domain 1 investments to support project implementation and long-term sustainability of the interventions. Discussions have identified the need for a process to ensure sufficient funding to partners for projects, but also the need for a broader community conversation and process for developing an investment strategy to ensure long-term and ongoing impact. Deeper planning related to a process for the distribution of project incentive funds is scheduled for the August board meeting and through a board retreat in September.

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).

The KCACH has received funds from the State Innovations Model (SIM) grant. Prior to the establishment of the KCACH as its own legal entity, Public Health – Seattle & King County (PHSKC) managed this funding. As of August 1, 2017 all remaining SIM dollars are in the process of being transferred from PHSKC to the KCACH. Previously, the KCACH awarded a $50,000 grant to the Housing and Health Partnership to support community health workers in low-income housing settings. Remaining SIM funds may be awarded to this project pending Board approval with the presumption that the project may be relevant to demonstration projects and Domain 1.

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 materials.

King County has been a major contributor, providing meeting space and materials in addition to staff support above and beyond the staffing funded by either the SIM grant or the Backbone 2.0 contract beginning in April 2017. By deferring payment on the Backbone 2.0 contract until the end of 2017, King County is further supporting the KCACH.

Other community partners, including Navos, NeighborCare and others have provided in-kind meeting space for the KCACH. Finally, numerous organizations and individuals have devoted significant volunteer staff time to this effort. Of recent note are the contributions of Governing Board Co-Chairs, Betsy Lieberman and Esther Lucero, who have exceeded 20 hours per week of volunteer time to meet the leadership needs of the KCACH.

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.

In Phase I, we discussed building from existing projects to help inform the development and focus of the King County ACH (KCACH). Since then, we have established a Demonstration Project Committee (DPC) responsible for providing guidance to project development through Project-specific Design teams that follow this model. There are currently eight Project Design teams, which are responsible for developing project-specific applications submitted to the DPC. The DPC is responsible for making a recommendation to the KCACH Governing Board about the project portfolio that will result in the KCACH achieving its outcomes and transforming the system.

The participants involved in design teams and the Demonstration Project Committee (DPC) represent a broad spectrum of clinicians with expertise that extends across essential community providers: all Federally Qualified Health Centers (FQHCs) in the region, family planning providers, Indian Health providers, behavioral health providers, providers of substance use disorder treatment, the largest hospital and health systems in the region and other safety-net providers that serve low-income, vulnerable and medically underserved individuals. Initial data indicates that providers represented on design teams account for approximately 41% of Medicaid claims data for the region.

Many of the providers participating in the design teams have expertise in the evidence-based models being considered. Eight of the providers/organizations in Project 2A (Bi-Directional Care) have direct experience providing integrated care either in a primary care or behavioral health care setting; the Project 3A Design Team (Chronic Disease Prevention and Control) includes three providers with extensive knowledge about the Chronic Care Model and how best to implement the project in a targeted fashion to achieve expected outcomes, and our Project Design team for Addressing the Opioid Public Health Crisis includes eight providers with expertise in treating opioid addiction.

A complete list in addition to bios for many members are included as Attachment A.

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

Each of the Project Design team participants includes providers considered leaders in their field. In addition to their role in providing clinical expertise about project direction, another key expectation of

Design Team members has been to serve as provider champions by educating and informing other providers in their sector about project development and the opportunity the KCACH Demonstration projects offer them to help transform the delivery of health care. We will rely on provider champions on the design teams to reach out to their peers about becoming a partnering provider when the KCACH launches its Letter of Interest (LOI) to providers in mid-August 2017 (see Attachment B).

Clinical representation in each of the eight Project Design teams include:

KCACH Clinical Representation		
Bi-Directional Care		
Milena Stott	Valley Cities	Behavioral Health
Claudia D'Allegri	Sea Mar/CHCs	Federally Qualified Health Centers
Ryan Anderson	Neighborcare/CHC Council	Federally Qualified Health Centers
Phillip Capp	Providence/Swedish	Hospital Facilities
Mark Fadool	Odessa Brown/Seattle Children's	Hospital Facilities
Darcy Jaffe	Harborview/UW Medicine	Hospital Facilities
Angie Riske	Multicare	Hospital Facilities
Katrina Egner	Sound Mental Health	Behavioral Health
David Johnson	Navos	Behavioral Health
Ann McGettigan	Seattle Counseling Services	Behavioral Health
Vicki Evans	Molina Healthcare of Washington	Managed Care Organization
Julie Lindberg	Molina	Managed Care Organization
Melet Whinston	United	Managed Care Organization
Care Coordination		
Cameron Buck	UW Medicine Valley Medical Center	Hospital Facilities
Mary Pat O'Leary	City of Seattle	Long Term Supports and Services
Cindy Spain	United Health Care	Managed Care Organization
Milena Stott	Valley Cities	Behavioral Health
Joe Tangney	Navos/Navos Consortium LLC	Behavioral Health
Nancy Sugg	UW, Pioneer Square Clinic-Harborview	Federally Qualified Health Centers
Sarah Jackson	Highline Medical Center- Franciscan CHI	Hospital Facilities
Kathy Mullin	RN Director Care Coordination	Hospital Facilities
Hiroshi Nakano	Valley Medical Center	Hospital Facilities
Susan Stern	UW Medicine-Harborview	Hospital Facilities
Elizabeth Anne Newcombe	UW Medicine-Harborview	Hospital Facilities
Transitional Care		
Cameron Buck	UW Medicine Valley Medical Center	Hospital Facilities
Mary Pat O'Leary	City of Seattle	Long Term Supports and Services
Cindy Spain	United Health Care	Managed Care Organization
Milena Stott	Valley Cities	Behavioral Health
Joe Tangney	Navos/Navos Consortium LLC	Behavioral Health
Nancy Sugg	UW, Pioneer Square Clinic - Harborview	Federally Qualified Health Centers
Sarah Jackson	Highline Medical Center- Franciscan CHI	Hospital Facilities

Kathy Mullin	RN Director Care Coordination	Hospital Facilities
Hiroshi Nakano	Valley Medical Center	Hospital Facilities
Susan Stern	UW Medicine - Harborview	Hospital Facilities
Elizabeth Anne Newcombe	UW Medicine - Harborview	Hospital Facilities
Ethan Seracke	Sound Mental Health	Behavioral Health
Michele Conley	ETS – REACH	Substance Use Disorder Provider
Chloe Gale	ETS – REACH	Substance Use Disorder Provider
Mikel Kowalack	REACH	Substance Use Disorder Provider
Kim Power	REACH	Substance Use Disorder Provider
Tashau Asefaw	United Healthcare	Managed Care Organization
Diversion		
Adam Davis	FDCARES Puget Sound Regional Fire	Fire Department
Cameron Buck	UW Medicine Valley Medical Center	Hospital Facilities
Mary Pat O'Leary	City of Seattle	Long Term Supports and Services
Elizabeth Anne Newcombe	UW Medicine-Harborview	Hospital Facilities
Brigitte Folz	Harborview	Hospital Facilities
Kelley Craig	ETS – REACH	Substance Use Disorder Provider
Cathy Speelman	REACH	Substance Use Disorder Provider
Opiates		
Milena Stott	Valley Cities	Behavioral Health
Brian Allender	Valley Cities	Behavioral Health
Molly Carney	Evergreen Treatment Services	Behavioral Health
David Newman	Community Psychiatric Center	Behavioral Health
Jim Walsh	Swedish Hospital and Medical Center	Hospital Facilities
Brad Finegood	King County BHO	King County - Behavioral Health
T Madden	Private Practice Dentist	Oral Health
Jeb Shepard	WA State Medical Association	Primary Care and Specialty Physicians
Ricardo Jimenez	Sea Mar CHC	Federally Qualified Health Centers
Charles Watras	Sea Mar CHC	Federally Qualified Health Centers
Joe Merrill	Harborview Medical Center	Hospital Facilities
Richard Reis	Harborview Medical Center	Hospital Facilities
Chronic Disease		
Cindy Spain	United Health Care	Managed Care Organization
Claudia D'Allegri	Sea Mar/CHCs	Federally Qualified Health Centers
Jeff Hummel	Qualis Health	
Jim Stout	UW, Department of Pediatrics & Odessa Brown Children's Clinic	Primary Care Physicians
Marilena Morales	Neighborcare Health	Federally Qualified Health Centers
Marcus Rempel	Neighborcare Health	Federally Qualified Health Centers
MCH/Reproductive Health		

Sarah Prager	UW Family Planning	Specialty Care
Asfaneh Rahimian	SeaMar	Federally Qualified Health Centers
Mary Quinlan	Multicare-Mary Bridge Children's Health Network	Hospital Facilities
lara Sim	Seattle Children's	Hospital Facilities
Oral Health		
John Caron, DMD	HealthPoint (Community Health Center)	Federally Qualified Health Centers
Sarah Vander Beek, DDS	NeighborCare Health	Federally Qualified Health Centers

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.

Of the 58 clinical providers participating in the Project Design teams and the DPC, only two serve on the Governing Board. This was purposeful on the part of the KCACH; the call for participation in DPC and these teams went beyond the existing Board to the community and included all individuals who attended the KCACH community learning sessions. Participation on design teams and the DPC has focused on ensuring that we had participation from clinical providers and experts who serve the Medicaid population, but who are also eager to shape a reformed delivery system. The work of these design teams has involved sharing of best practices in those fields to inform project planning. For example, the decision by the Bi-Directional Care Design Team to elect all five evidence-based models offered in the toolkit for this project, rather than limit the models available to providers, was based on ensuring that the project offers a viable pathway for practice transformation that meets providers where they are.

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.

The KCACH is using data from the Regional Health Needs Inventory and Medicaid-attributed lives data to better understand where clients are receiving services and identify gaps in regional clinical capacity. The KCACH is launching an LOI Hand survey process to further develop information about the clinical capacity to implement selected projects. The goal of this LOI is threefold: to more formally educate a broader number of providers about the KCACH and opportunities under the Demonstration project; 2) to better understand gaps in clinical and health information technology (HIT) capacity; and 3) to establish a preliminary list of partnering providers. Letter distribution will be built on Medicaid attributed lives data and targeted collaboration with multiple organizations such as WSHA, WSMA, WAFP, and the local AAP chapter. Results from the survey will allow the KCACH to make targeted efforts to engage providers who are not currently at the table.

We will work with our current provider champions to help facilitate these connections and with the design teams on the content of the LOI. The KCACH plans to send out the LOI in late August 2017 with the goal of developing the list of partnering providers by mid-October 2017 for inclusion in the Project Plan application. Finally, we will work closely with the MCOs in our region to obtain basic demographic information about their contracted providers, including location, availability, accessibility, and language capabilities.

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 KCACH is partnering with local and state clinical provider organizations in project selection and planning in two key ways: involvement from these organizations in design teams and/or the DPC, and more general ACH engagement through the Governing Board. The KCACH has participated in regular meetings with WSHA and monthly meetings with the mental health provider association of King County. Examples of involvement at the Board level include a member who represents the Washington State Chapter of the American Academy of Pediatrics (AAP) and who engages regional AAP providers about the KCACH through her participation in four AAP subcommittees, including a Physician Champions group. Governing Board members from the hospital sector keep WSHA members, the Public Policy Committee of WSHA, and King County Hospitals for a Healthier Community apprised of the KCACH work. Another clinical Board seat including Federally Qualified Health Centers (FQHCs), who facilitate a strong connection to the Community Health Council of King County. The current chair of the Council, Michael Erikson, is actively involved in the DPC and project 2B and 2C design teams. Looking forward, the KCACH has a provider engagement strategy that includes a deliberate effort with local and statewide associations to bolster this work. One example of this strategy is a plan for one or more "provider forums" co-hosted with these organizations in September 2017.

Attachment(s) Required

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

B. *SUPPLEMENTAL: Draft provider letter of interest*

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 ACH's success as part of the 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.

The KCACH has used administrative, vital statistics, population survey, and program data to guide project selection and planning, including population estimates (Office of Financial Management), demographic and social data (American Community Survey, DSHS Community Risk Profiles), Behavioral Risk Factor Surveillance System, birth records, death records, Pregnancy Risk Assessment Monitoring System, all-payer hospitalization data, Medicaid eligibility and claims data, First Steps Database, Community Checkup, and dental service utilization data. These data have either been provided by the state (ACH Starter Pack data, 1519/5372 measures from RDA, Healthier Washington Dashboard) or obtained from local sources.

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.

The KCACH is using data to identify needs to inform project selection, such as leading causes of disease (e.g. behavioral health concerns are a major driver of hospitalization) and health disparities (e.g. greater room for improvement on diabetes performance metrics among American Indian/Alaska Native Medicaid members), and to scope project scale (e.g. number of Medicaid members by zip code). The Performance Measurement Workgroup (PMW) has delegated backbone staff to provide tailored data support to Project Design teams. Data are also being used with design teams to identify data gaps, such as who is excluded from claims-based measures (e.g. asthmatics who have not utilized asthma-related services) to better understand potential target populations for each project (e.g. ED visits by zip code), and identify highest volume Medicaid health providers. Selected data have been posted on the KCACH

RHNI website, which includes interactive data tools for all ACH regions.

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

The KCACH identified cross-cutting data gaps in its Phase I certification application, including volume of care by provider, service type and diagnosis. The KCACH worked with other ACHs to prioritize these data gaps for the state, which has responded with additional analysis of Medicaid claims data. The KCACH is now planning to use a "reverse engineering" approach to plan projects for success, specifically, to identify Medicaid members with the greatest room for improvement and the highest volume Medicaid providers. To move the region-level needle on any measure, projects will need to involve these Medicaid members and providers. KCACH data staff are also analyzing local data to better understand demographics, health status and risk factors of Medicaid members.

Data-related Collaborations

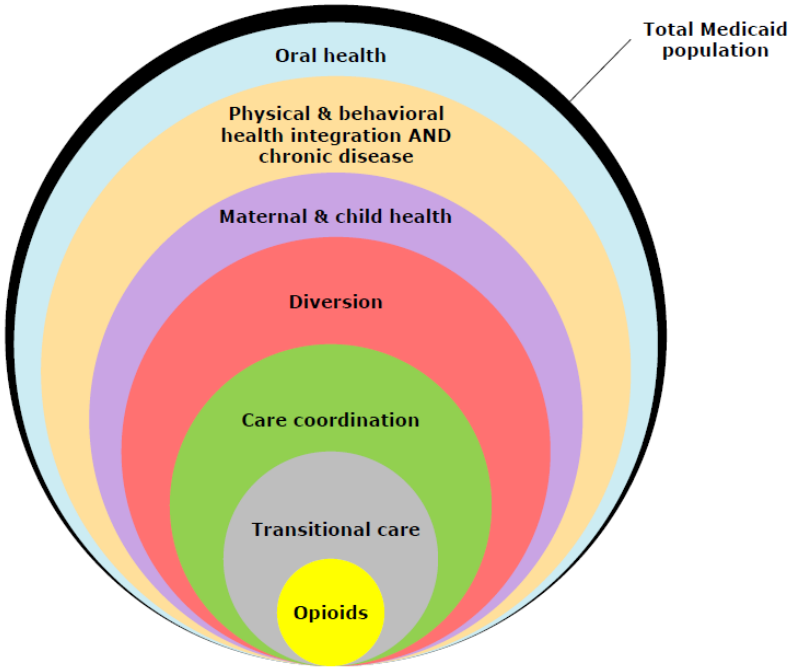
4. Describe if the ACH is collaborating, or plans to collaborate, with other ACHs around data-related activities.

Since 2015, the PMW has supported multi-ACH data partnerships and advocated for ACHs to work together to identify cross-cutting data needs and solutions. As data capacity is not equally distributed across Washington state, the PMW has transformed state-provided data into interactive data webpages for all regions. The PMW has also facilitated dialogue with the state to prioritize cross-cutting data gaps, leading to a regular HCA/ACH Demonstration data call, a venue through which the ACHs and the state can tackle common data issues. The PMW is actively pursuing opportunities for multi-ACH alignment around investments in core data infrastructure for population health management (including a data services partnership with the Olympic Community of Health), and has called upon the state to offer guidance on data governance and interoperability for the demonstration projects.

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.

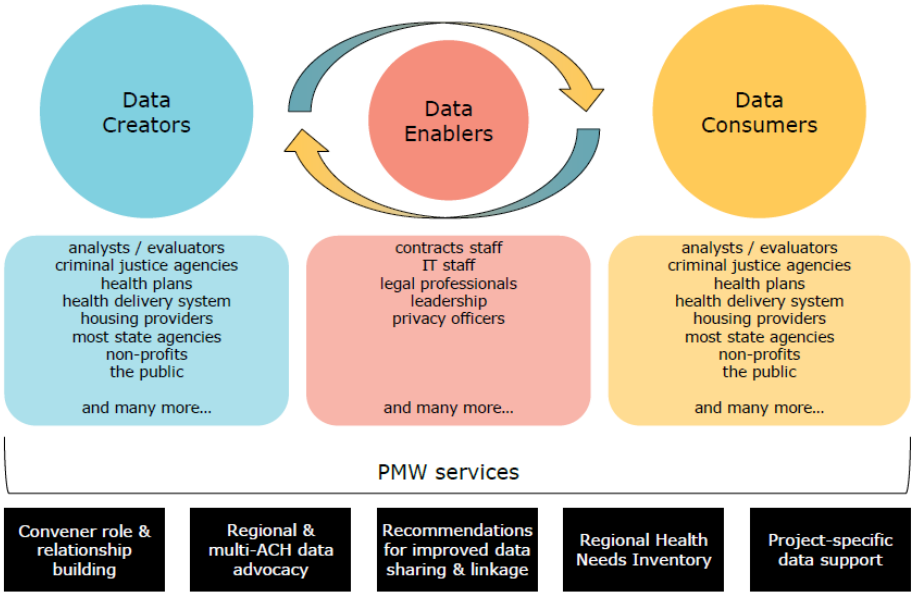
The PMW has identified data governance, interoperability, and population health management as critical components of a data-driven Medicaid Demonstration. The PMW recognizes that smart data investments are necessary to ensure data and analytic efficiency across the overlapping target populations with support from multiple data perspectives.

Data systems design should account for overlapping target populations



The PMW is also considering how to leverage existing infrastructure such as an ongoing data integration project between the public health and human services departments supported by the King County Information Technology department. As trust is essential for data governance, the PMW's multi-disciplinary approach will be expanded to include additional partners, such as the use of electronic medical records for population health management.

PMW's multi-disciplinary approach to addressing data fragmentation



Data creators, enablers and consumers theme adapted from *Toward a Structure for Classifying a Data Ecosystem*, Seeder A., Smart Chicago, 2014, http://www.smartchicagocollaborative.org/toward-a-structure-for-classifying-a-data-ecosystem/

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.

The PMW conducted an initial rapid assessment of provider data/data system capacity through a review of existing state and local surveys and initiatives, which included perspectives from health and human service providers (e.g. substance misuse treatment providers, first responders, housing and criminal justice agencies), MCOs, academic researchers, IT staff, and care coordination software vendors . In addition, through the LOI process used to determine project partners, the KCACH is assessing (1) use and name of electronic health record systems and (2) use and functions of automated care management data/record systems. Later this year, the KCACH plans to conduct an in-depth qualitative (e.g. key informant interviews) and quantitative (e.g. provider survey) assessment of provider health data/data system capacity.

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

The KCACH will develop a methodology for attributing Medicaid members to providers/provider teams so regional incentive payments can be allocated to participating partners. This approach will supplement region and state-level accountability set by CMS. A variety of approaches have been discussed, including empanelment, building on existing data infrastructure (e.g., chronic disease registries or a care coordination hub approach, such as Pathways). The ACH is also working with the King County IT Subcommittee to develop a work plan for assessing the current state landscape as well as a plan for a future state system. Important considerations are to invest in an approach that works at the clinical level and population level (e.g. performance measurement), and that aligns with interoperability guidelines to support data linkage across sectors. Finally, any data system must have the capacity to provide regular feedback to the KCACH on progress toward goals for each of the performance metrics to allow for continuous quality improvement and identification of needed course corrections.

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

In parallel with question 6, the KCACH conducted a rapid assessment of available results/reports on health and human service workforce capacity, to be supplemented by a more rigorous assessment involving primary data collection later in the year. Additionally, the KCACH has worked with the Washington State Health Workforce Sentinel Network to understand how it could be used to inform workforce capacity strategies. The KCACH has also begun conversations with local non-profit and professional organizations (e.g. Workforce Development Council of Seattle-King County, WSHA, WSMA, Community Health Center Council) to align data efforts for assessing provider workforce capacity and patient access to care. It is anticipated that as the KCACH project partnerships solidify, an effective approach for assessing provider HIT and workforce capacity will be identified.

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

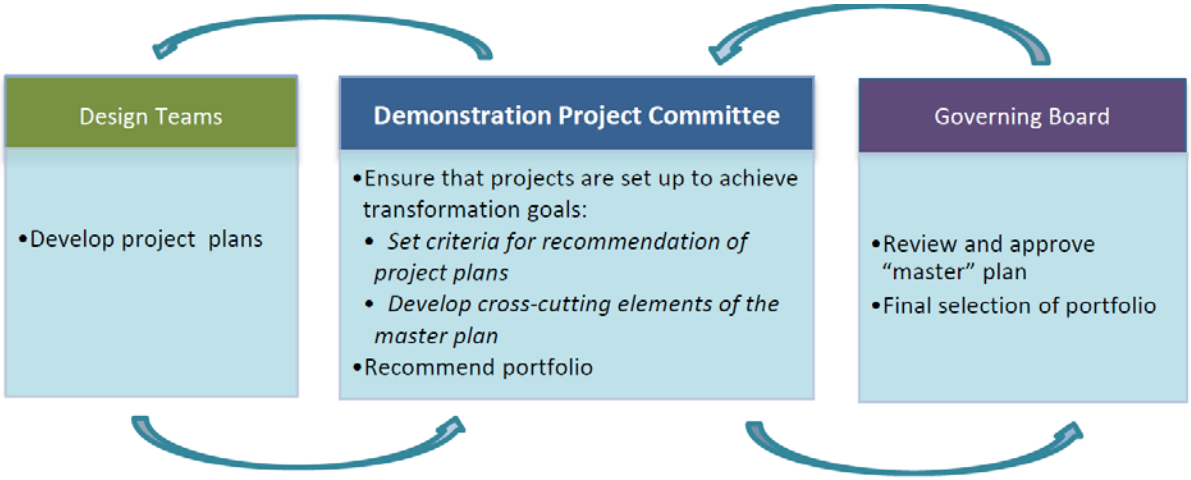
1. Provide a summary of the anticipated projects and how the ACH is approaching alignment or intersections across anticipated projects in support of a portfolio approach.

The KCACH has formed design teams that are currently developing proposals for the 8 projects listed in Domains 2 and 3 based upon guidance in the Demonstration toolkit. Each design team includes representatives from the essential sectors who are critical to the success of each project:

2A	This project supports physical and behavioral health providers in advancing whole-person approaches through (1) population-based screening and (2) access to specific interventions when needs are identified, with a focus on those at greatest risk of negative outcomes, high acute care utilization, and need for integrated care.
2B	As a foundation for care coordination, Pathways Community Hub will be implemented in one or more sub-populations. Several target populations are under consideration, including: mothers and children with a chronic condition; adults with single or multiple chronic conditions; and adults with a behavioral health condition and at least one risk factor.
2C	This project builds upon existing transitional care approaches in diverse settings and creates more systematic connections across our community to support beneficiaries transitioning from inpatient hospitals, emergency departments, psychiatric hospitals and jails.
2D	This project puts in place an overarching strategy to divert appropriate individuals from jail and hospitals/EDs through three approaches (Community Paramedicine model, Law Enforcement Assisted Diversion, and Emergency Department Diversion).
3A	The opioid project focuses on two goals: (1) improved adherence to opioid-prescribing guidelines, including provision of non-opioid pain management resources and supports for providers; and (2) expansion of low barrier medication assisted therapy.
3B	This project incorporates training of evidence-based and culturally responsive counseling and successful referrals with connection to care through new pathways via community-based agencies and health care providers to improve access to quality reproductive health services.
3C	This project will focus on integrating oral health preventive care (screening/education, fluoride varnish, dental referral) into primary care and connecting dentists to health care teams.
3D	The chronic care model will be utilized and the design team is considering a chronic disease management incentive payment program that initially focuses on two high-prevalence and complex cost bundles: a respiratory and a cardiovascular bundle (which includes diabetes).

To address the alignment and intersectionality of the projects, including the implications of Domain 1

health and community systems capacity building, the KCACH formed a Demonstration Project Committee (DPC). The DPC is a 20-member multi-sector committee whose charge includes the recommendation of the portfolio of projects to the ACH Governing Board.



The DPC meets bi-weekly to monitor the progress of design teams and to provide feedback and direction to them. In early May, the DPC developed guidance for the design teams. As the work progresses, the need to address the alignment and intersections of the projects is becoming clear. The DPC is working with HMA (DSRIP consultants) to identify opportunities for increased alignment across our project portfolio, particularly focused on target populations, impact on performance metrics, project strategies and tactics. After HMA conducts this alignment analysis, the DPC will review this information and make recommendations to project teams for needed revisions.

Using this patient-centered approach, the DPC, with support from HMA, will carefully consider the Domain 1 investments needed across projects. The KCACH anticipates it will build on existing data infrastructure and invest in an approach that works at both the provider and population level, aligns with interoperability guidelines to support data linkages across sectors, and is sustainable after the Demonstration ends. Similarly, we expect workforce alignment across several projects. These will help inform KCACH investments in Domain 1, and we will look for opportunities to work with the state and other ACHs on Domain 1 strategies.

In addition to these efforts, the DPC is forming work groups that will include additional subject matter experts to provide recommendations on specific issues/topics necessary for the DPC to put together a balanced and comprehensive project portfolio. For instance, one subgroup consisting of MCOs and health systems, will develop recommendations to help the KCACH address issues of attribution and empanelment of Medicaid enrollees in support of projects.

All of the work on project portfolio alignment will then go before the Governing Board and play a key role in their decision-making about the project portfolio that the KCACH will submit in November.

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.

The KCACH has been in conversation with a number of ACHs, particularly as it relates to Domain 1. As many King County providers serve clients that cross ACH borders, we are having conversations with neighboring ACHs on chronic disease and opioid projects. Our DSRIP consultant is also working with two other ACHs, Greater Columbia and Cascade Pacific Action Alliance, and are identifying further areas for

collaboration and shared learning, including approaches to strengthen project portfolio alignment.

The KCACH also intends to participate in the Pathways collaborative being developed with several ACHs to work toward alignment with providers and MCOs in serving patients, with an eye toward system transformation that will be sustained beyond the Demonstration.

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

MCOs have been working closely with the KCACH on alignment of Demonstration projects with value-based purchasing, as well as on specific projects like bi-directional care integration and care coordination. All five MCOs have designated representatives who actively serve on the DPC. Each Design Team has at least 1 MCO representative participating in developing projects. The KCACH is committed to partnering effectively with the MCOs, particularly when it comes to care management and coordination, including the development of a shared care plan, as well as the move to value-based payment.

ACH backbone staff as well as ACH partners (e.g. health systems) are having conversations with MCOs to determine their interest in specific projects. For instance, a few MCOs have indicated their interest in Pathways. MCOs have also expressed their willingness to work with the KCACH on assuring that requisite data for project implementation will be available. That said, the preference is for the data to come through the HCA versus arrangements with individual MCOs.

Project Plan Submission

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

Risk: Given the size and complexity of King County, there is a risk of not engaging sufficient providers serving the Medicaid population in the project selection and planning process given the ambitious timeframes set out by HCA.

Mitigation Strategy: Based upon the Medicaid provider data, we are able to determine the providers who serve the largest number of Medicaid clients, and will be reaching out to them to confirm their interest in participating in projects.

Risk: There are several key questions that would help us put together a successful application. These include: 1) whether the KCACH needs to specify strategies aimed at achieving performance on each of the identified metrics within a project; and 2) how projects will earn dollars for metrics that cut across multiple projects.

Mitigation Strategy: We continue to seek clear answers from HCA. We are also working on demonstrating how each ACH project leverages and intersects with other ongoing efforts that will drive toward achieving specific targets.

Risk: Selecting a portfolio of projects may be challenging, particularly without more information about provider incentives/budget necessary to accomplish what is being proposed. In addition, the scope and magnitude of investments in Domain 1 also need to be determined.

Mitigation Strategy: We have brought on consultants who are experienced in DSRIP projects and who can provide the expertise to assure that we have a realistic and achievable plan.

Risk: Regional projects taken on by different ACHs may not create a “whole person care” system across

the state, as people travel between ACH regions, particularly in regard to variation in care management strategies and regional investments in technology and data platforms.

Mitigation Strategy: The KCACH will work with statewide organizations, such as WSHA and WSMA, to encourage statewide systems that serve the Medicaid population. The KCACH will also continue to identify opportunities for collaboration and shared approaches across ACH regions.

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

Using a recently released Medicaid claims data product provided by the state per the request of the KCACH, we are now able to identify total number of claims and beneficiaries by provider, service type (e.g. dental, ED, inpatient, outpatient, professional) and diagnostic condition. These data are being used to identify the top providers (in terms of volume) currently providing care to Medicaid members residing in King County with the help of the Performance Measurement Workgroup. The ACH will reach out to engage these providers.

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

In terms of provider engagement, we categorize providers as: (1) traditional health care delivery partners and (2) non-traditional partners. For traditional health care delivery partners, the ACH will partner with professional organizations (e.g. WSHA, WSMA, WAFP, and the local AAP chapter) to reach out to Medicaid providers. For non-traditional partners, the ACH will work with existing health, social services, and community-based coalitions (e.g. King County Human Services Coalition, Healthy King County Coalition, Equal Start Coalition) including the ACH's Community/Consumer Voice (CCV) committee. Outreach to providers will be prioritized based on the populations the Demonstration projects intend to serve.

For purposes of the project plan, the ACH will be gathering a non-binding letter of interest (LOI) from providers. The KCACH plans to send out the LOI in August 2017 with the goal of developing the list of partnering providers by mid-October 2017 for inclusion in the Project Plan application. Once we have received approval of our project plan, the ACH will obtain letters of commitment.

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.

Design teams were asked to submit initial project scopes to the DPC on July 14. This included identifying essential partners who are engaged in the project design now and who are expected to be engaged in implementation. The DPC provided feedback to the design teams about the engagement of providers, as needed. As the DPC membership includes a range of community and social/human services providers and MCO representatives, the engagement of a broad range of providers and payers is a high priority.

Additional detail on provider engagement is addressed in the Clinical Capacity section above.

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.

Initial guidance to the design teams required that project plans include a focus on system-wide

transformation that can be sustained through value-based purchasing. The project portfolio will be designed to ensure that collectively the projects can improve outcomes and demonstrate return on investment (ROI). It is through this combination of improved outcomes and ROI that implemented projects will show their value and make the case for ongoing Medicaid funding.

In addition, as the Governing Board and community members consider priorities for key "leave behinds" (i.e., informed/activated patients; shared care plans; integrated and connected health, human, and social services), consideration will be given to long-lasting, transformative investments that will enable the delivery system to look quite different by 2021.

The KCACH will work with HMA to address sustainability in the project plans, including a deeper dive into value-based purchasing (VBP) and analysis of other VBP arrangements that are working nationally. We have already begun this investigation, both in conversation with MCO partners who will be instrumental in connecting ACH VBP strategies with MCO VBP arrangements, and through opportunities such as the Nemours/Academy Health meeting on July 20, which included a session on social impact investing. Additionally, ACH Governing Board members will be attending the America's Essential Hospitals' Medicaid Summit meeting in September to learn from other states on strategies for sustainability.

The DPC and design teams are basing their strategies on data that identify populations and approaches that address the toolkit metrics and prove most cost effective and compatible with VBP. Design teams have been asked to identify how the strategies will be sustainable by the end of year 5. The KCACH representatives to the State's Value Based Purchasing Task Force have also been added to the Finance Committee to link conversations about project design, value based payment and overall sustainability at all levels of planning.

By having an early emphasis on sustainability, the KCACH can assure projects are being designed to lead to sustained improvements in systems, care delivery, and/or practices and align with the interests of potential long-term funders, such as the MCOs. Additionally, deliberate linkage to Domain 1 strategies will be essential to project plan development. Success in Domain 1 (VBP, HIT, and workforce) will enable long-term project success and achieving metrics. The KCACH will build upon existing infrastructure and local investments to leverage the impact of the Demonstration and determine the models that meet the triple aim of access, outcomes and costs. Reinvestment strategies will be focused on strategies that can be sustained.

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	
☐	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.
Tribal Engagement and Collaboration	
☐	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.*
Community and Stakeholder Engagement	
☐	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	
☐	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 are 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	
☐	A. Current bios or resumes for identified clinical and workforce 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	
None	
Transformation Project Planning	
☐	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	
☐	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 the vision in an efficient manner.*
Governance and Organizational Structure	
☐	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	
☐	C. Statements of support for ACH certification from every ITU in the ACH region.
Community and Stakeholder Engagement	
None	
Budget and Funds Flow	
None	
Clinical Capacity	
None	
Data and Analytic Capacity	
None	
Transformation Project Planning	
None	