Phase II Certification Submission Template

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.

Aligning with the Healthier Washington priorities, Southwest Washington ACH (SWACH) convenes partners to create sustainable, equitable, and innovative care that continuously improves the overall health and well-being of the communities we serve, striving to create and maintain the healthiest region in the state.

By convening and supporting regional, multi-sector, collaborative partners focused on whole person care, addressing the social determinants of health, and rewarding quality and value, SWACH will improve outcomes, lower costs, and improve the health of the population across the region. SWACH will evolve into a regional asset, providing long-term coordination and alignment focused on achieving the Quadruple Aim post-Demonstration.

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

Our regional discussions and assessments show the SWACH region struggles with many of the same issues low-income communities and Medicaid beneficiaries experience throughout the state and nation, including:

- Inadequate primary care and behavioral health care access;
- Poor outcomes for chronic disease management;
- High rate of emergency department use for non-emergency care;
- High rate of hospital readmissions;
- High rate of opioid related health, substance use, and criminal justice issues, and
- High rate of teen pregnancy.

Urban communities are adjusting to the economic consequences of a growing economy and gentrification, including shortages in affordable housing and resultant homelessness. Our more rural

communities struggle with a number of social determinant factors, most notably the lack of living wage employment opportunities.

RHNI data reveal that vulnerable communities across our region are challenged to meet the basic needs of daily life. Historical trends suggest social risk factors, such as health inequities & disparities, inter-generational poverty, and immigration status could contribute to poor health, low educational attainment, and recidivism[1]. SWACH partners have prioritized addressing these broader risk factors as a means to improving the health outcomes of the population.

Approximately 20% of what affects a person's overall health is directly related to the delivery of health care. SWACH will align regional resources to focus on transforming the health care delivery system along with the social support system to better address the more prevalent issues affecting the health and well-being of our population.

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

SWACH's overall strategy focuses on transforming three systems which affect a large percentage of the population currently experiencing the most profound health inequities and disparities in the region: health care delivery, community social services, and jails and emergency services.

By building upon its progress integrating physical and behavioral health care across the region, and developing a community care coordination system, SWACH will create a collaborative framework to address the region's needs and priorities. SWACH will bring regional health care system partners, along with a broad array of other partners and stakeholders, together to form Demonstration Collaboratives. These multi-sector Demonstration Collaboratives (DCs) will use regional data to design specific interventions to address access to care, chronic disease management, opioid use and its impact, care transitions, and diversion to the best care setting. SWACH will provide infrastructure, services, and resources to support these DCs and will ensure alignment and focus on addressing the social determinants of health, whole person care, and value-based payment across the work of the DCs. To date, there are not agreed-upon, prioritized strategies. More critical at this juncture is to create the right approach to take us to actionable strategies that have multi-sector buy-in and are clearly connected to output, outcome, and impact measures.

This transformed approach will ensure people receive the best care in the most appropriate setting, from an individual, organizational, and population health perspective, and will provide the mechanism to achieve improved outcomes across the region. By transforming systems, we believe the improved outcomes our approach will demonstrate will be valuable to providers and payers across the spectrum, not just those within the Medicaid system, ensuring the sustainability of the transformed systems.

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

[1] https://aspe.hhs.gov/system/files/pdf/201476/MedicaidJustice.pdf

SWACH is utilizing a network of workgroups that are inextricably connected to citizens and providers on the ground to inform the selection of Demonstration projects.

The Data and Learning Team (DLT) supports the work of SWACH by providing analysis and context for the regional data, highlighting the regional needs. The DLT membership is comprised of representatives from MCOs, physicians, behavioral health, hospitals, education, criminal justice, crisis, housing, and public health.

Our Consumer Engagement strategy supplements the DLT analysis with community-identified needs and priorities directly from those affected by these issues. Our Healthy Living Collaborative (HLC) Community Health Advocates and Peer Support (CHAPS) network, on the ground, and working within our most vulnerable and marginalized communities across SW Washington, ascertain the issues as seen through the eyes of those experiencing them. CHAPS then share learnings back to SWACH to provide authentic, lived experience which enriches the statistical data.

SWACH workgroup members add their subject matter expertise and experiences in their specific communities. Workgroup members also add insights regarding workforce availability, HIT/HIE functionality, and value-based care and payment considerations to deepen the understanding of how projects will address regional needs and priorities.

Workgroup recommendations are passed to the Regional Health Improvement Plan (RHIP) Council for project selection approval. Aggregating and aligning insights from data, the community, and partner subject matter experts will ensure the projects selected directly address the needs and priorities of the region.

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.

Our workgroups have been conducting extensive environmental scans which form the basis of our active resources inventory. This inventory catalogs the initiatives, projects, and work currently underway in the region.

The inventory, coupled with data about the providers serving the Medicaid population, provides the starting point from which DCs will be formed to design and implement specific projects under the Demonstration. SWACH will convene regional partners, stakeholders, and Tribes to provide an opportunity for each interested participant to understand its strengths and weaknesses, and share its areas of expertise with other regional partners to ensure we are capitalizing on community resources and investments currently available, and connecting these resources and investments to new opportunities to address regional needs and priorities.

This approach will allow for DCs to take advantage of current working relationships and initiatives, as well as include additional partners and services to implement project plans.

SWACH will support the DCs by providing services and shared learning opportunities across DCs to ensure efforts are aligned to address regional needs and priorities, and best practices are shared and built upon.

SWACH staff will maintain updated resource inventories throughout the Demonstration to ensure effective, feasible, and sustainable transformations that are aligned with initiatives and investments present in the region.

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

Whole person health requires the integration of physical and behavioral health coupled with a system to coordinate clinical and community-based care and supports. Successful implementation of these initiatives will provide new ways to manage chronic disease, transition care, divert care from inappropriate settings, and reduce opioid related events. We intend for investments supporting integration and our community-based care coordination system to be reused across all our projects.

As we invest in health information technology (HIT) to support integration, and link the Pathways Hub to the HIT system, we envision these investments supporting all strategy work under the Demonstration. Likewise, we see investments in workforce development, especially community health workers, supporting a wide swath of providers and community organizations across projects. We also intend for our investments in evaluation of our work to provide valuable data which will be used in numerous ways across all projects and across the elements of Domain 1 of the Demonstration.

The DCs will share learnings allowing the region to identify best practices which will allow them to be standardized and reused across the region.

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.

Early SIM grant work and early adopter participation highlighted weaknesses in the ACH governance structure. By mid-2016, it was apparent the governance structure was creating organizational dysfunction, prompting the Board to create a committee charged with developing a more effective governance model. The committee focused on a model that would provide for representation of the varied partners, stakeholders, and Tribes, while affording appropriate fiduciary oversight for the ACH. The new model was adopted by the Board in November, 2016, at which time it also agreed to terminate all members, dissolve the governance structure in place, and conduct an open application process for appointing members to the new governance bodies.

Each member of the new Board of Trustees serves in his or her individual capacity with a fiduciary duty to the ACH. The Board's decisions will support and sustain our work pursuant to the Demonstration project, as well as the work and health of the organization as a Washington state nonprofit, 501 (c) 3 corporation, beyond the 5-year Demonstration project timeline. While the composition of the Board does meet the STCs requirements, members do not officially represent an employer, organization, or sector.

Cognizant of the need to have sector and organizational representation as part of the Demonstration, and as part of the ACH's role as a convener, the new governance model provided for a 25+ member Regional Health Improvement Plan (RHIP) Council comprised of the organizations and sectors with the greatest connection to the region and impact on the ACH meeting its mission and goals. As such,

these Council members are expected to represent the views and positions of the stakeholders, partners, and Tribes they represent. SWACH expects that Council members will be proactive and consistent in reaching out to their sector for dialogue and feedback. As an early adopter, the MCOs and behavioral health providers serving Medicaid beneficiaries have been identified and contracted, and these sectors are well-represented on the RHIP Council.

For example, our RHIP Council has our two primary MCOs represented, and we invite the other three to attend RHIP Council meetings and allow participation from these representatives. Our Board has two hospitals represented, and the RHIP Council has four hospitals represented. We have physical and behavioral health providers on the Board and the RHIP Council, as well as a workgroup dedicated to Clinical Integration, open to members from every provider group serving Medicaid in the region.

Both leadership and staff participate in various statewide groups which represent sector positions, ensuring a wider array of representatives are appraised of the direction and progress of SWACH.

To date, we have not identified conflict among sector partners; however, we will consider adopting a Sector Representation Policy should this change in the future.

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)

Through targeted outreach, we have added members to our Board, RHIP Council, and Workgroups to increase geographic (Skamania and Klickitat representation), sector (philanthropy), and skill set (finance) representation.

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.

Our governance structure was specifically designed to mitigate conflict of interest concerns. Periodic review of SWACH bylaws, conflict of interest (COI) policy, and contracts are conducted to ensure organization-wide policies, remuneration, and benefits are appropriate and conform to the COI policy. Board members and CEO sign annual disclosure forms stating they have received, read, understand, and agreed to comply with the COI policy and asked to disclose any known conflicts of interest.

Board members serve in their individual capacities, not as representatives of employers, organizations, or sectors, negating a conflict of interest based solely upon the members' affiliations. If any Board member believes another member has a conflict of interest, it is his or her duty to raise the perceived conflict so it can be addressed pursuant to the COI policy.

The members of the RHIP Council and Workgroups are representing the interests of the employer, organization, or constituency they represent. The intent is for their view to be articulated through the lens of their organization's willingness to commit and be held accountable. The RHIP Council is intended to bring partners, stakeholders, Tribes, and the community together to find consensus on needs, priorities, and approach.

Staffing and Capacities

4. Provide a summary of staff positions that have been hired or will be hired, including current recruitment plans and anticipated timelines.

Hired:

CEO – entrepreneurial leader steeped in health care delivery, payment, and reform; skilled in working with a board to succeed as a change agent; experience leading an organization charged with transforming regional health care delivery and building a sustainable organization for the future.

CFO – experienced financial leader able to develop strong financial policies and procedures; track and account for revenue from multiple sources, including federal, state, and local government, as well as private and grant funding; experience working with a Board of organizations with complex finances.

VP Clinical Integration – clinician able to form relationships and build trust with the provider community; informed of regional needs and priorities; understanding of history and current state of integration in the region; strong track record of assisting providers in transformation activities.

VP Community Care Coordination – clinician experienced with the social services sector of SW Washington; able to form relationships and build trust with the provider and social services sectors; informed of regional needs and priorities;

VP Partnerships, Policy, and Equity – coalition builder experienced in developing cross-sector partnerships to address regional needs and priorities; experience advocating for public policy to improve systems; strong commitment to equity and social justice; ability to work with the community to ensure authentic community voice.

VP Prevention and Program Alignment – experienced health care delivery system leader with knowledge of regional needs and priorities; strong commitment to equity and serving underserved populations; ability to work with large, cross-sector coalitions to address the opioid crisis; ensure work across the ACH is aligned and meeting Demonstration timelines and requirements.

Consumer Engagement Coordinator – experienced community advocate able to build rapport and trust with communities within the SWACH region; skilled at working with community health advocates; commitment to serving vulnerable and underserved populations; committed to ensuring authentic community voice in the work of the ACH.

Currently Recruiting:

Administrative Coordinator – administrative support across organization.

SWACH utilizes contracted partners for data and analytics, strategy and facilitation, communications, tribal engagement, and financial modeling.

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.

Our Phase I application indicated the SWACH Board of Trustees had adopted the Model Tribal Communication and Collaboration policy, but had not yet began implementing the requirements of the policy, but was relying upon Board member, Steve Kutz, Director of Health and Human Services of the Cowlitz Nation as our primary Tribal representative and connection point.

Since Phase 1, HCA shared with the SWACH its intention to conduct a Tribal Workshop to educate and guide SWACH leadership and staff regarding appropriate communication and collaboration with Tribes. We expect this meeting to occur in Early September. In addition to the HCA workshop, we have arranged for a follow-up training for our Board, RHIP Council, and workgroup members to address matters specific to the Tribal nations in the SW region.

ACH staff has been recruiting Cowlitz Tribal representation for governance bodies and workgroups to supplement the support Steve Kutz has been providing. We have also contracted with a Tribal consultant to provide SWACH assistance with making deeper connections within the Cowlitz Nation's health and community support systems, connect us with Tribal leadership within the Yakama Nation, and implementing the Model Tribal Communication and Collaboration policy.

At the request of SWACH, the Klickitat County Commission sent a letter to the Yakama Nation sharing that Klickitat would be working with SWACH for the Demonstration, and requesting an opportunity to introduce SWACH to the Yakama Nation. We are preparing a letter to be sent to the designated Tribal Council Representative for Health and Human Services of the Yakama Nation. We will ask HCA to review the letter, and upon approval, we will ask Steve Kutz to assist with delivery.

Our tribal consultant will be assisting SWACH to deepen our connection to the Yakama Nation and we will ensure we can meet the needs of the Yakama Nation with respect to participation on the Board, RHIP Council, and workgroups as appropriate and preferred.

Other SWACH Tribal engagement efforts:

- SWACH VP of Clinical Integration has engaged the Deputy Director of Health and Human Services for the Cowlitz Nation

- SWACH VP of Community Care Coordination has engaged the Health Director of the Cowlitz Nation

We are identifying opportunities for the ACH to support and assist the Cowlitz Nation with integration and community-based care coordination.

Next steps and opportunities to deepen communication and collaboration:

- Tribal workshops and trainings for staff, Board, RHIP Council, and workgroup members
- Continued outreach to include Tribal representation on governance committees and workgroups
- Ensure implementation of Pathways HUB is coordinated with, and complementary to, efforts currently implemented in Tribal communities, and designed to meet the needs of Tribal members.
- Work with the Northwest Portland Area Indian Health Board (NPAIHB) to align and complement data specific to Tribal health needs and disparities

We understand Tribal communities struggle with capacity issues and we intend to go to Tribal communities, and to support their engagement and involvement to the greatest extent desired.

2. If applicable, describe any opportunities for improvement that have been identified regarding the Model ACH Tribal Collaboration and Communication Policy and how the ACH intends to address these opportunities.
(Enter "not applicable" if no changes)

Not applicable

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

The SWACH Board is very fortunate to have the guidance of one of its own members, Steve Kutz of the Cowlitz Nation. Steve has helped to shape the mission and vision of the ACH, and the goals for the organization with respect to the Demonstration project. Steve has also been able to provide context for data on the Tribal population.

Specifically, it has been noted that members of the Cowlitz Nation struggle with transportation to Clark County for services given the lack of available public transportation. This has been noted for the Community Care Coordination Workgroup.

Additionally, data reflects work with chronic disease management would improve outcomes in this population. Our workgroups will look for specific steps to improve the chronic disease management protocols for Tribal members. Also, through our work with the Healthy Living Collaborative (HLC) we have identified that the Tribe recently lost a diabetes prevention program, and SWACH has noted this for the RHIP Council.

Board Training

4. Demonstrate the steps the ACH has taken since Phase I Certification to ensure the ACH decision-making body receives ongoing training on the Indian health care delivery system, with

a focus on the local ITUs and on the needs of both tribal and urban Indian populations. Identify at least one goal in providing ongoing training in the next six months, the steps the ACH is taking to achieve this goal and the timing of these steps.

Steps taken since Phase 1:

- Requested HCA training for leadership and staff for September
- Contracted with a Tribal subject matter expert to provide training specific to the Cowlitz and Yakama Nations
- Requested assistance from the NPAIHB to ensure appropriate training on urban Indian population needs and how they can differ from Tribal Nation population needs

SWACH has a goal of ensuring we are addressing the needs of urban Indian populations as well as Tribal Nation populations. Over the next six months, SWACH will take the following steps towards achieving this goal:

- Schedule Training with NPAIHB to understand the differences between urban Indian and Tribal Nation populations for Fall 2017
- Compare data on urban Indian and Tribal Nation populations
- Share analysis of data with workgroups
- Meet with members of urban Indian and Tribal Nation populations
- Continue implementation of the Tribal Model Communications and Collaboration Policy
- Ensure diverging needs are noted and addressed in Project Plan Portfolio

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.**

Design funds have allowed SWACH to address the lack of bandwidth and capacity identified in Phase 1 by implementing the following strategies:

Strategies/Processes	Rationale	Timeline/Accountability
Transition Healthy Living Collaborative of SW Washington (HLC) to a program under the SWACH umbrella	SWACH will benefit from the work of the trusted Community Health Advocates and Peer Support (CHAPS) network within these communities and will expand upon the success of the HLC.	Underway SWACH staff is working with HLC staff to ensure a full transition is complete by October 1, 2017

Strategies/Processes	Rationale	Timeline/Accountability
Community Engagement Coordinator (CEC) hired	Ensure robust and culturally appropriate outreach is continuously occurring; ensure community member input is brought back to SWACH for incorporation into project selection and design	Ongoing CEC shares learnings from community engagement with SWACH staff at weekly update meetings and shares ACH updates back to the community
We go ***to*** communities rather than expect community members to come to large stakeholder meetings to ensure authentic relationship with the communities we serve	We best serve vulnerable communities if we work together; our work must be done ***with*** communities, not to or for them.	Ongoing CEC builds trust by attending community meetings, providing information and education on SWACH and the opportunity to participate, and solicit feedback on the challenges and barriers faced by Medicaid beneficiaries
Website/Listserv	Allows SWACH to share information widely and provide a one-stop catalog for past meeting agendas, and minutes.	Ongoing Communications team and web master responsible for working with SWACH staff to keep website and listserv current and operational

Quantitative and qualitative indicators define successful engagement. Some quantitative indicators are how many people we reached, how many communities we touched, and how many follow-up requests for engagement we received. A qualitative indicator is when community members help identify an issue affecting their community and we engage community members in being a part of designing the solution.

We have identified additional barriers to address:

- Klickitat County's late attribution to the region for the Demonstration
- Gaps in engagement with specific geographic and cultural populations

SWACH's approach to these barriers:

Strategies/Processes	Rationale	Timeline
Build and nurture partnerships with Klickitat County community-based organizations	SWACH will be more successful engaging with community members if we are introduced by trusted community partners	Underway SWACH staff has visited Klickitat County numerous times. Events planned for Fall, 2017
Build and nurture partnerships with rural communities	Rural communities experience different issues than their urban counterparts and SWACH needs input and feedback from rural community members to appropriately select and design projects.	Ongoing SWACH staff will continue to build relationships and trust
Work with CHAPS and to connect with culturally specific communities	Developing the trusted relationships necessary to allow for honest, candid input can be difficult. SWACH works with individuals trusted in these communities to help us receive deeper, richer, input from community members who do not attend other meetings and focus groups.	Ongoing CEC works with contacts to build relationships and identify communities where deep engagement has not occurred.

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

Indicators of successful engagement:

- Participated in six community engagement efforts reaching nearly 200 people
- Strengthened and expanded communication strategies and tools
- Improved leadership, staff, and community communication skills allowing us to share complex information to diverse audiences

These activities have resulted in:

- Positive feedback from participants in community engagement efforts
- Interest and excitement from community members eager to learn about the Demonstration and to engage with SWACH

- Several community groups comprised of sector partners and Medicaid beneficiaries requesting regular updates at their meetings and opportunities for input in the Demonstration planning process

As part of our community engagement efforts we have made substantial progress on completing our environmental scan for the Pathways project. The environmental scan includes identifying community-based organizations that currently employ care coordination, a list of places the target population receives services, and current gaps in services. This scan is verified and supplemented by input from community members through CHAPs outreach.

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?

SWACH's strongest strategy is going into the communities we serve to speak with Medicaid beneficiaries to ensure we receive honest and candid feedback, from a variety of beneficiaries, in a variety of neighborhoods, with a feedback loop through our Data and Learning Team.

Community member input has influenced the project selection process thus far by:

- Highlighting primary care access as a challenge; SWACH uses impact to primary care access as a decision criterion
- Highlighting how lack of public transportation in rural areas makes it difficult for community members to travel to appointments and how a community-based care coordination system would be a way to address this challenge

SWACH will incorporate community member input through the following:

Mechanism	Rationale
Open Board meetings (open Webinar line) with opportunities for public comment	Allowing for public comment at the beginning and end of a meeting, in person or via Webinar, enables the public to offer input during the meeting
Open RHIP Council meetings with Webinar line and opportunity to participate in the meeting discussions and breakout sessions	Including all insights and points of view in the selection and design process will deepen our understanding and enrich the result
Engagement of community members in the communities we serve	Through attendance at events and gatherings already occurring, by invitation of trusted community members, we will obtain candid, honest, and accurate input. Many Medicaid beneficiaries do not have time and capacity to attend additional meetings.

Mechanism	Rationale
Work with CHAPS and other trusted members of specific communities	To ensure authentic community input, SWACH works with those who are trusted leaders in their communities to lead discussion on important community issues. Medicaid beneficiaries are more likely to provide candid input to a friend, family member, or trusted neighbor than to a group at a public event.
Behavioral Health Advisory Board (BHAB)	50% of members have lived experience with behavioral health issues. A number are, or have close family members who are, Medicaid beneficiaries.

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.

Phase 1 design funds have enabled SWACH to address our lack of bandwidth and capacity. We've hired staff and convened workgroups. Workgroups completed environmental scans of the activities, provider organizations (clinical and community-based), and impact of current work across the region. These scans identify the partners crucial to effective Demonstration Collaboratives (DCs). We will focus on including providers serving Medicaid beneficiaries to transform the health care delivery, community services, and jail and emergency services systems.

While we continue to work through governance structures such as our Council, workgroups, and community engagement sessions, we realize participants are sometimes hesitant to offer criticism or complaints in an open forum. We therefore also conduct individual meetings and discussions to ensure we are learning of all the concerns and issues on the minds of providers. We intend to hold provider match sessions this fall to assist providers in understanding their strengths and weaknesses, and to help identify effective and efficient provider partnerships to implement the Demonstration project plan portfolio.

One challenge we face is the difficulty in communicating across many sectors, with a variety of organizations of varying maturity and capabilities. To address this challenge, we have designed various communication strategies to attempt to reach these groups. Our web site, newsletter, meetings – group and individual – all provide opportunities to keep our providers informed, aligned, and engaged. We also rely upon those organizations involved in efforts throughout the region to be a messenger for us. We have been fortunate to have partners such as Clark County Public Health

Advisory Board, Clark County Medical Association, and others share information with their constituencies on our behalf. We circle back to these organizations to ensure we are also using their learnings to inform our work.

While this will be an ongoing responsibility of the ACH, we believe we have successfully engaged those providers who serve the lion's share of the Medicaid population.

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

SWACH's success with partnering provider engagement is evident from the rosters of our workgroups. Among our engaged partners we count the Council for the Homeless, the Housing Authority for Clark as well as Skamania and Klickitat Counties, Clark County Sheriff's Office, Community Voices are Born, ESD 112, Vancouver School District Family Resource Centers, and the Dental Foundation, all actively engaged in serving the Medicaid population. These organizations are examples of the many partnering providers SWACH has brought to this work and who will further partner with our clinical providers in our DCs to implement projects to under the Demonstration.

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.)***

Our governance structure is the main vehicle to receive partnering provider input. Additionally, staff meet one-on-one with providers to ensure candor and input. Partnering providers serving the lion's share of the Medicaid population are engaged and represented on at least one governance group. Board and RHIP Council meetings are open to the public and public comment (Board) or participation (RHIP) is encouraged. A public call for partnering providers will be made prior to the match sessions to form DCs.

The clearest example of partnering provider input informing the project selection process is the RHIP Council's recommendation, and Board's adoption, to undertake the Community-based Care Coordination project and to utilize the Pathways HUB as specified by the toolkit. SWACH held community information sessions to learn about Pathways. The RHIP Council reviewed the information about Pathways, as well as the need for a better way to approach community-based care coordination expressed by partnering providers, and unanimously voted to undertake this project.

Partnering provider input will continue to be incorporated in the ongoing process and will be very important in evaluating whether some projects will be able to meet the scale and sustain requirements specified in the project toolkit.

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)?

Board meetings are held from 9 – 12 the third Thursday of each month in an open setting, open to the public. Meetings dates are posted on the SWACH calendar on our website with an agenda and supporting materials posted at least 72-hours before the meeting. All meetings are conducted using webinar technology with a phone in option. Public comment periods are at the beginning and end of each meeting, pursuant to the SWACH Open Meeting Policy.

RHIP Council Meetings are also open to the public. Meetings are held from 9 – 12 the third Tuesday of each month at the Clark College CTC Campus. Meeting materials are posted to the website prior to the meeting and webinar and voice options are made available. Additionally, we include non-member participants in the email distribution for meeting notices, materials, and summaries.

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?

See response to question 7.

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

The Board has authorized its Executive Committee (EC) to review and decide matters arising between meetings with tight timelines. It has empowered the Chair to decide when a decision should be referred to the entire board. When the EC acts between meetings, at the next Board meeting, the Chair explains the issue, reason for the use of the EC authority, and the decision on this issue. The decision appears as an agenda item for discussion and appears in the minutes of the Board meeting to ensure transparency.

Should the Chair decide the matter requires a vote of the full Board, the Board has agreed to use phone when necessary to make decisions between board meetings. In the event of a phone meeting, the meeting notice will be posted on our website with as much notice as possible, and a webinar number will be made available. An email to our listserv will be sent noticing the phone meeting.

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

We have developed a comprehensive communication strategy and process, utilizing various methods of communication to meet our diverse stakeholder needs.

- Host in-person group and individual meetings, emails and phone calls
- Present at other groups meetings
- Website
- Link to other sources of information (HCA, other ACHs)
- Newsletter
- Plans include our own informational videos and presentations

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 15, 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 10, 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 design funds have been used to establish the infrastructure necessary for engagement, education, project selection, project design, and certification to prepare for the implementation of the Demonstration. This includes hiring staff, contracting with consultants to provide specific subject matter expertise, building relationships with the community and potential partnering providers, and

reviewing models, current data, potential software, and projects underway in Washington and other states.

Staff and consultants also worked to support the Board of Trustees and Regional Health Improvement Plan (RHIP) Council and their efforts in understanding the scope of the projects and evaluating how the region will engage to manage the Demonstration. Work has been done in the exploration of HIE/HIT options and implementation of the Pathways HUB. These funds were also used to acquire leased office space and for general operating expenses.

2017 Phase 1 Design Fund Spend:

- ACH Administration/Project Management 32%
- Community and Stakeholder Engagement 14%
- Health Systems/Community Capacity Building 14%
- Information Technology 10%
- Project Plan Development 30%

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

Phase II design funds will be used to support the work of the ACH through staff and consultants who will:

- Convene appropriate partners
- Assess readiness of participants
- Evaluate data needed for project plan development
- Coordinate project plan design
- Develop tools and provide technical assistance to support partnering providers
- Engage community members

SW ACH will support partnering providers to:

- Evaluate organizational strengths and weaknesses
- Identify and quantify organizational gaps and needs
- Articulate need for organizational technical assistance, training, and coaching
- Evaluate organizational technology solutions and systems
- Articulate workforce needs

The support will involve cost assessments and evaluations to assist Demonstration Collaboratives (DCs) and SWACH in projecting costs to the Demonstration and to the ACH for project planning.

Project planning will establish milestones, timeframes, and reporting mechanisms.

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.

In addition to the actual and proposed expenditures listed in response to question 2, project design funds investment by category is as follows:

Data:

- Providence CORE to assist with data design, analytics, developing a self-monitoring system, and designing an evaluation program
- Data analyst to work directly with SWACH staff and workgroups
- IT and analytics consulting for DCs
- IT support for SWACH

Clinical

- VP Clinical Integration
- Ruckelshaus Center to assess collaborative capacity
- Clinical Integration Workgroup support
- Clinical provider technical assistance, training, and coaching on integration, care coordination, and value-based payment
- Technology to support integration and other Demonstration projects
- Workforce development and support
- Shared services as they are identified
- Community-based Care Coordination Services
- Financial assistance to allow for project planning

Financial:

- CFO
- Financial Management software
- Consulting for project incentive modeling
- Staff accountant
- Audit preparation

Community and Program Management:

- VP Partnerships, Policy, and Equity
- VP Community Care Coordination
- VP Prevention and Program Alignment
- Community Engagement Coordinator
- Financial assistance DCs and Partnering Providers to allow for project planning
- Convening and attending community meetings
- Merger with Healthy Living Collaborative
- Equity Training
- Tribal Training
- Legal Counsel
- Staff and support for DCs
- Evaluation support for DCs

- Shared learning program

Strategic Development

- CEO
- Consulting
- Convening Partners

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

The SWACH Executive Committee approved the approach for projecting and budgeting for project design funds on August 10, 2017. Upon notification of SWACH's Phase 2 award, the CEO and CFO will prepare a budget for the award amount reflecting expenditures designated by funding sources. The full Board will approve this budget. All funds will be tracked to budget and designated by funding source in the accounting software system. The Finance Committee and the Board review financial statements each month.

Financial policies are in place to maintain accountability and appropriate security for all funds managed by SWACH. These policies require monthly notification to the Board regarding expenditures exceeding budget by $5,000 and Board approval for expenditures exceeding budget by $25,000. SWACH will have its first financial audit for the fiscal year ending June 30, 2017. As part of that audit, all financial policies and procedures will be reviewed and evaluated.

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.)*

Working with two other ACHs, SWACH has engaged KMPG to assist us in developing options for project incentive funds. We will receive Excel-based tools to allow for discussion and modeling with participating partners.

KPMG has also organized information sharing sessions with PPS entities (ACH counterparts) in New York to discuss the DSRIP choices made for their Demonstration and the pros and cons of their early evaluations regarding choices. KPMG has been leading the discussion of the differences and similarities in WA and NY, various methods for distributing those funds, and the impact of each method. The goals of this work are to provide the most effective incentive plan and to target investments in processes and infrastructure that will assist in moving providers to value-based contracts.

Preliminarily, SWACH is proposing a framework which includes set incentive fund percentages, shifted over the life of the Demonstration, to be put into funding categories:

- ACH Indirect
- Community Resiliency Fund
- Infrastructure Capacity Building Fund
- Incentives to DCs

Incentive distribution is inextricably linked to the overall project plan, the RHIP Council will recommend the ultimate model and the Board will vote to accept or reject the RHIP Council's recommendations on project plan portfolio, budget, and incentive distribution model.

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).

SWACH received funds under the SIM project grant that have been used to modify the governance structure and develop the infrastructure of the organization in preparation for the Demonstration. With the integration of The Healthy Living Collaborative (HLC) in the SWACH structure, HLC will contribute funding from several sources which will continue to support work on equity and community strength. While some of these funds are intended for work with a focus on health improvements, they are not specifically focused on the Medicaid population. This work is nicely aligned and offers an opportunity for SWACH to extend the work of the Demonstration to populations beyond the Demonstration.

The HLC is in the fourth year of a 1422 contract with DOH that has components focusing on improving lifestyle and health care delivery. As the HLC works with community health workers and advocates, this work is a natural connection to the Pathways HUB being implemented by SWACH

HLC/SWACH has recently received a grant from the United Way of the Columbia Willamette to ensure an equity lens is developed and used with all ACH and Demonstration work.

7. Describe what investments (e.g., convening space, volunteer positions, etc.) have been made or will be made for the demonstration through in-kind support from decision-making body/community members in the following capacities: data, clinical, financial, community and program management, and strategic development.

Data:

- MCOs time developing data sharing agreements
- Data and Learning Team members' time preparing and attending meetings
- Board, RHIP Council, and workgroup members' time reviewing data and attending meetings
- Clark County Public Health data and expertise

Clinical

- Board, RHIP Council, and workgroup members' time preparing and attending meetings

Financial

- Finance Committee members' time preparing and attending meetings
- Clark County Public Health assistance with grant accounting procedures

Community and Program Management

- Board, RHIP Council, and workgroup members' time preparing and attending meetings
- Convening space and meeting technology (speaker phone, screens, projectors, etc.)
- Office Furniture

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.

SWACH incorporated clinical expertise and leadership in every aspect of the ACH's work by including clinicians at the staff, governance, and workgroup levels.

Our governance structure is designed to capitalize on clinical input. SWACH workgroups make recommendations to the RHIP Council, which is the governance body charged with making project selection recommendations to the Board and incorporating workgroup suggestions into the project plan portfolio for Board approval. The RHIP Council is composed of leaders from across the region representing sectors working with the Medicaid population and has a population-wide perspective on the region.

Each workgroup reached consensus on a strategic, phased approach to first evaluate project opportunities, then collaboratively develop a clinical design and structural framework for each project and provide leadership to craft project design, implementation, and evaluation mechanisms to achieve targeted outcomes, while considering scalability, sustainability, transformational impact, and risk identification.

Clinician support for a community-based care coordination system was a strong factor in the decision to implement Pathways. Clinical expertise was also instrumental in identifying the connections between six of the Demonstration projects and the targeted outcomes.

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

SWACH expects champions to assert themselves as thought leaders at the workgroup level, serve as a positive voice within their own organization, and interact with other providers at events and meetings at the regional, state, and national levels. Provider champions emerged in our workgroups as these bodies developed charters and chose leadership. We allowed this process to occur organically to allow those who have the time, stature, and commitment to fulfill the role to emerge.

As partners form Demonstration Collaboratives (DCs), a formal process for identifying and connecting provider champions across DCs to facilitate shared learning of successes and challenges and to develop best practices for gaining support and acceptance for transformation initiatives will begin. A clinical provider must serve on the Executive Committee of each DC, affording another opportunity

for champions to share their expertise. SWACH will pursue opportunities for our champions to participate in discussions regionally and statewide.

As many provider champions are still actively seeing patients, these provider champions will be a direct link for evaluation of consumer experience at each phase of development and implementation of the Demonstration; their feedback and insight will be captured as part of our evaluation program.

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.

SWACH struggled with engaging clinical provider organizations in the Demonstration prior to the finalization of the waiver in January, 2017. While clinical providers have made strides in integrating behavioral and physical health care, it was difficult to drive engagement in the Demonstration without answers to many of the partner's questions. In an attempt to mitigate the lack of time to develop a true consensus-driven approach to transformation and the Demonstration, we retained the assistance of the Ruckelshaus Center as a first step in assessing whether barriers to consensus existed and how to design outreach and engagement to ensure our clinical partners would participate fully.

Based upon individual interviews with clinical providers across the region, the Ruckelshaus Center has provided the ACH with an overview of the risks to an incredibly short consensus building which informed our clinical provider engagement strategy. Through this process, clinical input from both urban and rural providers was received and used to design the process for project selection and planning currently in use. All workgroups have clinical providers, from varying clinical sectors and licensures as members. The expertise and experience of the clinical providers shape the recommendations these workgroups make to the RHIP Council for incorporation into project selection and planning, and ultimately project plan portfolio completion.

As the SWACH Data and Learning Team identify priority populations, the clinical providers on our workgroups are able to provide the context for the data, and make recommendations for options to address these issues. Most significantly, clinical provider support for a community-based community care coordination system was crucial to SWACH's decision to move forward with the Pathways Hub as the strategy for approaching this Demonstration project.

Clinical provider input directed the SWACH Opioid Task Force to ensure the regional clinical guidelines developed by the Healthy Columbia Willamette Collaborative were a starting point for SWACH work as the providers in the region were already implementing these guidelines.

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.

With the assistance of our data partners, Providence CORE, we have analyzed and used data sets from sources such as the RHNI and hospital Community Needs Reports as indicators of capacity, specifically wait times for non-urgent primary care appointment, emergency department use for non-emergency complaints, and time to appointment for referrals to specialists. This data indicates how long patients are waiting to see primary care and specialists in the region. We supplemented this data with

interviews of those organizations seeing the majority of the Medicaid population. We continue to work with our region's MCOs to understand clinical capacity issues from their perspective as well.

The SW region has a significant shortage of providers serving the Medicaid population, most acute in primary care and specialty care. This shortage has impacted the region's ability to advance clinical integration and has emerged as a primary challenge to be addressed for Demonstration success.

As part of project selection discussions, workgroups have looked at the workforce necessary to complete work on particular Demonstration projects and begun to suggest ways to address these challenges. Some suggestions involve a redesign of how the current workforce is being utilized, including more training of current providers to increase their skills and capacity, as well as the creation of new positions to increase communication and coordination amongst providers and their organizations and patients.

We have also engaged the following agencies to develop strategies to address known clinical capacity issues and issues that will be clearer as we develop specific Demonstration implementation steps.

- Allied Health Center of Excellence
- AIMS Center
- Area Health Education Center for Western Washington
- Washington Association of Community and Migrant Health Centers
- Washington State Board for Community and Technical Colleges
- Workforce SW Washington
- OHSU Department Of Psychiatry Residency Program

Our DCs will ultimately be responsible for identifying their individual workforce needs. Once SWACH understands these specific needs, we will support the DCs in meeting these needs. One of the services SWACH will provide is the regional knowledge base for workforce issues and solutions, and SWACH will be a champion at the state and national levels to drive workforce programs and policies that address the issues identified by our DCs.

In the short-term, the ACH has been working with current regional partners to address the shortage of primary and behavioral health care providers.

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).

SWACH staff and partners attend many local and statewide organizations' events and meetings to ensure the ACH is learning and collaborating with numerous groups and ACHs across Washington, including WSHA, WSMA, WACMHC, WCAAP, WAFP, Foundation for Healthy Generations, the rural health consortium, the SW Behavioral Health Alliance, and the Clark County Medical Society. We have representatives attend the meeting from these groups and invite representatives from these groups to attend ACH meetings and share information and feedback.

Our work with both WSHA and WSMA has provided opportunities to understand where standards are in place at the hospital and provider level, as well as some of the other initiatives being undertaken in the region and how they impact the hospitals and providers in our regions. This will allow for better alignment among participants and for efficiencies in the reuse and reallocation of deliverables across initiatives.

Our work with the SW Behavioral Health Alliance has been invaluable in engaging and communicating with the behavioral health providers in our region.

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.

SWACH has used the following data sources (see Data Attachment for more detail):

- HCA "Starter Set" data
- Healthier Washington Dashboard
- DSHS ACH and Community Risk Profiles
- BRFSS and HYS data
- WA First Steps database
- HCA Medicaid enrollment reports
- HCA provider report
- HCA/RDA measure decomposition
- Clark / Skamania County Jail data
- Community Checkup
- Aggregate data from MCOs and 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 by SWACH leadership, staff and workgroups to explore populations to inform the theory of action; identify health care needs, gaps, and disparities; select projects and estimate

potential project impact; identify priority populations for projects; identify partnering providers and organizations; understand community needs; engage stakeholders; design and plan projects; and assess workforce capacity and gaps.

SWACH's governance structure includes the Data & Learning Team (DLT), which supports data-driven decision-making by reviewing and interpreting available information, identifying data gaps and needs, and making recommendations regarding project and population selection. The DLT reviews and discusses aggregate data and asks clarifying questions to inform recommendations for the RHIP Council and other workgroups. For example, the DLT is exploring available maternal health data from a variety of sources to determine whether pregnant women or high risk pregnancies or pregnant women with specific conditions (including opioid use disorder) are appropriate populations for community-based care coordination.

DLT report outs are shared at RHIP Council and workgroup meetings.

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

SWACH has identified several data and analytic gaps:

- Lack of direct access to source data to answer questions in a timely manner
- Lack of detailed information on potential priority populations: e.g., SWACH has identified pregnant women with substance use disorder, pregnant women with mental health conditions, particularly depression, and high risk pregnancies as potential areas of interest, but does not have access to detailed information about size and characteristics of these populations
- For project selection, SWACH would like to model the community impact of implementing different projects with different populations but we lack both a framework for this model and data to feed into the model

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

- The SWACH DLT provides a forum for partners and stakeholders to collectively identify and address data needs. See questions #2 and 5
- SWACH 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 will contract with CCS to develop and implement a data platform to support community-based care coordination
- SWACH has used publicly available local and national data sources, as well as extrapolated from research as a proxy, to assist with project and population selection
- SWACH is collaborating with Clark County Public Health for additional CHAT analysis beyond what is publicly available (e.g., prenatal care initiation by trimester by age, by language); Clark County Public Health is also establishing data sharing with Klickitat and Skamania Public Health to access their CHAT data on behalf of SWACH requests
- SWACH has submitted data requests to HCA for data on providers and regional performance inclusive of Klickitat County, and has worked collaboratively with other ACHs to identify data request priorities (e.g., PRISM scores, ED utilization, co-occurring conditions)

- SWACH has submitted data requests to HCA for number of Medicaid lives per organization, per provider
- SWACH has begun conversations with both MCOs to receive data to supplement publicly available sources
- SWACH has initiated development of an assessment to allow organizations to provide data for baseline estimations in the absence of state provided baseline data

Data-related Collaborations

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

SWACH works closely with Pierce County 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.

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 will be aligning regional data collection and monitoring efforts, assessment tools, and reporting where possible. They plan to share best practices where one region may be high performing on a measure or project. SWACH and Pierce also have similar data governance structures (the DLT) and have collaborated on content and approaches.

SWACH has been participating in group discussion with all ACH leaders about HIT/HIE and our CEO has been a lead on identifying better tools to access and share data for SWACH and other ACHs. She has been actively involved in commencing a pilot of Pre-manage/EDIE in the SW region to test if Pre-manage is a way to assist providers with HIE efforts to support integration.

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.

SWACH's DLT (see questions #2 and 3) includes representation from public health, behavioral health, MCOs, health systems, and community partners representing multiple sectors. These partners bring sector-specific content expertise to the DLT to assess community needs and review available information to make recommendations re: project and population selection. Additionally, RHIP Council and workgroup members have participated in environmental scans to provide information on existing analytic infrastructure. Clark County Public Health has been a strong partner in sharing and analyzing data as a partner on DLT, the RHIP Council, and workgroups.

DLT members bring data from their own organizations and help make connections with others who may be able to provide data to answer questions and inform planning. For example, the local public health jurisdiction is able to access CHAT data to help identify populations that may not be accessing timely prenatal care (see question 3 above). SWACH has also reached out to county jails for information on their populations. These conversations occur iteratively as questions and needs are identified.

SWACH has begun conversations with both Molina and CHPW regarding data sharing to inform project planning and ongoing monitoring during implementation. We are also exploring the use of

Pre-Manage for a clinical information sharing and will work with the MCOs to design a process for addressing some of the barriers to use for behavioral health providers due to attribution issues.

Once Demonstration Collaboratives (DCs) form, we will require certain reporting from the DCs and from partner members to inform SWACH monitoring of Demonstration initiatives. This will assist the DC in understanding its strengths and weakness as well as assist SWACH in focusing efforts on priority populations.

Provider Data and Analytic Capacity

6. Demonstrate the ACH's engagement process to identify provider data or data system requirements needed to implement demonstration project goals.

The ability to share data is critical to the success of all the Demonstration projects. SWACH has begun to assess the region's HIT/HIE capacity and how that capacity will affect data capture and data exchange. To that end:

- SWACH will 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
- SWACH will field an initial assessment of partnering provider readiness to participate on DCs projects by Fall 2017, which will include questions related to current and planned provider data, data system capacity, HIE capabilities, and needs to implement Demonstration projects.
- SWACH is currently working with Qualis to inventory the EHR systems in use across the region
- SWACH is working with HCA and One Healthport to understand the timeline and functionality of the Clinical Data Repository (CDR) and whether the CDR will provide required functionality to support the Demonstration projects
- SWACH is participating in the All Payer Claims Database Data (APCD) Release Workgroup to ensure ACHs have access to data
- SWACH is identifying the HIE models being used in Oregon by providers also serving the SW ACH region
- SWACH reached out to provider and clinical partners to ensure workgroup members could speak to provider data and data system requirements are included in any discussions around project plans
- SWACH will contract with Dr. Sarah Redding, developer of the Pathways HUB model, and Care Coordination Systems (CCS) to assist in the design and implementation of the Pathways HUB model

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

- SWACH has begun developing a framework for self-monitoring and continuous improvement, including identifying supplemental process and outcome measures for regional incentive structures, processes for data collection, and frequency and granularity of reporting. This is a major component of the work Providence CORE has been contracted to provide

- SWACH partnered with 2 additional ACHs to leverage dollars to cover the costs of the national consultants (CCS, Dr. Redding) to understand the data system requirements and to implement Pathways HUB
- SWACH is assisting the region in developing shared HIE capability and is engaging providers and community-based organizations in discussions on the current systems in play in the region and providers' appetite for a broader move to a regional HIE strategy.
- SWACH is serving as the regional information conduit for how the CDR and APCD could support HIT/HIE needs during the Demonstration and beyond.
- SWACH is conducting the assessment described in question 6 for more details on HIT requirements and barriers

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.

Through the Community Care Coordination workgroup, SWACH has completed an environmental scan to determine Community Health Worker, Community Health Advocate, and Peer workforce capacity to address community-based care coordination needs in the region, especially with respect to implementing Pathways HUB.

Additionally, the following have been engaged to develop strategies to address known clinical capacity issues and issues that will emerge as we develop specific Demonstration implementation priorities:

- Allied Health Center of Excellence
- AIMS Center
- Area Health Education Center for Western Washington
- Washington Association of Community and Migrant Health Centers
- Washington State Board for Community and Technical Colleges
- Workforce SW Washington
- OHSU Dept. Of Psychiatry Residency Program

Our DCs will ultimately be responsible for identifying their individual workforce needs. Once SWACH understands these specific needs, we will support the DCs in meeting these needs. One of the services SWACH will provide is the regional knowledge base for workforce issues and solutions, and SWACH will be a champion at the state and national levels to drive workforce programs and policies that address the issues identified by our DCs.

In the short-term, SWACH has been working with current regional partners to address the shortage of primary and behavioral health care providers.

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.

SWACH has proposed committing to six projects: 2A, 2B, 2C, 2D, 3A, and 3D. 2A and 3A are required projects, and 2B was approved in April, 2017. Projects 2C, 2D, and 3D will be voted upon at our next RHIP Council meeting and subsequently by the Board. This project recommendation stems from the interconnectedness of these projects. Our workgroups and RHIP Council members have found great synergy amongst these projects and believe we will maximize our incentive earnings and Demonstration success by requiring our Demonstration Collaboratives to incorporate all six projects into their transformation efforts.

SWACH will support care delivery transformation, prevention and health promotion, and payment redesign for three interdependent systems of care through multiple Demonstration Collaboratives composed of multi-sector partners and community voices to:

> **Transform clinical care delivery** by supporting a Collaborative of providers across the care continuum to enable physical and behavioral health integration, implementation of chronic care practices, and establishment of prescribing guidelines in the clinic setting;
>
> **Transition and divert** individuals in and out of the Emergency and Jail Systems by supporting these Collaboratives to create or deepen partnerships for community-based prevention, treatment, and support services and;
>
> **Coordinate care** through SWACH by building a community-based care coordination Pathways HUB as a service to all care coordinating partners in our region.

The use of Demonstration Collaboratives, working on the six identified Demonstration projects will enable each project to be a tool in transforming our health care delivery system, our community-based coordination system, and our emergency services and jail systems to ensure Medicaid beneficiaries receive the best care in the most appropriate setting.

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.

SWACH has a close relationship and philosophical alignment with Pierce County ACH and Better Health Together. Leadership holds regular joint meetings to build and align strategy. The

organizations hold shared contracts with Foundations for Healthy Generations, Pathways/CCS, and KPMG and have similar contracts with Uncommon Solutions and Providence CORE. 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. SWACH partners in these ways to create efficiencies of shared learning, resources, and expenses across ACHs.

SWACH 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.

SWACH is also working collaboratively with the other ACHs around opioid interventions and strategies, understanding that shared partners will require standardizations for protocols such as prescribing guidelines.

SWACH has a burgeoning partnership with CPAA around addressing populations in Cowlitz and Wahkiakum Counties as the realities of Medicaid beneficiaries do not adhere to regional borders. We recognize the need for cross-ACH planning to ensure maximum investment of limited project funds and to ensure we are not overburdening shared partnering providers.

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

SWACH has a close working relationship with the contracted MCOs in the region and they have been very engaged in the process to inform project selection and implementation. We meet one-on-one with each MCO leadership team on a regular basis. These discussions are designed to ensure ACH strategy is in general alignment with MCO needs and challenges, especially with respect to value-based payment strategies. MCOs have been instrumental in assisting SWACH in understanding provider capacity, barriers to clinical integration, value-based payment, and HIT/HIE challenges. Recent conversations center on supporting clinical integration across the region and MCO payment methodologies for the Pathways HUB Model and aligning these payment mechanisms with MCO/HCA contracts. Additionally, we are pursuing data use agreements with our contracted MCOs for more robust data sharing.

All five MCOs are engaged with SWACH's various governance committees and workgroups (Board of Trustees, Regional Health Improvement Plan Council, Behavioral Health Advisory Board, Data & Learning Team, Clinical Integration Workgroup, Opioid Task Force, and Care Coordination Workgroup). MCOs not currently seated on the Board or RHIP Council have been invited to participate at RHIP Council meetings and offer comment at Board meetings. SWACH and Molina Healthcare have been meeting regularly to assess clinical integration and to work on solutions to challenges such as workforce issues and lack of HIE functionality in the region.

Project Plan Submission

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

Risk: Timeline for submission

The timeline for submission is extremely short, making it potentially difficult to obtain commitments from partners on the timeline specified by HCA.

Mitigation Strategies:

SWACH has engaged partners at an executive leadership level to continuously align the goals and outcomes across the varied sectors and partners.

SWACH is keeping HCA apprised of our progress and discussing strategies to resolve potential issues in advance of occurrence.

Risk: No baseline data available until December

Many partnering providers are frustrated and concerned that baseline data for the milestones and outcome measures will not be available before December.

Mitigation Strategies:

SWACH is working with CORE and other partners to estimate baseline data to give partners an idea of our current state. We are also looking to other DSRIP States in an attempt to project possible targets for outcome measures.

SWACH continues to work with HCA to explain the issue and look for possible solutions.

Risk: Partners in multiple ACHs will not commit to different ACH strategies

Some partners are active in more than one ACH making it potentially difficult if they are asked to implement competing strategies across their service areas.

Mitigation Strategies:

SWACH is committed to working with all ACHs to determine strategies and investments that work for our partners in multiple ACHs.

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

Working in partnership with our contracted MCOs, partners, and community members, SWACH identified the physical and behavioral health providers serving over 90% of the Medicaid population in the region. We then contacted these organization the CEO and/or VP of Clinical Integration met with the organization leads to discuss the Demonstration, SWACH's mission and vision, and engagement opportunities. Each organization was invited and encouraged to provide representatives for workgroups and/or attend meetings to plan, select, design, and implement Demonstration projects. Priority was given to those partnering providers serving the Medicaid population and those most likely to impact our transformation goals.

In addition to clinical providers, our workgroups have all completed inventories of non-clinical providers in the region and we have reached out to those organizations not previously engaged with the work of SWACH. These workgroup members are very connected to the region and have been instrumental in identifying partners missing from the work. Our CHAPS network has added to our provider inventory and will continue to inform us of community partners currently not engaged with the ACH.

Some specific examples of how we identified partners include asking the Behavioral Health Providers Alliance to help identify and appoint representatives to our workgroups, working with our regional Community Services Organizations to identify community organizations serving the Medicaid population, and partnering with Clark County Public Health for access to their regional resource and asset mapping tool.

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

SWACH recognizes it must identify the key resources required by all Demonstration Collaboratives and invest in those resources to ensure capacity, alignment, maximum potential to impact regional success, and to instill confidence in our partnering providers that we will be supporting them and their efforts throughout the Demonstration.

SWACH intends to provide all potential partnering providers with technical assistance and tools to allow potential partners to assess their strengths, gaps, and needs with respect to working within a Demonstration Collaborative to achieve the project toolkit outcomes and earn incentives.

These tools include:

- Executive Summary of the SWACH Demonstration Collaborative model
- Discussion Guide for organizations to use internally to identify key project elements and personnel within their organization
- Framework for distribution of incentive dollars

SWACH will assist potential partners in forming Demonstration Collaboratives (DCs) representing the broad spectrum of providers necessary to achieve transformation. Once partnering providers understand the commitments required, we plan to ask for Letters of Intent from the partnering providers who will be joining Demonstration Collaboratives, by October 15, 2017. Priority in DC partnerships and incentive payments will be given to providers based upon number of Medicaid lives served and potential for impact on transformation.

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.

SWACH will ensure DCs have the right balance of clinical provider, support services, and community-based organizations to develop a co-created transformation project plan. The collective plan will need to describe a set of strategies and commitments to transforming the systems of care outlined above, and how they intend to utilize the Pathways HUB as a community-based care coordination service. DCs will have the opportunity to find an optimal collaborative project design and deep penetration through community partnerships that address care transformation. SWACH will review DC project plans to ensure the plan meets SWACH's requirements for broad-based provider participation, impact to large numbers of Medicaid lives, and the ability to scale and sustain the transformation upon conclusion of the Demonstration.

Examples of how we have identified a broad spectrum of partnering providers include working with our regional Community Services Organizations to identify community organizations serving the Medicaid population, partnering with Clark County Public Health for access to their regional resource and asset mapping tool, working with 211 to identify community resources, and mining the collective knowledge of our workgroups and Community Health Advocates.

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.

SWACH's framework utilizes DCs to drive the long-term success of the work and projects under the Demonstration by facilitating partners to:

- Work collaboratively to define strategies that capitalize on their collective strengths and capacity
- Redesign payment mechanisms to reward defined outcomes
- Build and nurture relationships and share investments necessary to sustain the new model beyond the Demonstration
- Share learnings and collectively identify next stage evolutions

SWACH's self-monitoring system and rigorous evaluation will:

- Identify areas of savings across the DCs which can then be shared to support work post-Demonstration.
- Identify other funding sources to braid with MCO value-based payments to support new models of care

SWACH is creating a Community Resiliency Fund from earned Demonstration incentive payments to:

- Ensure a funding source to expand Demonstration projects to populations in addition to Medicaid
- Provide capacity to invest in reducing health disparities and inequities
- Address the social determinants of health

SWACH includes the continued role of the ACH in providing the infrastructure to enable shared learning, data analytics and evaluation, governance, and the collective voice to highlight policy and system barriers as part of the post-Demonstration work to be sustained by new payment models, shared savings and braided funding, and aligned community investment. SWACH will also use the revenue stream provided from the Pathways HUB to sustain this regional service post-Demonstration.

Attachment(s) Required

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

Attachments Checklist

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

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

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

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