

Phase II Certification Submission Template

ACH Phase II Certification: Submission Contact	
ACH	North Sound ACH
Name	Elizabeth Baxter, MPH
Phone Number	360-386-5745
E-mail	Liz@NorthSoundACH.org

Theory of Action and Alignment Strategy – 10 points

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

1. Define a clear and succinct region-wide vision. 138

The vision of the North Sound ACH is to improve the health of people living in Snohomish, Skagit, Island, San Juan and Whatcom counties. The Board reaffirmed this in July as displayed in the image below.

The ACH continues to develop and leverage partnerships to address challenges impacting population health, such as access, capacity, workforce, and resources. Improving population health requires incorporating strategies beyond the health care delivery system, such as education, built environment, affordable housing and food. The ACH understands that doing things *differently*, may be more critical and difficult than doing *more* of the same. We're looking for opportunities where counties, hospitals, CBOs and foundations invest together on upstream strategies. DSRIP allows for key infrastructure investment that can be sustained during and after the demonstration, to expand IT and interoperability, an expanded workforce and deeper partnerships.

Defining 'True North'

To improve health of the people who live in Snohomish, Skagit, Island, San Juan and Whatcom counties, the North Sound ACH will:

- Work with private, public sector and tribal partners to create innovative and sustainable community-led solutions.
- Use strategies that advance equity and reduce disparities in operations, decisions and governance.
- Look upstream, midstream and downstream to identify solutions that include, and go beyond, traditional healthcare approaches.
- Embed the perspectives of clients, patients, and community members in operations, decisions and governance.
- Use ACH partnerships to leverage other opportunities for federal, state investments
- Operate in a lean, efficient manner that optimizes the ability of our partners to carry out the work toward transformation.

Lenses that Drive the North Sound ACH:

- Acknowledge the conflict that exists with the North Sound's desire to work upstream, and the Demonstration's focus on clinical outcomes
- Acknowledge and respect the sovereignty of our Tribal partners
- Focus on communities most impacted by disparities/inequities
- Leverage evidence and emerging data
- Be innovative, and allow flexibility across the region
- Avoid duplication/reduce waste
- Create system-level, sustainable changes
- Agree to first seek understanding, then seek agreement



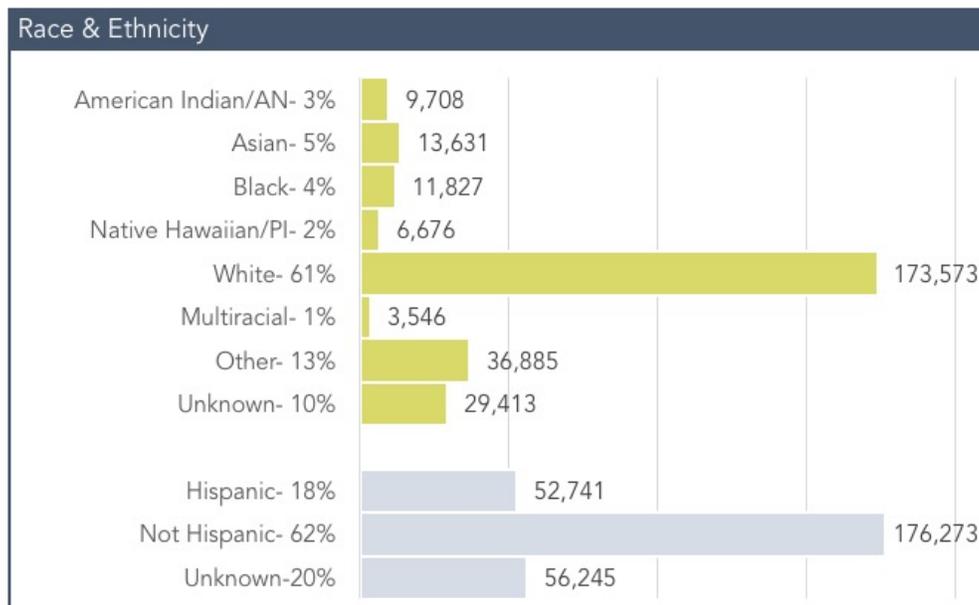
Building Healthier Communities
In Snohomish, Skagit, Island, San Juan & Whatcom Counties

2. Summarize the health care needs, health disparities, and social risk factors that affect the health of the ACH's local community. 191

The North Sound region is geographically large with diverse populations, including 8 tribal nations. The five counties that range from urban settings connected by highways, while increasing distance from population centers of Seattle, Everett, Mount Vernon and Bellingham

mean much more limited access to services in rural and remote areas. One of our counties is **only** accessible via ferry, and by ferry from island to island within the county. Being 15 miles from a service is vastly different when those miles are along I-5, as opposed to across the Salish Sea. While statewide 27% of residents are on Medicaid, in Skagit County it is 31%, and 60% of tribal members are on Medicaid. Using the Washington Tracking Network, we find wide variability in social risk factors in key areas and presented this data to the Program Council on August 3rd to prepare them for presentation of possible projects in September.

Demographics: Medicaid

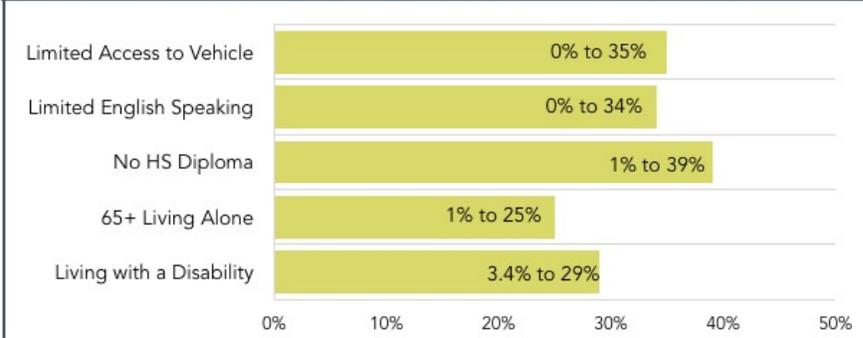


Office of Financial Management (OFM), Washington State. 2015. HCA Medicaid Only enrollment. Healthier Washington Data Dashboard. 10/1/15-9/30/16.

Social Determinants

	Limited Access to Vehicle	Limited English Speaking	No HS Diploma	65+ Living Alone	Living with a Disability
Washington	7%	8%	10%	10%	10%
Island	4%	2%	5%	12%	15%
San Juan	4%	2%	5%	14%	13%
Skagit	5%	7%	12%	11%	14%
Snohomish	5%	8%	8%	8%	12%
Whatcom	7%	5%	9%	11%	13%

Differences in Social Determinants within North Sound Communities

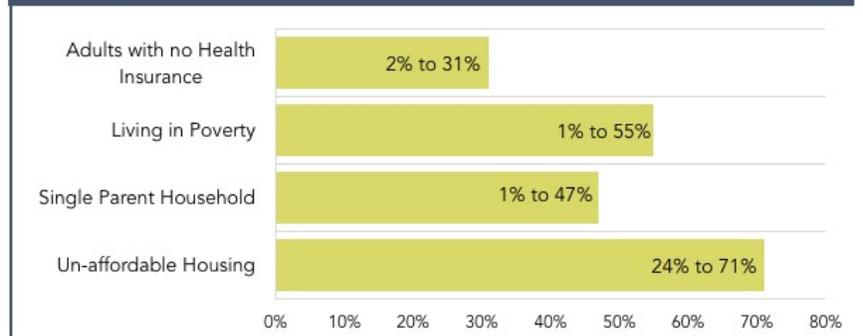


Washington Tracking Network, WA Department of Health. 2010, 2011, 2012, 2013, 2014, 2015.

Economic Determinants

	Adults with no Insurance	Total Living in Poverty	Single Parent Household	Un-affordable Housing
Washington	16%	13%	13%	37%
Island	11%	9%	9%	37%
San Juan	18%	11%	10%	39%
Skagit	17%	12%	12%	38%
Snohomish	12%	10%	12%	40%
Whatcom	14%	15%	12%	39%

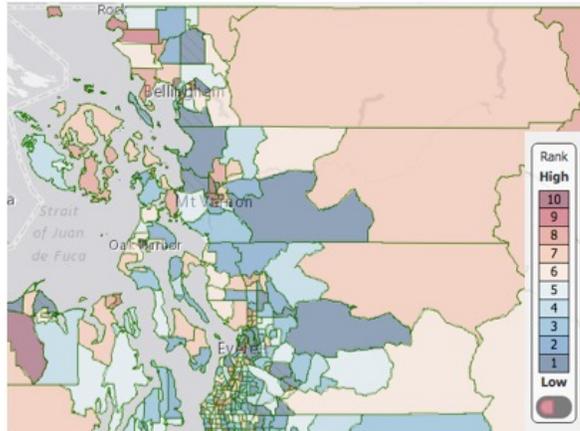
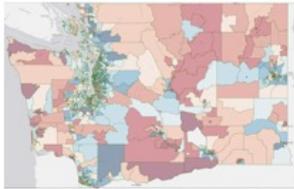
Differences in Economic Determinants within North Sound Communities



Washington Tracking Network, WA Department of Health. 2010, 2011, 2012, 2013, 2014, 2015.

Life Expectancy

	Age	Range
Washington	80	68-91
North Sound	81	71-90
Island	82	77-86
San Juan	84	79-90
Skagit	80	76-85
Snohomish	80	71-88
Whatcom	81	72-86



Washington Tracking Network Ranking

- Community's rank between 1 (lowest) and 10 (highest).
- Each number represents 10% of the communities.
- For example, if your community is ranked a 7 for health disparities, it means that 60% of the communities in Washington State have a lower level of health disparity and 30% have a greater level of disparity.

Washington Tracking Network, WA Department of Health. 2010-2014.

In 2015, data from the region's county and hospital community health assessments identified three priority areas: care coordination, behavioral health, and addressing health equity. As updated CHAs/CHNAs become available we will refine our understanding of the region's health needs and priorities.

3. Define your strategies to support regional healthcare needs and priorities. 227

The North Sound will support regional health by using current and upcoming state, county, hospital and partner data to refine understanding of available data and the data gaps. There is Board agreement that addressing disparities is primary, so when data shows regional variations (for example, reporting on limited access to affordable housing), that data will drive policy and place-based strategies.

While committed to delivery system reform, we believe that in order to achieve improvements in health equity we must look downstream, midstream and upstream, and lean into uncomfortable dialogue about class, privilege and race. With close to 40% of people on Medicaid identified as people of color or 'other' our strategies must start where the data shows the most compelling need.

To foster transparency in prioritizing regional health priorities, the Board has agreed to:

- Select projects that align with identified regional healthcare needs;
- Prioritize reducing disparities and increasing equity;
- Use local and regional SMEs, who have a working knowledge of the region's needs and assets;
- Be transparent in the criteria used, the process by which the criteria will be used;
- Synthesized available and relevant data to inform ACH processes and decisions, including priorities and criteria, and project selection

- Leverage use of consultants as needed, in areas such as embedding an equity lens, modeling funds flow, domain 1 activities of HIE/HIT, workforce needs and strategies and population health.

4. Describe how your project selection approach addresses the region-wide needs and priorities. 147

The North Sound ACH started with self-formed workgroups organized around the eight toolkit project areas, comprised of diverse stakeholder participants. This approach enabled partners to share local and regional knowledge, identify opportunities for collaboration, evaluate current data, and explore potential strategies. Utilizing regional data, the workgroups are developing strategies to address regional needs, leverage existing resources, build partnerships, and meet toolkit requirements.

Simultaneously, the Program Council made a recommendation to screen potential project areas based on three criteria: whether the data supports a regional need, whether partners exist to meet the metrics, and how projects align with the toolkit models. The Program Council approved a framework to guide submission of Demonstration projects, based on the Toolkit, review of state and federal program criteria, and stakeholder input. This framework (shown below) will be used by workgroups, the Program Council, and the Board of Directors during project selection decisions.

North Sound ACH Project Framework

Required Project Elements

- The project is transformational and aims to accomplish something new, different, better, or more expansive than current efforts
- The project is not duplicative of other work in the region (prefer complementary, additive, or expand on other work)
- The project uses an evidence-based model recommended in the Toolkit
- The project addresses the metrics required by the Toolkit
- The project addresses a regional health need, as supported by data
- The project is relevant to Medicaid, with potential to improve health outcomes for Medicaid enrollees
- The project has potential to increase access to health care and other services
- The project has the potential to reduce disparities
- The project considers social determinants of health

- The project does not protect obsolete models, but does not break models that are working without an adequate improved model
- The project uses a workforce that is currently available and/or increases capacity of available workforce
- The project has a plan for sustainability beyond the demonstration project years
- The project has the potential to be scaled up and expanded
- The project has incorporated stakeholder and public input, and has a plan for continued engagement
- The project has identified potential negative consequences, as well as strategies to mitigate negative impacts
- The project is feasible to implement, including potential cost impacts
- The project can be flexible, and may be implemented in diverse areas, or with diverse populations
- If the project cannot be translated to other populations or geographies, there is a clear explanation of why, as well as expected outcomes that would benefit the region
- The project aligns with current CHAs and CHIPs
- The project has the potential to positively impact multiple project areas

Optional Project Elements

- The project has engaged multiple provider partners
- The project has potential for collaboration across ACHs
- The project has the potential to significantly impact health outcomes and/or reduce inequities
- The project builds on, or leverages existing infrastructure and supports local efforts for transformation
- The project has incorporated, or will incorporate, an evaluation plan
- The project has the potential to address an area of critical need in the region, or an area with high acuity

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. 200

The North Sound ACH acts as a neutral convener, facilitating collaboration across stakeholders to leverage existing resources and efforts, and build regional capacity through strategic investments. Launched prior to the Demonstration, the ACH has forged long lasting relationships that go beyond the Demonstration, to improve health across the region. The ability to braid philanthropic funds, community benefit, health system and health plan investments, will allow further innovation beyond the Demonstration.

The ACH is actively mapping assets and opportunities, to develop relationships that better align and coordinate efforts. Examples include:

- Supporting Snohomish County’s application for a Chief Health Strategist, in order that community assessment teams better understand local needs and priorities
- Seeking foundation support for regional learning opportunities such as participation in

the Equity Summit in Chicago in April.

- Discussion with foundations to support efforts outside of the Medicaid Demonstration, especially for vulnerable populations.

In 2018 we will publish an updated RHNI that refines regional needs, existing efforts/initiatives underway, and potential opportunities for partnership within and outside of the Demonstration. We will continue to build strong relationships with local partners, with an ACH goal to support a portfolio of projects that have investments from funders (government and philanthropic), investors, and payers.

6. Describe the interventions and infrastructure investments that will potentially be shared or reused across multiple projects. 343

Core infrastructure: a centrally located office, with meeting space, drop-in office space, and technology (cloud-based systems such as Zoom, EFax, UberConference line, etc.) that can be used by partners. The ACH envisions a small footprint in terms of core staff, while encouraging shared use of business and technology infrastructure to support regional work across projects and partners.

Staffing/support: a percentage of design/incentive funds to support IT infrastructure, and other resources across projects. For example, ACH’s investment in Pathways could be used across multiple projects, and support populations beyond Medicaid. Support for staff in partner organizations can engage in multiple projects and community engagement efforts (i.e. supporting a partial FTE in San Juan County Public Health).

Tribal partners: The North Sound is home to eight tribal nations, with 60% of tribal members on Medicaid. Using a portion of design and incentive dollars to support tribal partners begin the process of designing tribal projects builds relationships and shared learning that can be used across projects, build capacity among our tribal partners and expand the ability of other partners to learn from initiatives being implemented out by the tribes.

Data & learning team: The North Sound ACH will establish and support a group of thought partners to plan how to meet data and analytic capacity needs of the region, and explore ways to fund needed technology support for those partners. Working with Community Commons, Change Lab Solutions or the Equity Atlas will expand understanding and visualization of data.

Population Health Strategies and Tools: Improving population health requires both clinical management of individuals in the group, and addressing underlying determinants of health status across the group. Understanding the needs of people on Medicaid and the broader population across our region is critical to our goal of improving health. If Washington’s churn rate is similar to Oregon’s (which was estimated at 50%) there is a great deal of overlap in needs of vulnerable population regardless of payer. We will contract with consultants to identify best practices for community education, behavioral change campaigns, and ways to measure population health.

Attachment(s) Recommended

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

outcomes.

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

Governance and Organizational Structure – 10 points

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. 307

The North Sound ACH has a single decision making body – a Board of Directors – that has fiduciary accountability for the nonprofit corporation. The Board has five standing committees - Executive, Finance, Program Council, Tribal Alignment and Governance. The Bylaws were restated in March 2017. The Board has all required sector representation. Our sectors include: physical and behavioral health, health systems, public health, MCOs, tribal partners, community members, long term support and services, counties, social determinants of health. Nominations are sent to the Governance Committee, which deliberates, votes and forwards recommendations to the Board for election to the Board.

The Governance Committee has worked collaboratively with Board members to reduce redundancies and ensure appropriate representation across sectors, resulting in:

- Each tribe in the region has a voting seat (currently five tribes have appointed representatives)
- Nominations from County Councils/Commissioners to foster communication with County leadership (currently all five counties have nominated representatives)
- Health systems leaders, public health directors, MCOs and LTSS each met to recommend a nominee from their respective sector

Board members have agreed to engage others in their sector, bring sector perspectives to the ACH Board, and represent the ACH back to their organizations and communities. For example, the hospital member on the board meets monthly with leaders from other hospitals/health systems to keep them updated and bring concerns to the Board meetings. The newly formed Tribal Alignment Committee allows time for tribal partners to work separately with consultants, staff, and Board leadership to fully understand the implications of Board decisions prior to any Board vote.

In addition to the Board, stakeholder sectors are engaged on the Program Council, workgroups, and other opportunities. The ACH is committed to engaging a range of

stakeholder perspectives and providing opportunities for input by convening meetings and other engagement opportunities for behavioral health providers, front-line clinicians, public health workers, and consumers.

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) 158

Since the Phase 1 Application, the North Sound ACH has officially transitioned from a Governing Body to a Board of Directors. The first meeting of the Board was held in June 2017. Several Governing Body members chose to transition to the Program Council. Remaining Governing Body members, and several new nominees were considered by the Governance Committee for a slate of Board members for election. In addition, new officers were elected in July 2017 and the previous Board Chair was added to the Executive Committee.

The ACH is committed to including Medicaid enrollees and non-professional community members on the Board of Directors, and have statements of interest from two community members for consideration at the Board’s annual meeting in December.

Since adopting the Tribal Communication and Collaboration Policy at the May Governing Body meeting, the Board has added a Tribal Alignment Committee, which will be added to the bylaws during the review of bylaws at the annual 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. 263

As the ACH moves toward project selection, fund allocation, and target population decisions, it will be incumbent on the Board and Program Council to articulate existing and potential personal and professional conflicts of interest and mitigate those conflicts. All Board members are required to review the Conflict of Interest Policy, sign a disclosure form annually, and identify verbally any conflicts of interest at the beginning of the board meeting where an agenda item poses a conflict. Identifying strategies to mitigate or manage conflicts is an upcoming required board training session.

Once a conflict is identified the Board member is allowed to continue in discussion, but would recuse themselves from voting if a vote is taken.

To support the Board in identification and understanding of conflicts of interest, the ACH Board had a facilitated session at the June Board meeting. During this session, Board members self-identified more than 30 potential conflicts, and agreed to acknowledge and “lean into” conflicts when they arise, seeing conflict as an acknowledgement rather than a barrier. The Board saw strength in expressing conflict at the table in an open and explicit manner, and is committed to learning how to acknowledge and mitigate conflict. The ACH has invited RCs from the Manatt Team to provide additional training around mitigating and managing conflict during the August Board meeting.

The Board and Program Council meetings are open to the public, with opportunities for public

input, with materials and minutes available on the website. Transparency related to conflict, and learning how to address conflict is a commitment of the Board and Program Council.

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. 229

To date the ACH has hired:

- Executive Director: Hired by the Board. Responsible for the organization, staffing, reporting, deliverables, primary relationship with State, evaluation, and vendors. Staffs Board and Steering Committee.
- Deputy Director: Responsible for project staff, project selection process, and overall project management. Staffs workgroups.
- Data and Analysis Manager: Responsible for data analysis, synthesis, and translation to staff, Board, and partners. Maintains relationship with LHJs and tribal partners related to data.
- Project Manager (three positions): Responsible for management of workgroups, specific projects, monitoring and reporting on projects.
- Community Engagement Coordinator: Responsible for engaging community-based organizations and developing strategies to engage members of the public, including Medicaid beneficiaries.
- Executive and Governance Administrator: Responsible for administrative support to ED, Board, and Board committees

The ACH is either actively recruiting or in the final phases of developing job descriptions for:

- Pathways Director: Responsible for development and rollout of Pathways Hub planning and development. Goal to onboard by October.
- Finance and Administrative Manager: Responsible for financial integrity and reporting, and potentially contracting. Goal to onboard by September.
- Tribal and Clinical Liaison (will use PM job description as source draft): Responsible for monitoring alignment with tribal partners, health system, and other clinical partners. Goal to onboard in September.
- Administrative Assistant: Responsible for administrative support to Deputy Director and Project Managers. Goal to onboard by August.

Attachment(s) Required

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

Attachment(s) Recommended

- E. Sector representation policy describing any agreements or expectations for decision-making body members to communicate with and engage partners within a defined**

sector.

- F. Revised visual/chart of the governance structure, if there have been significant changes since Phase I Certification.**
- G. Revised organizational chart that outlines current and anticipated staff roles to support the ACH, if there have been significant changes since Phase I Certification.**

Tribal Engagement and Collaboration – 10 points

Collaboration

1. Provide an update on the ACH efforts described in Phase I Certification, particularly for any next steps identified. 310

Since the beginning of the North Sound ACH there have been seats for all tribal partners to appoint a member to the (then) Governing Body. After reviewing the HCA Guidance on sector representation, and after deliberation by the Governance Committee and Board, it was decided to create seats for each of the eight regional tribes on the North Sound ACH Board, recognizing that as sovereign entities no tribal representative can speak for another tribe. The ACH currently has five of eight tribes represented on the Board, and tribal partners are working with the other three tribal governments to explore participation.

In July 2017, Councilman Nickolaus Lewis (Lummi Nation) provided a training on tribal Sovereignty to the Board of Directors. This was a profound learning experience for Board members, with several stating that they had a deeper understanding of the government to government issue, and that the North Sound ACH is not a peer relationship for the tribes. Board members also were moved by the presentation of tribal history in the state of Washington, and several expressed desire for more information on the region's tribes and their members' healthcare needs.

One outcome of this training was approval of a Board letter of support for the communication submitted by the American Indian Health Commission for Washington State, advocating that Demonstration funds be directly allocated to the tribes to support tribal specific ACH efforts, including planning and design funds.

The ACH will form a Tribal Alignment Committee in September 2017 in accordance with the Tribal Collaboration and Communication Policy. Tribal partners have met with ACH staff to discuss implications of ACH decisions on tribal members, and the Tribal Alignment Committee will meet prior to the September Board meeting when Project selection will be on the agenda, so that the Tribal Alignment Committee can weigh in on impact of project selection on tribal partners.

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) 280

The Governing Body approved the North Sound Tribal Collaboration and Communication Policy in May 2017. The ACH included several additions in areas to the State's draft policy, including:

1) Updated framing statement in Section 1:

Recognizing the sovereign nation status of the tribes in the state of Washington, and that the North Sound Accountable Community of Health (ACH) is not a government entity, the purpose of this policy is to establish a clear and concise collaboration policy and communication procedure between the ACH and tribal governments, Indian Health Service (IHS) facilities, and Urban Indian Health Programs (UIHPs) in the

development of all ACH policies or actions. The North Sound ACH cannot require participation of any tribal entity. Appointment of a tribal representative to the ACH Board of Directors is entirely voluntary. The Medicaid Demonstration aims to transform the health care delivery system through regional, collaborative efforts led by Accountable Communities of Health (ACH) and tribal governments and new, supportive services to address relevant social determinants of health.

- 2) Updated Section 2 to state that: *The ACH will hold one seat on its Board for each tribe in the North Sound region to appoint a representative to sit on the board as a full voting member of the Board. This agreement will be included in the North Sound ACH bylaws.*
- 3) Updated Section 7 to include “at least” in order to ensure that the policy is reviewed each year regardless of whether there is a request: *This policy will be ... reviewed and evaluated at least annually, or sooner at the request of any tribe or UIHP, or at the request of a majority of the North Sound ACH board members.*

3. Demonstrate how ITUs have helped inform the ACH’s regional priorities and project selection process to date. 174

Tribal partners in the North Sound region have been engaged in the region’s ACH since the beginning, even prior to submitting the application to become a regional ACH. Tribal partners offer examples of creative strategies to approach care of vulnerable populations that all partners in the region can learn from. Tribal partners held voting seats on the Governing Body, and currently hold five voting seats on the Board.

The ACH’s tribal partners have demonstrated innovative approaches to housing and its relationship to physical and behavioral health care, building supportive housing units that wrap recovery, addiction, employment and family support services, bringing services to the individual/family rather than requiring that families navigate complex systems when they are in crisis.

In addition, the oral health project area has been influenced by the opportunity that tribal partners have to utilize Dental Health Aide Therapists (DHATs). There is interest in the North Sound region to support training of DHATs for broader population, and the experiences of tribal partners will enhance the ACH’s ability to strategically grow this workforce.

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. 183

In July 2017, following the Phase I application, Councilman Nickolaus Lewis (Lummi Nation) provided a training on tribal Sovereignty to the Board of Directors. The materials from the training are being made available to Board members to facilitate continuous learning. This training is part of a series of planned trainings, with Board members requesting follow-up

learning opportunities about each tribe, along with Board meetings to be held at tribal locations. The Board has expressed interest in learning more about the disparities faced by tribal members across the region, and the ACH will support this request by providing data, particularly for specific project areas, when available.

In addition to trainings and tribe-specific data, the Board is exploring opportunities to rotate meeting locations to be onsite at tribal locations. This would provide an opportunity to increase tribal engagement, continue to build meaningful relationships, and offer Board members an opportunity to learn more about specific tribes and the impact of ACH decisions and actions. The Board has also added the Tribal Alignment Committee to the governance structure, to ensure Board decisions are evaluated by tribal partners.

Attachment(s) Required

A. Demonstration of adoption of the Model ACH Tribal Collaboration and Communication Policy, either through bylaws, meeting minutes, or other evidence. Highlight any modifications that were agreed to by all required parties.

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

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

Attachment(s) Recommended

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

Community and Stakeholder Engagement – 10 points

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. 277

Barriers noted in Phase 1 are being addressed through strategic communication and outreach by the Community Engagement Coordinator, allowing her to capitalize on her relationships across the region, and find ways to meet in communities at their routine gatherings. We are aware of other barriers such as transportation, childcare, and meals, which can now be addressed using Phase 1 Design funds.

Other challenges/strategies include: 1) translation of HCA/ACH-speak into plain language to address literacy and health system literacy, as this will enhance understanding of our approaches; 2) financial resources for barriers such as limited transportation, child care; 3) alternate locations/times for engagement opportunities; and 4) exploring partnership with the region’s higher education language departments to support translation of materials into other languages. We will also leverage conferencing and virtual technologies to accommodate participation for those that are unable to travel or be onsite.

The Coordinator will develop and implement the ACH’s community engagement plan, including the formation of a Community Council to inform the project planning process, and advise strategies to further engage the community, including Medicaid enrollees. The Coordinator will connect with community leaders and other with direct relationships with Medicaid enrollees. The community engagement plan will lay out multiple avenues for meaningful engagement, and enable participation for a wide range of community members and stakeholders. The plan will be completed and published by late September, allowing for implementation immediately after.

The North Sound ACH is actively recruiting Medicaid enrollees to serve on the Board, Program Council and the Community Council. So far, we have two submissions of interest for Board membership, and hope to have several more prior to the Board’s annual meeting in December.

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

engagement. 293

Successes include:

- Three meetings in Anacortes between May 1st and July 20th with an average of 75 attendees each, resulted in shared learning and visioning about potential projects, overlaps and intersections, understanding of Pathways HUB, and addressing equity in the project areas. Several attendees have sought opportunities to engage at the governing and decision-making level. The sessions led to reduction of siloed discussions, recognizing that people on Medicaid cross and overlap the project areas.
- ACH staff met with key stakeholders in San Juan County, including the Board of Health, Hospital District Board, EMS chiefs, and the Community Network. This provided opportunity for ACH staff to hear from a range of stakeholders and learn more about San Juan County’s needs from their purview.
- The ACH met with health system leaders from all five counties, fostering understanding and partnership for clinical and system engagement in the project planning process, identifying clinical champions, SMEs, and potential pilot sites for projects.
- Our ED outlined an engagement plan for North Sound several years ago detailing key tenets for success: be clear about the questions; only ask questions where the input is going to be of value; value and use the input you receive; and report back to communities to let them know how their input was used. Success is about building strong and lasting relationships. We plan routine meetings across our region where we head to people instead of depending on them coming to us.
- The ACH is cultivating non-Medicaid partners for engagement. At recent meetings with Seattle Public Utilities, the ACH Executive Director met with partners in who lead air and water quality, housing, parks/greenspaces, and zoning – and heard their desire to be more engaged in decisions that influence long term health, including activities of the ACHs.

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? 267

Partner organizations host local meetings and invite the ACH; we seek public input at both Board and Program Council meetings, and take input via email and in person. Two recent examples: 1) Providence hosted a meeting in Everett with philanthropy, public health, county executives, hospital leaders, population health partners, and City of Everett to share Snohomish County’s input on the Demonstration projects; 2) Four meetings in Friday Harbor, hearing from public health, EMS chiefs, community partners, people on Medicaid, the Board of Health and the hospital district board. These two sets of place-based meetings informed the framework for workgroups, project selection, and ideas for populate the board and board committees, and potential for rotating meetings.

The Community Engagement Coordinator is building a directory of community organizations

who reach people on Medicaid, is attending their meetings and planning future ones, so that we can leverage the relationships they have in their community, and acknowledge their leadership. Those sessions provide input on project selection and will continue through October gathering community input is included in our Project Plan Portfolio submission.

The ACH is seeking applicants for the Community Council, to be comprised primarily of people with current or past Medicaid experience. The Council will meet in person at least quarterly, with other remote opportunities to weigh in via survey or email. The Council will provide a user perspective to program options and directions, and communications tools and strategies.

The Board and Program Council seek public input at each meeting to foster decision-making processes. Chairs of both bodies use directed questions and probes to encourage public input at key points.

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. 412

The North Sound ACH has successfully engaged clinical and community providers in the project plan development. We have clinical practitioners participating in the Program Council, its workgroups, and the Board, but its timing and location makes it challenging for them.

A Primary Care leadership group has formed, providing entrée to front line clinicians, which will help us assess readiness, workforce needs, and willingness to utilize community care coordinators in clinical settings. To date, we have primary care providers, nurses, BH and SUD therapists, dentists, dental hygienists, social workers, care coordinators, educators, and policy makers engaged in our workgroup/project plan development.

Some providers see participation as a path to funding for a particular project. Once fund allocations become clearer we may lose their interest, and we're working improve framing of strategies as region-wide and incentive based, with or without immediate funding.

CBOs often operate on small budgets, and yet they are most likely to join workgroups and committees – not expecting reimbursement for their time. We will include methods to provide incentives for their involvement in the planning and implementation stages of projects.

Continued engagement of partners may wane if they feel like their project or priorities are not included in the ACH's project portfolio. To mitigate, the ACH has developed a project framework, in conjunction with stakeholders, to guide project selection. Having clear, transparent criteria articulated early in the process will help partners understand decision-making processes, and develop recommendations that will meet established project expectations.

The ACH has been communicating the differences between incentive and grant funds, and clarifying the process for fund allocation. The ACH is hopeful that more information will be made available from HCA that will help inform stakeholder communications.

Additional strategies to strengthen provider relationships, and mitigate potential challenges, include:

- Reimbursing time for those who participate during planning phase to ensure dedicated time for ACH activities at partner organizations; this may also help us recruit key partners to the process;
- Funding educational opportunities, regional/national conferences, continuing education credits, bringing SMEs to the region, including replacing lost wages.
- Funding partner participation in learning collaboratives in either regional or subject-focused areas (e.g., visualizing data, equity strategies, plain language communication)
- Rotating meeting locations and times, to optimize potential for participation; shared use of technology for virtual audio/video participation.
- Maintaining strong and collaborative working relationship with our tribal partners. Providing resources to tribal partners who participate in ACH activities is a way to both foster engagement and mitigate risk of losing that connectivity.

5. Describe any success the ACH has achieved regarding partnering provider engagement. 87

- The ACH has workgroups in all eight project areas, with primary care, BH, SUD, EMS and care coordination providers from all five counties.
- We have fire and EMS chiefs from all counties meeting to discuss regional use of technology and HIE;
- All five LHJs collaborated on the Chief Health Strategist, housed at Snohomish County PH, and agree to form a Data Learning team to enhance the region’s knowledge and capacity.
- Workgroups are beginning to other potential partnerships that they can work on, such as housing and transportation.

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.) 147

The North Sound ACH has required that partners understand the Toolkit, the metrics and measures, and deliverable timelines. Partnering providers serve on the Board, Program Council and workgroups.

Workgroups are led by partnering providers, who have agreed to include other providers working in that particular policy area. The workgroup structure is well suited for this engagement, as it is peer supported and peer led. We have not put any limitations around workgroup participation. Participants are sharing resources, best practices, learning

opportunities, current models/strategies, regional successes, and local capacity and additional partners.

The workgroups will use an agreed upon project framework during their deliberation process, shaping the recommendations that will go before the Program Council. There are also workgroup leaders who serve on the Program Council, carry cross-project strategies forward for in the selection process, and will identify how planning funds could be used to support project implementation.

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)? 96

Board and Program Council meetings are open to the public and accessible in-person or virtually. All meetings have a public comment period. Meetings are held in Mount Vernon, central to the North Sound region, with accessible facilities. In 2018, the ACH will rotate meetings throughout the region, including tribal locations, to foster learning and partnership. We take feedback during breaks, via email, and post all meeting materials on the website.

Meetings dates and times are posted on the ACH calendar online for all of 2017, minutes of all meetings are kept and posted on the website.

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? 166

Meetings are held in Mount Vernon, central to the North Sound region, with accessible facilities. Typically, 10-15 members of the public attend Board meetings. In 2018 the ACH will rotate meetings throughout the region, including tribal locations to help foster learning and partnership. The ACH attempts to accommodate a range of travel schedules, including locations and times convenient for ferry schedules. The ACH uses conferencing technology with toll-free audio to accommodate virtual participation. We have not yet had a Board meeting without meeting quorum.

Meeting materials are provided via email attachment, and posted online, at least 5 days in advance of meetings. Written materials are in plain language. Our goal in 2018 is to make materials available in Spanish via the website and explore other languages as needs arise. All Board and Program Council meetings are open to the public, and minutes are accessible on the website. We use a toll-free conference line for participants who wish to listen to Board or Program Council meetings live.

9. Discuss how transparency has been handled if decisions are needed between public meetings. 102

The Executive Committee has the authority to make decisions (other than changing bylaws) in between Board meetings. This authority is used sparingly. If the Executive Committee makes a decision in between Board meetings, Board members are notified by email, and it is noted on the agenda of the next Board meeting. Minutes of an emergency meeting are treated as other meetings, with agendas and minutes posted on the website. If needed, Board bylaws allow for

an emergency meeting to be called. The Board utilizes either audio/video teleconference, or can take a vote via email. This would also be posted on the website.

10. Describe the ACH's communications strategy and process. What communication tools does the ACH use? Provide a summary of what the ACH has developed regarding its web presence, including but not limited to: website, social media and, if applicable, any mobile application development. 116

The ACH is developing a communication strategy, in consultation with a Public Health Communications specialist. This will include branding, a style guide, key framing messages about the ACH, and the relationship of the Demonstration to our overall goals. This communication strategy will be applied to all messaging with stakeholders, partners, and community members, including Medicaid enrollees. This strategy is scheduled to be completed in fall 2017.

The ACH uses several communication tools, including a website and e-newsletter. The website, updated in spring 2017, includes all Board and Program Council materials, links to key Healthier Washington materials, calendar, contact information, general information and a repository. The ACH's monthly e-newsletter is disseminated to about 600 individuals, using MailChimp.

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

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: May 25, 2017

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

YES

Date of Approval: July 21, 2017

Project Design Funds

1. Discuss how the ACH has used Phase I Project Design funds. Provide percent allotments in the following categories: ACH Project Plan Development, Engagement, ACH Administration/Project Management, Information Technology, Health Systems and Community Capacity Building, and Other. 135

To date, the majority of Phase 1 Design funds have been used to support ACH Administration and Project Management, Project Plan Development, and Stakeholder/Community Engagement. Most funds have been used to hire core staff and provide supporting infrastructure (e.g., furniture, equipment). Design funds were received June 30th, and July financial reports will not be available prior to submitting the Phase II Certification Application, therefore the percentages below are estimates of the breakdown to date. Using data from the time and expense tracking system (Harvest App) we have used Phase 1 Design funds for Project Plan Development: 11%; Engagement: 1%; Administration/Project Management: 5%; Information Technology: 1%; Health Systems and Community Capacity Building: 0%; Other: 0%.

The Board approved a budget that included Phase 1 Design funds, and approved an approach to using Phase 2 Design funds.

2. Describe how the ACH plans to use Phase II Project Design funds to support successful Project Plan development. 246

While Board approval was received for expenditure of Phase 1 Design funds, which incorporates hiring all core staff and Project Managers for project plan development. The Board has given preliminary approval for the approach to use of Phase 2 Design funds. We anticipate approval of the 2018 budget at the December Board meeting, including our plans for usage of the Phase 2 funds over the 5 years of the demonstration.

Preliminary plans include support for infrastructure of the North Sound ACH over the five years of the demonstration in these areas, optimizing resources that can be shared with

partners:

- Core staffing for five years, including executive and governance support, finance and contracting expertise, community, tribal and clinical engagement;
- Technology and infrastructure investments, including project management tools for staff, and share with partners, to monitor and track progress, deliverables, and outcomes;
- Contract with consultants for subject matter expertise, including HIE, workforce analysis, data sharing agreements, and financial modeling;
- Finalizing a business plan with the Board to assure that Design funds are leveraged toward successful project planning and implementation, and define strategies for the ACH to succeed in finding sustainable and braided funding
- Facilitating and funding collaborative learning opportunities and contracting with partners to support their participation with a goal of leadership development and growing expertise across the region. Support could include covering the cost of registration, training, consultants, stipends for participants. Preliminary list of focus areas include data analysis and visualization, health equity strategies, collaborative decision making.

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. 300

The North Sound ACH plans to use Design funds to support core capacities in the following areas:

- Funding and supporting a Data & Learning Team with a focus on Population Health Improvement Alignment, mentoring, support for partners to take part in regional and national trainings (e.g., conferences), and support for consultants and facilitators to manage and foster collaborative learning among participants
- Enhance Data & Analytic Capacity for the core ACH team and our partners. Examples include licensing for Tableau, Lucid Chart, ArcGIS, R, County-level survey oversampling (BRFSS, PRAMS). The goal is to enhance access and capacity across the region to enable sustainable transformation efforts beyond the Demonstration.
- Procurement of project and performance management software, optimizing the extent to which this is available to partners across the region.
- Procurement of space in the Skagit Valley, which is centrally located, while maintaining a core team in Bellingham. The ACH is looking to establish an office in Mount Vernon or Anacortes that can house core staff, allow partners to use the space for ad-hoc/drop-in work space and allow for shared meeting/conference room space. The search for available, open space that is wired for in-person and remote access is challenging in the region, and the ACH hopes to provide a resource that outlives the Demonstration and brings value to partners.
- Contacting consultant to completion a business plan that lays out the path to sustainability, and strategic steps to guide that path. Work is scheduled to be complete by late 2017/early 2018.

- Hiring a Finance Manager and audit preparation, with the goal of completing annual audits beginning in 2018.
- Financial support to engage clinical champions and other clinical experts and SMEs, such as stipends or some other financial arrangements.
- Building reserves to cover at least 6 months of core administrative expenses, including facilities and staffing.

4. Describe the process for managing and overseeing Project Design fund expenditures. 263

Board responsibility for financial oversight has been delegated to the Finance Committee, chaired by the Board Treasurer. The Finance Committee approved the ACH’s Fiscal Policies and Procedures Manual which lays out the process for all North Sound ACH expenditure tracking and oversight. Until the Finance Manager is hired (anticipated in August 2017) all expenses must be approved by the Executive Director, who has extensive experience in managing large project budgets. A Delegation of Authority Agreement has been approved by the Board, articulating what expenditures need Board approval and what is delegated to the Executive Director.

The ACH has a two-step review and approval process for all expenditures, requiring two people be involved with all transactions. The cost centers were set up in February 2017 to track the three SIM cost centers, and transitional cost centers for Design and Incentive dollars. When information becomes available reporting requirements, we will re-align the cost centers.

We use APLOS, a cloud-based financial system, which includes our banking, financial reporting, accounting oversight and technical assistance. The ACH can track transactions by vendor, purpose (e.g., SIM Admin-Governance, Demonstration Project Planning, Community and Stakeholder Engagement) and by task (e.g., staff meeting, project management, partner meetings, travel). The ACH uses the same categories for time and expense tracking using the Harvest App, a cloud-based time tracking application.

All contracts are kept in shared folders, along with invoices received from vendors. Monthly financials are run from APLOS, including a bank reconciliation report, Income Statement, Budget to Actuals Year to Date, and other reports if requested by the Finance Committee or the Board.

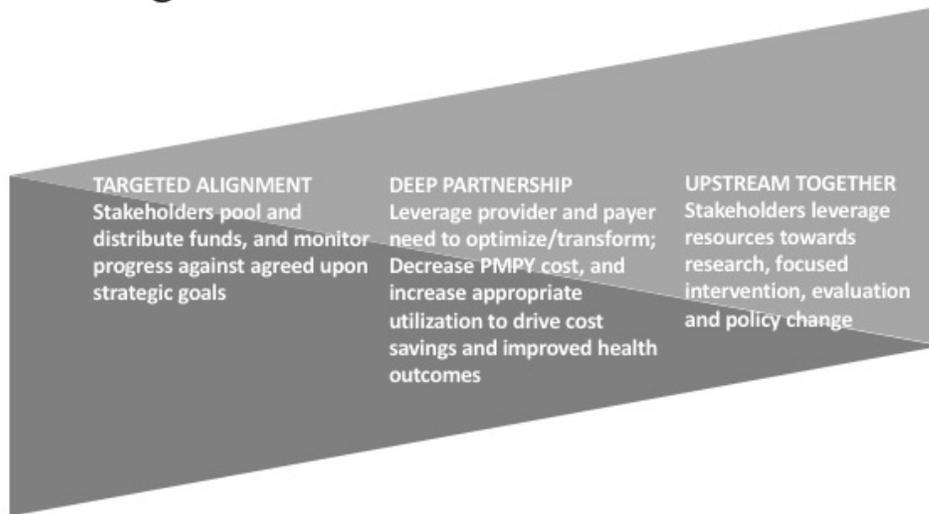
Incentive Fund Distribution Planning

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.) 105

The North Sound ACH engaged Point B Management Consulting to assist the Board and Executive Director in crafting a strategic approach to allocating Design and Incentive dollars. The Board agreed to an approach that will next shape decisions about fund allocation during the July Board meeting.

The Board mapped out a roadmap that moves the ACH toward sustainability by leveraging the role of the Demonstration. In July the Board adopted the path outlined in these two images.

How we get there matters



NSACH Approach to Sustainability and Transformation

	TARGETED ALIGNMENT 2017-18	DEEP PARTNERSHIP 2019-20	UPSTREAM TOGETHER 2020-	COMMUNITY HEALTH Future State?
SUSTAINABILITY COLLABORATION	<ul style="list-style-type: none"> Initial partners - health system and health plans and tribal systems Develop partnership with community and social service providers 	<ul style="list-style-type: none"> Deepen partnership with health system and health plans and tribal systems Strengthen partnership with upstream community based providers 	<ul style="list-style-type: none"> Primary relationships are shared with community based providers, tribal systems health systems and health plans 	<ul style="list-style-type: none"> Hub for health system, health plans and community based providers; continue deepen relationship with tribal partners,
SUSTAINABILITY COLLABORATION	<ul style="list-style-type: none"> Leverage and allocate Design and Planning \$\$ Invest in capacity for partners to lead projects 	<ul style="list-style-type: none"> Funding target shifts to 80% Demonstration, 20% other 	<ul style="list-style-type: none"> Funding shifts to 70% Demonstration, 30% other 	<ul style="list-style-type: none"> Driven by portfolio that does not include Demonstration funds
PROGRAM PORTFOLIO	<ul style="list-style-type: none"> Demonstration focused Continue SIM work to build regional health equity coalition Medicaid focus Report on Demonstration milestones/deliverables 	<ul style="list-style-type: none"> Decrease PMPY costs Make decisions about investments in cost-savings ACH invests in capacity for partners to lead projects Leader in strategies to embed equity 	<ul style="list-style-type: none"> Identify root causes Resource community systems to change policy and attract revenue to the region to move upstream investments ACH invests in capacity for partners to lead projects Measure outcomes Identify other opportunities to partner with federal and state 	

The next steps with Point B will move toward a development of a detailed business plan, which the Board hopes to develop by the end of the year.

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). 115

The North Sound ACH currently has \$330,000 in SIM funds remaining to draw down in 2017

and 2018. SIM funds were used to support an Early Win project focused on LARC – training providers and clinic staff about LARC, insertions and how to gain access to preceptors. We anticipate that the Demonstration will build on this early work as part of the Project Plan submission.

We are planning to use remaining SIM dollars to support forming a Regional Health Equity Coalition, including financial support for the entity that agrees to house/staff the coalition. This will foster collaborative learning around improving equity, reducing disparities and identifying partnerships to embed equity in local, regional and state decision making.

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. 246

The North Sound ACH receives multiple investments/donations from community partners, some of whom serve on the Board of Directors. In-kind contributions include:

- WAHA subleases office space, belonging to PeaceHealth, to the ACH for \$12/year
- PeaceHealth provides phones, mail services, cleaning, maintenance, security, and utilities
- The North Sound BHO provides weekly conference room space, printing, copying, meeting refreshments, meeting technology, and staff support for set-up
- The Skagit County Commissioner’s office provides meeting space twice a month
- Skagit County Public Health provides refreshments at the Program Council meeting twice per month
- Meeting space has been provided by Providence, Arlington Fire Department, and Whatcom Center for Philanthropy
- Meeting refreshments have been provided by MCOs, Providence, and private donors
- A law office donated desks and office supplies in 2016
- There have also been private cash donations for projects
- Countless volunteer hours to support development and planning of Demonstration projects, including sending staff to participate in project-specific workgroups.
- PeaceHealth, Providence and North West Regional Council have donated finance and HR leadership to assist with position descriptions, review of policy manuals, and interviewing candidates
- Executive Committee members (from North Sound BHO, North West Regional Council, PeaceHealth, Verdant Health, and community member) have contributed to development of the funds flow strategic planning, and business plan development
- Northwest Regional Council donated time for their CFO to review and refine the Fiscal Policies and Procedures, and our approach to B&O tax reporting.

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

Clinical Expertise

1. Demonstrate how clinical expertise and leadership are being used to inform project selection and planning to date. 210

A Coalition has self formed, including participants from the region’s largest clinical health systems and primary care practices, serving a consulting role for clinical subject matter expertise, identifying clinical champions, and advising on project implementation. They have agreed to foster frontline clinician engagement. The group has met four times, and invited the North Sound ACH ED and DD to attend. At the next meeting, they will discuss how to formalize their role with the North Sound ACH governance structure (i.e., becoming a board advisory committee.)

Additionally, each project workgroup includes clinical expertise in its membership, who agree engage front line clinicians for feedback during the project planning process. As project plans finalize, and evidence-based models are selected, each workgroup is using clinical experts to consult and refine the approaches selected, identifying synergy with current practice, and where they may be barriers to implementation. Clinical input has been used as a basis for selecting the Chronic Care Model, in identifying opportunities for bi-directional integration, and in outlining challenges in bi-directional integration for Island and San Juan counties in particular. BH providers have also articulated the challenges due to timing of changes to the BHO as we move toward FIMC, and how that impacts our approach to bi-directional integration and opioid projects.

2. Discuss the role of provider champions for each project under consideration. 153

In addition to the newly formed Provider Council, clinical provider insight and input is vital to the project planning process. In each workgroup, clinicians are consulted regarding the potential impact of project selection, approaches, activities and strategies for implementation. In later stages we will ask them to consult on data that we receive, outreach to other providers and in seeking commitments to partner so that we reach our process outcomes measures (P4R). The following serve as provider champions in specific project areas:

- Bi-Directional Integration: Frances Chalmers, MD Skagit Pediatrics; James Bochsler, MD, PeaceHealth
- Opioids: Thomas Tocher, MD, CHC Snohomish
- Care Coordination: Tove Skaftun, RN, CHC Snohomish
- Diversions: Federico Cruz-Uribe, MD Sea Mar CHC
- Connie Davis, MD Skagit Regional
- Reproductive and Maternal/Child Health: Astrid Newell, MD Whatcom County Public Health
- Oral Health: Dr. Sue Yoon Lee, Snohomish CHC
- Chronic Disease: Ione Adams MD, Sea Mar CHC

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. 241

The ACH Executive Director and staff have presented at and regularly attend larger gatherings of clinicians, including the Whatcom County Provider Council and the Snohomish Medical Society. These gatherings include representation from rural and urban areas. At each session information is shared about the ACH, and input is gathered from attendees about the approach to project selection, potential partners, models under consideration, and their insights on target populations to prioritize. Those insights are shared with the workgroups and Program Council.

A self formed primary care coalition, including participants from the region’s largest clinical health systems and primary care practices self reports that they have 70% of Medicaid lives assigned in the region. In the next month we will determine with them if they play a formal connected role to the ACH and the decision making body. ACH staff are invited to the meetings, and gain input from the clinical and practice experts at the table. The coalition includes leaders who have a presence in all five counties, and if it becomes a formal part of the ACH structure, it would expand to include rural and small practice providers, and tribal partners.

If this group decides to formally align with the ACH decision making body, we would use this group to assist with clinician engagement, consultation and participation in project planning and implementation. The coalition will use technology, flexible timing, and convenient locations to bolster clinician participation and reduce burden on partners.

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. 437

The ACH is consulting with North Central ACH, who has already worked with QUALIS to complete clinical workforce assessment and readiness in their region for full integration. We are modeling our approach from their successes. Our Data Manager is consulting with QUALIS to determine how to implement an assessment process in the North Sound region.

For us to be successful. the ACH’s clinical partners must commit to take part in the assessment activities, so we are using clinical members of workgroups, and the newly formed provider council to encourage engagement with this assessment process.

These discussions will be further supported by the ACH’s assessment of current clinical capacity. The Research and Data Analyst is completing a review of available data, including Health Professional Shortage Areas (HPSA) and current Electronic Health Records usage. The updated RHNI will be completed in early 2018 after updated CHNAs become available. This will be used to inform selection of target populations and implementation strategies. In addition, the ACH will leverage existing HCA workforce data and tools from the following entities: Health Workforce Council, UW Center for Health Workforce Studies, Department of Health – Rural Health Office, Practice Transformation Support Hub, Allied Center for Health Excellence, and Area Health Education Centers to identify workforce challenges and opportunities for each of the selected project areas.

Once the scope of regional capacity is understood, and gaps have been identified, the ACH

will work with partners to identify strategies for addressing gaps. This process requires inclusion of the entire range of workforce operating in the clinical milieu, including ancillary, support staff, and clinical providers. Addressing these clinical workforce gaps includes engaging regional educational institutions in the planning process. For example, ACH staff are exploring partnerships with local Community and Technical Colleges and their role in certification and capacitation of ancillary and non-clinical staff. These efforts have taken place relative to specific workgroups such as training MAs and other allied health professionals in behavioral health integration and more broadly in the context of supporting transformation and workforce capacity at the systems level. The ACH is currently working with QUALIS to assess clinical capacity and readiness in the region, and working with Practice Transformation coaches and coaches to support readiness. Their partnership will continue throughout the demonstration.

Finally, tribal nation partners in the region offer unique approaches and innovative models to addressing barriers in the clinical workforce, such as a pilot with the Swinomish and Lummi tribes with mid-level providers and oral health care. Partnerships and engagement with tribal partners include the frame of learning from their innovation in these areas and expanding that knowledge base throughout the 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).

ACH staff regularly attend meetings of local, regional, and statewide clinical provider organizations, including the Whatcom Provider Council, Snohomish Medical Society, and the Washington State Hospital Association, to inform and update our activities and to seek input, insights and access to clinician experts and champions who can support project selection, planning and implementation.

Seeking opportunities to partner with statewide and regional associations provides for cross sector collaboration (i.e., developing with WSHA a statewide approach to Opioid project planning), cross ACH planning (i.e., ACH collectively leveraging HCA/DOH to produce a statewide report on workforce), and WSMA discussions on how to effectively communicate with providers across the state, as examples. We are seeking to forge relationships in the near future with the state’s nursing and dental associations, and other clinical state groups in SW and BH.

We also see opportunities ahead to partner with faculty at UW in schools of public health and medicine, to leverage current teaching on best practices; community colleges who are training for other health careers, such as EMTs, paramedics, medical assistants, dental technicians and community health workers.

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

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. 240

The 2017 RHNI, will use the same sources as the 2015 version, adding data products provided by HCA, and data sources recommended by project workgroups. The ACH identified the following sources for the 2017 RHNI; in addition to local, county and community CHAs, **sources marked with *** are currently in use to identify the region's health needs, inform project selection and identify potential target populations:

National

- Centers for Disease Control and Prevention: National Center for Health Statistics
- US Census Bureau: Censure Reporter, American Fact Finder
- **Community Commons: Community Health Needs Assessment***
- County Health Rankings & Road Maps: County Health Rankings
- **Dignity Health: Community Needs Index***

State

- **Department of Health: WA Tracking Network*, Health Professional Shortage Areas (HPSA)*, School and Child Care Immunization Reports, Communicable Disease Reports, Rapid Health Information Network data, Health of Washington State reports, Chronic Disease Profiles*.**
- Office of Superintendent of Public Instruction: Healthy Youth Survey, State Report Card, K-12 Data & Reports
- Department of Commerce: Annual Point in Time Homeless County reports
- **Department of Health & Human Services: Community Risk Profiles***
- Washington Health Alliance: Community Check-Up
- Health Care Authority: Annual Reports
- University of Washington: Alcohol and Drug Abuse Institute's substance use data and reports

Regional

- Northwest Education Service District 189: State of Children & Families Report
- United Way: ALICE Report
- Opportunity Council: Prosperity Project, Early Learning and Family Services Community Needs Assessment

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. 246

The North Sound ACH will synthesize data to inform project selection and planning. The ACH's Data Manager supports all workgroups, providing data at state, regional and county levels, to inform known needs; and at the census tract level, including identifiable disparities, to facilitate selection of possible target populations.

Starting in July 2017, routine presentations to the Program Council and Board will summarize

the data given to workgroups, to facilitate decision making driven by available data. The ACH will finalize a Data & Analytic Work Plan by Fall 2017. The Work Plan outlines high level goals to ensure appropriate data are identified, analyzed, synthesized, and disseminated in a timely manner:

- Synthesize information for the ACH's data-driven decision making for project selection, project plan applications, planning and implementation;
- Develop methods of sharing data with partners across the region, in clear and understandable language;
- Workgroup specific data presentations, to foster the model selection, discussion of possible target populations, and identify possible data gaps;
- Build charter and populate a region-wide Data and Learning team to expand regional capacity to address data and information needs in collaboration with regional partners and the state, leveraging the recent award to Snohomish County to hire a Chief Health Strategist for the region.

The North Sound ACH has agreed on a framework for project selection for the Medicaid demonstration, developed in partnership with staff, Program Council and workgroups. The framework requires that data and evidence based strategies support the project selection.

3. Identify any data and analytic gaps in project selection and planning efforts, and what steps the ACH has taken to overcome those barriers. 258

The ACH has identified data and analytic gaps, and taken measures to ensure timely and complete resolution. This process includes an Information Issue Management Registry to document data and analytic challenges, easily accessible by all ACH staff via Google Docs. Issues are documented, assigned, and resolved efficiently and effectively. The following gaps and potential solutions are identified so far:

- *Inability to download Tableau workbooks from Healthier Washington dashboard*
Detailed the challenge to AIM team, of inability to download files when making decision-making presentations. AIM is attempting to problem solve; North Sound ACH may purchase its own Tableau licenses which should resolve the issue.
- *Lack of interpretation guidance and methodology of HCA data products*; AIM staff have committed to creating a data product workbook.
- *Access to WADOH's CHAT data query systems*; WADOH has not made a decision whether ACHs can access.
- *Medicaid-only vs. duals data*; HCA data products present data on both Medicaid-only and Duals. Decision is pending from HCA on which population is an allowable target population.
- *County-level sample for BRFSS and PRAMS*; Discussed issues of project related metrics and the survey sample size with WADOH. Will discuss issues with county health department staff in August.
- *Lack of pediatric/youth data*; Working with workgroups to identify data sources that would assist in project selection.
- *Lack of evaluation planning*; Contacted CHEE to discuss evaluation support previously

provided to the ACH, and how the ACH can prepare for evaluation requirements. Staff are scheduled to meet with CCHE in early August. Decisions will be captured in the Data & Analytic Work Plan.

Data-related Collaborations

4. Describe if the ACH is collaborating, or plans to collaborate, with other ACHs around data-related activities. 200

The North Sound ACH benefits from statewide partnerships among and across the ACHs. Examples include:

- 1) Since data is based on enrollee residence, but services are provided across ACH boundaries making it critical to have strategic partnership with neighboring ACHs in projects and target populations.
- 2) We are pursuing a formal agreement with King County to continue their support of data in Tableau.
- 3) Five ACHs contract with Providence CORE, and we are negotiating to join that collective and share in data and analysis resources.

To more effectively tackle data and analytics challenges and needs, the ACH:

- Participates in weekly cross ACH discussions of data challenges and opportunities, developing joint data requests.
- Participates in ACH-HCA Demonstration Data Call where data needs are discussed between ACH and AIM staff. ACHs can present data requests to HCA/DOH and ACHs can provide feedback to optimize needs that cross regions.
- Collaborates with Olympic ACH to develop a data and analytic work plan, troubleshoot data barriers, and select appropriate analysis methodologies for various datasets.
- Consults with North Central ACH re: their Primary Care Medical Home assessment, and with other ACHs implementing Pathways to foster opportunities for sharing information data across regions.

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. 197

The North Sound conducted an RHNI in 2015 with workgroup members representing public health, tribal health systems, hospitals, and specialty care, a model that is informing development of the ACH's Data & Learning Team.

In July 2017, the ACH began researching data collaboratives with King, Pierce, Olympic and Southwest ACHs to clarify available data that influences project selection and the planning phase.

The ACH has met with our five LHJs to assess existing analytic infrastructure and opportunities for collaboration, and will next meet with tribal partners. We have developed a framework for a Data & Learning Team, with a goal to build regional capacity to support data-driven population health planning by:

- Overseeing the 2017 Regional Health Needs Inventory

- Aligning county community health improvement planning
- Building a regional data and analytic mentor program
- Establishing region-wide data sharing agreements as needed
- Creating an annual learning plan for regional trainings
- Exploring data sharing agreement with tribal partners and health systems

The North Sound MCO partners are highly engaged we seek uniform ways to engage their data sets and capabilities, which will greatly assist questions around cost and expenditures, leveraging claims and other payer data.

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. 202

It is critical to identify provider data and system requirements in order to successfully plan and implement projects, stakeholder and clinical engagement strategies. By creating the Data & Learning Team, the ACH will work with clinical and community partners to leverage existing analytic infrastructure. Standing up new efforts or strengthening existing infrastructure in the areas of HIE/HIT remain a priority across the region, supporting all three Domains.

In addition to inventory of EMR/EHRs, discussions with clinical partners will lead to better linkages between EPIC and other EMRs, Emergency Department Information Exchange (EDIE), PreManage and other platforms. As projects are selected, we then add improved linkage of Emergency Medical Services (EMS) and Community Paramedics through ImageTrend, or similar platform. This is an area where cross-ACH approaches can leverage the most change.

Improved data sharing agreements and interoperability between the ACH and clinical systems remain a priority for many workgroups. Improved utilization of the Prescription Monitoring Program (PMP) has surfaced in the opioids workgroup. Templates, registries and other ways for disparate partners to identify patients of mutual interest is a priority in workgroups. We will also leverage the Practice Transformation Support Hub, the Clinical Data Repository and other statewide resources as they become available.

7. Demonstrate the ACH’s process to identify data or data system requirements needed to oversee and monitor demonstration project goals. 228

The ACH will use a best practice approach to oversee and monitor project data needs. The Collaborative Requirements Development Methodology (CRDM), developed by the Robert Wood Johnson Foundation and the Public Health Informatics Institute, documents project workflows and functional requirements for data/information systems that support those workflows. Visual CRDM tools assist stakeholders in understanding how a data or information system can support the work of monitoring project goals and add value to those implementing project goals.

ACH staff have created a crosswalk of the P4R and P4P elements, allowing for an easier view of what data elements will be tracked to earn incentive dollars, and are using this tool with workgroups to drive project selection – assuring that projects can meet the required metrics. We are working with CHEE on an additional tool – to align evaluation expectations with

available data and to monitor project implementation. ACH staff have a meeting scheduled with CCHE staff in early August to discuss opportunities.

Data challenges fall into several areas: 1) aligning varied age of data sets; 2) lack of clarity about which data sets include or exclude dual eligible, tribal members, non-adults; and 3) the deadline to select projects falls prior to having baseline data. Mitigation strategies for all three are 1) better communication with HCA/DOH or other sources of data; 2) using some local/provider data as a proxy; and 3) patience.

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. 163

The ACH is using a multi-faceted approach to identify workforce capacity and needs: workgroups and partner engagement, state data sources, and the Data and Learning Team. In addition, the ACHs are working collaboratively on producing a statewide workforce summary that can be regionalized with our partners, workgroups and stakeholders, aiming for completion in mid-Fall 2017.

To adequately understand regional needs, the ACH, in collaboration with community and clinical partners, will leverage HCA workforce data from the Health Workforce Council, UW Center for Health Workforce Studies, Department of Health – Rural Health Office and, Practice Transformation Support hub, Allied Center for Health Excellence, and Area Health Education Centers which identify current workforce capacity, gaps, strategies and best practices to fill those gaps, Workgroups will augment, ‘on the ground’ knowledge of their practices.

QUALIS Practice Transformation will assess clinical workforce capacity in the individual primary care clinic setting, to evaluate existing capacity for integration and care transformation projects as well as training or workforce development needs.

Attachment(s) Required

None

Transformation Project Planning - 15 points

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. 645

The ACH convened eight workgroups aligned with the project areas beginning in April 2017. Workgroup leads solicited interest from potential partners, and began reviewing potential projects that align with toolkit requirements and regional needs. Progress has been reported to the Program Council monthly. The ACH developed a project framework in August outlining clear, transparent criteria for project selection. Workgroups will present project recommendations based on this framework to the Program Council on September 7.

The Program Council will deliberate, and vote, moving recommendations for project selection to the Board's September meeting. The ACH aims for a portfolio of projects that leverage alignment and synergies across project areas, address upstream social determinants of health, and establish core infrastructure to improve Care Coordination through the Pathways HUB. Potential projects include:

- **Bi-Directional Integration:** includes behavioral and physical health providers; is considering the Collaborative Care Model (AIMS Center), and mechanisms to share FTE and other resources across agencies and sectors, including the development of Telehealth options. (looking at shared strategies with other ACHS)
- **Opioid Use:** considering expanding access to treatment including buprenorphine, expansion of provider capacity and training to address Opioid Use Disorder in primary care, expansion of access to naloxone for overdose prevention, stigma reduction, and engagement with youth. (looking at shared strategies with other ACHS)
- **Care Coordination:** The Program Council voted in May to include the Pathways model in its Project portfolio. Workgroup participants are considering how the model will cross project areas with the ACH serving as a regional HUB, with possible satellite HUBs for rural counties and tribal partners; also working with MCOs to align Pathways with the Health Homes Model.
- **Transitional Care:** includes participants from long-term support and services and skilled nursing; considering the Coleman Model for care transitions, especially for patients moving from inpatient settings to the community.
- **Diversion Interventions:** participants from EMS are considering the Community Paramedicine Model, including HIE investment. There are also several localized, multi-sector initiatives working with high utilizer efforts that are multi-sector supporting existing efforts in Everett in Whatcom County that are being discussed.
- **Reproductive and Maternal/Child Health:** includes participants from Planned Parenthood, LHJs and others; considering building on the LARC early win project to expand training for providers and clinic staff on most effective contraception methods, and specific practical training on insertion; for MCH, the focus has been on reducing and addressing adverse childhood experiences (ACES) using evidence-based approaches through nursing intervention with women with high-risk pregnancies, and improve rates of Well Child

Checks and childhood immunizations.

- Access to Oral Health Services: considering ways to improve integration of oral health services into primary care, and establishing mobile/portable dental services, particularly to serve rural areas; opportunities to address workforce and population health issues (e.g., building on the DHAT model of the Swinomish tribe); and to address coding practices and HIE solutions.
- Chronic Disease Prevention and Control: includes participants from MCOs, CBOs and health systems; considering the Chronic Care Model more broadly and uniformly across the region; seeking opportunities to align and coordinate across other project areas.

In preparing the portfolio, we have had three sessions pulling all workgroup participants together to explore the overlaps and intersections of the project areas. There is consensus that we will optimize the ability to reach the metrics by looking at projects from the perspective of enrollees and providers. Siloed approaches don't work for either of them, so we will see more success and sustainability by blending and aligning projects where we can. For example, addressing the use of opioids among pregnant women who also have BH issues, and were just released from jail, may be a perfect use of the Pathways model.

From the woman's perspective it is a strategic approach to meet her needs/issues, while the portfolio may write them up as 4 or 5 project areas. We are committed to a whole person approach in our planning and implementation phases.

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. 193

ACH leaders have a weekly call to discuss areas that cross the state, looking for ways to optimize joint learning, investments and leverage. Examples of cross-ACH collaboration include:

- Development of Pathways approach and tools, including ACH-led multi site meetings with Sarah Redding to discuss implementation strategies.
- Joint conversations with our MCO partners regarding rollout and eventual support for Pathways and its alignment with Health Homes.
- Strategies to leverage a statewide approach to Domain 1 issues including HIE, HIT, Workforce and Population Health
- King, Pierce and North Sound region have had preliminary conversations about the 'border' areas and how to address providers and community members who live in one region but may receive services in another, which is an impetus to have common or at least complementary strategies.
- Cross-ACH calls to share an approach to project planning and implementation, beginning with opioids.
- Sharing expertise and tools across ACHs. For example, North Sound ACH shares its conference line for weekly ACH calls; Better Health Together shared its Pathways manager for a webinar on Pathways for North Sound; share internal resources (i.e., BHT and North Sound jointly paid for an accounting review related to B&O tax.)

3. Demonstrate how the ACH is working with managed care organizations to inform the development of project selection and implementation. 149

The ACH has ensured that MCOs are actively engaged at all levels of the ACH, including the

Board, Program Council and workgroups. The Board includes a rotating seat for MCO partners, so MCOs are engaged at all levels of project selection and identification of target populations.

In addition, we held a separate session with Dr. Sarah Redding (Pathways founder) and our MCO partners to flesh out ways to align and leverage the Health Homes model. Our meeting resulted in agreement that North Sound could pilot that alignment, then share strategies with the other ACH regions. We will continue to work collaborative with MCOs on this.

The ACH is working to engage MCOs directly in project implementation, data sharing and project sustainability. The ACH has agreements with two consultants (John Kitzhaber, MD and Point B Management Consultants) to facilitate these important discussions, which we aim to begin in September 2017.

Project Plan Submission

4. What risks and mitigation strategies have been identified regarding successful Project Plan submission? 328

The North Sound ACH acknowledges inherent risks leading to project submission. Timelines and deliverables are fast approaching, while the longer term picture is still unclear—ultimately impacting the ACH’s ability to be transparent, and display strong leadership. For potential challenges to success, we’ve either developed or are developing strategies to mitigate these risks, including:

- Successfully navigating the community’s desire to pursue all eight project areas, given the level of complexity, reporting requirements, and outcome metrics associated with being successful in all eight. Mitigation includes a transparent set of criteria to guide project selection, and clear messaging about the need to select projects with the highest-levels of confidence in success, understanding the impact on potential earnings.
- Unrealistic partner expectations for project selection—the early process of forming workgroups and soliciting project ideas created expectation of a granting approach when funds are received. The ACH will not be able to fund every project. The ACH is mitigating this risk through reframing expectations, clear and open communication, and transparent selection criteria.
- Meaningful engagement of stakeholders and sufficient public input opportunities throughout project selection with compressed timelines. The ACH has articulated a process and timeline for project selection, including defining points of engagement and expected outcomes.

Overall, the ACH is working to ensure the success of the Project Plan by developing clear and consistent messaging around processes, multiple opportunities for engagement, expected outcomes, and overall strategy and vision. This also includes clear messaging about Demonstration parameters, toolkit guidance around evidence-based strategies in each project area, and timelines associated with deliverables.

We will also leverage the Program Council and the Board, so that recommendations and decisions are coming from community and system leaders, not driven by perceived staff

priorities.

To emphasize the importance of the metrics, and to clarify overlapping metrics, staff developed these crosswalks for P4R and P4P metrics for the workgroups to assist with project selection recommendations, These were also shared with the Program Council on August 3rd.

	2A: Bi-directional Integration	2B: Care Coordination	2C: Transitional Care	2D: Diversion Interventions	3A: Opioids	3B: Repro/MCH	3C: Oral Health	3D: Chronic Disease
Pay for Reporting								
Report against QIP metrics	X	X	X	X	X	X	X	
Identify number of practices and providers implementing integrated evidence- based approach (es).	X							
Identify number of practices and providers trained on evidence-based practices: projected vs. actual and cumulative	X							
% PCP in partnering provider organizations meeting PCMH requirement	X	X						
Number of partnering primary care providers who achieve special recognitions/certifications/licensure (for medication-assisted treatment, such as buprenorphine administration, for example).	X							
Depression Screening and Follow-up for Adolescents and Adults	X							
Number of partners trained by focus area or pathway: projected vs. actual and cumulative		X						
Number of partners participating and number implementing each selected pathway		X						
% partnering provider organizations using selected care management technology platform		X						
% partnering provider organizations sharing information (via HIE) to better coordinate care		X	X					
% of partnering provider organizations with staffing ratios equal or better than recommended		X						
Number of new patients with a care plan		X						
Total number of patients with an active care plan		X	X					
VBP arrangement with payments / metrics to support adopted model		X	X					
Number of partners trained by selected model / approach: projected vs. actual and cumulative			X					
Number of partners participating and number implementing each selected model / approach			X	X				
% of partnering provider organizations with staffing ratios equal or better than recommended				X				
Number and locations of MDs, ARNPs, and PAs who are approved to prescribe buprenorphine.					X			
Number and locations of mental health and SUD providers delivering acute care and recovery services to people with OUDs.					X			
Number and list of community partnerships. For each include list of members and roles.					X			
Number of health care providers, by type, trained on AMDG's Interagency Guideline on Prescribing Opioids for Pain.					X			
Number of health care organizations with EHRs or other systems newly put in place that provide clinical decision support for the opioid prescribing guideline, such as defaulting to recommended dosages or linking to the PDMP.					X			
Number of local health jurisdictions and community-based service organizations that received technical assistance to organize or expand syringe exchange programs.					X			
Number of partners trained by selected model / approach: projected vs. actual and cumulative						X		
Number of partners participating and number implementing each selected model / approach						X		
Number of Medicaid beneficiaries served: projected vs. actual and cumulative						X		
Number of partners and providers trained on the evidence-based approach: projected vs. actual and cumulative						X		
Number of partners and providers implementing the evidence-based approach(es)						X		
Number of Medicaid beneficiaries served: projected vs. actual and cumulative							X	
Number of partners and providers trained on the evidence-based approach: projected vs. actual and cumulative							X	
Number of partners and providers implementing the evidence-based approach(es)							X	
Number of partners trained by selected model / approach: projected vs. actual and cumulative								X
Number of partners participating and number implementing each selected model / approach								X
Identify number of new or expanded nationally recognized self-managed support programs, such as CDSMP and NDPP.								X
Identify number of home visits for asthma services, hypertension.								X
Identify percent of documented, up to date Asthma Action Plans.								X
Identify number of health care providers trained in appropriate blood pressure assessment practices.								X
Identify percent of patients provided with automated blood pressure monitoring equipment.								X

Pay for Performance	2A: Bi-directional Integration	2B: Care Coordination	2C: Transitional Care	2D: Diversion Interventions	3A: Opioids	3B: Repro/MCH	3C: Oral Health	3D: Chronic Disease
Antidepressant Medication Management	X							
Comprehensive Diabetes Care: Eye Exam (retinal) performed	X					X		
Child and Adolescents' Access to Primary Care Practitioners	X					X		
Comprehensive Diabetes Care: Hemoglobin A1c Testing	X					X		
Comprehensive Diabetes Care: Medical Attention for Nephropathy	X					X		
Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence	X	X	X					
Follow-up After Hospitalization for Mental Illness	X	X	X					
Inpatient Hospital Utilization	X	X	X	X		X		
Medication Management for People with Asthma (5 – 64 Years)	X					X		
Mental Health Treatment Penetration (Broad Version)	X	X						
Outpatient Emergency Department Visits per 1000 Member Months	X	X	X	X	X	X	X	
Percent Homeless (Narrow definition)		X	X	X				
Plan All-Cause Readmission Rate (30 Days)		X	X					
Substance Use Disorder Treatment Penetration		X						
Percent Arrested			X					
Medication Assisted Therapy (MAT): With Buprenorphine or Methadone				X				
Patients on high-dose chronic opioid therapy by varying thresholds				X				
Patients with concurrent sedatives prescriptions				X				
Substance Use Disorder Treatment Penetration (Opioid)				X				
Childhood Immunization Status					X			
Chlamydia Screening in Women Ages 16 to 24					X			
Contraceptive Care – Access Measures (NQF# 2903, 2904, 2902)					X			
Performance assessed by annual improvement on at least one of the Contraceptive Care Access measures.					X			
Mental Health Treatment Penetration (Broad Version) (Women/children)					X			
Prenatal care in the first trimester of pregnancy					X			
Substance Use Disorder Treatment Penetration (Women/children)					X			
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life					X			
Well-Child Visits in the First 15 Months of Life					X			
Dental Sealants for Children at Elevated Caries Risk						X		
Ongoing Care in Adults with Chronic Periodontitis						X		
Periodontal Evaluation in Adults with Chronic Periodontitis						X		
Primary Caries Prevention Intervention as Part of Well/III Child Care as Offered by Primary Care Medical Providers						X		
Utilization of Dental Services by Medicaid Beneficiaries						X		
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)							X	

5. Demonstrate how the ACH is identifying partnering providers who cover a significant portion of Medicaid beneficiaries. 140

A self-formed coalition of primary care practices who comprise about 70% of Medicaid enrollees in managed care in the region has begun meeting. The coalition includes the region’s health systems and hospitals, (Providence, PeaceHealth, Skagit Regional Health, Island Hospital, Whidbey General), FQHCs (Sea Mar, Snohomish CHC, Unity Care), and Family Care Network. This coalition meets monthly, inviting ACH staff, serving an advisory capacity for initiatives, providing clinical and practice perspectives.

Additionally, the ACH is using data provided by the HCA, DOH and MCO partners to assist in identifying other providers serving significant numbers of Medicaid beneficiaries and seek engagement with them. Finally, leadership from providers under contract with the North Sound BHO, and partnership with providers working with tribal partners will ensure access and potential reach to providers who see the majority of Medicaid lives in physical and behavioral health.

6. What strategies are being considered to obtain commitments from interested partnering providers? What is the timeline for obtaining these commitments? 87

Current energies focus on developing and sustaining relationships, with commitments from interested partnering providers being solicited at all levels of governance and within each workgroup. We have begun identifying potential partners (clinical and community) with capacity to develop MOU's and contracts that outline sharing of design and planning funds, while developing more detailed contracts for sharing incentive dollars based on pay for reporting and pay for performance earnings. These design and planning commitments will be in place in advance of submission of a successful project plan template.

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. 178

The ACH has a culture of collaboration and open communication among partnering providers. Although the five counties vary significantly in their geography, demographics and the organizations serving them, the process of convening these disparate sectors and stakeholders benefit from a shared value of advancing health. These relationships predated the Demonstration and will persist beyond its term.

Data regarding Medicaid utilization and attribution is incorporated into project planning and solicitation of partnering providers. All current partners are asked to identify other providers missing from current project design and planning, and ACH staff work to ensure communication and outreach activities reach a broad spectrum of care and related social services.

Each workgroup is asked to be on the lookout for potential partnering providers not currently participating, which means that workgroups are constantly adding new faces to the table and expanding their collective scope of knowledge.

One element of the agreed upon framework is to examine the range of potential partners in each project area, attempting to assure that reach those who can have positive impact on changing the delivery system.

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. 231

The ACH includes criteria about sustainability in all deliberations for project planning, implementation, and subsequent incentive investments and funds flow. This includes consideration at the operational level of project planning, and at the higher levels of discussion at the Program Council and Board. The ACH's vision its role as leveraging funding sources beyond the five-year timeline of the Demonstration and identifying long-term funding and capacity building. In addition, the sustainability question stimulates ideas for regional, transformational investments of earned incentives, and moving beyond requests for expansion of existing programs within certain sectors.

Examples include:

1) discussions with MCOs around payment for completed Pathways has raised the goal of opportunities with Medicare payers and commercial plans;

2) the Bi-Directional Integration workgroup discussed implementation of Medicare G-Codes in the Medicaid environment to allow for reimbursement of services provided under the Collaborative Care Model (i.e. non-clinical behavioral health providers stationed in the medical milieu).

As clinical, health system and community partners consider what is needed to move towards integration, their conversations force them to consider more visionary models. This sustainability discussion has begun at the workgroup planning level, is certainly a part of the Board strategic thinking and planning, and will be part of the planning and implementation phases. Sustainability measures are not built into the metrics, so it is essential that the ACH Board set explicit markers and evaluate progress toward those ends.

Attachment(s) Required

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

Attachments Checklist

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

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

	If an ACH does not have four quarters of financial statements available, provide as many as possible.
<input checked="" type="checkbox"/>	C. Completed Phase II Project Design Funds Budget Template, which includes Projected Project Design fund budget over the course of the demonstration, additional funding sources, and in-kind resources that the ACH expects to leverage to prepare their Project Plans and build the capacity and tools required to implement the Medicaid Transformation Project demonstration.
Clinical Capacity	
<input checked="" type="checkbox"/>	A. Current bios or resumes for identified clinical and workforce subject matter experts or provider champions. <i>Re-attach bio or resume even if previously provided in Phase I Certification. ACHs should also include any additional bios or resumes, if applicable.</i>
Data and Analytic Capacity	
None	
Transformation Project Planning	
<input checked="" type="checkbox"/>	A. Initial list of partnering providers or categories of partnering organizations interested in or committed to implementing projects.

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

<i>None</i>
Clinical Capacity
<i>None</i>
Data and Analytic Capacity
<i>None</i>
Transformation Project Planning
<i>None</i>