

Phase II Certification Submission --- Pierce County ACH

ACH Phase II Certification: Submission Contact	
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Theory of Action and Alignment Strategy – 10 points

Description

Provide a narrative describing the ACH's regional priorities and how the ACH plans to respond to regional and community priorities, both for the Medicaid and non-Medicaid population. Describe how the ACH will consider health disparities across populations (including tribal populations), including how the ACH plans to leverage the opportunity of Medicaid Transformation within the context of regional priorities and existing efforts. Identify and address any updates/improvements to the ACH's Theory of Action and Alignment Strategy since Phase I Certification. Provide optional visuals if helpful to informing the narrative; visuals will not count toward the total word count.

Instructions

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

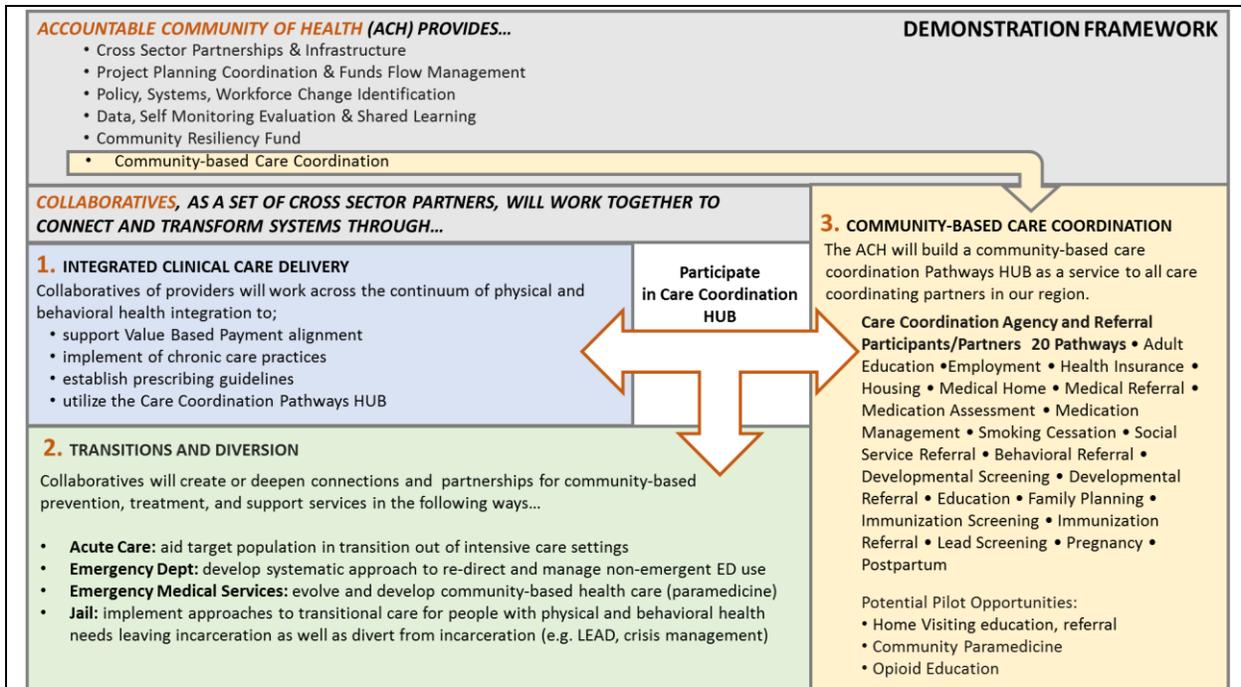
ACH Strategic Vision and Alignment with Healthier Washington Priorities and Existing Initiatives

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

Pierce County Accountable Community of Health (PCACH) will support care transformation and payment redesign through multiple **Collaboratives** of diverse partners and community voices for three interdependent systems of care.

- The way we **transform care delivery** by supporting a collaborative of providers across the continuum to integrate physical and behavioral health, implement chronic care practices, and establish prescribing guidelines in clinical settings.
- The way we **transition and divert** individuals in and out of Emergency and Jail Systems by incentivizing these **Collaboratives** to create or deepen partnerships for community-based prevention, treatment, and support services.
- The way we equitably **coordinate care** through the ACH by building a community-based Pathways HUB as a service to all care coordinating partners in the region.

Rather than discreet project proposals, PCACH is focused on systems change and will incentivize the community to use this **Collaborative model** to transform care delivery, transition and divert ineffective or high-cost utilization of services, and to utilize community-based care coordination to improve whole person health. Our current health delivery system is a profit-center and must move to a cost-center approach to realized long-term change. Without change we will fail to reach the goal of improved health. Our vision is to guide these **Collaboratives** to create new relationships or build on existing partnerships between health systems, Tribal governments, community-based organizations, jails, emergency services, and others. This approach will allow the community to think, act, and learn together and to use investments appropriately to transform systems rather than fund independent siloed projects. This will also leverage resources across project areas and create sustainability beyond the waiver.



By convening partners to create sustainable, equitable, and innovative care that continuously improves the overall health and well-being of the communities we serve, PCACH endeavors to become the healthiest region in Washington State. We will use data to set regional priorities and measure impacts of initiatives that align stakeholder efforts and investments. PCACH will provide infrastructure and resources to build regional assets that enable partners to better serve our shared constituencies.

Beyond DY5, PCACH sees itself as a catalyst and facilitator for:

- advancing and measuring MTD projects
- enhanced community-based care coordination
- shared learning
- policy and system solutions
- pooling resources to continue 21st century health care system transformation
- health innovations based on clinical and community-identified gaps

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

In 2016, Pierce County served nearly 228,000 Medicaid enrollees; this represents 12% of Washington’s Medicaid population and 27% of the total Pierce County population. The region has higher rates of unemployment and poverty than the state average, and lower median income – despite high cost of living. Medicaid members in the region have a greater likelihood of experiencing homelessness, with Hispanic and Black individuals more likely to be without housing.^[1] Pierce County experiences higher obesity and smoking rates than the state average. The region has identified the following health challenges and needs:

- **Behavioral health, including mental health and substance use treatment:**
Opiate use climbed through 2015, and treatment admissions for opiates have greatly

^[1] DSHS ACH Measure Decomposition: Homelessness, Broad Definition.

increased, particularly related to heroin use. Adults and teens in Pierce County report more days of poor mental health and feelings of hopelessness than the state overall.^[2]

- **Reproductive, maternal, and child health:**
Teen and unintended pregnancy rates are higher than state average, while lower percentages of Medicaid enrolled women use long-acting reversible contraception.
- **Diabetes:**
While the region has average diabetes diagnosis rates, people with diabetes in Pierce County are less likely to receive recommended annual treatment such as blood sugar testing and eye exams.^[3]
- **Access to care:**
Parts of Pierce County are designated as primary care health professional shortage areas.^[4] Among ACHs, this region ranks lowest for the percent of Medicaid members who have a substance use disorder diagnosis and receive treatment.^[5] Hispanic and Black patients are less likely to receive follow-up care after an ED visit related to alcohol or drug dependence.

Regional assessment efforts^[6] by hospitals and the local health jurisdiction echo these areas of concern, identifying access to care, mental health, tobacco use, obesity, and behavioral health as top community priorities.

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

Existing and planned activities to support Pierce County's regional healthcare needs and priorities include:

- Clinical care delivery system strategies:
 - Integrated care to support whole person health
 - Community-based care coordination
 - Chronic care management
 - Opioid prescribing guidelines
- Diversion strategies
 - Low barrier buprenorphine program
 - Mobile outpatient treatment van
 - Law enforcement assisted diversion (LEAD)
 - Community paramedicine
 - Syringe services programs
- Transitional Care Strategies
 - Interventions to reduce acute care transfers
 - Care Transitions into Mental Health
 - Primary and Behavioral Health needs leaving incarceration
 - Chronic Disease Management leaving the ER
 - Opioid Respite Intervention

^[2] BRFSS and Healthy Youth Survey

^[3] Healthier Washington Data Dashboard: Diabetes Diagnosis, Diabetes Eye Exam, and Diabetes HBA1c Testing Measures

^[4] DOH Primary Care Shortage Areas Map: <ftp://ftp.doh.wa.gov/geodata/layers/maps//primary.pdf>

^[5] DSHS Cross System Outcomes Measures: <https://www.dshs.wa.gov/sesa/research-and-data-analysis/cross-system-outcome-measures-adults-enrolled-medicaid-0>

^[6] TPCHD CHIP: <http://www.tpchd.org/about/community-health-improvement-plan/>; Multicare CHNA: <https://www.multicare.org/community-health-needs-assessment/>

Pathways care-coordination will provide services that improve linkage to care and address social determinants of health such as Pierce County's higher than the state rates of unemployment and poverty. Opioid initiatives are woven throughout PCACH's strategies. These include implementation of opioid prescribing guidelines, transitions of care and diversion strategies, and Pathways service bundles for opioid injectors and prescription opioid users. Whole person care and integration of primary and behavioral health will address the region's behavioral health and chronic disease concerns. While maternal and child health and oral care may be optional projects, we will address these project areas through the Pathways Hub.

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

PCACH will use partner **Collaboratives** to craft effective, feasible, and sustainable projects consistent with the goals of Healthier Washington. **Collaboratives** will receive recommendations from:

- The Data and Learning Team, regarding data analysis, priority populations, and issue areas
- Community engagement, regarding community-identified needs and concerns
- Clinical/social services providers, regarding social determinants of health and clinical concerns

PCACH will ensure **Collaboratives** have a balance of provider and community-based organizations and that project designs follow HCAs Project Plan Template guidance. **Collaboratives** will identify project options, evidence-based strategies, workforce concerns, HIT/HIE functionality, and value-based care and payment.

Project selection criteria will include:

- Alignment with regional health priorities
- Ability to address need without duplication
- Impact on Medicaid lives and return-on-investment within 2-3 years
- Ability to address health equity and social determinants of health
- Ability to spread and scale
- Readiness to implement
- Data to measure need, outcomes, and evaluate impact
- Legality/feasibility
- Project weight

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.

Several workgroups have conducted environmental scans which form the basis of our resource inventories. These inventories catalog the work currently underway in the region, with the intent to incorporate and expand successful efforts across the work under the Demonstration and Healthier Washington.

PCACH uses these inventories to convene providers, both clinical and community-based, in work sessions to ensure all providers can share their strengths, weaknesses, and areas of expertise with other regional providers and to envision how organizations can work collaboratively across a transformed model. PCACH will maintain these inventories throughout the Demonstration to assist effective, feasible, and sustainable partnerships aligned with already existing initiatives in the region.

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

The Pathways Hub is an infrastructure investment that will be shared across multiple projects and has the potential to resolve gaps in health information technology and population data systems identified

in the region. PCACH will invest in training for community health workers to become proficient in the Pathways model. Care-coordinating and referral agencies will receive stipends and incentives to receive training from and to partner with the hub. These investments will encourage workforce development and implementation of a common data platform that will provide real time population health data.

PCACH is also exploring investments in:

- Telehealth/telepsychiatry
- regional strategies for communication/referral for providers partnering through the collaborative care model

Attachment(s) Recommended

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

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

Governance and Organizational Structure – 10 points

Description

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

Instructions

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

ACH Attestation(s)

ACH has secured an ACH Executive Director.

YES

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

YES

ACH Structure

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

Board members serve as representatives of their sectors or Tribe. Sectors engage with PCACH through their Board representative and through the governance councils of the shared learning structure. Sector composition was deliberated by a steering committee of the previous ACH backbone agency. That body made recommendations to the Board of Trustees. Concrete examples of sectors engaging with the decision-making body include the following:

- Community Voice Council (CVC) conducted a SWOT analysis regarding the Pathways Hub model and priority population
- Provider Integration Panel (PIP) developed a white paper regarding the collaborative care model and rules of engagement for bi-directional integration
- Care Coordination Workgroup conducted an environmental scan of regional care coordination and referral agencies.

These activities have or will be presented to the Board of Trustees.

Board members are expected to communicate with their sector or Tribe to ensure information flows to and from the sector. Members do not represent their personal views or their organization's interests alone. Representatives achieve this by attending sector-wide meetings, presenting PCACH information, and bringing back recommendations and concerns to the Board. PCACH's Executive Director also attends these meetings periodically to present information.

Here are several concrete examples of how sector representatives communicate to others in their sector:

- The Board's social services sector representative attends Human Services Coalition meetings.
- The Board's behavioral health representative attends Optum-BHO meetings.

<ul style="list-style-type: none"> ▪ The Board’s labor representative attends regional labor related meetings in the region. ▪ MCOs have two seats on the Board. Representatives caucus with their sector and vote accordingly.
<p>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)</p>
<p>On June 19, 2017, the Board of Trustees added a voting Tribal seat to the Board, bringing Tribal representation to two seats. This ensures that both Tribes within the region, the Nisqually and the Puyallup, can designate a representative to the Board.</p> <p>PCACH is planning to add two committees of the Board in coming months. These are the Tribal Collaboration Committee, to ensure Tribal interests and concerns are considered, and the Funds Flow Ad Hoc Committee, to provide oversight regarding funds flow design for the Collaborative Model.</p>
<p>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.</p>
<p>Periodic review of PCACH bylaws, conflict of interest (COF) policy, and contracts are conducted to ensure agency-wide benefits and compensation are appropriate and that partnerships conform to the COF policy. Board members and Executive Director sign annual disclosure forms stating they have received a copy of, read, understand, and agree to comply with the COF policy. This policy applies to anyone with financial interest as defined in the COF policy. Procedures to address conflicts of interest include the following:</p> <ul style="list-style-type: none"> ▪ Board members are required to disclose conflicts to the Board immediately. ▪ Disinterested members discuss material facts, decide if a conflict exists, and identify arrangements that can mitigate the conflict. ▪ If conflict exists but no more advantageous arrangement exists, disinterested members may accept the arrangement regardless of the conflict. ▪ If the Board believes a member failed to disclose a conflict, they will inform the Board member and permit him/her to explain the alleged failure. If conflict exists, disciplinary action may be taken.
<p>Staffing and Capacities</p>
<p>4. Provide a summary of staff positions that have been hired or will be hired, including current recruitment plans and anticipated timelines.</p>
<p>Current Staffing:</p> <ul style="list-style-type: none"> ▪ Alisha Fehrenbacher, Executive Director (Hired January 2017): Serves as practical visionary to help people see themselves in a transformed health environment, constructing crosswalks from current to future states. Conceptualizes critical paths to achieve deliverables. Brings stakeholders together to analyze data and evaluate projects that improve population health across the region. ▪ Alisa Solberg, Chief Operating Officer (Hired March 2017): Plans and directs daily activities. Supports PCACH strategic plan, provides leadership for PCACH team and support to the Board of Trustees. ▪ Meg Taylor, Chief Financial Officer (Hired July 2017): Develops, implements, maintains financial and administrative systems, processes and reporting to support PCACH strategic plan. Key leadership role in strategic decision-making.

- **Lena Nachand, Director of Community Health** (Hired March 2017):
Development, implementation, and operation of community-based care coordination system. Supports care coordination workgroup to develop project plan synergistic with PCACH’s Portfolio of Projects.
- **Vanessa Perdomo, Operations Coordinator** (Hired March 2017):
Responsible for day-to-day operations. Ensures partners, members, and stakeholders receive excellent customer service. Maintains expenditures within budget, facilitates several programs, controls inventory, handles logistics, and oversees facility needs.
- **Reyneth Morales, Program Manager** (Hired July 2017):
Supports several PCACH program areas: community engagement, integration of behavioral health and primary care, community based care coordination, and the Opioid Task Force.
- **Maggie Goodwin, Senior Financial Analyst** (Hired July 2017):
Develops, implements, and maintains systems, processes and reporting. Supports implementation of business systems infrastructure, accounting/financial reporting, financial analysis, budgeting and planning, capital tracking, and grant reporting.
- **Virginia Bartman, Accounting Assistant** (Temporary position/no Bio attached):
Maintains day-to-day accounting functions; financial statement preparation, maintenance of the general ledger, cash management; accounts payable; payroll; tracking and reporting of grants and contributions; and other accounting and administrative functions.

Associate Director (AD) and Chief Financial Officer (CFO) are currently recruiting the following positions noted below. Interviews are currently underway. Job listings are posted on PCACH’s website, emailed to community partners, posted to Indeed, and Idealist. Community partners are asked to boost job listings through their networks. Operations Coordinator selects qualified candidates to interview with the AD, CFO, members of the Board, and Community Voice Council (CVC). The Tribal Liaison job description is under development for release in August.

- **Tribal Liaison:**
Develops policies and analyses that support government-to-government relations between PCACH and Tribal governments and that address health disparities in AI/AN communities. Facilitates effective communication and dialogue between PCACH and Tribal entities with respect to AI/AN health care delivery and needs to inform demonstration projects.
- **Community Voice Council Coordinator:**
Supports Community Voice Council, ensures adequate resources to carry out CVC charter. Assists CVC in creating, maintaining comprehensive community engagement system. Facilitates shared learning and communication between CVC and other ACH structures. Ensures CVC is active in co-creating and recommending demonstration projects.
- **Communications Specialist:**
Promotes cross-sector partnerships across various communications platforms. Develops and maintains communication plans. Writes and edits internal and external communications.

Attachment(s) Required

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

Attachment(s) Recommended

- E. Sector representation policy describing any agreements or expectations for decision-making body members to communicate with and engage partners within a defined sector.**
- F. Revised visual/chart of the governance structure, if there have been significant changes since Phase I Certification.**
- G. Revised organizational chart that outlines current and anticipated staff roles to support the ACH, if there have been significant changes since Phase I Certification.**

Tribal Engagement and Collaboration – 10 points

Description

Provide a narrative describing specific activities and events that further the relationship and collaboration between the ACH and Indian Health Service, tribally operated, or urban Indian health program (ITUs), including progress on implementing the requirements of the previously adopted Model ACH Tribal Collaboration and Communication Policy or other unanimously agreed-upon written policy. Identify and address any updates/improvements to the ACH's Tribal Engagement and Collaboration since Phase I Certification.

Instructions

Provide a response to each question. Total narrative word count for the category is up to 1,000 words.

Collaboration

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

In Phase I, PCACH described plans for Tribal Engagement and Collaboration. At that time, the Board of Trustees had adopted the Model Tribal Communication and Collaboration policy, but had yet to establish proper communication channels between PCACH and local Tribes or implement internal procedures and accountabilities to ensure ongoing communication. We also described our plans to meet with the Health Care Authority (HCA) and the American Indian Health Commission (AIHC). These meetings were intended to educate and guide PCACH staff regarding appropriate communication and collaboration with Tribes and to plans next steps.

Since that time, PCACH has made significant strides, including:

- PCACH's Associate Director and Director of Community Health had two meetings with HCA and AIHC. Topics included Tribal health delivery areas, referred and purchased care, IHS as the payer of last resort, and next steps regarding communication.
- The Board added a second Tribal-specific Board seat so both Puyallup and Nisqually Nations (the two Tribal Nations with land within the ACH boundaries) would have the opportunity to appoint a representative. The attached Tribal Collaboration and Communication Policy has yet be updated to reflect this change.
- Letters were sent to the Tribal Chairs of the Puyallup and Nisqually Nations with a standing invitation for Council designees to join the Board and other ACH councils. Appropriate staff were carbon copied.
- PCACH also participated in a Tribal Workshop hosted by HCA and AIHC (July 21, 2017) at the Muckleshoot Health and Wellness Center. This was a very positive first meeting between Puyallup and PCACH leadership. From that meeting the Nisqually Tribe's health care leadership expressed real interest in exploring working directly with the Pierce ACH.

Specific steps ahead include:

- After the Tribal Engagement Workshop, PCACH's Executive Director discussed the Pathways Hub model for improving care coordination in the region with Jennifer LaPointe of the Puyallup Tribal Authority. Jennifer described the Tribe's care coordination expertise and expressed interest in becoming a care coordinating agency with the Hub. We are optimistic

<p>this will be an opportunity to deepen collaboration and gain the Tribe’s input into the design of the Pathways Hub.</p> <ul style="list-style-type: none"> ▪ The Puyallup Tribe is a “spoke” agency in the region’s State-Targeted Response to the Opioid Crisis Grant Hub and Spoke effort. A member of the Tribe’s behavioral health clinic will attend Opioid Task Force meetings along with a second representative of the Tribe involved in the Overdose Prevention and Naloxone Distribution grant. ▪ PCACH will hire a Tribal Liaison in coming months. This position will be responsible for procedures to ensure PCACH complies fully with the Model Tribal Communication and Collaboration Policy and for developing government-to-government relationships with the Tribes in the region. This person will also develop ongoing Tribal Workshops and trainings for staff and Board of Trustees. PCACH has had conversations with Seattle King ACH about sharing this position to assist both ACHs build relationships with the Muckleshoot Tribe, which resides between the two regions.
<p>2. If applicable, describe any opportunities for improvement that have been identified regarding the Model ACH Tribal Collaboration and Communication Policy and how the ACH intends to address these opportunities. <i>(Enter “not applicable” if no changes)</i></p>
<p>Not applicable.</p>
<p>3. Demonstrate how ITUs have helped inform the ACH’s regional priorities and project selection process to date.</p>
<p>PCACH has been focused on establishing appropriate, conscientious, respectful communication with the two Tribal Nations within the ACH region, the Nisqually and Puyallup. PCACH understands the expectation to receive input from ITUs. However, because of the pace of relationship and trust building, PCACH believes that seeking input from the ITUs within our boundaries at this time would be counter-productive to our relationship-building efforts with the Puyallup and Nisqually.</p> <p>Moving forward, it is our hope to build a strong, bi-directional partnership that benefits both Tribal Nations and PCACH. That will require significant time learning about the Tribe’s specific population needs and the projects they desire. It is the responsibility of PCACH to respect the wishes of the Tribes regarding the amount of interaction and involvement they have with PCACH.</p> <p>PCACH recognizes that Tribes may or may not have interest in health systems beyond their own Tribal facilities. They also may or may not have interest in PCACH involvement in their health systems. Building bona fide relationships will inform PCACH what is and is not of interest to the Tribal Nations within the county boundaries. PCACH will create flexibility for ITU input into project design and overall participation throughout the duration of the Demonstration timeline.</p> <p>As described above, we are hopeful that community based care coordination will be a starting point for collaboration and co-creation of a project mutually beneficial to the Puyallup Tribe and the broader Pierce County region.</p>
<p>Board Training</p>
<p>4. Demonstrate the steps the ACH has taken since Phase I Certification to ensure the ACH decision-making body receives ongoing training on the Indian health care delivery system, with a focus on the local ITUs and on the needs of both tribal and urban Indian populations. Identify at least one goal in providing ongoing training in the next six months, the steps the ACH is taking to achieve this goal and the timing of these steps.</p>

Since Phase I certification, PCACH has worked with HCA and AIHC to schedule and execute our ACH Tribal Workshop on July 21, 2017. This event was attended by Board members, Regional Health Improvement Plan Council members, Community Voice Council members, and staff with approximately 35 people representing PCACH.

Training goals for Board members including gaining an understanding of:

- the status of Tribes as sovereign nations
- why this sovereignty is important
- how Tribal relationships are different than typical collaborative relationships
- the specific health equity challenges experienced by Tribal members
- the complexity associated with paying for Tribal healthcare
- the lack of access to pertinent Tribal health data
- why Tribal Nations may hesitate to participate in the ACH

We also look forward to learning from the expertise of Tribes that have already accomplished many of the goals of the ACH, including whole-person care.

The new Tribal Liaison staff person will work with human resources staff to develop the following trainings for the ACH:

- In partnership with HCA and AIHC, we will develop a presentation of highlights from the Tribal Workshop. PCACH members who attended the workshop will present at each of the Councils and at the Board of Trustees meetings to share their learnings with those who could not attend. These presentations will happen August-September.
- Annually, the Board will undergo training similar to the Tribal Workshop training.
- All staff will undergo annual Tribal orientation training and at the time of hire.

Attachment(s) Required

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

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

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

Attachment(s) Recommended

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

Community and Stakeholder Engagement – 10 points

Description

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

Instructions

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

ACH Attestation(s)

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

YES

Meaningful Community Engagement

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

Barriers and challenges to community engagement, with Medicaid beneficiaries in particular, include *lack of resources to attend meetings; lack of trust, requiring intentional relationship building; and the need for culturally and linguistically appropriate messaging.* To address these challenges:

- **PCACH provides stipends for members of the Community Voice Council (CVC) to attend monthly meetings and to cover travel and childcare costs.** CVC members are recruited for their lived experience with navigating a fractured healthcare system, economic insecurity, racism, homelessness, behavioral health challenges, incarceration, and domestic and other forms of violence. They are current and former Medicaid beneficiaries; Medicare and Veteran’s Administration beneficiaries; uninsured; and/or work closely with these groups in the community (community health workers). CVC members act as ambassadors to and from their communities. The ACH relies heavily on input from the CVC to inform project selection and design and must invest to ensure community participation.
- **PCACH contracts with Foundation for Healthy Generations (Healthy Gen) and other community based organizations that have existing, trusted relationships with communities throughout the region.** Healthy Gen helps raise awareness about the ACH, its value, and recruits geographically and culturally diverse community members to participate in the ACH’s shared learning structure. A major component of Healthy Gen’s strategy is to attend already existing community meetings supported by agencies that serve Medicaid beneficiaries. Meeting people where they are rather than asking them to come to us breaks down barriers and builds trust.

- **Healthy Gen created culturally appropriate literature and a low-threshold interview process to recruit CVC members and to build firm relationships among staff and Councilmembers.** These relationships support genuine engagement and sustained involvement because people enjoy coming to meetings, seeing friends, and working together on important issues that impact their neighborhoods.

Successful community engagement results in the community co-designing or co-developing the process. PCACH used the strategies above to engage the community, recruit for the CVC, and support the council to level-set around our goals. Next steps in defining successful community engagement will be to ensure the CVC is co-designing the process with the community and the ACH. We measure the following criteria to gauge success. The CVC will:

- create its own meeting agendas, topics for discussion, and strategies for community health
- develop a cohesive voice to communicate with the community and with other councils
- liaisons will attend meetings of the Board, Regional Health Improvement Plan, Provider Integration Panel, Data and Learning Team, Opioid Task Force, and Care Coordination workgroup and will carry that voice into those meetings
- liaisons from other Councils will attend CVC meetings
- CVC liaisons will serve as ambassadors to and from community coalition and collaborative meetings

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

Successes include:

- PCACH solicited MCOs for support in building a robust community engagement system. In response, United HealthCare donate \$15,000, which will be used to provide CVC stipends, food at meetings, and to support quarterly listening sessions throughout the region.
- Meeting people in their own communities has been very successful, resulting in recruitment of a dedicated and cohesive CVC from across Pierce County.
- CVC liaisons are very active, with impeccable attendance at other council meetings. In many ways, the CVC is the most well-informed component of our structure.
- CVC members recently completed a SWOT analysis of the Pathways Hub model. Liaisons have begun to report the findings of this exercise to the Board and other councils. They are currently involved in helping draft the request for proposals for care coordinating agencies in Pierce County to be compensated for hiring community health workers trained in Pathways.

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?

Elements of project selection and planning informed by community input include the following:

- During the June 6 and July 11 CVC meetings, councilmembers considered regional health data and made recommendations regarding the priority population for a Pathways Hub pilot project.
- During the July 11 & August 2 CVC meetings, councilmembers conducted a SWOT analysis regarding Pathways Hub implementation in Pierce County.

CVC recommendations and outcomes of the SWOT will be included in the Pathways proforma that will go before the Board for approval in August. These activities will also help meet requirements for the Pathways Hub national certification process. The PIP's white paper and rules of engagement will inform decisions for how **Collaboratives** approach project selection and design.

Next steps for public input into project selection and planning include:

- The Opioid Workgroup will do an environmental scan and gaps analysis of the region's capacity to address the opioid use crisis, make recommendations about priority populations and promising practices, and suggest investments the ACH might make to have the broadest impact.
- The recently formed Care Coordination Workgroup will help design and implement the Pathways Hub. This group may become the Community Advisory Board, which will provide ongoing oversight for the community owned Hub.

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.

Since Phase I, PCACH has experienced the following barriers and implemented corresponding strategies to better engage providers and community-based organizations:

- Clinical providers are less available during business hours. To address this barrier, PIP meetings are held at 7am. Workgroup meetings are held at 6pm.
- Some providers have been resistant to transformation or believe movement toward fully integrated managed care will result in substandard patient care. A great deal of political ground softening and awareness building about the ACH's role in integration has been necessary to bring providers to the table.
- PCACH has a strong substance use disorder presence at the Provider Integration Panel and Regional Health Improvement Plan Council, but there is concern about integration and the role of SUD providers in the transformation process. PCACH staff hold one-one-one meetings with these providers to better understand and address concerns and to consider potential solutions and necessary system changes.
- Community-based organizations often do not have resources or capacity to send staff to ACH meetings. To meet this barrier, PCACH representatives attend various collaboration meetings; Human Services Coalition, Homeless Coalition, Chronic Disease Showcase, Perinatal Collaborative, High-Utilizer of Emergency Services Coalition, Leaders in Women's Health, and First 5 Fundamentals. We present information, collect feedback, and send pulse test surveys to member organizations who cannot participate on ACH councils.

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

Successes include:

- PCACH was formed at the end of January 2017. While there was some provider engagement happening under the previous ACH, relationships with hospitals, clinics, and provider

networks were limited and insufficient. PCACH's Executive Director has done intentional engagement and relationship building with a diverse group of providers. PCACH solicited applications from this provider network to create the Provider Integration Panel. The PIP created and approved a charter, which recommends a list of multi-sector providers. PCACH works to ensure parity and inclusion according to the charter.

- The Executive Director has also successfully engaged elected officials in the ACH transformation work, giving momentum and direction to the FIMC mid-adopter conversation. She has developed relationships within Pierce County government to raise awareness about the importance of financial integration. We recently received word that conditional approval of FIMC mid-adopter status has been achieved.
- In one-on-one meetings with providers, PCACH has collected information about covered lives, status of integration, and key obstacles to moving along the continuum of integration. To support full integration and whole person care, we have begun an inventory of priority populations for each provider and an assessment of their willingness and ability to coordinate their efforts with toolkit priorities and projects such as chronic conditions, transitions of care, diversion interventions, care coordination, and prescribing guidelines. We are also taking stock of other barriers to achieving project demonstration goals, including workforce gaps, VBP progress, technology and information exchange barriers, and barriers to culturally appropriate care.
- RHIP Council completed a baseline environmental scan and gaps analysis across each of the following project areas: care coordination, opioid use crisis, transitional care, and diversions. They were asked about their organization's capacity to move toward fully integrated managed care. This information was used to develop the ACH's MTD strategy.
- Provider Integration Panel drafted a white paper on bi-directional integration of care and the collaborative care model. The group is also editing a Rules of Engagement document. Drafts of these documents will be presented to the RHIP Council and the Board of Trustees for approval.

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.)

The main mechanisms for securing partnering provider input are the Regional Health Improvement Plan Council and the Provider Integration Panel. These groups meet monthly. To ensure input from a broader network of providers, staff regularly attend coalition and collaborative meetings across the region to present information, collect feedback, and survey organizations that cannot participate on ACH councils. These meetings include:

- Leaders in Women's Health
- Quarterly Chronic Disease Prevention Showcase
- Optum (BHO) Behavioral Health Organization
- Addressing High Utilizers of Emergency Services
- Human Services Coalition
- Bonney Lake Homeless Services
- Community Health Worker Collaborative

- Perinatal Collaborative
- First 5 Fundamentals

Information is communicated through these networks to invite provider organizations to the ACH table, survey providers for their input, and ensure providers are aware of project selection and planning progress.

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)?

PCACH Board of Trustee and Council meetings are open and accessible to the public except for executive sessions. All open meetings have time dedicated to public input on the agenda. Board meetings are announced in advance and posted to the website calendar. Meetings are held regularly, from 10am to noon, on the third Tuesday of every month at the Portland Community Center. This space is located on a bus line and has ample space for public attendance.

To date, we have received public comment at Board meetings regarding the opioid use crisis and its impact on residents, points of clarification and commentary regarding ACH strategy and direction, and suggestions regarding the makeup and diversity of Board and Council membership. In response, PCACH has made meeting materials more broadly available, adjusted or deepened strategy and scheduled one-on-one meetings to better understand how to address concerns. We have also scheduled comprehensive equity and diversity training for the Board of Trustees and staff, revised the way we recruit for open Council and staff position, and invited members of the public to sit on oversight committees.

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?

PCACH Board of Trustee meetings occur in the same location each month. Council meetings rotate throughout the region. We have experienced challenges with maintaining attendance at rotating sites because members have difficulty finding new locations each month.

Meeting announcements, agendas, and minutes are posted to the ACH website and emailed to Council and Board members in advance of each meeting. Call-in and webinar capability is available to accommodate those who cannot attend in person. Sign language and translation services are also available.

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

To date, there have been no decisions made between regularly scheduled public meetings. PCACH leadership takes great care to ensure decision-making happens at regular meetings.

The agency’s bylaws state that if a decision is required between meetings, “notice of special board or committee meetings (stating the date, time and place, and purpose of the meeting) shall be given to a Director in writing or by personal communication with the Director not less than ten days before the meeting.” Public notice of special meetings will follow the same protocol with announcements and agenda posted to the ACH website.

Notice of special meetings ensures that Directors (Trustees) and the public are aware of all decision points.

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.

PCACH currently uses a website and MailChimp to market its activities and information to nearly 200 stakeholders and partners across the region. News blasts go to the entire membership every time an ACH meeting, informational webinar, or community meeting is added to the calendar. We ask our partners to boost announcements through their professional networks. These platforms enable PCACH to communicate meeting dates and topics, presentation and meeting materials, raise awareness around project areas, provide information and links to HCA regarding the Transformation Demonstration, and post job opportunities.

PCACH will hire a communications specialist who will develop a comprehensive communications plan and explore broader marketing and social media platforms to foster cross sector partnerships and promote the PCACH mission. This plan will reflect the complexity of communication needs across a multitude of audiences.

Attachment(s) Required

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

Budget and Funds Flow – 15 points

Description

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

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

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

Instructions

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

ACH Attestation(s)

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

YES

Date of Approval: June 19, 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: August 2, 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.

Phase I Project Design funds have been used to build internal administrative capacity, to engage with outside consultants to supplement internal expertise, and to create systems and processes to support the planning and implementation of the demonstration projects.

Since the Phase I certification, PCACH has filled key staff positions that expand our ability to engage with the community and manage and plan for funds flows and data exchange and measurement. These positions include CFO, Senior Financial Analyst, Manager of Community Engagement, Communications Specialist, and Community Voice Coordinator.

We have signed a lease for office space that will accommodate our full staffing plan and have completed job descriptions and posted for all key open positions. Additionally, we have entered into contracts for consulting services to assist us with key planning activities, including vision and approach, partnership structure, data strategy, IT infrastructure design and project portfolio evaluation.

We are collaborating with other ACHs on two separate consulting engagements: 1) with KPMG to provide technical assistance with the project analysis and DSRIP funds flow modeling, and 2) with the Foundation for Healthy Generations and Pathways Community HUB Institute to design and implement a care coordination model and for workforce development.

Phase I Design Funds by Category and Percentage:

1. PCACH Project Plan Development - 19%
2. Engagement – 16%
3. PCACH Administration/Project Management – 22%
4. Information Technology (primarily data strategy and capacity) – 15%
5. Health Systems and Community Capacity Building – 19%
6. Other (including contingency) – 9%

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

ACH Project Plan Development (29%): Funds to be used to bring in outside consultants to supplement our internal capabilities and expertise in workforce development, care coordination and clinical and financial integration planning. Additionally, the funds will be used to convene our Waiver and Investment Committee and to provide the operational support for that group throughout the planning phase. (See response to question 3 below for a description of this committee)

Engagement (14%): Funds budgeted to expand the community engagement efforts through the collaboratives and our existing council structures. We will be recruiting and hiring key staff to broaden our communications and outreach to the community and to build our tribal liaison office and Community Voice Council support.

ACH Administration/Project Management (21%): Funds are budgeted to increase focus on enterprise risk management, including ensuring adequate levels of liability insurance and engaging legal counsel for contract, risk management and compliance review. Additionally, we have planned to increase the level of board and governance training. Funds are to be used for annual audit and tax compliance work as well as to finalize our 501(c)(3) status. We have also budgeted in this category for all facilities, office operations, recruiting and retention, and fiscal functions.

Information Technology (13%): We will continue to engage Providence CORE to assist in building our internal data strategy and data capacity, as well as providing support to our partners in the Collaboratives to build the data capture structures within their projects. Additionally, we will invest in region-wide HIE solutions to be incorporated into our project plans. This budget supports a financial analyst who will begin to build internal ACH capabilities to translate data into financial and metric reporting. The budget also includes outsourced IT security and process oversight of all ACH business systems and data and cyber security insurance.

Health Systems and Community Capacity Building (20%): Funds to be used for project management support within the Collaboratives as well as staff support for our community councils and tribal liaison office. Additionally, we will invest in the care coordination technical platform and training, which will

to allow us to launch pilot projects in early 2018. We have also budgeted for significant recruiting and training efforts and outside human resource and workforce development support.

Other (3%): General reserve for contingencies.

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.

Our first investment is in our people and building administrative capacity and we intend to use Project Design funds to complete the recruitment of key staff for clinical integration, project management, care coordination HUB clinical oversight, and tribal engagement. This will focus our project planning on the key clinical and community-based drivers of success.

We are working with Providence CORE to assist us with our data strategy and data evaluation capabilities, and intend to use Project Design funds to invest in necessary technologies to interface with data sources, evaluate performance data, and report performance to providers.

We have formed a Waiver and Investments Committee, which is a sub-committee of the Board chaired by two Board members and comprised of our Finance Committee chair and up to seven independent, non-Board members from the business, education, managed care, healthcare finance and social services sectors. The Executive Director and CFO will provide operational support as standing members. The Committee will provide oversight over the funds flow strategies and five-year Demonstration budget planning and authority to provide recommendations to the Board on the initial project plan. This Committee will continue to direct the investment strategies for the ACH throughout the Demonstration and help fashion the long-term vision for the role of the ACH and the sustainability of its work in the community into the future.

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

PCACH has developed a detailed operating budget which aligns with the funding and expenditure categories from the budget templates that were provided with Phase I and Phase II certification. This budget was approved by the Board on June 19, 2017. Each month, actual financial results are reviewed by the Finance Committee against that approved budget. New contracts for services or activities outside of the budget would require review by the Committee and the Board prior to inception of any work.

All contracts are reviewed by the CFO and signed by the Executive Director. Operational expenditures are also all reviewed by the CFO prior to check signature by the Executive Director or Associate Director. We believe these internal controls provide the necessary accountability for Project Design funds.

Incentive Fund Distribution Planning

5. Describe the ACH's Project Incentive fund planning process to date, including any preliminary decisions, and how it will meet the Project Plan requirement. (Note: In the Project Plan, the ACH will be required to describe how Project Incentive funds will be distributed to providers.)

We have engaged KPMG to help us design our funds flow strategy to incentivize participation and performance towards project metrics and to target investments in processes and infrastructure that will lay the groundwork for improving the capabilities of providers to manage VBP contracts.

While decisions have not yet been made, PCACH has already considered a high-level funds flow framework that consists of the following four elements:

1. Funds that will be used by the ACH for DSRIP project management and region-wide investments and support for the benefit of all Collaboratives. These will be focused on projects such as HIT/HIE, workforce development and community engagement.
2. Fixed funds to support Collaboratives with their DSRIP project management and project costs.
3. Performance-based funds to help align Collaborative incentives with the measurements that the ACH is held accountable to during the DSRIP program, such as engagement criteria, outcomes and reporting requirements.
4. Dedicated funds to certain partners who span across providers and Collaboratives to build capabilities and capacity for sustaining their participation.

Key representatives from the health systems, MCOs, provider groups and community agencies will participate on the Waiver and Investments Committee. Their input during the design of the projects will ensure that our incentive funding strategy is well-understood by the providers and that the methods we choose will serve the purpose of incentivizing participation and performance in the projects and supporting necessary investments in infrastructure and process change.

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).

In conjunction with contributions from our health system partners, SIM grant funds were our sole source of funding prior to receiving Phase I Design funds. The use of the funds aligned strongly with Demonstration activities and goals by allowing us to build the legal, operating, and governance structure of PCACH and to put in place the tools that help us to engage with the community and with our partners in advance of our successful completion of Phase I certification. These funds were used in part to:

- Set up our non-profit, 501(c)(3) legal entity
- Hire and recruit the initial management team
- Establish the governance structure and recruit members of the Board
- Implement organizational risk management processes
- Develop the accounting system and financial reporting and processes
- Build administrative capacity and tools

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.

Board member organizations and community partners have provided, and will continue to provide throughout the demonstration, space for committee meetings and workgroup sessions. Additionally, these organizations donate the time for their executives, clinicians, and employees to attend Board meetings, committee meetings, council and panel sessions, and ad hoc strategy and planning sessions. We will look in the future to receive additional in-kind support such as clinical and integration subject-matter expertise on a consulting basis and space and supplies to support our community engagement work.

We are exploring relationships with key governmental agencies, most notably the state Department of Health and the federal Health Resources Services Administration to support our workforce strategies and care coordination platform approach through in-kind participation. Refer to the Phase II Design Budget Template – Additional Funding for description and scope of in-kind funding.

The ACH will be tracking in-kind donations, including volunteer time, in the future and will appropriately report it in our financial results.

Attachment(s) Required

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

Clinical Capacity – 15 points

Description

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

Instructions

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

Clinical Expertise

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

The Provider Integration Panel (PIP) provides clinical leadership for project selection, planning, and implementation. Under the leadership of Dr. Huang, Primary Care Medical Director Multicare, and Dr. Davydow, Medical Director of Behavioral Health CHI Franciscan, the workgroup drafted a white paper on bi-directional integration of care and the collaborative care model. The group is also editing and reviewing a Rules of Engagement document to be used by the Health **Collaboratives** and providers in the region as they undertake project planning and integration efforts. Drafts of these seminal documents will be presented to Regional Health Improvement Plan Councilmembers and the Board of Trustees for approval.

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

Bi-directional Integration:

- Dr. Huang chairs the PIP and leads review of the Rules of Engagement for cohort of integration partners.
- Dr. Davydow drafted the Bidirectional Integration/Collaborative Care Model White Paper with recommendations from the PIP for an evidence-based regional integration approach.

Community-Based Care Coordination:

- The Care Coordination Workgroup completed an environmental scan of care coordination and referral agencies in Pierce County. This scan will be used to determine potential project partners and target population for the Pathway Hub. PCACH has contracted with Kathy Burgoyne, Foundations for Healthy Generations, and Dr. Sarah Redding, Care Coordination Systems, to provide subject matter expertise regarding the Pathways Hub Model.

Transitional Care:

- Dr. Huber, Chief Medical Officer Behavioral Health Multicare, sits on the PIP and the Opioid Task Force. He provides leadership regarding transitional care for opioid users with skin and soft tissue infections to avoid hospital readmissions.

Diversion Interventions:

- Mike Newhouse, Russ McCallion, and Dan Beckman represent Fire and Rescue Services and provide deeper understanding about how emergency medical systems can be integrated into the transformation work. State Senator O'Ban and Carol Mitchell represent the Pierce County Executive's Office and provided leadership regarding Crisis Management and Response and partnership in moving toward Mid-Adopter status for fully integrated managed care.

Chronic Disease Management:

- Julie Lindberg, Molina, and Dr. Cruz-Uribe, SeaMar, are chronic disease experts and have been instrumental in helping ACH leadership in understanding and developing strategies for integration.

Addressing Opioid Epidemic:

- Dr. Gough, Chief Medical Officer Molina Healthcare of WA, sits on the Opioid Taskforce, providing Molina data to help the region understand opioid prescribing and use trends. She has written a white paper outlining points of alignment between PCACH and Molina initiatives.

Maternal and Child Health:

- Dr. Plawman, Addiction Fellowship Director Multicare, chairs the Opioid Workgroup. She treats pregnant women with substance use disorder, directs a residency program, and informs practical guidance on implementing opioid prescribing guidelines in training programs.

Oral Health:

- Glen Puckett, Senior Program Officer Delta Dental of Washington, provides expertise to ACH leadership regarding integration of oral health into fully integrated managed care and whole person health.

Clinical Input

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

The Provider Integration Panel (PIP) is a diverse provider group representing both urban and rural areas of the region:

- **Urban providers (Tacoma/Lakewood):** Multicare, CHI Franciscan, Community Health Care, Comprehensive Life Resources, Planned Parenthood, Greater Lakes Mental Health
- **Rural providers (Key Peninsula/Sumner/Gig Harbor/Roy/Graham/Lake Tapps/Long Branch/Orting):** Northwest Physicians Network, Pediatrics Northwest, Prosperity House, Korean Women’s Association (these organizations serve rural communities throughout the region).

Prospective clinical partnering providers involved in project planning through the PIP, who do not hold positions on the Board of Trustees, include the following:

- City of Tacoma Fire Department
- Comprehensive Life Resources
- Planned Parenthood of Great NW & Hawaiian Islands
- Korean Women’s Association
- Northwest Integrated Health
- West Pierce Fire and Rescue
- Metropolitan Development Council
- Prosperity Wellness Center

The PIP holds monthly meetings. A smaller group of providers meets more frequently to take a deeper dive into core issues such as VBP alignment, workforce gaps, data and analytics, and information technology exchange issues. These meetings result in recommendations and guidance documents (i.e. white paper on bi-directional integration of care and the collaborative care model and

Rules of Engagement document that will be used by the Health *Collaboratives* and providers in the region as they project plan and undertake integration efforts). Ultimately, these efforts, recommendations, and guiding documents will be considered by the Board in October when a final decision is made regarding project selection.

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.

PCACH is currently partnering with 37 key providers in our region, including physical and behavioral health, and community based providers. These providers cover 90% of the Medicaid population in Pierce County. As mentioned above, input and feedback is collected via Provider Integration Panel and Regional Health Improvement Plan Council meetings. We also conduct one-on-one interviews with councilmembers to assess the capacity of each organization to implement the projects under consideration.

We now know more about covered lives, status of integration, and key obstacles to moving along the continuum of integration. To support full integration and whole person care, we have begun an inventory of priority populations for each provider and an assessment of their willingness and ability to coordinate their efforts with toolkit priorities and projects such as chronic conditions, transitions of care, diversion interventions, care coordination, and prescribing guidelines. We are also taking stock of other barriers to achieving project demonstration goals, including workforce gaps, VBP progress, technology and information exchange barriers, and barriers to culturally appropriate care.

These activities have helped surface naturally occurring affinities among partners to collectively respond to the transformation demonstration. These naturally occurring affinities will be explored to identify opportunities for collaboration as we move toward integration. Additionally, we will conduct a full partner inventory over the summer to bring laser focus to the gaps we have identified and to support collaborative project planning.

We have identified areas of weakness in the region’s behavioral health, substance use disorder, and primary care provider workforce; and gaps in health information technology and exchange.

Preliminarily, PCACH is considering the following solutions:

- Telehealth and telepsychology as potential solutions to workforce gaps in urban and rural areas of the region
- The Pathways Hub is an interim solution for primary care workforce gaps; we will hire a Clinical Manager to provide oversight for care coordinating agencies partnering through the Hub
- Preliminary conversations have happened with the Puyallup Tribe to explore ways to assist, encourage, and incentivize members of their clinical residency program to be retained within the region’s workforce.
- PCACH leadership is also exploring solutions to recently identified licensure barriers for the State’s behavioral health residential treatment programs.

PCACH recently established a relationship with Workforce Central to explore workforce development solutions, workplans, and timelines. Linda Nguyen, Workforce Central Chief Executive Officer and chief staff to the Pierce County Workforce Development Council (WDC) has agreed to join the Waiver and Investments Committee of the PCACH Board and to assist leadership in considering workforce solutions.

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).

In addition to working with Northwest Physicians Network, Pediatrics Northwest, and Delta Dental of Washington State, PCACH works closely with Washington State Hospital Association (WSHA), and Washington Association of Community and Migrant Health Centers (WACMC). Examples of partnership include the following.

- Our team has attended WSHA’s meetings to help develop recommendations for addressing the opioid use crisis.
- PCACH’s Executive Director has made this area a special focus of hers. She has:
 - had ongoing conversations and meetings with WSHA to better understand the state’s health information technology and exchange challenges and to inform possible solutions.
 - delivered presentations to and had conversations with WACMC representatives regarding community-based care coordination and Pathways Hub Model.
 - arranged for meetings and presentations with the founder and developer of Pathways, Dr. Sarah Redding, for WACMC and other ACHs across the state.
 - participated in meetings with Healthcare Authority regarding MACRA/MIPS, data sharing, and aligning the Pathways Hub Model with Apple Health/MCO contracts and with Health Homes.

Attachment(s) Required

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

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

Data and Analytic Capacity – 15 points

Description

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

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

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

Instructions

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

ACH Data and Analytic Capacity

1. List the datasets and data sources that the ACH is using to identify its regional health needs and to inform its project selection and planning process.

Pierce County ACH has used the following data sources¹:

- HCA "Starter Set" data
- Healthier Washington Dashboard
- DSHS ACH Profile
- CHARs hospitalization data (from Tacoma-Pierce County Public Health)
- BRFSS data (from TPCHD)
- WA First Steps database
- HCA Medicaid enrollment reports
- HCA provider report
- HCA/RDA measure decomposition
- Pierce County Jail data
- Community Checkup
- Aggregate data from MCO and delivery system partners
- UW Center for Health Workforce Studies reports

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.

Data are being used routinely by ACH staff, leadership, and governance groups to explore populations, to identify health care needs, gaps, and disparities; select projects and estimate

¹ Please see PCACH-Data and Analytic Capacity-Attachment A

potential for project impact; identify target populations for projects; identify partnering providers and organizations; understand community needs; engage stakeholders; design and plan projects; and assess workforce capacity and gaps. One of PCACH's governance groups, the Data & Learning Team (DLT), supports data driven decision-making by reviewing and interpreting existing data and reports, identifying data gaps and data sharing needs, and making recommendations regarding project and target population selection to leadership and other governance groups.

Data and recommendations from the DLT drive conversations at the Community Voice Council, Regional Health Improvement Plan Council, Provider Integration Panel, Opioid Task Force, and Care Coordination Workgroup. In turn, discussions and recommendations from these groups guide ACH leadership and are reported to the Board to inform decision-making. This forms the basis of the ACH's shared learning system.

The next step is to translate shared learning into action. ACH will incentivize health provider **Collaboratives** to operationalize the lessons distilled in the shared learning structures into strategies to meet regional health needs via effective partnerships and shared accountability to outcomes. Each Collaborative will include, at a minimum: hospitals; physical, behavioral health and substance use disorder providers; community based organizations addressing chronic disease, syringe exchange, EMS, criminal justice, community-based care coordination agencies, MCOs, etc.

With technical assistance from the ACH, MCOs, Qualis, Providence CORE, and KPMG, each Collaborative will create a project plan, including data analysis relating to population health, social well-being, and healthcare utilization. **Collaboratives** will be asked to use this analysis to determine root causes of ill health. For example, local obesity might be attributed to cultural issues, living in a "food desert", or a lack of exercise opportunities. This kind of "upstream" thinking will be linked to each Collaborative's project selection and design.

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

PCACH has identified several data and analytic gaps:

- Lack of direct access to source data to answer data requests from ACH partners in a timely manner (i.e. official baselines, targets, or benchmarks and we do not have measure data at the health plan, health system, or provider level.
- Lack of information on the size and characteristics of potential priority populations. For example, PCACH has identified Medicaid members with co-occurring BH and chronic conditions as a target population, but does not have access to detailed information.
- For project selection, PCACH would like to model the community impact of implementing different projects with different populations. We lack both a framework for this model and data to feed into the model.

PCACH has taken the following steps to address data gaps and barriers:

- The PCACH Data & Learning Team (DLT) provides a forum for community stakeholders to collectively identify and address data needs. (See responses to questions #2 and #5)
- PCACH has contracted with Providence CORE to provide data and analytic support; has executed a shared services contract with KPMG to assist with modeling funds flow and project impact; and has contracted with CCS to develop and implement a data platform to support community care coordination.

<ul style="list-style-type: none"> ▪ PCACH has used publicly available and proxy data sources to assist with project and target population selection. ▪ PCACH has submitted data requests to HCA for data on target populations, providers, and utilization, and has worked collaboratively with other ACHs to identify data request priorities. ▪ PCACH has initiated conversations with MCO and delivery system partners to receive data to supplement publicly available sources.
Data-related Collaborations
4. Describe if the ACH is collaborating, or plans to collaborate, with other ACHs around data-related activities.
<p>Pierce County collaborates closely with SWACH and Better Health Together on data-related activities. The three ACHs have contracted individually with Providence CORE to provide data & analytics support, and have collectively contracted with KPMG to support project planning efforts.</p> <p>The ACHs have collaborated on identifying data needs, measures of interest, and data requests to HCA. They held a joint planning session focused on data needs and are aligning regional data collection and monitoring efforts, assessment tools, and reporting. They also plan to share best practices where one region may be high performing on a measure/project. Pierce & SW have similar data governance structures (i.e., the DLT) and have collaborated to refine this approach across the regions.</p>
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.
<p>The PCACH Data & Learning Team includes representation from providers, health systems, MCOs, behavioral health, public health, social services, and community groups representing multiple sectors. Staff from Tacoma-Pierce County Health Department co-chair the group. The DLT leverages multiple data sources to assess community health needs, select and implement projects, monitor progress, and evaluate impact. DLT materials can be viewed on the PCACH website: http://www.piercecountyach.org/documents/.</p>
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.
<p>PCACH Provider Integration Panel provides a regular forum to engage providers and collect information on data and data system capacity.</p> <p>ACH leadership has also conducted meetings with executive leadership and IT/IS personnel at Northwest Physicians Network, each of the MCOs, Multicare, CHI Franciscan, CCS/Pathways Hub, and WSHA. Topics range from understanding gaps in the data system, where the ACH can support implementation of adequate platforms, securing data sharing agreements, access to claims data and heat mapping, and connecting care coordination data into the clinical systems. ACH has also had several conversations with HCA regarding data sharing between Health Homes and the Pathways/CCS data platform.</p> <p>Next steps toward a thorough understanding of gaps and solutions include establishing a HIE/Interoperability Workgroup to serve at the frontline of this work.</p>
7. Demonstrate the ACH’s process to identify data or data system requirements needed to oversee and monitor demonstration project goals.

Specific efforts include:

- PCACH plans to field an initial assessment of provider readiness to partner on transformation projects by Fall 2017. This assessment will include questions related to current and planned provider data, data system capacity (including HIT/HIE), and needs to implement Demonstration projects.
- PCACH has begun developing a framework for self-monitoring and continuous improvement, including identifying supplemental process and outcomes measures for regional incentive structures, processes for data collection, and frequency and granularity of reporting. The monitoring system will support project implementation and will be functional by Q1 2019.
- PCACH will also leverage available information from the HCA VBP survey, particularly any questions related to barriers and enablers to VBP, including interoperable data systems, data sharing, and quality measurement.

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.

PCACH's process for assessing the region's workforce includes the following efforts.

- One-on-one meetings between PCACH's Executive Director, Uncommon Solutions, and members of the Regional Health Improvement Council to understand local workforce challenges of cross-sector partners; substance use disorder, behavioral health and clinical care providers, community-based care coordination and referral agencies.
- Meetings with MCOs and state agencies (Department of Early Learning, Department of Health, Department of Social and Health Services, & regional Workforce Development Councils) to understand workforce challenges of broader provider networks and state initiatives. Partnerships are being established now between PCACH and the emerging Health Care Workforce Council.
- Center for Outcomes Research and Education (CORE) is developing a Provider Inventory Survey to assess regional clinical capacity for integration, gaps, and provider suggestions for addressing gaps. This survey will be completed in September and October.
- PCACH staff will assist HCA to conduct the Value Based Payment Provider Survey with regional health organization administrators.
- Certification for the Pathways Hub requires an environmental scan of care coordinating and referral agencies to ensure adequate workforce capacity to serve priority populations. PCACH's Director of Community Health is currently conducting this scan with the assistance of the Care Coordination Workgroup and Community Voice Council.
- The Associate Director and Uncommon Solutions are conducting a scan of related statewide workforce reports and resources.
- PCACH recently established a relationship with Linda Nguyen, Workforce Central CEO and Chief of Staff to the Pierce County Workforce Development Council. Her name has been put forward to sit on the PCACH Waiver and Investments Committee. Her expertise will be vital in understanding workforce gaps and solutions².

This information presented in September and October through a series of technical assistance workshops for **Collaboratives** to use in developing their project plans. The project plan design template asks **Collaboratives** to further describe their workforce needs. Results from these processes will inform the region's workforce assessment plan, investments the ACH will make, and the ongoing

² Please see PCACP-Clinical Capacity-Attachment A

needs that must be addressed. ACH Councils will review this plan and Board of Trustees will provide final approval.

Attachment(s) Required

None

Transformation Project Planning - 15 points

Description

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

Instructions

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

Anticipated Projects

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

Following are the anticipated projects that will go before the Board of Trustees for final decision in October 2017.

Required Strategies

- Bi-directional Integration of Physical and Behavioral Health through Care Transformation
- Community-Based Care Coordination
- Transitional Care
- Diversion Interventions
- Implement Opioid Clinical Guidelines
- Chronic Disease Prevention and Control

Optional Strategies

- Reproductive and Maternal/Child Health
- Access to Oral Health Services

Project selection criteria include:

- Alignment with regional health priorities, ACH mission, values
- Ability to address documented need without duplication of efforts
- Impact on Medicaid lives and return-on-investment within 2-3 years
- Ability to address health equity and social determinants of health
- Ability to spread and scale project across the region
- Readiness to implement project
- Is there data and analytical infrastructure to measure need, outcomes, and evaluate the impact of the project
- Legal feasibility-is the project controversial?
- Earning potential-is the project weighted to provide significant funds flow?

PCACH’s portfolio of projects will support care transformation and payment redesign for three interdependent systems of care through multiple **Collaboratives** of diverse partners and community voices:

- The way we transform care delivery by supporting a collaborative of providers across the continuum to enable physical and behavioral health integration, implementation of chronic care practices, and establishing prescribing guidelines in the clinic setting
- The way we transition and divert individuals in and out of the Emergency and Jail Systems by incentivizing the **Collaboratives** of providers to create or deepen partnerships for community-based prevention, treatment, and support services
- The way we equitably coordinate care through the ACH by building a community based care coordination Pathways HUB as a service to all care coordinating partners in our region.

As discussed above, PCACH is focused on systems change rather than discreet projects and will incentivize the community to use this **Collaborative** model to transform care delivery, transition and divert ineffective or high-cost utilization of services, and augment community-based care coordination to improve whole person health. Our current health delivery system is a profit-center and must move to a cost-center approach in order for long-term change to be realized. Without change we will fail to reach the goal of improved health. Our vision is to guide these Collaboratives to create new relationships or build on existing partnerships between health systems, Tribal governments, community-based organizations, jails, emergency services, and others to change the status quo. This approach will allow the community to think, act, and learn together and to use investments appropriately to transform systems rather than fund independent siloed projects. It will also help to leverage resources across project areas and create change that is sustainable beyond the waiver.

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.

PCACH has a close relationship and philosophical alignment with Southwest ACH and Better Health Together. Leadership hold regular joint meetings to compare and align strategy. The agencies hold shared contracts with Foundations for Healthy Generations, Pathways/CCS, KPMG and have similar contracts with Uncommon Solutions. The three ACHs also partner deeply and engage in shared learning with respect to the planning and implementation of the Pathways Hub and solutions for state and regional health information exchange and technology gaps. PCACH partners in these ways to create efficiencies of shared learning, resources, and expenses across these ACHs.

PCACH has expanding partnerships with CPAA, GCACH, NSACH, NCACH and King County. We are exploring our common interest in Pathways and sharing what we have learned in working with Healthy Gen, Pathways Community Hub Institute, Dr. Redding and CCS platform.

PCACH has burgeoning partnerships with Olympic ACH and CPAA around opioid project planning as the realities regarding the opioid use crisis do not adhere to regional borders. We recognize the need for cross ACH planning to ensure maximum investment of limited opioid project funds.

We are also considering sharing a Tribal Liaison position with King County because we have similar challenges and opportunities to engage the Tribes in our regions.

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

PCACH has several mechanisms for working with MCOs to inform project selection and implementation:

- One-on-one with each MCO leadership team and are currently having follow-up meetings. These discussions are designed to ensure ACH strategy is in general alignment with MCO needs and that we understand MCO pain points. We also gain better understanding of provider capacity and gaps in movement toward integration, value based payment, and health information exchange and technology challenges. Recent conversations center around MCO contributions to the Pathways Hub Model and aligning these funding mechanisms with MCO/HCA contracts.
- All five MCOs serve on PCACH’s various committees, councils, and workgroups (Board of Trustees, Regional Health Improvement Plan, Community Voice Council, Data & Learning Team, Provider Integration Plan, Opioid Task Force, and Care Coordination Workgroup).
- MCO’s that do not currently sit on the Board will be asked to sit on the Waiver and Investment Committee to assist with the development and oversight of funds flow design.
- PCACH has also provided connectivity between MCOs and conversations happening with Pierce County regarding “mid-adopter” status and movement toward fully integrated managed care.

Project Plan Submission

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

Potential risks for not being able to submit a successful project plan include:

- Disregarding or misunderstanding the business models and interests of MCOs, hospitals, clinics, providers (behavioral health, social service, and clinicians) or the needs of the community
- Building improper agency structure, visioning, goals, or planning and sustainability processes
- Conflicts of interest
- Misalignment with regional and statewide goals
- Failing to navigate the political landscape

Mitigation strategies include:

- PCACH engages MCOs, hospitals, and clinical and social service providers at all levels of our work to ensure we address concerns throughout planning; and to ensure we understand the various business models (and pain points). We also engage the community to understand the needs and expertise of residents.
- PCACH contracts with technical assistance firms KPMG, CORE, Uncommon Solutions, and Foundation for Healthy Generations to ensure adequate capacity and that PCACH’s vision, mission, and goals align with the values of our community, with the Medicaid Transformation Demonstration, and with DSRIP lessons learned in other states; to ensure we capture all possible infrastructure investments; and that we adequately address sustainability of the ACH work.
- PCACH will create independent governance and oversight of the funds flow and investment strategy of the agency by establishing a Waiver and Investment Committee, made up of Board members and disinterested non-Board community members. PCACH will also observe and enforce the Conflict of Interest Policy.
- PCACH cross collaborates with other ACHs to ensure our approach is consistent with statewide goals and aligns with broader regional concerns.

<ul style="list-style-type: none"> ▪ PCACH meets one-on-one with multisector community members and agencies to ensure we hear their voice in real-time and address concerns. We take individual input and bring it back to the Councils and Board for consensus.
<p>5. Demonstrate how the ACH is identifying partnering providers who cover a significant portion of Medicaid beneficiaries.</p>
<p>PCACH has met with and received information from each of the five MCOs in the region regarding their provider networks and population mix, most notably the number of Medicaid lives served by their providers (Multicare, CHI Franciscan, Seamar, Community Health Centers, Pediatrics Northwest, Northwest Physicians Network, Comprehensive Life Resources, Greater Lakes Mental Health). PCACH’s Executive Director intentionally engaged these particular providers to cross reference and compare information received from the MCOs to ensure we are engaging all providers that serve the Medicaid population. MCO’s and providers are routinely engaged through one-on-one meetings with PCACH leadership and throughout the ACH shared learning structure on all Councils, workgroups and Board of Trustees.</p>
<p>6. What strategies are being considered to obtain commitments from interested partnering providers? What is the timeline for obtaining these commitments?</p>
<p>We have drafted letters of interest/commitment to be used by <i>Collaborative</i> partners. These will be required by the November project plan submission.</p> <p>We have also developed a “regional inventory” interview guide designed to collect critical information to inform project planning, key inputs for pre-planning of funding, and resources critical to project success. PCACH is collecting this information from as many health systems and providers as possible, particularly those interested in participating in behavioral health integration as a “<i>Collaborative</i>”.</p> <p>PCACH will identifying key resources needed across multiple projects and will invest in those resources where there is alignment and maximum potential to impact regional success. <i>Collaboratives</i> may be new or existing collectives that can be scaled up as needed. The opportunity for <i>Collaborative</i> teams is to find an optimal project design and deep penetration through community partnerships that addresses care transformation. The ACH will ensure <i>Collaboratives</i> have the right balance of provider and community-based organizations. Plans will describe strategies and commitments to transforming the two systems of care outlined above and how the Pathways HUB will be used. We believe this process will assist in obtaining commitments from partners.</p>
<p>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.</p>
<p>Using guidance from the Demonstration Toolkit, PCACH bylaws, charters, and rosters establish criteria for ensuring and prioritizing engagement with providers from a broad spectrum or sectors. Sector/member representation guidelines are used by the various Councils to ensure parity and inclusion of providers critical to improving how care is paid for and delivered. Chairs of the Board of Trustees, Councils, and workgroups, together with the Executive Director and staff assigned to support Councils and workgroups, are accountable to ensure adherence to the bylaws and charters of the agency, which are reviewed annually.</p> <p>The process for identifying and prioritizing engagement with a broad spectrum of care and related social service providers includes the following:</p> <ul style="list-style-type: none"> • Board of Trustees: PCACH leadership and Board of Trustees cultivate and maintain sector representation of partnering provider and social service agencies according to the sector representation section of the agency’s bylaws.

- Shared Learning Structure/Councils: The Provider Integration Panel, Regional Health Improvement Plan Council, Community Voice Council, Data and Learning Team, Opioid and Care Coordination Workgroups cultivate and maintain representation from a broad spectrum of partnering provider and social service agencies, community members, and Medicaid beneficiaries according to the membership representation sections of each group’s charter.
- Collaboratives: Following are questions contained in the Collaborative Project Plan Template that ensure a broad spectrum of partnering provider and social service agencies have been considered:
 - How does this Collaborative create clinical-community linkages between health care delivery, public health, and community-based activities to promote healthy behavior?
 - How do these partnerships among clinical, community, and public health organizations fill gaps in needed services?

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.

PCACH is taking the following approaches to project sustainability.

- Maintaining critical ACH infrastructure and functions:
 - Convening multi-sector partners and community members to create shared learning
 - Maintaining a neutral entity and governance structure
 - Providing data analytics connected to outcomes and payment
 - Identifying and addressing policy and systems barriers and opportunities
 - Sustaining a community care coordination system for the region. Contracts with Medicaid and commercial payors are currently under development to ensure sustainability for the Pathways Hub.
- Capturing efficiencies and savings in the health care system to sustain successful projects and invest in “upstream” work that impacts the root causes of disease and illness. PCACH has created the following mechanisms to ensure continued investment in these areas:
 - **Community Resiliency Fund:** PCACH will create a pool of money based on Demonstration earnings and efficiencies created across the systems of care.
 - **Waiver and Investment Committee:** This committee of the Board of Trustees is made up of a majority of disinterested community members. Its purpose is to provide oversight and recommendations regarding Waiver funds flow and to manage the Community Resiliency Fund.
 - **Additional funding:** PCACH will seek additional funds to sustain these structures and functions including; community benefit funds, philanthropic dollars, and other public and private sources.
- Assessing partnering providers during project plan development to identify existing community resources and assets that will sustain successful projects.
 - **Demonstration Interest Discussion Guide** asks potential provider partners about in-kind investments they will make (i.e. data, clinical, financial, community, program management, strategic development, etc.)
 - **Collaborative Project Plan Template** asks Collaborative partners to describe how their **Collaborative** will be sustainable after DSRIP funding ends and if there will be a positive return-on-investment (and to whom) within three to five years. This can be stated in

terms of a potential downward effect on healthcare utilization for Medicaid clients. Successful project plans will include strong sustainability and return on investment strategies.

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	
None	
Clinical Capacity	
None	
Data and Analytic Capacity	
None	
Transformation Project Planning	
None	