

Phase II Certification Submission Template

ACH Phase II Certification: Submission Contact	
ACH	North Central Accountable Community of Health
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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.

Current Word Count: 1249

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

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

The vision of the North Central Accountable Community of Health (NCACH) is for every person in our region to achieve optimal health and experience the best health care possible. We strive for all community members to be empowered with the resources needed to obtain excellent physical, mental, and social well-being. We will work toward this vision by leading a collaborative approach to transform the system of care from one that is fragmented to one that is connected and sustainable. We rely on 4 guiding principles:

1. Ensure patients receive culturally appropriate services that address the whole person at multiple entry and exit points in the health care and social service system
2. Promote an innovative system of care in which community organizations and health care providers integrate and communicate to address patient needs
3. Plan for sustainability of the transformed system beyond the Demonstration including the network of providers and social service agencies
4. Use population health data to identify, target, and reduce health disparities through purposeful deployment of project resources

Through NCACH's role as convener, we activate Medicaid beneficiaries, health and social service providers, payers, and other community members to join in building a healthier region together. As long as our patients and community partners benefit from this collaboration, NCACH will continue to act in its current role or will find the appropriate agency to convene our community partners in the work of Healthier Washington beyond the Demonstration.

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

North Central Washington is a rural area with significant health challenges. We have 19.4 people per square mile compared to the Washington State average of 101.2 people per square mile. With our small population and large area, the cost of care per patient can be significantly higher and

maintaining care in the local communities financially difficult. Obtaining basic care may result in a full day event and lost wages for a patient.

North Central faces gaps in health care access. 19.9% of NCACH’s residents are uninsured compared with 12.9% statewide. The region has 162 mental health care providers per 100,000 people, 39% below Washington State’s average of 266 per 100,000 people. The ratio of primary care physicians to patients (1:1,329) is 32% below the state average. These disparities, in combination with shortages in housing (NCACH has 184 HUD assisted units per 10,000; Washington State has 303 HDD assisted units per 10,000) and transportation (35,608 non-emergency medical transports in 2015) make it difficult to address the high prevalence of chronic disease in our region. For example, 2 out of every 3 people are overweight or obese in the North Central region.

The region’s large Hispanic community (well over one-third of the population) presents language and other challenges for culturally appropriate health care delivery. The Hispanic community is twice as likely to have an individual fall below 100% of the federal poverty level compared to non-Hispanic individuals living in the region (Hispanic 27.5%; Non-Hispanic: 13.5%). These statistics emphasize the major role the Hispanic community will play in how NCACH chooses the project plans that will impact the quality of care for North Central Medicaid patients.

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

NCACH knows that integration of Behavioral and Physical health is a key initiative of the Healthier Washington framework to sustainably improve our region’s health. Our Whole Person Care Collaborative (WPCC), which includes Physical and Behavioral health providers region-wide, is a cornerstone structure and starting point through which we will implement evidence-based and data-informed approaches. These approaches will have a lasting impact on our community and will interface with all 6 NCACH selected projects.

Choosing Fully Integrated Managed Care (FIMC) mid-adopter status for 2018 is integral to our Whole Person Care vision, and taking on this challenge early is laying the groundwork for the North Central region to provide truly integrated care and achieve outcome targets within the Demonstration timeframe. NCACH will use Demonstration funds through the WPCC to enable local providers to transform care in ways that will be successful and sustainable under value-based payments (VBP) after the Demonstration ends. Other investments, such as the Pathways HUB and Transition/Diversion efforts, will forge better connections between clinical care and community services and bring community providers into the work of the Demonstration who can help patients address the Social Determinants of Health. These strategies will ultimately drive down utilization and costs on the medical side of our community health environment and improve health outcomes.

Finally, NCACH established Coalitions for Health Improvement in each local health jurisdiction that act in an advisory role to the Board to ensure that input on health equity and regional disparities for projects is collected at the local level and formally presented to the Board for consideration in their decision making process.

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

NCACH’s multi-faceted approach ensured project selection aligned with regional needs. The Board analyzed the December 2016 Community Health Needs Assessment (CHNA) completed by hospitals and public health jurisdictions in our region. This assessment, which included local data and community input, revealed several regional priorities including: Mental healthcare access, access to primary care, high school graduation rates, obesity, affordable housing, drug and alcohol abuse, access to healthy foods, and diabetes. NCACH then held 6 widely advertised community forums at

locations throughout the region and electronically distributed surveys with recorded presentations to 550 stakeholders including Medicaid beneficiaries, providers, and other community partners.

Based on this input, the Board selected Care Coordination, Transitions, Diversions and Chronic Care in addition to the two mandatory projects. We are now working with the state, managed care organizations (MCOs), providers, and tribal and community partners to refine our plans for the selected projects.

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

Behavioral health-medical integration, investment in adoption of evidence-based care models enabled and incentivized by VBP, and implementation of the Pathways HUB will not only address Projects 2A and 2B, but also Projects 3D (Chronic Disease care), 2C and 2D (Transitions/Diversion) through more effective care coordination, and 3A (Opioids) through adoption of clinical guidelines on opioid prescribing and pain management. Regional 24/7 nurse call line services and enhanced use of telehealth will reinforce these care improvements. Some project elements will stand independently. For example, Diversion will engage local prosecutors and judges handling drug use crimes to divert offenders to needed substance use treatment rather than incarceration. NCACH will ensure that every project element chosen and the investments we make in them are interconnected and mutually reinforcing to the overall goals of Healthier Washington. In addition, they involve integration with existing efforts, such as current initiatives at the county level on opioids, the effort to develop inpatient mental health capacity within the region, and the collaboration of our rural hospitals through the North Central Hospital Council. NCACH's longstanding and rich mix of community and clinical partners makes this interconnectedness possible and assures it will continue into the future.

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

As described above, NCACH emphasizes interventions and infrastructure investments that are mutually reinforcing and regional in scope. Beyond the Demonstration projects already mentioned, NCACH partners have emphasized data sharing among electronic medical records (EMRs) as a key to integration of care. Increasing EMR interoperability will also support other regional initiatives including the Pathways HUB, region-wide 24/7 nurse call line, and other systems to help medical providers connect patients with providers who address the Social Determinants of Health. In addition, the Pathways HUB is a regional resource addressing aspects of multiple projects.

North Central's largest hospital is routinely transferring patients out of the area due to the lack of inpatient beds, while Critical Access Hospitals struggle to fill their patient beds. NCACH will pursue opportunities for better coordination to address this disconnect.

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.

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.

Current Narrative Word Count: 996

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.

When NCACH was originally organized, the Leadership identified the sectors that needed to be represented on the Board. Knowing this work focused on improving the region's health, including caring for Medicaid beneficiaries, NCACH knew that the medical community played a significant role and ensured medical sector representation included all provider types (FQHC, rural hospitals, Behavioral Health, and large hospitals). NCACH knew that this work needed to include vital community-based organizations outside of the medical field and incorporated representation from agencies in sectors such as public health, business, and social services. During Phase I Certification, NCACH identified the need to more authentically include the community and consumer voice and developed voting Board positions for representatives from three community-based Coalitions for Health Improvement (CHI) and a Medicaid beneficiary. NCACH recognizes that decisions impact members differently in each county, and NCACH ensures equitable county representation (Chelan, Douglas, Grant, and Okanogan) when selecting Board members. If imbalances develop in Board representation, NCACH has two At-Large Board seats that can be used to fill identified gaps.

To expand outreach and ensure communication with the broader members of each sector, NCACH provides staff support to assist Board members in outreaching and communicating with their respective sectors through presentations at sector meetings, summarizing feedback from sector partners for the entire Board. A primary example of this is NCACH's involvement in the North Central Hospital Council meetings. NCACH staff was invited to this meeting by a Board member to present to its council members, and NCACH progress is now a standing agenda item at Council meetings. The

comments collected at Council meetings are provided back to the Board, and the Board utilizes the comments in the decision making processes of the NCACH.

**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)**

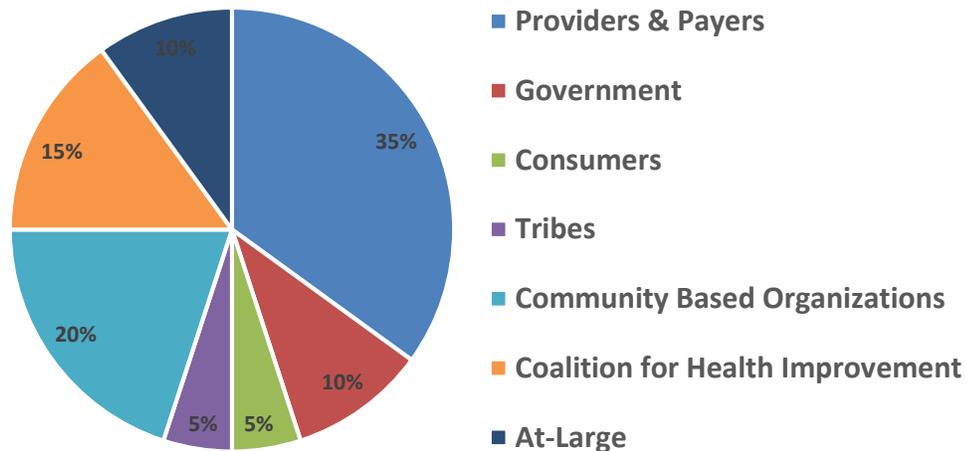
As outlined in our Phase I Certification process, the original charter and bylaws of the NCACH included a provision to develop a Leadership Council that would act as an advisory council to the Board. Since the original bylaws were developed, the CHIs have become vibrant and active vehicles for community engagement. Given this evolution, the Board decided to support and empower the CHIs to be the authentic voices of the local communities instead of creating a separate Leadership Council. On May 1st, the Board voted to forgo establishing the Leadership Council and developed a formalized structure for the CHIs to provide direct feedback to the Board by adding a voting Board seat for each CHI. NCACH has been working with the local health jurisdiction within the three CHI regions to enhance their role, identify and formalize CHI membership, and nominate a Board member. These functions are outlined in a formalized charter that was developed and approved at the July 10th Board meeting.

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.

NCACH maintains a Conflict of Interest Policy that describes how each Board member should approach their personal and financial conflicts. Annually, each Board member is expected to fill out a disclosure form to identify potential conflicts. At the beginning of each Board meeting, the Board Chair asks if any members have a conflict with any agenda items. All Board members, including the Board chair, must disclose potential conflicts at this time. Board members do not need to recuse themselves unless there is a direct personal financial benefit to themselves or their family members. If a conflict needs clarification, the remaining Board members have the right to have the Board member with the identified conflict step out while they determine if a conflict is such that the Board member needs to recuse himself or herself from the vote. The development of the NCACH-Chelan Douglas Health District (CDHD) Hosting Agreement is an example in which this policy has proven successful. The NCACH Board chair, who is the CDHD administrator, recused himself from the initial conversation pertaining to the contract, has provided responses back to Board member questions, and recused himself from the final vote on the contract.

NCACH will repeat this process, which is outlined in the Board-adopted Conflict of Interest policy, with other items that will require recusal of members due to the Board structure and representation. NCACH maintains a proportional Board with 35% of our sector representation dedicated to providers and payers and 65% dispersed among other sectors.

Sector Representation with Full Board



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.

NCACH has an Executive Director who provides direct oversight of the daily operations and strategic direction of the organization, an Executive Assistant that assists our Executive Director and maintains meeting minutes for all NCACH meetings, a Program Manager who assists in workgroup development and the general operations of the organization, a Director of Whole Person Care who coordinates the Medical Providers' engagement in the Demonstration, and a Program Development Specialist who assists in workgroup planning and review of data for the Demonstration projects. Complementing the work of the Demonstration Project, NCACH has chosen to participate in the mid-adopter process and has 0.5 FTE of staff time dedicated to coordinating Fully-Integrated Managed Care Advisory Committees and workgroups.

Specific to data analytics, NCACH recently hired a Program Development Specialist who is compiling our current data resources and needs into a summary report. This individual will work with contracted data analytic support (Providence CORE) to meet the data needs of the demonstration.

To obtain true community engagement in our local communities, NCACH has contracted with our local health jurisdictions to provide local support to our CHIs to gather stakeholder engagement and to convene and obtain meaningful consumer engagement. The Board is currently reviewing the level of assistance each CHI will need and looking at NCACH's current and possibly a future staffing model to determine the most appropriate way to allocate staff time to support each CHI

NCACH believes our current internal staff plan meets the needs of the Demonstration and our community. To complete the project plan application, NCACH is reviewing consultants to refine the process of funds distribution and data analytics.

Finally, NCACH believes there will be a need for consultants to assist providers in making the appropriate clinical and EMR modifications that will align with the payment changes resulting from value-based payments (VBP).

Attachment(s) Required

- A. Copies of charters for committees and workgroups that outline purpose, members, responsibilities, and scope. (WPC, FIMC, CHI)**
- 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.**

Additional Attachments:

- H. NCACH-CDHD Policy on Funds Distribution - Draft**

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.

Current Word Count: 902

Collaboration

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

Prior to Phase I Certification, the NCACH Board approved the Model Tribal Collaboration and Communication Policy. The NCACH Executive Director Senator Parlette also initiated conversations with the Confederated Tribes of the Colville Reservation Vice Chair Mel Tonasket to explore how the Confederated Tribes of the Colville Reservation wanted to engage in the work of the Demonstration and to identify a tribal representative to serve on the NCACH Board. In addition, Senator Parlette reached out to state partners (i.e. Jessie Dean and Libby Watanabe, HCA) on May 10th to clarify the Sovereign Tribal Nations within the North Central region and to receive guidance on the best approach for NCACH to engage with those Tribal Nations.

With help from the Washington State Health Care Authority, NCACH identified two Tribal Nations that have members in our region. The Confederated Tribes and Bands of the Yakama Nation have members who receive care in North Central, but no reservation land within the NCACH service area. The Confederated Tribes of the Colville Reservation has reservation land in Okanogan County and direct linkages to the communities within North Central Washington.

Since Phase 1 Certification, NCACH has prioritized strengthening our engagement and communication with tribal partners. On June 26th, Senator Parlette connected with Tonya Kreis and Katherine Saluskin from the Confederated Tribes and Bands of the Yakama Nation to provide information about the Demonstration and to invite the Confederated Tribes and Bands of the Yakama Nation to become involved in the work of NCACH. Katherine and Tonya informed Senator Parlette that NCACH is outside of the Yakama catchment area. On July 3rd, Senator Parlette communicated with Katherine and Tonya via email that NCACH would continue to be a committed partner if the Confederated Tribes and Bands of the Yakama Nation decide to become involved in the work occurring in the NCACH region in the future.

NCACH has achieved great progress in regards to outreach to the Confederated Tribes of the Colville Reservation. On June 2nd, Senator Parlette connected with tribal Vice Chair Mel Tonasket and tribal member Molly Morris to discuss the involvement of the Confederated Tribes of the Colville Reservation in the work of NCACH and the appointment of Molly to the tribal Board seat. On June 2nd

Vice Chair Tonasket informally endorsed Molly to be the tribal representative on the Board, and Molly accepted the nomination. On June 23rd, tribal Chairman Dr. Michael Marchand signed a formal letter of support of the work of NCACH and formally endorsed Molly Morris to represent the Confederated Tribes of the Colville Reservation on the NCACH Board. On July 10th, the NCACH Board voted to approve Molly Morris to fill the open tribal seat on the Board.

During initial discussions with Molly regarding her engagement with the work of NCACH, she agreed to provide training to the NCACH Board. Molly developed a training focused on tribal history, Governance, and Indian Health Services (IHS). Molly delivered that training to the Board during the July 10th Board meeting.

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)

On July 21st, the NCACH Executive Director, NCACH staff, and tribal Board member Molly Morris met via conference call with Better Health Together Tribal Liaison to review the Tribal Collaboration and Communication policy. In that meeting, Molly Morris determined that the best approach to comply with the tribal policy would be to not establish a tribal committee but work directly with Molly on communications with the tribes. Molly will work with the Tribal Health and Human Services Director Alison Ball to ensure that communications related to the work of the NCACH are relayed to members of the tribe.

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

Initially, tribal members provided input on project selection through the Okanogan Coalition for Health Improvement meeting on March 24th, 2017. NCACH presented to members of the Okanogan CHI (which includes tribal representatives) to collect feedback on project selection. These individuals had an opportunity to complete a survey at the meeting or online to provide feedback on the projects they felt were most important to their community.

Given that the Confederated Tribes of the Colville Reservation land crosses two Accountable Communities of Health (Better Health Together and NCACH), NCACH understands the complexity this creates for the tribe in respect to their engagement in the Demonstration work. NCACH organized and held a conference call on July 21st to connect with Better Health Together to determine how we can better coordinate projects across the two Accountable Communities of Health. During this meeting, there was an understanding that we still have areas to improve in our direct outreach to the Confederated Tribes of the Colville Reservation and will work through our newly elected tribal Board representative Molly Morris to gain greater tribal input in the project plan application prior to the November 16th deadline.

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.

NCACH received training including the history of the Confederated Tribes of the Colville Reservation, tribal Governance and structure, and a detailed explanation of Colville Tribal Health and Human Services from our newly elected tribal Board member Molly Morris at the July 10th Board meeting.

Molly offered to schedule a tour of an IHS facility in the Confederated Tribes of the Colville Reservation for all NCACH staff and Board members. On September 11th, following the NCACH Governing Board meeting in Omak, Washington, NCACH will have an official tour of the IHS facility that services tribal members in the Omak area. NCACH is currently developing a schedule of monthly Board trainings and will include annual tribal education into that schedule.

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.**

Additional Attachments:

- D. Communication between NCACH, HCA, and Yakama Tribes**

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.

Current Word Count: 1,939

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.

NCACH defines successful community engagement as our ability to receive input from health care consumers (specifically Medicaid beneficiaries) on the Demonstration, present that input to the Board, and have that feedback meaningfully impact Board decisions throughout the course of project planning and implementation. This process was first demonstrated through the selection of the NCACH Demonstration projects in May 2017. NCACH presented the potential North Central Demonstration projects to community members and partners (550+ individuals), gathered feedback in person and through online surveys, and incorporated that feedback in the project selection.

After Phase I Certification, NCACH implemented short and long-term strategies to ensure ongoing input of community members, including Medicaid beneficiaries. Since June 1st, NCACH participated in several meetings and events which included Medicaid beneficiaries to receive input on project planning (see Q2). Currently, this feedback has assisted NCACH in refining our process of how best to further engage consumers as we move into project planning.

Through the Coalitions for Health Improvement (CHIs), NCACH shares Demonstration information to create a formal process for bi-directional feedback between community members and the Board. Each Coalition is open to any member of the community interested in the work of the NCACH, and Coalition leadership is expected to ensure their membership is diverse, including Medicaid beneficiaries. Within each CHI, NCACH has contracted with an organization to hold focus groups with Medicaid beneficiaries in the fall of 2017 and gather input on patient level issues. The input gathered

at the local CHI meetings and the consumer focus groups will be compiled by each CHI and presented to the Board and/or appropriate workgroups when making further decisions pertaining the Demonstration.

NCACH recognizes limiting factors to participation such as meeting times, locations, and childcare. NCACH plans to utilize design funds, which are less restrictive than current SIM funding, to create internal staffing capacity to hold meetings at more conducive times and locations for consumer attendance, develop creative funding solutions to address transportation and childcare issues, and ensure that engagement in Demonstration work is not a financial burden to consumer representatives.

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

On July 13th, NCACH partnered with the Washington State Department of Social and Health Services to host a Consumer Integration Forum updating consumers (including Medicaid Beneficiaries) on Fully Integrated Managed Care (FIMC) Contracting and gathering input on local health needs. The top 3 needs identified by consumers were mental health access, housing, and youth engagement (i.e. youth centers)

The Chelan-Douglas CHI recently went through the process of electing their NCACH Governing Board member. Within the initial meeting, they identified the current sector gaps of the NCACH Board and nominated two candidates to fill the Chelan-Douglas CHI representative Board seat. Coalition members completed voting on August 4th with 90% of members voting for their chosen candidate (55% is average USA voting turnout). On August 7th, the NCACH Board elected Brooklyn Holton to be the Chelan-Douglas CHI representative on the Board.

On August 5th, NCACH attended the Columbia Valley Community Health back-to-school night. This event attracts 1,000 individuals (predominately Medicaid beneficiaries). NCACH asked parents what the biggest health problem is in Wenatchee, Washington. Out of 211 responses, participants' top three selected problems were drug and alcohol use (45%), Mental Health (20%), and obesity (19%). Of respondents, 40% completed their forms in Spanish, and NCACH utilized a community volunteer that was fluent in Spanish to ensure that those participants were able to understand and provide meaningful responses to the questions.

On August 8th, The NCACH Executive Director presented to the Columbia Valley Community Health Board, which is made up of greater than 50% Medicaid beneficiaries, to provide an update and gather feedback on the current process NCACH is taking to address the work of the Demonstration.

On August 7th, the NCACH Board accepted Medicaid beneficiary Tyler Paris to fill the consumer seat on the Board which will ensure direct participation in the decision making process by a Medicaid beneficiary

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?

In addition to the several examples provided in Q1, CHI meetings include a diverse group of stakeholders including Medicaid beneficiaries. NCACH presented at each CHI in the region (Chelan-Douglas, Grant, and Okanogan) to gather input on project selection. At the Grant County CHI, attendance included two parents of a child on Medicaid who struggles with mental health issues.

These individuals provided input on project selection and continue to engage in NCACH through the CHI.

The three CHIs act as the advisory group to the NCACH Board; they serve as venues for all community partners to provide input on the direction of the Demonstration. Each CHI will meet routinely to share and gather input on important decisions pertaining to the Demonstration, and that information will be provided to the Board.

To ensure a regional perspective on the project plan application, prior to November 16th, NCACH plans to host a public forum and attend 1 community outreach event (6 total events) in each local health jurisdiction specifically focused on reaching Medicaid beneficiaries. At these events, staff will ask beneficiaries focused questions to help narrow the evidence-based approaches and target populations within the toolkit. The first outreach event occurred August 5th (Chelan), and the next event is scheduled for September 30th (Grant). The August 5th event specifically asked participants what the greatest health need is in Wenatchee. The responses to that question will be incorporated in the decision making process of NCACH workgroups and Board when we determine the target populations and evidence-based approaches for Project 3D Chronic Disease Prevention and Control.

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.

There continues to be a steep learning curve for providers regarding their engagement in the Demonstration including what engagement means and how engagement will result in tangible improvements for their patients. NCACH is working to educate providers, including defining the funds flow process for providers, and encouraging provider engagement in the 6 selected projects through the Whole Person Care Collaborative (WPCC). Attending in-person meetings is difficult for providers; NCACH is working to improve telecommunication capabilities by providing video conferencing. To ensure frontline provider engagement, NCACH staff is visiting clinics to meet in-person with providers.

Community-based organizations are struggling to find their role in delivery system transformation, given the historic barriers and differences between the medical and social services communities. The initial drive to create this engagement in NCACH has come through the CHIs. Each CHI provides a venue to explore each organization's involvement in the Demonstration and a direct process for feedback to the NCACH Board. NCACH is working to determine, through the funds flow process, how social service providers will be able to access Demonstration dollars and how to take potential shared savings reinvestment from the Demonstration work to create sustainable care processes that link to the social determinants of health. This conversation will initially occur with our partners who experience shared savings (MCOs and providers), and then further bring in our community-based partners to refine how our region will create a sustainable mechanism to fund their involvement in the Demonstration. Further refinement of funds flow will be determined in additional workgroups (defined in Q6) that involve members outside of the medical community.

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

NCACH has successfully engaged every medical provider organization in our region through its WPCC and through a partnership with Qualis Health and the Practice Transformation Hub. Qualis Health

completed a Patient Centered Medical Home – Assessment (PCMH-A) in 14 clinics and has had direct contact with every provider in the region.

The mid-adopter process for FIMC established strong relationships in the Behavioral Health communities through the FIMC Advisory Committee. The FIMC Advisory committee meets once per month with four subgroups. Behavioral Health providers, community organizations, and county jail leadership regularly attend meetings.

We continue to strengthen our engagement with rural hospitals by attending the North Central Hospital Council meetings; NCACH updates are a standing item at those meetings.

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.)

Through the WPCC, NCACH asked clinical leaders to define how Primary Care and Behavioral Health providers will address the 6 selected projects. During June and July WPCC meetings, there was consensus that Projects 2A and 3D were very relevant to the WPCC. For Projects 2B, 2C, 3A, and 3D, the WPCC determined the collaborative is the best venue to provide the Primary Care and Behavioral Health engagement and will continue to make recommendations to the Board on decisions that impact the Demonstration, but it is not the whole story. Additional workgroups are currently forming to address important aspects of the projects not addressed by WPCC. For example, the Opioid and Transition/Diversion efforts will involve interfaces with law enforcement, jails, emergency departments and EMS that would probably not be part of WPCC efforts. Workgroups currently under development include:

- Creation of the Pathways HUB
- Diversion/Transitions Project
- Opioid Crisis Project
- Chronic Disease Prevention and Control Project

The three CHIs act as the advisory group to the NCACH Board and are venues for all community partners to provide input on the direction of the Demonstration. Each CHI will meet routinely to share and gather input on important decisions pertaining to the Demonstration, and that information will be provided to the Board.

NCACH staff utilized three of the region’s subject matter experts (Dr. Butler, Dr. Freed, and Glenn Adams RPh) on June 30th to discuss their recommendations on clinical interventions for the Opioid project across the region.

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)?

NCACH Board meetings are open to the public and occur on the 1st Monday of the month. NCACH’s most recent Board meeting had 33 community members and partners in attendance. A Board meeting is held in each local health jurisdiction at least two times per year to allow for local

participation. Board announcements are distributed to our community and stakeholder partner list one week prior with previous meeting minutes and the upcoming meeting agenda. Formal decisions pertaining to the Demonstration are made at an open Board meeting.

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?

Meetings rotate once a quarter (i.e. July 10th Board meeting in Grant County), and video/audio conferencing is provided for remote participation. To encourage community input, NCACH provides a public comment period at the start of Board meetings for partners to provide feedback on the work of NCACH. Meeting materials are posted online and emailed out to participants on our community and stakeholder list one week prior to Board meetings.

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

The Board has delegated limited powers and duties to the executive committee to make decisions between Board meetings. The Board also holds a mid-month board phone call (3rd Wednesday of the month) to update board members on the Demonstration work. Any decisions of the executive committee or the Board made between meetings are ratified by the entire Board at the next scheduled Board meeting, which are always open to the public.

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.

NCACH is finalizing its new webpage (www.ncach.org) to create a user-friendly feel and provide more details and links to partners. Our current webpage (<http://www.mydocvault.us/>) averages 580 visits per week with 182 unique visitors. An online calendar provides upcoming meetings and allows users to add meetings to their personal calendars.

NCACH utilizes our distribution list of 553 individuals to send updates of the Governing Board, workgroup meetings, and all NCACH materials. NCACH is a rural community, and face-to-face connections are an important communication tool. NCACH works hard to attend local meetings of other coalitions and organizations and always provides a recap of those meetings to the Board through the Executive Directors report at Board meetings. NCACH will continue to utilize our CHIs, which routinely have 20 -30 participants at each meeting, to be local venues to update community members on NCACH work and serve as formal mechanisms for bi-directional feedback from local community members to the Board.

Moving forward, NCACH is building internal capacity for community engagement tools including enhancing our online presence and translating consumer materials into Spanish.

Attachment(s) Required

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

Budget and Funds Flow – 15 points

Description

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

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

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

Instructions

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

Current Word Count: 1,064

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: __7/10/17__

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: __7/10/17__

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.

SIM dollars have covered the cost of convening including space, technology investments such as GoToMeeting, and expanding staff capacity including hiring a Whole Person Care Director and Project Development Specialist to manage workgroups.

NCACH is in the process of utilizing Phase I Project Design funds to secure contractors with subject matter expertise in data analytics and funds flow distribution. NCACH plans to work with these contractors on two primary objectives. First, complete the necessary milestones for a successful project plan application. Second, complete an analysis and provide recommendations on needed infrastructure enhancements for NCACH to be successful in project implementation and scaling for DY2 – DY5. NCACH will provide funding for support staff for our three on-the-ground Coalitions for Health Improvement (CHIs) to expand and sustain engagement of Medicaid beneficiaries and NCACH partners in the Demonstration.

Budget projections estimate that we will spend approximately \$775,000 of Design I funding through the project plan application process (DY1:Q3 – Q4). NCACH Board approved a budget with expenditures in the following categories: 10% Project Plan Development and Engagement, 28% ACH Administration/Project Management, 5% Information Technology (including consultants), 33% Health Systems and Community Capacity Building (specifically for partnering providers), and 24% on other funded services such as our administrative service agreement and B&O taxes (in case required).

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

Phase II Design funds will be used in DY2 – DY5 to support project management and community and stakeholder engagement of the 6 selected projects. NCACH will utilize 60% of Phase II Design funds to support NCACH staff capacity to plan, implement, and scale projects over the next 4.5 years. To maintain sound human resource and financial management practices, NCACH contracts with Chelan-Douglas Health District (CDHD) and allots 13% of Design funds for the contract.

A portion of Design funds will be reserved for data analytics and funds flow processes to track metrics and pay for outcomes with our partner organizations. To maintain strong community engagement, NCACH allocates 10% of Design funds to support the CHIs through direct contracts with local organizations and dedicating internal NCACH staff. Finally, 25% of Phase II Design funds is reserved for additional incentives to partners who complete project milestones.

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

Data capacity will be supported through internal NCACH staff time and a contract with Providence CORE.

Clinical capacity will be supported through the Whole Person Care Collaborative (WPCC) led by our Director of Whole Person Care who will guide providers through the process of change management.

NCACH contracts with the CDHD for financial capacity. NCACH plans to contract with a subject matter expert to develop a funds flow process that will be utilized by the executive committee to review funding allocations.

Community engagement capacity is funded by dedicated NCACH staff time and contracts with the local health department/district to support the CHIs. NCACH staff will ensure growth of community engagement efforts and successes by providing ongoing support to the NCACH webpage, ensuring consumer input is gathered through local outreach to Medicaid beneficiaries, and assisting in presentations and forums for community partner groups.

Program management and strategic development will be provided by the Executive Director and the Board. The Board is responsible for the overall alignment and direction of the NCACH. The Executive

Director will ensure daily operations of the organization continue to align with the vision, direction, and priorities approved by the Board.
4. Describe the process for managing and overseeing Project Design fund expenditures.
Project design funds will be overseen by the NCACH Governing Board as part of their fiduciary responsibility, and the Board reviews the updated budget each month at the Board meeting. For day to day operations, CDHD provides financial management as the NCACH backbone, and the NCACH Executive Director oversees expenditures and investments. CDHD has qualified accounting staff and allocated budget codes within their finance department to ensure all funding is coded appropriately for Demonstration and SIM dollars. Expenditures not staff related occur through an invoice process utilizing purchase orders (PO) to track payments and code dollars to the correct account. Staff timesheets are tracked through Microsoft Access and each hour is coded to the appropriate department and funding source (i.e. SIM) based on staff activities. All expenses and staff hours are signed off by the Executive Director prior to any payment being made.
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.)
NCACH is developing a process to distribute Demonstration funds to partners involved in the WPCC. Provider organizations involved in the WPCC may receive initial funds to help them plan for care transformation by submitting change plans to NCACH. Providers will receive funds based on deliverables in their plans to transform their care delivery models. Moving forward, transformation plans will include specific metrics (process and outcome) that providers will need to achieve to receive additional funds. Though this plan is specific to WPCC members, NCACH plans to replicate a similar method for other partnering organizations involved with Demonstration projects.
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).
NCACH receives funding through the SIM grant and the Demonstration Project. SIM dollars have been used for Whole Person Care meetings and to engage and assess partnering Primary Care and Behavioral Health providers. This work has prepared providers to be active participants in the Demonstration.
7. Describe what investments (e.g., convening space, volunteer positions, etc.) have been made or will be made for the demonstration through in-kind support from decision-making body/community members in the following capacities: data, clinical, financial, community and program management, and strategic development.
Data and Clinical: NCACH has partnered with quality managers at local hospitals on a crosswalk of Medicaid Demonstration project metrics with clinical quality metrics (i.e. MIPS/ACO, MCO). NCACH partnered with CDHD to utilize data from the recently completed Community Health Needs Assessment that identified regional health disparities and priorities. This data was presented to the NCACH Governing Board to guide project selection. Financial: In partnership with CDHC Administrator Barry Kling, and the Whole Person Care Collaborative, NCACH staff developed a draft funds flow model to support the process in which we will distribute funds to partners.

Community: The initial successes of CHIs have been attributed to dynamic volunteer leadership established within each of the three CHIs to recruit members, develop meeting materials, and provide strategic direction.

To allow for Governing Board meetings in every county of the region, community partners donated meeting spaces in locations such as Samaritan Hospital, Pateros Fire Hall, Okanogan Behavioral Health Care, and Moses Lake Community Health.

To better reach Hispanic Medicaid beneficiaries, NCACH has received in-kind translation services from community partners who are fluent in Spanish and English.

Program management strategic development: NCACH Governing Board dedicated time developing our strategic plan at quarterly Governing Board retreats. Beyond the work of the Board, other local leaders have donated time on the VBP Taskforce (John Doyle, Confluence Health), and local opioid workgroups (Steve Clem, Douglas County Prosecutor).

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.

Current word count: 1,191

Clinical Expertise

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

The Whole Person Care Collaborative (WPCC) was initiated under the SIM grant to drive systematic clinical quality improvement across North Central Washington. It is led by a committee representing key Primary Care and Behavioral Health provider organizations serving a majority of the Medicaid beneficiaries of North Central Washington.

In a response to the NCACH's request for input on Demonstration project selection and involvement at our June and July meetings, WPCC agreed it should take primary ownership of Projects 2A and Project 3D and help develop the Primary Care and Behavioral Health response to projects 2B, 2C, 2D, and 3A.

Moving forward, clinical leaders in the WPCC will evaluate the progress of individual members relative to project work plans, Demonstration milestones, and progress toward achievement of relevant clinical quality metrics. The WPCC will provide the Board with regular updates on progress towards Demonstration project objectives and progress of its partnering providers.

To broaden involvement in NCACH work and to stay engaged with all regional hospitals, NCACH members attend monthly North Central Hospital Council meetings to present updates and solicit feedback. At the March 21st meeting, the regional hospital CEOs/Administrators emphasized that Care Coordination and Chronic Disease Prevention were the most important projects to the hospitals.

To ensure local subject matter experts are able to provide input on the work, NCACH staff routinely meet with providers. Specific to the Opioid project, NCACH staff met with the clinical leaders in the region (Dr. Butler (Columbia Valley Community Health), Dr. Freed (Confluence Health), and Glenn Adams RPh (Confluence Health) on June 30th; those leaders identified four main initiatives including prescription processes for pain patients, family education on opioid take back programs, increasing medication assisted treatment prescribers, and the use of NARCAN in emergency rooms.

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

Provider champions will be engaged to ensure we are creating system and process changes that are feasible at the care delivery level. A key example of this is the engagement of Primary Care and Behavioral Health champions within the WPCC to identify ways to create an optimal process for bi-directional integration. Bi-directional integration does not work solely by co-locating providers in the

same building. There are a number of processes that need to be completed and trust built between providers before true integration occurs.

To continue to determine the best way to implement change plans and provide funding to providers, NCACH will work with provider champions who have knowledge and skills in clinical leadership and reporting of clinical quality measures. This expertise is needed to identify the practicality of the work needed to report measures identified within the Demonstration Project Toolkit. We continue to identify providers in our region who are subject matter experts and incorporate them in project planning and design.

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.

Both Physical Health and Behavioral Health provider input was directly provided in development of the WPCC charter and membership agreement. This document defines how clinical providers of all types will be able to participate in the work of the Demonstration. At the July 10th meeting, the WPCC recommended the charter and membership agreement should be submitted to the NCACH Governing Board for final approval.

Currently, the WPCC is developing the “Investing in Change through the Whole Person Care Collaborative” document outlining how provider organizations can apply for and receive Demonstration project incentive funds. This document has been shared with all Physical Health and Behavioral Health provider organizations in the region electronically and was discussed with Collaborative members at the June, July, and August WPCC meetings.

NCACH staff also continue to gather input from providers through the work done by the Qualis Health assessments, the meetings at the North Central Hospital Council, and individual meetings and correspondence with partnering providers. To further expand clinical engagement, NCACH is supporting a 2017 fall workshop that will be hosted by the apparently successful MCO bidders in the region that is focused on engaging not only administration, but frontline providers.

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.

Beginning in May 2017, all WPCC member organizations, with assistance from Qualis Health and others, have agreed to conduct a self-assessment of their current operations relative to the evidence-based PCMH-A evaluation tool for Primary Care and MeHAF tool for Behavioral Health. These assessments will identify improvement opportunities to be addressed in the transition to whole person care and value-based payment (VBP). As of July, Qualis Health and the P-TCPI efforts have completed 10 clinic assessments, received a tour of 6 additional clinical facilities, and initiated conversations with every Physical Behavioral Healthcare provider in the region.

Every WPCC member organization will work with the consultant of its choice (or internal experts) to develop a transformation plan. Each plan must specifically identify necessary changes in behavioral health integration, staffing patterns, IT infrastructure, care coordination arrangements, and other aspects that will be needed to provide whole person care. Each plan should include a budget reflecting the costs of this transition to be funded by the Demonstration and describe how the changes will be sustained through VBP beyond the timeframe of the Demonstration. The transformation plans will be reviewed by the WPCC for completeness and evaluated by the NCACH Board for approval.

NCACH also recognizes there will be regional needs and gaps (i.e. 24/7 nurse call line). The WPCC will work to identify these gaps and identify mechanisms as a group to improve clinical outcomes as a region.

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).

NCACH has worked and continues to work extensively with statewide associations and other organizations in developing its strategies. Both the MacColl Institute and Kaiser Permanente staff have provided valuable guidance in the development of the WPCC. NCACH's Executive Director presented on the current state of ACHs at WSHA's National Rural Hospital Leadership Conference in Chelan on June 27th. NCACH has solicited advice from the Bree Collaborative (Ginny Weir) and AIMS center (Sarah Barker) on bi-directional integration, and members from a variety of organizations regularly attend and contribute at monthly NCACH WPCC and Board meetings. On August 7th, NCACH's Executive Director presented to "The Wednesday Night Study Group", a group of health care lobbyists from insurers, purchasers, hospitals, providers, disease groups and business who discuss health care policy, to update them on the current state of the Demonstration from the ACH perspective.

NCACH is working with Qualis Health, in partnership with the Pediatric – Transforming Clinical Practice (P-TCPI) Initiative and the National Rural Accountable Care Consortium (NRACC) to coordinate transformation efforts into one regional evaluation. Both Qualis Health and the P-TCPI coordinators provide updates on what clinics they have engaged with at the WPCC meetings every month.

Outside of the WPCC, NCACH continues to reach out to our local provider organizations and is listed on the North Central Hospital Council as a standing agenda item. NCACH has maintained a strong partnership with our North Central Behavioral Health Organization (NCBHO), and we provide regular updates to each other's Governing Boards.

Finally, NCACH continues to focus on involving the leaders of small organizations. For example, on June 20th, NCACH presented to the Cascade Medical Center Board of Commissioners meeting to update them on the work of the Demonstration and gather input from leaders of the small medical facilities, and on August 8th NCACH completed the same presentation to the Columbia Valley Community Health Board.

Attachment(s) Required

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

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

Data and Analytic Capacity – 15 points

Description

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

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

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

Instructions

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

Current Word Count: 1,447

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.

During project selection, NCACH utilized the regional Community Health Needs Assessment (CHNA) data set. This assessment, released in December 2016, includes health disparity data from the behavioral risk factor surveillance system, healthy youth survey, census data, and the Washington State Department of Health Community Health Assessment Tool. After data was collected for the CHNA, an extensive community voice survey was completed to gather input on the greatest health needs from the local stakeholders that was included in the final report. For project planning, NCACH is using the RHNI data sets that were released in spring of 2017 and the recently created AIM Center data workbooks to define our target populations and geographical locations.

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 Board analyzed the results of the CHNA to identify the 6 selected projects. The CHNA reviewed regional health disparity data, compiled that data into presentations, and completed a community voice survey with forums in each of the 4 counties. This survey went out to 400+ stakeholders in our community. The results identified several regional priorities including: Access to care (particularly for mental health), substance abuse, diabetes, obesity, high school graduation as well as access to affordable housing, and healthy foods.

NCACH then held 6 widely publicized community forums in April 2017 and electronically distributed surveys and recorded presentations to 550 partners for input. Based on this effort, the Board at an open meeting on May 8, 2017, selected Care Coordination, Transitional Care, Diversion Intervention, and Chronic Care in addition to the two mandatory projects.

NCACH staff reviewed the project metrics and plans for the 6 selected projects and created a data roadmap that identifies data NCACH needs to gather and analyze to identify target population and specific metrics to track that will ensure we are successfully improving patient outcomes. This roadmap will be used in NCACH workgroups to identify target populations and geographic location to pilot initial projects, refine project plan details, and monitor the success of those plans over the Demonstration.

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

For project selection, NCACH had the available data and staff capacity to analyze, collect community input, and make an informed decision around project selection. Now that NCACH is in the project planning phase, we understand that we need to enhance internal and contracted analytical capacity to enable successful project planning and implementation through data collection, analysis, and monitoring. To build infrastructure, NCACH hired a program development specialist (start date: July 31st), who will work in conjunction with Providence CORE to complete data analysis needs for the project plan application and provide recommendations for analytical resources needed to measure success and report metrics through the Demonstration. This includes identifying current data gaps including co-morbidity data, local opioid prescribing data, and jail and law enforcement data. The program development specialist is currently starting this process by using the data roadmap created by the NCACH team to identify current data gaps. In addition, the program development specialist and CORE will work with local partners to put the systems and data sharing agreements in place to collect this data.

Data-related Collaborations

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

ACHs have partnered together to identify their data gaps and the ability for the Health Care Authority to meet those needs. This includes collaborative discussions around the impacts of the state's data sharing agreement, and how each ACH is approaching the level of data they will request from the state compared to what they will need to collect at the local level.

NCACH selection of Providence CORE was informed by discussions with other ACH leaders who chose to utilize CORE's services and those leaders who selected other consultants.

Understanding that every provider will be impacted by Value-Based Payments (VPB) in a similar manner, ACHs are currently coordinating together to crosswalk Medicaid measures (the common measure set) and Medicare measures. This will help each ACH identify the additional workload our partnering providers may face to meet the new reporting demands under VBP.

Specific to project planning, NCACH will work with other ACHs to better define the data needs and solutions to the similarly selected projects such as the Pathways Care Coordination HUB.

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.

NCACH worked collaboratively with the Chelan-Douglas Health District to review and interpret the data in the CHNA that was shared with the Board. The CHNA was originally produced by three local entities (CDHD, Community Choice, and Confluence Health), with the NCACH region in mind; data included in the CHNA is broken down into the NCACH service area.

With the implementation of Fully-Integrated Managed Care (FIMC) on January 1st, 2018, the NCACH FIMC Contracting advisory committee has been working to develop a regional Early Warning System. This system includes the apparently-successful MCO bidders, three county jails, all Behavioral Health providers, the North Central BHO and HCA working together to identify, collect, and analyze data that will indicate gaps in patient care due to the transition.

To gain a greater understanding of opioid prescription data, NCACH has been working with Confluence Health (a regional hospital) to start identifying conditions with a high degree of variation in opioid prescribing to indicate where consistent guidelines would be beneficial in reducing the number and degree of opioid prescriptions for acute pain.

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.

To prepare for FIMC, NCACH partnered with Qualis Health to complete a Behavioral Health IT assessment. This assessment reviewed the current EHR used by providers, the new EHRs providers will use under Integrated Managed Care, and how the transitions will impact provider's ability to report clinical and billing data to the MCOs. This report was reviewed at the IT/EHR workgroup, which includes all MCO partners, and the group has come up with an action plan to address gaps.

Through the Whole Person Care Collaborative, Qualis Health has worked with Primary Care providers to complete a patient centered medical home assessments (PCMH-A). A major component of the PCMH-A includes an evaluation of a facilities current data reporting and analytics capacity. Once every Primary Care provider has completed this assessment, NCACH will be able to review the current gaps in data analytics and reporting and create a work plan to aid each provider in enhancing their current systems to successfully report and improve Demonstration and VBP quality measures.

NCACH has been working with the North Central Hospital Council, a meeting of all hospitals in the region, to define how North Central can best address the issue of interoperability between providers. The initial step is to review the possibility of a regional platform or a regional clinical data repository that each provider will have access to.

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

NCACH has created a data roadmap to define the different data sets needed to identify target populations. NCACH will first work to identify what data can be provided by the AIM team, what data we can receive from our MCO partners, and what data will need to be gathered by partnering providers. NCACH will work with Providence CORE to set up the needed data sharing agreements and infrastructure to collect and store public and sensitive data. This will include reviewing the current HIT infrastructure in place with providers, what system NCACH will need to establish to collect and store data, and how those two systems will be able to communicate.

This process will be duplicated when we are defining data system needs for the Pathways Care Coordination HUB to ensure this project meets data compliance, has the correct data sharing and

business associate agreements in place, and is able to report data to the partners in a transparent manner.

NCACH has been working with the North Central Hospital Council to identify a regional platform or a regional clinical data repository that each provider will have access to. This will be done in parallel with the Healthier Washington initiative which is focused on the Link4health clinical data repository system and enhancement of electronic health records (EHRs) in every medical clinic.

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.

NCACH has worked with Behavioral Health provider organizations to review their current workforce capacities and how that workforce (or workforce gaps/vacancies) impacts current access to care and penetration rates. Within that assessment, Behavioral Health providers defined how changes to their current staffing models would improve mental health penetration.

Physical Health providers completed Qualis Health’s patient centered medical home assessment (PCMH-A) in Q1 – Q3 of 2017 which evaluates clinical capacity to provide care coordination and measure quality improvement. The assessment will identify staffing gaps in each clinic and provides recommendations to their current staffing model to provide improved patient centered care.

Moving forward, NCACH is partnering with all nine ACHs to gain a better understanding of the statewide assistance each ACH will receive in workforce development, what assistance NCACH will receive from state associations (i.e. WSHA, WSMA), and how that will be incorporated in our regional efforts to better refine workforce gaps in our project plan application.

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.

Current Word Count: 1,999

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.

NCACH implemented a multi-faceted approach to ensure project selection aligned with regional needs.

The December 2016 Community Health Needs Assessment (CHNA) completed in our region revealed several regional priorities including: Access to care, particularly for mental health; substance abuse; diabetes; obesity; education; affordable housing; and healthy foods.

NCACH then held 6 widely publicized community forums in April 2017 and electronically distributed surveys and recorded presentations to 550 partners for input. Based on community input, the Board at an open meeting on May 8, 2017, selected Care Coordination, Transitional Care, Diversion Intervention, and Chronic Care in addition to the two mandatory projects.

Six key considerations were articulated and applied during the Board's project selection process:

1. Project selection should be shaped by patient and community needs, not by the institutional needs of any sector or organization.
2. It would be better to do fewer projects well than to take on more projects than could be delivered effectively, notwithstanding the financial incentive to select all eight projects.
3. The projects are interrelated, and the portfolio of selected projects, if implemented well, would to some extent address the purposes of projects not selected.
4. It is crucial to select (and then implement) projects that do not emphasize the payment of service costs with Demonstration funds (except perhaps in a start-up phase), but instead focus on a sustainable approach through which Demonstration dollars would no longer be needed after the Demonstration to deliver the services and innovative care models involved.
5. The Whole Person Care Collaborative (WPCC), organized over a year before the Demonstration, provides a powerful framework through which to apply Demonstration resources in support of care transformation.
6. Changing practice patterns and organizations is a very difficult and slow process. A well organized and focused effort involving mutually-reinforcing initiatives will be needed to meet Demonstration objectives in the time available.

The projects selected by the Board reflect these considerations and make up a set of mutually-reinforcing initiatives:

- The WPCC, which brings together Primary Care and Behavioral Health provider organizations region-wide, provides a framework through which many of the care transformations of the Demonstration will be achieved. WPCC will use Demonstration funds to support the development and implementation of Change Plans from each member organization. Initial planning funds and consulting services will enable provider organizations to develop plans (with required milestones and metrics) for the many changes needed to provide integrated whole person care in a sustainable manner under the new incentives created by value-based payments (VBP) and other changes. Further awards of Demonstration funds to WPCC members will be used to implement these Change Plans during the Demonstration. WPCC will also serve as a learning collaborative for providers as they work to implement care transformation.
- Through the WPCC, NCACH’s Demonstration efforts will directly address not only behavioral health integration but also important aspects of the projects on Transitions and Diversions, the Opioid crisis and Chronic Disease Prevention and Control. For each of these projects, better whole-person care that integrates behavioral and physical health, while connecting patients with community resources to help mitigate health-related social issues, will directly improve the performance of the care system. This will be relevant whenever those patients are involved in Transitions (such as discharge from a psychiatric hospital or nursing home), have problems that could result in a need for Diversion options (such as alcoholism, bipolar disease or homelessness), are at risk of developing (or already have) opioid problems related to chronic pain, or have Chronic Disease risks or symptoms (such as obesity or hypertension). For our patients, these are not separate projects but various aspects of life and health care.
- WPCC Change Plans will address care coordination, and participation in the Pathways HUB as it builds out to cover the region. More effective care coordination directly addresses important aspects of behavioral health integration, Transitions and Diversion, the Opioid crisis and Chronic Disease Prevention and Control.
- NCACH plans to use care coordination systems – current systems and, when available, the Pathways HUB – as a mechanism for funding the access of Medicaid beneficiaries to community-based services addressing the Social Determinants of Health (SDH). The point here is to make services addressing the SDH an integral part of the health care system, not a disconnected silo.
- WPCC is important, but it is not the whole story. Additional workgroups are currently forming to address important aspects of the projects not addressed by WPCC. For example, the Opioid and Transitions/Diversion efforts will involve interfaces with law enforcement, jails, emergency departments and EMS that would probably not be part of WPCC efforts. Workgroups currently under development include:
 - Creation of the Pathways HUB
 - Diversion/Transitions Project
 - Opioid Crisis Project
 - Chronic Disease Prevention and Control Project

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.

NCACH is committed to participating fully in Domain 1 initiatives as HCA further defines those initiatives and the roles of ACHs. We expect (and hope) that this work will involve considerable collaboration among ACHs.

We hope to collaborate with other ACHs on the Pathways HUB. There are opportunities for shared learning and also the possibility of shared purchasing of HUB information systems. ACHs implementing the HUB may be able to share the cost of creating interfaces between the HUB information system and provider EMRs. We have already been in touch with other ACHs interested in the HUB and look forward to the time when all the ACHs have made their project selections, so we can continue work with those selecting the HUB.

NCACH has shared its plans for the WPCC with leaders of the state’s ACHs and looks forward to opportunities to collaborate with them on any related initiatives they may adopt.

NCACH leaders are active in statewide conference calls of ACH leaders – those convened by HCA and those convened separately by the ACH leaders – and are committed to taking advantage of any opportunities for cross-ACH collaboration arising from those discussions.

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

MCOs have been an integral part of NCACH’s formation from the beginning and hold a voting seat on the ACH Governing Board. We view MCOs as critical partners in the design and implementation of Demonstration projects. Each MCO is a member of our WPCC workgroup, and they are active participants in all of NCACH’s Coalitions for Health Improvement. One of the major advantages we see in being a mid-adopter region is that we now know which MCOs will be active in the region and can get down to work with them. NCACH leadership has already had separate meetings with the three MCOs who are Apparently Successful Bidders for our region, and is in the process of scheduling a session for NCACH leaders and all three MCOs. Our intention is to make this a regular meeting in order to assure that MCOs are fully engaged in NCACH’s work, especially its Demonstration projects.

Project Plan Submission

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

The biggest challenge in developing successful project plan submissions is that each involves many partners, and a project that depends on many partners must include them in the planning if it hopes to succeed. This can only result from extensive discussions and negotiations among many organizations. Although NCACH understands that DY2 is considered a planning and development year, we strongly believe that the sooner we begin implementation, the more likely it is that ambitious care transformations will occur in time to demonstrate an effect by the end of 2021. We hope to be ready for implementation before the end of 2018. We have a sense of urgency about this, yet we also understand that we must take the time necessary to adequately involve partners. We are addressing this need for urgency and collaboration in three main ways:

1. The WPCC already includes every Primary Care and Behavioral Health provider in the region. It was formed over a year ago because we knew their involvement would be critical. WPCC will be an important venue through which project plans are developed.

2. Each local health jurisdiction in the region (Okanogan, Grant and Chelan-Douglas) organized a broad group of community partners and social service providers, called a Coalition for Health Improvement (CHI) in 2014 when the concept of ACHs was first introduced. Since then, CHIs have been instrumental in development of NCACH. The Board recently voted to formalize the CHIs by providing a half FTE of staffing for each to help organize and grow them, and by creating a voting seat on the Board for each CHI. The CHIs will be an important avenue for partner, community member, and Medicaid beneficiary involvement in the development of project plans.
3. We are in the process of forming workgroups for NCACH projects. Each workgroup will have a charter and will draw its members mainly from WPCC and the CHIs, though others (such as MCO representatives) will be recruited as needed.

NCACH is also concerned about data issues. The most pressing need is to develop or obtain solid baseline data on important project metrics; without which, any subsequent data collection may be meaningless. We are not convinced that the state will be able to provide such data and are looking at options for developing this capacity within the region.

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

NCACH has made it a priority to reach out to every clinical facility in the region and we know we are working with every major Medicaid provider in the region through the WPCC. Our work as a mid-adopter region has facilitated our connection with Behavioral Health as well as Physical Health providers.

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

NCACH has developed a WPCC membership charter and membership agreement that will be approved by the NCACH Board on September 11th, 2017. By signing the membership agreement, an organization becomes eligible for a Change Plan Development Award and, if the change plan is considered adequate, a Change Plan Implementation Award. We believe this funding, along with the opportunity to be part of an active learning collaborative, will incentivize provider organizations to commit to Demonstration project activities. Behavioral and Physical Health providers will be included in this process.

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

NCACH's Board includes a wide variety of partners. NCACH's three CHIs are an important asset in assuring broad partner engagement. CHIs include a very wide range of partners. Clinical organizations, social service providers, local elected officials and community members are among the participants. Over 500 people in the region have been involved at some point since CHIs began meeting in 2014. More recently, CHIs were an integral part of project selection. CHIs are the primary mechanism through which NCACH assures that a very broad range of community partners are engaged in NCACH's work. CHIs are now formalizing with the adoption of charters to help set expectations of members while ensuring broad participation of a wide range of sectors is possible.

North Central's work to prepare for FIMC as a mid-adopter region has also involved an extensive series of Advisory Committee and related workgroup meetings. This has further engaged Behavioral Health providers, consumer representatives and other interested partners. We expect to fold these groups into the CHI effort after full contract integration occurs on January 1, 2018.

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.

It is NCACH’s firm policy to not fund service delivery costs or other operations costs for service providers, or for other project activities, except in the context of a project plan leading to sustainability in the absence of Demonstration funds after 2021. There will be startup costs in some projects – for example, the initial purchase of IT infrastructure and software for the Pathways HUB. But no such investments will be made until a practical sustainability plan, with commitments from funders, is developed. With regard to clinical transformation efforts funded through the WPCC, one of the requirements for Change Plans is a clear plan for sustainability. Implementation awards for providers’ Change Plans will not be made in the absence of such plans. Those plans must demonstrate how the proposed changes will position the provider organization to provide integrated whole person care under new payment approaches such as VBP after 2021. The same emphasis on sustainability will occur in planning other aspects of the Demonstration. Sustainability is a core value of NCACH in all of its Demonstration efforts.

Attachment(s) Required

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