

Phase I Certification Submission Template

ACH Certification Phase I: Submission Contact	
ACH	Better Health Together
Name	Alison Carl White
Phone Number	509.499.0482
E-mail	Alison@betterhealthtogether.org

Theory of Action and Alignment Strategy

Description

Each ACH is expected to adopt an alignment strategy for health systems transformation that is shared by ACH partners and staff. The goal is to ensure the work occurring within the region (e.g., clinical services, social services and community-based supports) is aligned and complementary, as opposed to the potential of perpetuating silos, creating disparate programs, or investing resources unwisely.

Provide a narrative and/or visual describing the ACH’s regional priorities and how the ACH plans to respond to regional and community priorities, both for the Medicaid population and beyond. Please describe how the ACH will consider health disparities across all populations (including tribal populations), including how the ACH plans to leverage the opportunity of Medicaid Transformation

References: ACH 2016 Survey Results (Individual and Compilation), SIM Contract, Medicaid Transformation STC Section II, STC 30

Instructions

Please ensure that your responses address of the questions identified below. Total narrative word-count range for entire section is 400-800 words.

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

In 2012, the [Empire Health Foundation](#) joined with community health leaders to seize on the opportunity created by the ACA to dramatically reduce health disparities in our region. Conversations around “[Odds Against Tomorrow](#)” exposed alarming health inequities, including a 17-year life expectancy difference between Spokane neighborhoods and that Native Americans suffer more than any other ethnicity with a mortality rate 1.6 higher than Caucasians in Washington due to disparities related to obesity, substance abuse and smoking¹.

Fast forward to 2017 – Better Health Together aligned efforts to develop a regional health transformation Theory of Action (TOA) focused on decreasing health inequities and improving community health. Our momentum and effect continue to expand as we collectively deliver on key community priorities:

- Reducing and retaining uninsured rates to under 5%.
- Supporting Rural Health Coalitions for Adams, Lincoln, Stevens, Ferry and Pend Oreille Counties.
- Launching a Pathways Hub pilot focused on jail transitions in Ferry County, soon to include Spokane County.

We spent the first year and a half hosting community conversations to better understand our communities’ perspective on bright spots and to identify health disparities. These conversations uncovered several key concerns, such as access to care, chronic disease, obesity, Adverse Childhood Experiences, and inadequate access and coordination of community resources.

As our efforts evolved, we came to a shared definition of “good health” with a lens toward creating health equity where people live longer, more productive lives with fewer and less severe illness; take

¹ <https://www.srhd.org/documents/PublicHealthData/HealthInequities-2012.pdf>, p.44/76
Phase I Certification Submission Template (April 14, 2017)

personal responsibility with access to preventative supports; are nurtured and nurture others for emotional, social and psychological well-being; and complete high school and become employed in meaningful work that pays the bills with some left over for savings.

This vision assisted us in developing our Leadership Council and Board approved Health Priorities:

- Dramatically improve whole-person care through the integration of behavioral, physical and oral health systems.
- Expand oral health access.
- Develop strong community systems that link housing, education, transportation, food security and income stability to the health care system
- Dramatically decrease obesity rates across all populations through prevention.
- Scaling community-based care coordination to improve health.

Our TOA blends multi-sector strategies and initiatives to achieve our vision to radically improve the health of the region. The four core pillars of this work align community efforts to:

- Pay for outcomes both in health care and in social determinants of health.
- Create robust linkages between health care and social determinants of health to improve population health, achieve cost savings.
- Expand Equitable Access to Care to ensure culturally appropriate care in the best setting.
- Align community efforts to leverage funding and policy development through the use of Community Strategy Maps.

To test our TOA and satisfy our SIM funded Regional Health Project, we selected the Pathways Model to explore community-based care coordination. Pathways assist at-risk clients in overcoming barriers to their health by connecting them to social and health resources and services through evidenced based process. The Pathways technology platform provides real-time data to identify resource gaps, and monitor the effectiveness of best practice interventions and quality of the agencies and Care Coordinators implementing them.

A fundamental element of Pathways is the ability to braid funding from multiple sources to pay for outcomes. We plan to leverage the Pathfinder Hub to support a data-driven case for alignment of community investments needed to tackle the severe housing shortage, lack of jobs in rural areas, and insufficient transportation in our region. We feel confident in Pathways as a tool for collaboration, alignment, and braided funding to support our vision of better health and reducing health inequities.

Our Demonstration efforts will have a multi-tiered approach. We launched our planning process with an open Letter of Interest for optional project selection, framed as an all-call for community projects to inventory and identify projects with community momentum and interest. We've paired these efforts with targeted conversations with health system partners central to the development of an integrated whole person care system. This is a collaborative community approach to meeting individual mission and financial needs while developing a cohesive regional community health portfolio to improve population health.

BHT continues to look for opportunities beyond the waiver to support our community health vision and has successfully secured funds for other key initiatives from United Way, Health Sciences & Services Authority, Providence, City of Spokane, and Washington Dental Services Foundation. We intend to further align our Health Benefit Exchange contract for Navigator services by connecting the Pathfinder Hub through the Health Insurance Pathway. To address Oral Health Access, we are working with WDSF to support bundled billing for pregnant mothers and diabetics; working with Providence and EHF to support the launch of a Dental Residency Clinic in Spokane. Lastly, EHF has committed \$240,000 in 2017.

Attachments:

Theory of Action Graphic

Governance and Organizational Structure

Description

The ACH is a balanced, community-based table where health care, social, educational, and community entities influence health outcomes and align priorities and actions. To support this, the ACH must clarify roles and responsibilities, adopt bylaws that describe where and how decisions will be made, and describe how the ACH will develop and/or leverage the necessary capacity to carry out this large body of work.

References: ACH Decision-Making Expectations, Medicaid Transformation STC 22 and STC 23, Midpoint Check-Ins for Accountable Communities of Health, DSRIP Planning Protocol

Instructions

Please ensure that your responses address all of the questions identified below. Total narrative word- count range is 800-1,500 words.

ACH Structure

Better Health Together (BHT) has intentionally built a multi-tiered governance structure with distributed decision-making, joint ownership, and mutual accountability that drives innovation and creativity, fostering co-investment that leads to results, not process.

BHT is led by individuals and organizations poised to have the greatest impact on radically improving the health of our region. This structure supports regional stakeholder readiness to adopt an amplified “evidence-based, health in all policies” approach. BHT By-laws and Leadership Council (LC) charter were purposefully constructed to ensure broad multi-sector and cross-organization collaboration and engagement. The BHT Board was established in 2013 when BHT was incorporated, in accordance with adopted bylaws to reflect diverse community leaders and organizations that, if aligned, could dramatically improve the health of the region. We launched our initial health insurance expansion network by creating a LC that provided a forum for representatives from the needed sectors to achieve our audacious goals. The combination of strategic alliances and community engagement strategies safeguards that BHT can focus on the health status and priorities of the whole community and that no single entity, sector, or person dominates the decision-making or activities of the Accountable Community of Health.

behavioral health. Over the past two years, active coalitions have launched in many of our rural counties focusing on the social determinants of health and serving as community activators to improve health. In Stevens County, the Stevens County Commissioners host a quarterly health roundtable designed to support collaboration of health improvement across the county.

In 2017, the BHT board formalized the role of our Health Champions to include a designated Ambassador position for each Rural Health Coalition on the ACH Leadership Council. We are in the process of identifying Ambassadors for each of our regions.

Decision-making

BHT has embraced a dispersed ownership model of decision-making that positions the BHT board as “co-owners and co-investors” in the ACH, not merely a “community based spectator board.” This model has resulted in durable community partnerships that leverage core ACH investments by Health Care Authority and other organizations to create measurable, long-term outcomes.

In 2016, BHT adopted a community driven board recruitment process for four open seats, expanding the size and diversity of the board to 17 members. BHT broadly recruited applicants from our Leadership Council and community partners. Nominees were vetted by Board Governance Committee and approved by the Governing board, and BHT instituted terms limits of three, 3-year terms. BHT will continue to use an open community nomination process for future open seats.

The BHT Board serves as the final decision maker for all ACH related decisions. Decisions on Waiver Projects and Budget are informed by the discussion, activities, and recommendations of the LC, ACH Project Teams, Task Forces, and Health Champions. When decisions are presented to the LC for feedback, we call a voice vote, seeking consensus. If consensus cannot be reached, then a simple majority is used. Starting in 2017, we have allotted time for targeted small group activities to generate discussion and feedback in every LC meeting. BHT Board members are also active members of the Leadership Council, allowing for generative discussion and feedback to occur, and a summary is presented at Board meetings to inform their final decision.

BHT’s mission includes work that spans outside of the ACH, and as is standard practice for non-profits, Board meetings are not public. BHT relies on its three-chamber governance model for transparent communication and engagement between all bodies, and BHT board meeting minutes are made public on BHT’s website once approved. On ACH related agenda items, the Board will host an open comment period once a quarter, immediately before the meeting, beginning June 2017.

Specific to project selection, BHT will host a public community showcase of potential projects on June 14th where we ask the public for feedback and evaluation of proposed projects, and an additional open house style project showcase in August as projects plans are closer to being finalized by work teams.

The BHT Board will refrain from making decisions that contradict a recommendation of the ACH Leadership Council, Project Team or Council without first going back for further consultation. The BHT Board reserves the right to make policy decisions on behalf of the region based on urgency of timing but will communicate decisions to the ACH community.

BHT values a broad set of perspectives to inform our decision-making. We place a high value on local perspective and have formalized a local structure to encourage active participation through our Rural Health Coalitions and other Health Champions forums. Our community engagement structure includes built-in feedback loops between each of the three tiers that make up our ACH. Health Coalition Ambassadors convey information back and forth between Health Champion groups and the Leadership Council, while Board members serve on an attend Leadership Council meetings and receive a summary from BHT staff at each Board Meeting. (*See attached decision-making flowchart*).

Staffing and Capacity

In our commitment to transparent decision making, BHT has actively invested in communications and project staff to ensure accessibility to ACH staff to share concerns, ask questions, or request information. All Board meeting minutes are posted on our [website](#) once board minutes are approved. Once a quarter, beginning in June 2017, the BHT Board will host an open comment period from 12:30-1:30 as an opportunity for community members and organizations to engage with the Board. Present at this meeting will be at least two executive committee members and four BHT board members, plus BHT staff.

The Executive Director has authority to spend dollars as approved in the board adopted budget. Executive Director is accountable to provide monthly financial reports, mid-year adjusted budget projections and quarterly cash flow projections to the finance committee. The Executive Director additionally has operational authority to implement Board policy and strategy decisions.

The Executive Director is evaluated annually on performance. Any concerns about decision or actions outside of board direction will be evaluated as appropriate.

Executive Director

Name	Alison Carl White
Phone Number	509.488.0482
Email	Alison@betterhealthtogether.org
Years in Position	Hired June 2014

Data Capacity, Sharing Agreement and Point Person

Better Health Together has relied on the data information structure and sharing that the Health Care Authority has provided under the SIM grant. BHT intends to contract with Providence CORE to develop further data infrastructure to allow integration of HCA shared data, Pathways Data and other social determinant of health data. We have requested a data sharing agreement with HCA and expect to have guidance on next steps shortly. This is an area of focused development to ensure BHT can provide a proper level of data baselining for our project development and an ongoing system for measurement and tracking to assure successful implementation of the Demonstration projects.

Data Sharing Agreement with HCA?			
YES		NO	<i>In progress</i>

Data Point Person:

Name	Hadley Morrow
Phone Number	509.954.0831
Email	hadley@betterhealthtogether.org

Attachment(s) Required

- A. Visual/chart of the governance structure.
- B. Copy of the ACHs By-laws and Articles of Incorporation.
- C. Other documents that reflect decision-making roles, including level of authority, and communication expectations for the Board, committees and workgroups.
- D. Decision-making flowchart.
- E. Roster of the ACH decision-making body and brief bios for the ACH's executive director, board chair, and executive committee members.
- F. Organizational chart that outlines current and anticipated staff roles to support the ACH.

Tribal Engagement and Collaboration

Description

ACHs are required to adopt either the State’s Model ACH Tribal Collaboration and Communication policy or a policy agreed upon in writing by the ACH and every Indian Health Service, tribally operated, or urban Indian health program (ITU) in the ACH’s region. In addition, ACH governing boards must make reasonable efforts to receive ongoing training on the Indian health care delivery system with a focus on their local ITUs and on the needs of both tribal and urban Indian populations. Provide a narrative of how ITUs in the ACH region have been engaged to-date as an integral and essential partner in the work of improving population health. Describe and demonstrate how the ACH complies or will come into compliance with the Tribal Engagement expectations, including adoption of the Model ACH Tribal Collaboration and Communication Policy or other unanimously agreed-upon written policy.

References: Medicaid Transformation STC 24, Model ACH Tribal Engagement and Collaboration Policy, workshops with American Indian Health Commission

Please ensure that your responses address all of the questions identified below. Total narrative word-count range is 700-1,300 words.

Participation and Representation

Despite a difficult launch, over the past six months the BHT Board and staff determinedly increased our efforts to effectively engage with our tribal partners and have been met with positive response from many.

In August of 2016, BHT Staff and Board members participated in a Native Health learning session sponsored by the American Indian Health Commission at The Native Project. Jessie Dean (HCA) and Vicki Lowe (AIHC) provided an informational session on American Indians / Alaska Natives and Indian Health Services (IHS). Included was a facilitated conversation on how to increase and support collaboration between IHS/Tribal/Urban health facilities and the ACH. IHS/Tribal/Urban health facilities representatives communicated significant barriers to collaboration such as the logistical burden of traveling to Spokane for meetings as well as limited staffing capacity for ACH work. With an increased commitment to tribal representation, BHT noted that it would launch an open nomination process to recruit new board positions in September and specifically invite nominations from the Native community.

The BHT Governance Committee, with support from the BHT Board, prioritized tribal representation by appointing two of four open seats to tribal representatives. BHT accepted open applications and used a community driven process for nominations, and sent announcements of the nomination and application process directly to representatives of each of the Tribes in our region and The Native Project. Nominees were vetted by the Board Governance Committee and approved by the full BHT Board. First the Governance Committee screened for complete applications; unfortunately, one of the three tribal applications was submitted as incomplete and was subsequently screened out (in total 4 applications were submitted incomplete and screened out). The Governance Committee additionally placed a high value on ethnic diversity to ensure that we had increased diversity on the board. The board ranked applicants based on experience, leadership capacity, commitment to health equity, and ability to effectively move the ACH work forward. Jessica Pakootas of the Kalispel Tribe of Indians and Alison Ball of the Confederated Tribes of the Colville Reservation, were the highest ranked applicants and elected through this process. Please note Toni Lodge, CEO of The Native Project, did not apply. The board unanimously approved the slate of new officers and their terms began January 2017.

To further support active engagement, the BHT Board approved Jessica Pakootas and Alison Ball as the Co-Chairs of our ACH Tribal Leaders Partner Council in March 2017. The ACH Tribal Leaders Partner Council will serve as a forum for continued partnership, education, and shared learnings with IHS/Tribal/Urban health facilities as ACH work develops with a specific focus on providing impact analysis on projects and board policy decisions. In April, we hosted a planning session with Jessica and Alison Ball to determine our first few steps, and determined the following:

- There was a desire to level set with HCA about their vision for tribal engagement via local ACHs and through the Tribal Coordinating Entity. BHT agreed to set up a webinar with HCA to discuss, this occurred on April 26 with Jessie Dean, HCA Tribal Liaison.
- We identified the need for a BHT Project Manager to work collectively and individually with each of our tribal partners. This was suggested by our co-chairs. We posted the job position on April 10th and have hired Jenny Slagle, as our ACH Tribal Senior Project Manager. She will begin on May 15th. Jessica participated on behalf of the ACH Tribal Leaders Partner Council in our final interview with Jenny.
- We have set our first full Tribal Leaders Partner Council meeting for May 25th. Alison Ball and Jessica have agreed to reach out via phone to Tawhnee Colvin, Assistant Director for Health and Human Services for the Spokane Tribe of Indians, Toni Lodge of the Native Project and Rebecca Crocker of the Healing Lodge of the Seven Nations to encourage participation. Per the Tribal Collaboration and Communication policy, we intend to meet monthly for the next 5 months to insure direct contact with tribal representatives for feedback on potential BHT board policies.

In addition to direct involvement of the Kalispel and Colville Confederated Tribes on the BHT Board, in March 2017, Executive Director Alison Carl White met with Tawhnee Colvin, Assistant Director for Health and Human Service for the Spokane Tribe of Indians to discuss active engagement with the ACH and Medicaid Waiver projects. Tawhnee has shared that her team was already looking at opportunities to participate in ACH projects and welcomed additional engagement through the Tribal Leaders Partner Council and other work.

Lessons Learned

Where engagement with The Spokane Tribe of Indians, the Kalispel Tribe of Indians, the Colville Confederated Tribes (collectively called the “Tribes”), The Healing Lodge of the Seven Tribes, and The Native Project Urban Indian Health Center has been challenging, continuing conversations have helped us to recognize this is due to a combination of geographic logistics, time demands on tribal leaders, ineffective communication, and unintentional oversight on behalf of BHT.

As we formed our original ACH Leadership Council, there were passive attempts at engagement of The Native Project, Spokane Tribe of Indians, the Kalispel Tribe of Indians, and the Confederated Tribes of the Colville Reservation. We had limited active engagement, but attempts were made, comparable to other partners around the region. We appreciate the faithful engagement of the Kalispel Tribe of Indians consistently through our ACH Leadership Council and the Pend Oreille Health Coalition since the inception of our efforts.

After a tense acknowledgement at the State of Washington Tribal Consultation in May 2016, the BHT staff and board understood the need to actively shift our passive strategy to an intentional and respectful relationship, building effort that appropriately acknowledges the special relationship that tribes have in our region as Sovereign Nations. Since this consultation, BHT has prioritized building powerful and impactful relationships with the IHS/Tribal/Urban health facilities in our area.

Policy Adoption

In April of 2017, the BHT Board approved the Model ACH Tribal Collaboration and Communications Policy (*minutes attached*). The policy was sent to all three Tribes and the Native Project. Representatives from Kalispel and Colville Tribes were satisfied with the policy; Spokane Tribe and The Native Project did not respond to our request for comment.

Board Training

To add support with logistical challenges voiced at the education session, BHT hired Jenny Slagle in May 2017 as our ACH Tribal Senior Project Manager (*job description attached*); she will work collaboratively with the Tribes and Urban Indian Health Programs on ACH related work and help support and coordinate Medicaid Transformation Projects. Jenny is an enrolled member of the Yakama Nation and has worked for the Kalispel Tribe as they opened Northern Quest Resort & Casino. Most recently she served as the Communications Manager for The Native Project. We anticipate this role will greatly increase capacity for collaboration with IHS/Tribal/Urban health facilities. This Tribal Project Manager will travel frequently between the Tribes to be most available for engagement and will work to build relationships that will further open communication, trust, and opportunities for collaboration alongside Tribal communities as we explore Medicaid Transformation.

In future opportunities for continued learning, our May Board meeting will be hosted at The Camas Center for Community Wellness, the wellness center and clinic for the Kalispel Tribe (instead of a regular meeting in Spokane). In the Fall of 2017 we intend to host a Tribal education session for our Board and Leadership Council, similar to the previous session hosted by the American Indian Health Commission at The Native Project in August of 2016. We have reached out to Vicki Lowe (AIHC) and Jessie Dean (HCA) in an attempt to schedule in October or November but have not been successful yet. Also in May, our ACH staff will participate in a Tribal Client Relations Training based off of the [S. Brite, Inc.](#) Client Relations Manual, hosted by Empire Health Foundation.

Attachment(s) Required:

A. Demonstration of adoption of Model ACH Tribal Collaboration and Communication Policy (Board Minutes Attached)

Other Attachments:

B. Letters of Support (optional)

C. Job description for ACH Tribal Program Manager

Community and Stakeholder Engagement

Description

ACHs are regional and align directly with the Medicaid purchasing boundaries. This intentional approach recognizes that health is local and involves aspects of life and community beyond health care services. The input of community members, including Medicaid beneficiaries, is essential to ensure that ACHs consider the perspectives of those who are the ultimate recipients of services and health improvement efforts.

Provide a narrative that outlines how the ACH will be responsive and accountable to the community.

References: Medicaid Transformation STC 22 and 23, Midpoint Check-Ins for Accountable Communities of Health, [NoHLA's](#)

"Washington State's Accountable Communities of Health: Promising Practices for Consumer Engagement in the New Regional Health Collaborative," DSRIP Planning Protocol

Instructions

Please ensure that your responses address all of the questions identified below. Total narrative word-count range is 800-1,500 words.

Meaningful Community Engagement

As a newly formed entity led by new and established community leaders, BHT launched our efforts by hosting community conversations to develop an understanding of community needs, build authentic relationships, and generate new opportunities for collaboration and alignment. These conversations identified a network of 160 partners necessary to transform our health system. The following details our region-wide efforts:

- June-September 2013, hosted 109 individual and regional community conversations focused on promising health practices in each county and identifying highest areas of concerns
- September 2013, hosted first ACH regional convening for Health Champions with 104 cross-sector leaders in attendance
- January 2015, hosted second annual ACH regional convening for Health Champions to launch our community design session work to further develop a set of regional strategy action plans to catalyze action and alignment, with 83 cross-sector leaders in attendance
- February-March 2015, we hosted 6 intensive design sessions by priority area and a session on community network mapping, with 47 cross-sector leaders and program managers in attendance
- From June-September 2016, we hosted intensive community engagement and feedback sessions to develop a regional alignment of Population Health and Social Determinant of Health efforts and priorities. 78 organizations engaged in these sessions, which were compiled into our Community Strategy Maps (*attached*)
- From November 2016 to March 2017 we enlisted the help of the SRHD Data Center to conduct a regional linkage map survey. In total 165 individuals participated representing 95 organizations with 9,063 unique linkages between 565 organizations in the initial survey report
- Since June 2013, we have hosted 8-10 ACH Leadership Council (LC) meetings annually. Our ACH Leadership Council launched with 25 organizations with 53 organizations as of April 2017 and growing.

The most significant barriers to engagement are logistical. Our region is geographically spacious, covering 12,273 square miles. We understand that not every organization and individual can actively participate in meetings in Spokane, generally held during the work day. BHT is committed to traveling to our partners to demonstrate our commitment responsively meet the needs of community members and to fully understand their culture, challenges, and opportunities. Another challenge is the incredibly fast flow of information. The sheer complexity of creating shared knowledge across multiple sectors and partners makes it difficult to keep community members up to speed throughout this process. Wherever possible, we deploy our ACH team to add capacity. In fact, it is a rare day that ACH staff are in the office at all – the team is usually scattered across our 6 counties for meetings and outreach. Additionally, our Project Managers help to staff and coordinate Rural Health Coalition meetings to support local community work and serve as a link back to the regional perspective at the Leadership Council.

Partnering Provider Engagement

In March 2017, our ACH Governing Board (Board) approved an expanded policy formalizing the relationship between the Board, ACH Leadership Council (LC) and Health Champions (HC) to clarify the roles and responsibilities for membership. Beginning in June 2017 the BHT Board will host a quarterly open public comment period where community members can provide feedback directly to the Board from 12:30 pm - 1:30 pm immediately before board meetings in June, September, December, and February.

The Board receives a report on LC Meetings each month from one of our co-chairs, and at least 2-3 board members attend each LC Meeting, building trust and transparency between the two bodies. Each of our project teams, councils and task forces are co-chaired by a Board Member and LC Member to ensure open communication and alignment. Our LC meets monthly and is open to anyone who wants to be engaged. Membership to the LC is by organization and is initiated by signing our Community Commitment form which commits organizations to active participation in our collaborative vision for a healthier community.

Since BHT's inception, we have worked to link community priority areas with identified bright spots and accelerate our ability to move from one-off pilots to a regionally integrated community health system that results in population-level health improvement. This work has been realized through our Health Champions (HC), which are comprised of Rural County Health Coalitions, Community Strategy Teams, and Spokane Coalitions - all of which convene local health conversations on strategy and priorities, and feed local perspective back to the Leadership Council. To support and ensure open lines of communication and information exchange between the Board, LC, and HC, we request that Coalitions nominate a representative to serve on the LC on behalf of the coalition. This person is responsible for reporting updates and bringing back information to their respective coalitions. BHT will convene a quarterly call between all Health Champions to further opportunities for shared learning and alignment. This updated structure was met with only positive feedback when announced at our April 25, 2017, LC and we expect these new internal processes will greatly support meaningful engagement. Our Health Champions Ambassador Conference Call is tentatively scheduled for June 26, 2017, dependent on our partners' schedules. We partner intensively with the NW Rural Health Network (formerly the Critical Access Hospital Network) in this coalition work.

To further an aligned community effort, we utilize the Results Based Accountability model which articulates the ideal state of health in our community and identifies gaps, needed partners, and effective strategies. This model is commonly used for multi-sector collaboration in the region by Priority Spokane, United Way of Spokane County, and Providence Community Benefit. The flexibility of the model to reflect other community efforts accelerated alignment reflected in our Community Strategy maps, which around 75 organizations gave input into.

To support feedback and ability for the community to influence decisions, we will host additional sessions specifically designed for Medicaid Beneficiaries. We will use an “equity lens” to ensure representatives faced with high level of disparities (e.g., Tribal members, immigrants, persons of color, individuals with disabilities, the aged, or those with limited English proficiency, etc.) have the opportunities and support resources they need to be engaged in informing ACH priorities and activities by scheduling work sessions, interviews, and feedback groups during times that Medicaid beneficiaries and other community members are available, especially during “non-traditional” work hours. We will also provide resources to ensure meaningful engagement that includes resources for transportation, childcare, interpreters, accommodations for individuals with disabilities, and stipends for participation.

Transparency and Communications

We acknowledge there is often a gap in knowledge across partners due to the complexities of current health and social determinant systems. A shared understanding is critical for success in radically improving our community health system and, to that end, we host at least once a month open “Drop-In Hours” where community members and partners can walk or call in to talk to BHT staff about the ACH. We generally hold these hours at the end of the day (3pm-6pm) to allow time for folks to come in after their work day. This has been very well received with 23 people participating since we started in March 2017.

Time is one of the most limited resources for leaders working to transform our health system, so to assist in information sharing efforts and continuously ensuring a high degree of transparency, BHT invested heavily in a robust website and communication strategy for easily accessible information. The [Better Health Together](#) website includes meeting schedules for the whole year, as well as notes, documents, and recordings from every Leadership Council meeting. We regularly post synthesized content on our blog in easy to digest formats to make sure there is shared knowledge between our health care and social determinant of health partners. We posted our Designation Application and will post our Certification Application for Phase 1 and 2 as soon as it is submitted. Please see attachments for a comprehensive list of engagement opportunities.

BHT also produces two regular e-newsletters through MailChimp. The first newsletter is for ACH LC Members and has close to 200 subscribers with information about upcoming LC meetings, documents referenced, and notes on identified next steps. The second is a general newsletter list which includes nearly 1,000 voluntary regional and statewide subscribers and includes a quarterly newsletter and note from our Executive Director, links to 6 relevant blog posts with updates, and links to content from HCA. Additionally, we are active Twitter users, and attempt to tweet each meeting or discussions with partners to increase transparency.

As we enter into planning for demonstration projects, there are many more opportunities to engage with ACH work through workgroups and planning teams launching in June 2017. These sessions will seek broad engagement from the critical partners necessary to build a robust delivery system reform strategy. We intend to build on our Regional Health Needs Inventory data, regional priority focus, and our identified strategies from our social determinant and population health community strategy teams.

Attachment(s) Required:

A. Document with links to webpages where the public can access meeting schedules and other engagement opportunities, meeting materials, and contact information.

Budget and Funds Flow

Description

ACHs will oversee decisions on the disbursement of Demonstration incentive funds to partnering providers within the region. This requires a transparent and thoughtful budgeting process. Demonstration funds will be earned based on the objectives and outcomes that the state and CMS have agreed upon. Demonstration funds and funds from other federal sources (e.g., State Innovation Model sub-awards) should be aligned but ACHs cannot duplicate or supplant funding streams.

Provide a description of how Project Design funding will support Project Plan development.

References: Medicaid Transformation STC 31 and STC 35, DSRIP Planning Protocol

Instructions

Please ensure that your responses address all of the questions identified below. Total narrative word-count range is 800-1,500 words.

Project Design Funds

BHT launched our organization in 2013 with a strong infrastructure investment by the Empire Health Foundation and other funders aligned with BHT’s vision for improving community health. This allowed BHT to stretch our SIM grant dollars further in the development of our Accountable Community of Health. We built a strong, nimble staff that will support the continued work of our SIM funded ACH work, allowing Demonstration Project Design dollars to be invested in targeted capacity to achieve our regional health improvement goals and ensure adequate infrastructure. Phase 1 Certification dollars will be utilized in the following ways:

- Investment in Market Mover’s internal capacity for design, planning, and infrastructure activities
- Increase staff project management, allowing for increased support for Transformation design and planning activities
- Incenting our staff team to meet core deliverables, as approved by the Board of Directors, to hold our ACH team accountable in the same way we hold our Transformation partners

It is our intent to direct 95% of our Phase 2 Certification, FIMC Incentives, and Year 1 Design Earned Incentives to the provider community. BHT will take less than 5% in administrative fees from these funds with an intent to build community capacity, not a staff heavy ACH.

Fiscal Integrity

Better Health Together Board of Director’s Finance Committee meets monthly and the Audit Committee meets two times a year. The Finance Committee reviews monthly management reports that include balance sheets, profit and loss by program (class) actual to budget, and quarterly analysis on year to date performance. Additionally, the Finance Committee in partnership with the Executive Director and CFO lead the annual budget process. After review, the Finance Committee submits the monthly financials to the board for approval, generally as a consent agenda item. The full board is engaged in a two-month budgeting process that includes a Board Budget Overview in November and a final presentation for approval in December. The full board approves the annual budget. Please see attached board approved financial policies for Financial Controls and process.

Better Health Together contracts for back office services with the Empire Health Foundation. Empire Health Foundation employs Jill Angelo, Chief Financial Officer for Back Office Services, and Wendy Xue, Accounting Manager. Jill has been a CPA for over 20 years and has a B.A. in Business Management and

Accounting. She has held several executive level positions within the Spokane medical community over the past 14 years including medical clinics, hospitals, and a graduate medical education residency program. Wendy has more than 10 years of accounting experience and has a B.S. in Accounting and a B.A. in Marketing. She has worked as the accounting manager or full-charge accountant for an international travel company and several non-profits.

The Executive Director has spending authority for all approved budget items except for non-budgeted items over \$25,000 where the Executive Director will seek spending authority from the Finance Committee. Regarding staffing, the Executive Director retains hiring authority for all staff; for new positions outside of the budget, the Executive Director will seek approval from the Finance Committee.

Better Health Together back office contracts with the Empire Health Foundation provide all accounting functions. Back office services utilize QuickBooks Premier Nonprofit 2016 as our accounting software and payroll processing. QuickBooks "Class" are used to differentiate both programs and subprogram tracking. For example, BHT ACH Class will be sub-grouped into SIM, Pathways, and Demonstration. Please see sample Class Report in the attachments. The CFO is responsible for overall accounting and reporting, including review of all expenses, disbursements, transactions, and journal entries recorded. The CFO is responsible for reviewing and reporting to the Executive Director and the Executive Director and CFO report to the Board Finance Committee and the Board on financial results versus approved budget. The CFO is responsible for the creation of annual financial statements for audit.

Better Health Together intends to employ sufficient staff to meet community and program management and general financial capacities. We will expand our expertise as we have clarity about the role of the Financial Executor and state requirements for biannual reporting. As previously mentioned, we expect to invest in our community partners and market movers to support clinical and strategic design development to ensure our regional project portfolio reflects regional health needs and priorities and our community health system's mission and financial requirements.

As we move through the design process from May through October, we are prepared for the need to contract with subject matter experts related to models reflected in the toolkit and other strategic needs.

Better Health Together intends to contract with Providence Core to align our Demonstration metrics, BHT community priority metrics, and the Pathways Hub data into a structure. Furthermore, we are exploring robust partnerships with the Washington State Hospital Association for additional data sharing capacities to link Pathways to their EDIE, Pre-Managed, and internal health system reporting software. Finally, we intend to partner with Dr. Patrick Jones of Eastern Washington University to link his Spokane County Community Indicators and rural county work with our RHNI data.

Attachment(s) Required:

- A. High-level budget plan (e.g., chart or excel document) for Project Design funds to accompany narrative required above.

Clinical Capacity and Engagement

Description

The demonstration is based on a Delivery System Reform Incentive Payment (DSRIP) program. As such, there needs to be engagement and input from clinical providers, including but not limited to MDs, RNs, ARNPs, CHWs, SUD providers, and mental health providers such as therapists and counselors.

References: Medicaid Transformation STC 36, DSRIP Planning Protocol

Instructions

Please ensure that your responses address all of the questions identified below. Total narrative word-count range is 500-1,000 words.

As noted in the Community Engagement section, to date BHT has focused conversations with key “Market Movers” needed for successful systems change. These have included local medical and clinical directors, CEO of the Spokane Medical Society, and other leaders who work at a contract signing level. This has felt appropriate to us while our discussions remain at a systems level.

We do not assume these leaders represent practicing physicians. As we shift our community engagement efforts from big picture vision to operationally transforming our community health system, we are developing increased opportunities for key stakeholders, clinical champions, to provide specific feedback. Our efforts will start with our individual Health System Transformation plans. We expect that clinical integration and engagement from employed clinicians will be included in each system Transformation’s plan.

Our engagement efforts have always been open to the public, and we have benefited from and are grateful for participation by a few key physician champions: Dr. Gary Knox (Rockwood Clinics), Dr. Darin Neven (Consistent Care at Providence), Dr. Jeff Liles (Columbia Medical Associates), Dr. Jim Sledge, DDS (retired Dentist & UW faculty) and Dr. Bob Lutz (Rockwood Clinics and Spokane County Board of Health member). We have also added former family physician, Dr. Jay Fathi, to our BHT Board of Directors.

As we developed our Pathways Hub, we have received regular guidance from co-founder of the model, Dr. Sarah Redding. Additionally, we engaged with Medical Directors at United Health Care and Coordinated Care here and in Ohio, plus Clinical Managers from Molina, and a registered nurse. Additionally, several leaders in our community health sector are former nurses, psychologists and behavioral health specialists. Input from clinical experts aligned with our broader community feedback about the important need to increase our efforts for whole person care by creating stronger links between social determinants of health services and the health system.

In April 2017, we began recruiting for our Opioid Task Force. The Task Force will be co-chaired physician champion Dr. Matt Layton (WSU School of Medicine and Spokane Regional Health District Health Director for Methadone Clinic) and Torney Smith (Administrator Spokane Regional District). Also, nominated for this task force is Dr. Frances Gough, Medical Director from Molina, and Dr Samuel J. Huber, Chief Medical Officer for Behavioral Health MultiCare. We are in the process of nominating a clinical practitioner with Oral Health expertise to support our region’s effort to develop a comprehensive Opioid treatment and prevention program.

Moving forward in our commitment to engaging providers throughout the transformation process, we have hired Applied Insight to host two feedback sessions with clinical providers to further align our regional planning efforts and solicit feedback outside of our individual health system planning. The first session will be held in late June and will focus on an overview of the Demonstration Projects and

proposed model. We will be listening for investment that could be made to better link Primary Care, Pediatrics and Family Medicine with our Pathways Hub model to improve access to social determinants of health. We will also seek out information from discussions and surveys already conducted by the Spokane Medical Society and the Washington State Medical Society, and utilize other surveys, white papers, etc. they have created on value-based payments, workforce development and integrated care. The second session will be held in September to provide information on our linked individual Health System Transformation plans and our Medicaid Transformation Demonstration Regional Project Portfolio. We will work closely with the Spokane Medical Society, SEIU, Spokane Dental Society as well as the Clinic Directors from our five rural health clinics and FQHCs plus physician champions associated with each of the Tribes and Urban Indian Health Center to ensure that we have broad representation and perspective.

In these sessions, we will also look for clear input on *how* providers wish to be involved in this design work. We will ask for feedback in how to most accessibly communicate out information, and which kind of conversations providers want to participate in. We want to understand their perspective how the ACH can best support practitioners in keeping their patients healthy.

Attachment(s) Required:

- A. Bios or resumes for identified clinical subject matter experts or provider champions

Attachments Checklist

Application Section	Required Attachments	Recommended Attachments
Theory of Action & Alignment Strategy	None	None
Governance & Organizational Structure	<ul style="list-style-type: none"> A. Visual/chart of the governance structure B. Copy of the ACH's By-laws and Articles of Incorporation C. Other documents that reflect decision-making roles, including level of authority, and communication expectations for the Board, committees, and workgroups D. Decision-making flowchart E. Roster of the ACH decision-making body and brief bios for the ACH's executive director, board chair, and executive committee members F. Organizational chart that outlines current and anticipated staff roles to support the ACH 	None
Tribal Engagement Expectations	A. Demonstration of adoption of Model ACH Tribal Collaboration and Communication Policy, either through bylaws, meeting minutes, correspondence, or other written documentation	B. Statements of support for ACH certification from every ITU in the ACH region
Community & Stakeholder Engagement	A. Document with links to webpages where the public can access meeting schedules and other engagement opportunities, meeting materials, and contact information	None
Budget & Funds Flow	A. High-level budget plan (e.g. chart or excel document) for Project Design funds to accompany narrative required above.	None
Clinical Capacity & Engagement	A. Bios or resumes for identified clinical subject matter experts or provider champions	None