# Accountable Community of Health Certification Process
# Medicaid Transformation Project Demonstration

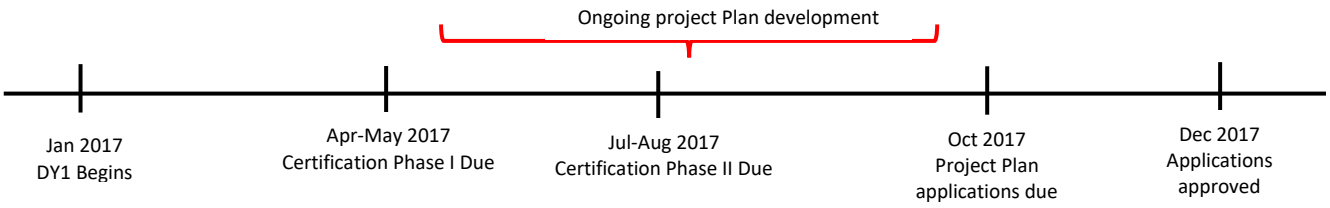
The certification process will ensure each Accountable Community of Health (ACH) is capable of serving as the regional lead entity and single point of performance accountability to the state for transformation projects under the Medicaid Transformation Project demonstration (demonstration). The certification process requires ACHs to provide information to demonstrate compliance with expectations set forth by the state and the Centers for Medicare and Medicaid Services (CMS). Through this process, the state will assess whether each ACH is qualified to fulfill the role as the regional lead and therefore eligible to receive project design funds. Specifically, certification will determine that each ACH meets expectations contained within the Special Terms and Conditions (STCs) including alignment with SIM contractual requirements, composition requirements, and organizational capacity expectations and development.

Certification criteria are established by the state in alignment with the demonstration STCs. Each ACH will submit both phases of certification information to the state within the required time frames. The state will review and approve certification prior to distribution of Project Design funds. Each ACH must complete both phases of certification and receive approval from the state before the state will consider its Project Plan application. Given the level of effort necessary to develop thorough project plan applications, ACHs will begin project plan development prior to completion of both certification phases.

The certification process, scoring criteria and subsequent awarded funding amount is at the sole discretion of the Washington State Health Care Authority (HCA). Certification will be scored according to the table below. ACHs must receive overall scores of 3 or higher in every category to pass the certification process. Additional information regarding the scoring process will be forthcoming.

| Score | Description | Discussion |
|---|---|---|
| 0 | No value | The response does not address any component of the requirement. |
| 1 | Poor | The response unsatisfactorily addresses the requirement and the bidder's ability to comply with the requirement, or has simply restated the requirement. |
| 3 | Acceptable | The response shows an acceptable understanding or experience with the requirement. Sufficient detail to be considered "as meeting minimum requirements." |
| 5 | Excellent | The response has provided an innovative, detailed, and thorough response to the requirement, and clearly demonstrates a superior experience with or understanding of the requirement. |

**Certification Process Timeline**




The certification materials submitted by the ACH will be posted on the HCA website for public review. Upon successful completion of the Phase I and Phase II certification, ACHs will earn Project Design funds. These funds go directly to ACHs as opposed to incentive payments, which will flow through the financial executer. Project Design funds are intended for ACH use on development, submission and oversight of a successful Project Plan application and execution.

To craft responses, ACHs should refer to the following key documents for important information outlining various obligations and requirements of ACHs and the state in implementing the Medicaid Transformation Project:

1. The Medicaid Transformation Project demonstration Special Terms and Conditions (STCs), which set forth in detail the nature, character, and extent of federal involvement in the demonstration, the state's implementation of the expenditure authorities, and the state's obligations to CMS during the demonstration period. The STCs were approved on January 9, 2017.
2. The Medicaid Transformation Toolkit, and any finalized protocols that support the demonstration STCs.
3. Other key documents and resources as listed in each section.

**Certification Submission Instructions**:

1. Please submit documents electronically according to the following specifications.
    a. Must be emailed to Medicaidtransformation@hca.wa.gov
    b. Must be formatted as one zip file comprised of completed certification submission template and attachment files.
        i. The overall zip file must be titled: "[ACH Name] - ACH Phase I Certification Submission."
        ii. The completed certification template file must be in PDF format and titled: "[ACH Name] – Certification Submission Template." All fields in the certification submission template must be complete.
        iii. Each attachment to the certification template must be a separate file in PDF format. The attachment must be named according to the ACH name, corresponding section and attachment letter. For example, for the visual/chart of the governance structure, "[ACH Name] - Governance and Organizational Structure – Attachment A" and the copy of the ACHs By-laws and Articles of

Incorporation, "[ACH Name] - Governance and Organizational Structure – Attachment B." All required attachments to the certification template must be included.

c. Must include contact information for the point of contact for any follow-up questions.

2. Certification Phase I must be submitted between: April 17, 2017 and May 15, 2017. Electronic copies must be submitted by 3pm PT on May 15, 2017.
3. Certification Phase II must be submitted between: July 17, 2017 and August 14, 2017. Electronic copies must be submitted by 3pm PT on August 14, 2017. Submission template forthcoming.

**Questions regarding the certification process must be directed to medicaidtransformation@hca.wa.gov.**

## *Certification Phase I*

ACHs must respond to a series of questions listed in the Phase I Certification Submission Template to demonstrate achievement of expectations in the following areas:

- Theory of Action and Alignment Strategy
- Governance and Organizational Structure
- Tribal Engagement and Collaboration
- Community and Stakeholder Engagement
- Budget and Funds Flow
- Clinical Capacity and Engagement

**Amount:** Each ACH is eligible to receive up to $1 million for successful demonstration of Phase I expectations. Funding[1] will be distributed if certification criteria are fully met (score of three or higher) and the ACH and HCA have executed a contract for receipt of demonstration funds.

**Submission**: Between 04/17/2017-05/15/2017

[1] Timing and amount of Project Design funding is contingent on CMS approval of all related protocols.

# Phase I Certification Submission Template (DRAFT)

| ACH Certification Phase I: Submission Contact | |
|---|---|
| **ACH** | Cascade Pacific Action Alliance |
| **Name** | Winfried Danke |
| **Phone Number** | 360.539.7576 |
| **E-mail** | dankew@crhn.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 within the context of regional priorities and existing efforts.

*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**

**What are the region's priorities and what strategies are in place to address these priorities across the region?**

The purpose of the Cascade Pacific Action Alliance (CPAA), an Accountable Community of Health (ACH), is to improve community health and safety. CPAA has developed three 'meta' goals that closely align with Healthier Washington's priorities and the Triple Aim:

1. Improving health by improving health equity and health outcomes for all residents, with a focus on addressing the social determinants of health.
2. Addressing whole person care by keeping residents healthy as long as possible and addressing all health needs with a focus on prevention and early interventions.
3. Reducing per-capita health care costs while improving the quality of care provided.

In 2014, the CPAA identified five priority areas:

1. Improving chronic disease management and prevention,
2. Improving access to services by focusing on provider capacity,
3. Improving care coordination and integration,
4. Preventing and mitigating adverse childhood experiences (ACEs), and
5. Enhancing economic and educational opportunities.

These health priorities provide the framework for the CPAA's Regional Health Improvement Plan (RHIP), which prioritizes high-impact strategies (see attached RHIP Compass document).

The CPAA has begun addressing these priorities through regional shared learning sessions that combine presentations and panel discussions by subject matter experts with small group conversations to deepen understanding and identify strategies to align efforts across sectors. The

CPAA has established work groups to advance care coordination and integration as well as ACEs prevention and mitigation, and has been actively engaged in two starter projects:

Since 2015, the *Youth Behavioral Health Coordination Pilot* addresses care coordination, access improvement, ACEs prevention and mitigation, educational opportunities enhancement, and chronic disease prevention.

Since 2016, the *Youth Marijuana Prevention and Education Program* addresses ACEs and chronic disease prevention.

**Describe how the ACH will consider health disparities to inform regional priorities.**

Improving health equity by focusing on the social determinants of health is an overarching goal for the CPAA that serves as a lens for all its work. Data identified in the regional health needs assessment about the most disadvantaged populations informs CPAA resource decisions. This includes available data on diverse tribal nations that suffer disproportionately from health disparities; we are continuing to expand tribal engagement efforts to inform regional priorities.

Additionally, the CPAA Board includes a seat for a consumer or Medicaid beneficiary and we are convening consumer focus groups to ensure we are hearing from people most affected by health disparities at all levels of decision-making.

**Describe strategies for aligning existing resources and efforts within the region. How is the work oriented toward an agreed upon mission and vision that reflects community needs, wants and assets**?

From the start, achieving collective impact has been a priority in the CPAA region. Having a common purpose, developing shared goals and having a shared leadership structure built trust and led to action quickly.

The Youth Behavioral Health Coordination Pilot is a prime example of this approach. The Thurston-Mason and Great Rivers BHOs contribute 70 percent of funding for care coordination and mental health treatment at pilot schools with a 30 percent cost share from schools. Other multi-sector partners provide education, evaluation, and other in-kind support.

**Describe how the ACH will leverage the unique role of DSRIP and consider the needs of Medicaid partners and beneficiaries to further the priorities identified above.**

Building on our pilot projects and other work, we will deepen the assessment of the specifics needs of our Medicaid partners and beneficiaries to inform the DSRIP project design. To ensure the needs of Medicaid partners and beneficiaries are integrated systematically into CPAA planning and action, they will be asked to serve on DSRIP work and advisory groups to help develop the projects and provide guidance during project implementation.

**Describe how the ACH will leverage the Demonstration to support the ACH's theory of change and what other opportunities the ACH is considering to provide value-add to the community**.

We intend to use the Demonstration as a way to deepen our engagement with partners and stakeholders, particularly the clinical delivery system, and accelerate overall system transformation. While targeted at Medicaid beneficiaries, many DSRIP investments will have positive spillover effects for other populations. Moreover, as we improve the clinical delivery system, we hope to capture

some cost savings to reinvest into nonclinical interventions. If we are successful, the improvements that we are able to make under the Demonstration will strengthen systems that benefit Medicaid beneficiaries and others. Simultaneously, the CPAA will continue its broader population-based health improvement efforts.

**Describe any in-kind contributions and non-Medicaid resources that have been identified for supporting the ACH's work over the near-term and long-term.**

The CPAA is exploring shared savings and reinvestment mechanisms to provide long-term sustainability to improve health, including establishing a regional wellness fund, which could provide resources for prevention and early intervention strategies that are not covered by traditional funding streams.

Over the last year, CHOICE provided almost $30,000 of in-kind contributions for legal services. The Anthem Foundation provided $10,000 in support of shared learnings. United Healthcare has provided $50,000 of general operating support. The CPAA also obtained $87,500 from the Cambia Health Foundation for the Youth Behavioral Health Coordination project. The Washington State Department of Health provided $262,880 for the Youth Marijuana Prevention and Education Program in 2016–2017. In addition, our partners and stakeholders have contributed hundreds of thousands of dollars in-kind for meeting space, meeting participation, etc. We anticipate that our partners and stakeholders will continue to make substantial in-kind contributions as we seek grants from non-Medicaid sources for the CPAA's work.

**Attachment(s) Required**

Not Applicable – RHIP Compass

## 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**

**What governance structure is the ACH using (e.g., Board of Directors/Board of Trustees, Leadership Council, Steering Committee, workgroups, committees, etc.)?**

The CPAA ACH is a single-member limited liability corporation (LLC), with the sole member being CHOICE Regional Health Network (CHOICE).

The CPAA's governance structure includes a board of directors, an executive committee, and a finance committee. The final decision-making authority lies with the LLC Board of Directors (CPAA Board). Additionally, the CPAA has a broad-based regional coordinating council and a support team that prepares council meetings, two standing work groups, one focused on care coordination and another on ACEs, and seven county-based local forums that engage the community at the local level.

**Describe the process for how the ACH organized its legal structure.**

CHOICE Regional Health Network sought counsel from the law firm, Davis, Wright & Tremaine, which compared different governance options and recommended that a single-member LLC would be the best option for the CPAA to organize its legal structure. Following this advice, the CPAA Council formed a governance work group to develop a LLC operating agreement, which is used in place of by-laws. The governance work group included participants from various counties and sectors, CHOICE directors, and a tribal partner. The CHOICE Board of Directors and the CPAA Council both reviewed and approved the proposed operating agreement, and the CPAA ACH LLC was incorporated on February 22, 2017.

**Decision-making**

**What decisions require the oversight of the decision-making body? How are those decisions made? (E.g. simple majority, consensus, etc.)**

The CPAA Board collectively has the authority, power, and discretion to manage and control the business, affairs, and properties of the CPAA ACH LLC, and to perform any and all other acts or activities customary or incident to its management in the ordinary course of its business. This is subject to limitations where CHOICE, the sole member of the LLC, may override an action of the CPAA

Board that CHOICE determines would be inconsistent with or jeopardize its federal 501(c)(3) nonprofit tax status.

Per the operating agreement, the CPAA Board endeavors to make decisions by consensus, but consensus is not required. Each director has one vote and proxy voting is prohibited. All decisions are made by a simple majority vote of Board Directors present, except when approving the CPAA budget, awarding a contract, appointing or removing officers, and removing a director for cause. These actions require a supermajority.

The Support Team helps to develop the CPAA Council agenda and the Council prepares and recommends decisions for the CPAA Board with input from local forums and/or work groups.

**How and when was the decision-making body selected? Was this a transparent and inclusive process? Include decision-making body's term limits, nominating committees, and make-up, etc.**

The CPAA Board includes 19 director seats that reflect the diversity of community sectors, partners, stakeholders and geographic areas coming together within the CPAA. More than half of director seats are non-clinical. Per the LLC operating agreement, the CHOICE Board of Directors appointed 51 percent of director seats: behavioral health provider, community hospital/critical access hospital, federally qualified health center/community health center, health system, provider network/PCP and public health. The CPAA Council appointed the remaining seats: at large, behavioral health organization, consumer or Medicaid beneficiary, criminal justice, education, managed care organization, and social services. The tribes will appoint the tribal government services director.

Using an online application form, CPAA Council members and other community members were encouraged to apply for CPAA Board positions through an open nomination process. During the March Council meeting, CPAA Council members reviewed the nominations and voted for CPAA Board Directors. All seats were filled except the consumer and Tribal government services representative positions. For these positions, recruitment is ongoing. The director term limits are either two or three years, to be determined by drawing lots.

**If a board seat is vacant, how will the ACH fill the vacancy?**

Board vacancies are filled using the same process that was initially used to appoint the director whose board seat has become vacant (see LLC operating agreement for details). CPAA Board Director recruitment seeks to maintain a balance of geographic and sector representation.

**How is decision-making informed? What are the documented roles and communication expectations between committees and workgroups to inform decision-making?**

Work groups, committees, and local community forums inform decision-making, with communications between the groups facilitated by staff. Shared learning events and subject matter experts also inform decision makers directly. Work group leads regularly report to the Council, and meeting summaries are publicly made available through email and the CPAA website. All work groups have or are developing charters to document roles of work group members, and clarify the purpose of the work group as well as the advisory role of the Council and legal decision-making authority of the CPAA Board.

**What strategies are in place to provide transparency to the community?**

CPAA uses multiple strategies to provide transparency to the community, rooted in a bottom-up approach. From the beginning, CPAA has emphasized the importance of building on existing community structures at the local level and engaging local communities in defining problems and

finding problem solutions. While regional in scope, CPAA has chosen to organize itself around seven distinct local community forums, which provide information to and receive information from a regional Coordinating Council composed of cross-sector representatives from the local forums and regional partners. This ensures that the regional Council remains closely connected to the local forums, that there is transparency in decision-making, and that the region combines local action with coordinated regional action. CPAA participants and CHOICE staff meet regularly with local forums across the region to communicate recommendations and decisions from the CPAA Council and Board and to solicit feedback from the local level. With the exception of executive sessions, all CPAA meetings are open to the public and all written meetings summaries are disseminated through email, newsletters, and posted on a public website.

**If the decision-making body makes a decision that is different from recommendations presented by committees and/or workgroups, how does the ACH communicate how and why that decision was made?**

If the CPAA Board makes a decision that is different from the recommendation presented from the CPAA Council, the Board is obligated to report and provide a rationale to the Council why the Board did not follow the recommendation (see LLC Operating Agreement).

**Describe how flexibility and communication strategies are built into the ACH's decision-making process to accommodate nimble decision-making, course corrections, etc.**

If needed, the CPAA Board can delegate authority to the Executive Committee to make decisions on behalf of the ACH. Additionally, the CPAA Board can make decisions through email or other communication means if the agreed-upon decision is unanimous.

**Describe any defined scope, financial accountability or other limits placed on staff or the Executive Director regarding decision-making outside of board approval.**

CPAA is finalizing an authorization matrix that specifies limitations of authority for the Executive Director, Board Chair, Board of Directors, and Committees. The CPAA Council and Board reviewed and approved the authorization matrix at the May Council and Board meetings (see attached authorization matrix).

**Executive Director**

Provide the below contact information for the ACH's Executive Director.

How long has the Executive Director been in that position for the ACH? Provide anticipated start date if the Executive Director has been hired but has not yet started.

| | |
|---|---|
| **Name** | Winfried Danke |
| **Phone Number** | 360.539.7576 ext. 125 |
| **E-mail** | dankew@crhn.org |
| **Years/Months in Position** | The CPAA LLC was formed in February 2017. Winfried has led the CPAA since its inception in 2014. He has led CHOICE Regional Health Network for almost 5 years. Winfried has 18 years of senior executive leadership experience. |

## Data Capacity, Sharing Agreement and Point Person

**What gaps has the ACH identified related to its capacity for data-driven decision-making and formative adjustments? How will these gaps be addressed?**

ACHs need to be able to collect, analyze, and develop user-friendly data reports for their funders, community partners and members, work groups, and decision-making bodies. Data must be accessible and actionable. While the CPAA has limited data collection and analytics capabilities in place, these capacities will need to be expanded substantially. This requires trained personnel and an adequate technology infrastructure.

CPAA is addressing its immediate data-related needs by contracting with Providence CORE to:

- Identify project-level measures
- Provide expertise on CPAA's planned data infrastructure
- Identify priority populations
- Interpret state or partner provided data
- Set benchmarks for project plans
- Assist with development of reporting infrastructure

CHOICE also plans to hire a data team to develop a regional dashboard that will assist community partners with their needs assessments. Additionally, we are exploring the possibilities of working with other ACHs to leverage statewide data systems. One potential example is the quarterly benchmarking system the Washington State Hospital Association currently uses.

**Has the ACH signed a data sharing agreement (DSA) with the HCA?**

The DSA process with HCA is in the early stages. CPAA and the HCA data team expect an agreement to be in place by 06/01/2017.

| **Data Sharing Agreement with HCA?** | | | |
|---|---|---|---|
| **YES** | | **NO** | **X** |

Provide the below contact information for the ACH point person for data related topics.

| **Data Point Person*** | |
|---|---|
| **Name** | Jennifer Brackeen (Temporary Point Person) |
| **Phone Number** | 360.539.7576 ext. 105 |
| **E-mail** | brackeenj@crhn.org |

*The point person will transition to a data staff member once capacities have been expanded.

## 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<br><br>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.<br><br>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* |
| *Instructions*<br><br>*Please ensure that your responses address all of the questions identified below. Total narrative word-count range is 700-1,300 words.*<br>**Participation and Representation**<br>**Describe the process that the ACH used to fill the seat on the ACH governing board for the ITUs in the ACH region to designate a representative.**<br><br>At present, the tribal government services seat on the CPAA Board remains unfilled. With the assistance of the Skokomish Tribal Health Director, CPAA developed the LLC operating agreement and connected successfully with many of the health directors of the federally recognized tribes in the region. However, the initial approach to ask the seven tribes in the CPAA region to agree on one representative to serve on the CPAA Board proved infeasible. Given that tribes are sovereign nations, many tribes feel that each tribe needs to be represented with a separate director seat on the board. Hence, the tribal government services board director seat remains unfilled.<br><br>In March 2017, following the recommendation of the CPAA Council, the CPAA Board adopted the Model ACH Tribal Collaboration and Engagement Policy. In keeping with the policy, CPAA is now seeking to establish a committee of leaders from each of the seven tribes to assess tribal implications of CPAA activities and to ensure that the needs and interest of our tribal partners are considered in the design of Medicaid Transformation Demonstration projects.<br><br>**Describe whether and how the ACH has reached out to regional ITUs to invite their participation in the ACH.**<br><br>To date, CPAA has had participation from the Cowlitz Indian Tribe, the Confederated Tribes of the Chehalis, and the Skokomish Indian Tribe. The South Puget Intertribal Planning Agency, a collaborative forum of five federally recognized tribes in our region, has also attended several CPAA meetings. Initial contacts were through mail, email, telephone, and personal meetings. For instance, |

the CHOICE Executive Director presented on the CPAA at a meeting of tribal health directors requesting tribal engagement, and a CPAA delegation visited the Skokomish Health Center last year. A site visit to the Confederated Tribes of the Chehalis is pending. The health director of the Skokomish Tribe participated in the CPAA Governance Work Group that developed the LLC operating agreement, and continues to be a resource to the CPAA on tribal engagement. Before adoption of the LLC operating agreement, CPAA contacted all seven tribes in writing to solicit feedback and encourage their engagement. Most recently, the CHOICE Executive Director has been in email and phone contact with the Tribal Council Chairwoman of the Shoalwater Bay Tribe learning about the appropriate engagement and representation of tribes in the CPAA.

As mentioned above, we are now reaching out to all seven tribes in our region requesting their participation in a committee to assess tribal implications of CPAA activities and projects.

**Describe, with examples, any accomplishments the ACH has realized in collaborating and communicating with ITUs, including <u>when</u> in the planning and development process the ACH first included or attempted to include ITUs.**

CPAA has sought to include ITUs in its planning and development process since its inception. CPAA experienced improved collaboration with the tribes soon after the American Indian Health Commission workshop at the Chehalis Confederation of Tribes in June 2016. At the workshop, CPAA had the opportunity to learn about the Indian health care delivery system with a focus on local tribal needs. As a result of the meeting, CPAA started working with the Skokomish Tribal Health Director as a tribal liaison and mentor. For instance, the Skokomish Tribal Health Director participated in the CPAA Governance Committee representing tribal interests in the development of the operating agreement. In follow-up to the meeting, CPAA reached out to other ITUs requesting their engagement.

At CPAA Council meetings, we have had participation from the Cowlitz Indian Tribe, the Confederated Tribes of the Chehalis, and the Skokomish Tribe. The South Puget Intertribal Planning Agency has also attended several CPAA meetings.

A CPAA delegation visited the Skokomish Tribe last fall to learn more about tribal health systems and the integration of tribal services, and toured the clinic. We have requested site visits to all other tribes in our region. The Confederated Tribes of the Chehalis Tribal Health Clinic visit is pending.

Finally, through our tribal engagement efforts, we have received letters of support from two federally recognized tribes. Please see attached documentation for details.

**Describe key lessons the ACH has learned in its attempts to engage with ITUs and the next steps the ACH will take to support meaningful ITU engagement and collaboration.**

Tribes are independent sovereign nations and as such emphasize the importance of government-to-government relations, yet ACHs are community-based organizations, not government entities. Tribes are busy with many demands placed upon them, which includes but is not limited to healthcare. Moreover, there is a complex, painful history that is vital to understand and affects relations with tribes to this day. All this raises questions on how to engage with tribes appropriately.

We have learned that tribes are partners, not stakeholders, reflecting their special status. We have also learned that each tribe is unique, and that it takes time to build authentic, trusting relationships with members and staff at each tribe.

We are committed to getting tribal engagement and collaboration right. This will take time and deliberate effort. Each tribe will need to be met on their own terms. As we engage in a customized, individualized approach to meet the needs of each tribe, we plan to visit with each tribe to learn how they would like to engage and be engaged in the ACH. We hope that all tribes will choose to participate in the CPAA Council; however, we are open to other forms of engagement. We plan to hire a tribal liaison to take the lead on engaging with tribes and support the committee of tribes to be established under the ACH tribal engagement policy as well as to engage tribes in the planning of the Medicaid Demonstration Project.

**Policy Adoption**

**Describe the process the ACH used to adopt the Model ACH Tribal Collaboration and Communication Policy. If the ACH has not yet adopted the Model ACH Tribal Collaboration and Communication Policy, what are the next steps, including anticipated dates, to implement the requirements?**

The CPAA Support Team reviewed the ACH Tribal Collaboration and Communication Policy in February and recommended approval of the policy. The CPAA Council and Board reviewed and adopted the policy on April 13, 2017, noting that this policy should serve as the minimum level of engagement, and more work is to be done in building authentic, trusting relationships with tribes. We expect to convene the committee of tribal leaders within the next two months with ongoing meetings thereafter. Having additional resources and capacity will be essential in order to move this work forward.

**Board Training**

**Describe how the ACH governing board will 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.**

We will work with Manatt and the American Indian Health Commission to ensure the CPAA Board receives ongoing training on the Indian health care delivery system. We will also ask the seven federally recognized tribes in our region to see who may want to lead this training. This year, Denise Walker, Wellness Center Director of the Confederated Tribes of the Chehalis, has volunteered to provide a first training in May.

**Attachment(s) Required:**

A. Demonstration of adoption of Model ACH Tribal Collaboration and Communication Policy, either through bylaws, meeting minutes, correspondence or other written documentation.

**Attachment(s) Recommended:**

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

## 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 Collaboratives," 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

**Describe the ACH vision for fostering an authentic relationship with the community members, including Medicaid beneficiaries.**

Reducing health disparities by focusing on the social determinants of health is the first goal the CPAA identified during the Regional Health Improvement Plan development. Any projects chosen by the CPAA will continue to have to meet this key criterion. The CPAA has used a bottom-up approach working with the local forums, work groups, CPAA Council, and CPAA Board to establish cascading levels of community engagement and decision making, with broad representation from many sectors. Among others, these sectors include social services, clinical providers, education, public health, health plans, criminal justice, workforce development, and local businesses. Over the past two years, we have established operating norms and foundational values in support of our vision of authentic community engagement emphasizing inclusion, transparency, equality, consensus-based decision-making, and shared learning. Each local forum is in a different phase of development, and we are continuing to build out and support the local forums so that they are robust vehicles for authentic community engagement.

We will go beyond these existing community engagement structures and engage with specific populations such as Medicaid beneficiaries and consumers through focus groups and through community partners that work with Medicaid beneficiaries and consumers regularly. We intend to recruit Medicaid beneficiaries in each county to learn more about what is working well and to identify any health barriers they are experiencing. Their perspective and expertise will then inform the project planning work groups. We will also seek to recruit Medicaid beneficiaries to these work groups and, if this should prove not feasible, plan to establish an ongoing project advisory group of Medicaid beneficiaries and consumers. Again, leveraging established relationships of community partners that work with Medicaid beneficiaries and consumers regularly will be an important way for us to receive

ongoing feedback during project planning and implementation. Additionally, we are seeking to recruit a Medicaid beneficiary, potentially from these focus groups, to serve on the CPAA Board as a consumer representative.

**What barriers/challenges has the ACH experienced or anticipate experiencing toward meaningful community and Medicaid beneficiary engagement?**

The most pressing immediate challenge is filling the consumer seat on the CPAA Board. We have reached out to a number of our partners in the community to fill this vacancy, but have not yet been successful. We are recruiting for this director seat so that we have consumers engaged at all levels of decision-making. If we are unable to identify a consumer to serve on the board, we will seek to fill the vacancy through a consumer-advocacy organization.

In general, a lack of capacity has been a challenge, limiting the ability of staff for meaningful engagement with the broader community, consumers, and Medicaid beneficiaries. Additionally, up until very recently, the work of the CPAA was mostly conceptual, which has made it difficult to engage busy consumers in tangible ways. As the work becomes more concrete and actionable in our communities and dedicated resourcing becomes available to support consumer engagement, we anticipate connecting with consumers will become easier.

**What opportunities are available for bi-directional communication, so that the community and stakeholders can give input into planning and decisions?**

Community members, partner organizations, and stakeholders have various opportunities to provide input into planning and decisions. With the CPAA's bottom-up approach, participation can occur at the local forum level, within work groups, at Council meetings, during public comment periods at Board meetings, through surveys, and newsletter feedback loops. All of the different groups and meetings represent opportunities for bi-directional communication from local communities to regional as well as state entities and vice-versa. Additionally, staff is available in between meetings for community members and stakeholders to express concerns, share suggestions, and comment on pending actions. Please see the attached decision making flowchart for details.

**How is that input then incorporated into decision-making and reflected back to the community**?

Representatives from the local forums, work groups, and the support team are participants of the CPAA Council. The Council considers survey results, recommendations from work groups, and other community feedback, including information collected from focus groups, to make recommendations to the board. At the end of every Council meeting, there is a check-in to identify what new information or questions need to be taken back to the local forums. With the exception of executive sessions, all meetings at all levels are transparent and open to the public. Written meeting summaries are distributed to participants as well as posted publicly, and members of the CPAA Board and Council are encouraged to report back to their local communities after council and board meetings.

**Partnering Provider Engagement**

**What strategies does the ACH employ, or plan to employ, to provide opportunities for engagement beyond the decision-making body to ensure that community partners are addressing local health needs and priorities?**

In each county, local community forums meet regularly to address local health needs and priorities. Social service providers, clinical providers and public health departments all participate in these forums, though the extent of their participation varies from one local forum to the next. Partnering providers also have the opportunity to engage in CPAA work groups – and they have done so, especially in the CPAA Care Coordination Work Group - and partnering providers will be key stakeholders in the Medicaid Transformation Demonstration project planning work groups. With its membership reaching deep into the clinical provider world, CHOICE is uniquely positioned to engage hospitals, community health centers, clinics, community-based providers, and other clinical providers throughout the region well beyond the CPAA decision-making body.

As part of the planned CPAA website upgrade, we will also explore opportunities for using the website for bi-directional communications with community partners. This will augment existing social media platforms (Facebook, Twitter, LinkedIn, etc.) that CPAA has been using to engaging in a dialogue with the community.

**What barriers/challenges has the ACH experienced or anticipate experiencing toward meaningful engagement of a broad spectrum of partnering providers?**

To date, a lack of clarity about some of the details of the Medicaid Transformation Demonstration (funding amounts, payment methodologies, etc.) has proven challenging for meaningfully engaging some partnering providers. Moreover, providers are extremely busy with their day-to-day activities and have found it challenging to free up time for community conversations. The CPAA has received consistent feedback that carefully selecting meeting times is important to improve provider participation. Holding meetings in the early morning, over the lunch hour or in the evening is essential to engaging clinical providers. However, by moving meetings during these times, CPAA is competing with family time and administrative time that clinical providers use to complete paperwork for patient files and ensure accurate reporting. Holding efficient, effective meetings will be of utmost importance.

**What opportunities are available for bi-directional communication to ensure that partnering providers can give input into planning and decisions?**

Partnering providers, along with all other partners and stakeholders, have various opportunities to provide input into planning and decisions. As mentioned previously, with the CPAA's bottom-up approach, participation can occur at the local forum level, within work groups, at Council meetings, during public comment periods at Board meetings, through surveys, and newsletter feedback loops. Partnering providers can also contact staff in between meetings to express concerns, share suggestions, and comment on pending actions. Moreover, given that they are expected to implement the chosen projects, partnering providers will have a key role in designing the Medicaid Transformation Demonstration projects. We plan to reach out specifically to providers that serve large numbers of Medicaid beneficiaries in our region to ensure their participation in project planning, decision-making, monitoring and evaluation. Please see the attached decision making flowchart for details.

**Transparency and Communications**

**Describe how the ACH does or will fulfill the requirement for open and transparent decision-making body meetings. Please include how transparency will be handled if a decision is needed between public meetings.**

CPAA Board meetings are advertised and open to the public. All board decisions are documented, meeting summaries are distributed to the board, CPAA Council members, monthly newsletter subscribers, local forums and posted on the CPAA website. If a decision needs to be made in between regularly scheduled meetings, the decision will be recorded and shared with the CPAA Council. The decision will also be posted on the CPAA website.

**What communication tools does the ACH use? Describe the intended audience for any communication tools.**

CPAA uses various tools to communicate with partners, stakeholders and the public. CPAA has a public website that is a repository for all documents and decisions. Meeting summaries are developed, distributed, and posted for all meetings. CPAA primarily communicates through email to share information about future meetings with interested partners, although upcoming meetings are also advertised through the CPAA online newsletter and website. Surveys are sent to gather information from different sectors. CPAA also communicates through in-person meetings (primarily CPAA Council and Board meetings as well as work group meetings), phone meetings (e.g., CPAA Support Team meetings), and in-person visits (e.g., stakeholder management). Additionally, social media is used to share information with the public about CPAA partner organizations and their clients using Twitter, Facebook, and more recently LinkedIn. To engage with Medicaid beneficiaries and consumers, we are scheduling focus groups to learn from their lived experiences and inform project planning. We are improving our website in order to make it more user-friendly.

**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**

**Describe how the ACH plans to use the Project Design funds to support Project Plan development and other capacities or infrastructure.**

Project design funds will increase current capacity to oversee demonstration project development, implementation and operations. Existing staff (Executive Director, Program Director, Program Support Specialists, and Operations Management) is budgeted at $235,916 through the end of Demonstration Year 1 (DY1). Additional positions will start June of 2017, including Community and Tribal Liaison, Data Analytics and IT Manager, Opioid Prevention Manager, Bi-Directional Care Integration Program Manager, Clinical Programs Specialist, and Administrative Support Specialist. The total cost of added capacity is budgeted at $209,588. Additional staff start in October of 2017, including Maternal Health/Chronic Disease Prevention Program Manager, Oral Health Programs Manager, Transitional Care Program Manager, Director of Clinical Programs, ED Diversion Program Manager, Healthcare Analyst, and IT System Coordinator—budgeted at an additional $75,937 through the end of DY 1.

This level of increase in staffing requires additional operational resources:

- Leased space, utilities, furniture, recruitment, and IT network costs of $85,000
- Equipment such as computers, laptops, telephones and copier costs of $55,000
- Consumable office supplies costing $10,000
- Additional contractual capacity to provide financial modeling, legal, clinical expertise, building data systems and infrastructure, accounting, and process improvement at approximately $115,000
- Increased travel expenses such as mileage over 7-county region, and travel to meetings and/or conferences, expected to cost $30,000
- Indirect costs including human resource management and administrative support in the amount of $122,466

**Fiscal Integrity**

**Provide a description of budget and accounting support, including any related committees or workgroups.**

The CPAA is currently executing an Administrative Services Agreement with CHOICE to perform administrative functions, including financial capacity. CHOICE will provide financial management, guided by established accounting procedures and overseen by the Executive Director and Operations Manager, in partnership with the accounting firm Wittenberg, CPA, which provides day-to-day accounting transaction processing, and audit firm Clark Nuber, which provides annual financial audit services.

The CPAA finance committee will meet quarterly to review financial reports and provide financial oversight of the approved budget. The CPAA finance committee will develop a budget with staffing support annually. Once completed, the CPAA Treasurer will recommend the budget for CPAA Board approval at the last board meeting before the end of the fiscal year. Following the approval of the budget by the CPAA Board, CHOICE management monitors expenditures on a monthly basis and provides quarterly reports to the CPAA Board.

**Define the levels of expenditure authority held by the Executive Director, specific committees (e.g., Executive Committee), and the decision-making body.**

The levels of expenditure authority are included in the attached authorization matrix, reviewed and approved by the CPAA Council and CPAA Board in May. These authority levels are in alignment with CHOICE Regional Health Networks' current financial policies and practices. The executive director, or his designee, signs all checks. Checks over $5,000 require an additional board member signature. The finance committee provides recommendations on the budget to the CPAA Board for approval. The executive committee does not have expenditure authority.

**Provide a description of the tracking mechanisms to account for various funding streams (e.g., SIM and Demonstration).**

Revenue and expenses for each funding stream are tracked separately using grantor and project account codes in CHOICE's cloud-based accounting software, MIP. Staff codes all expenditures according to the chart of accounts including grantor, cost center, and project code in addition the general ledger expense code. The result is a highly customizable system allowing management to track funds by grantor and project. Project staff also uses this system when completing timesheets and expense reports, to capture personnel expenses accurately on a specific project.

**Describe how capacities for data, clinical, financial, community and program management, and strategic development (specified in STC 22) will be met through staffing, vendors or in-kind support from board/community members.**

Following is an overview of roles and responsibilities required to successfully implement and sustain the Medicaid Transformation Demonstration Projects. The CPAA is currently executing an administrative services agreement with CHOICE to fulfill these needed capacities. Several staff positions have been identified as well as consultation services needed to expand current capacity.

**Data**

In order to have the necessary processes and resources to support data-driven decision making and formative evaluation, we will recruit for the following positions:

1. IT and Data Analytics Manager
2. Data Analyst
3. Healthcare Quality Analyst

These positions will create a data team that will provide data support to contribute to population health management modeling, including data aggregation, data analysis, data-informed care delivery, and data-enabled financial models. They will develop bi-directional data products for agency reporting as well as end user reporting. The team will be able to design, document, test, implement, and manage clinical quality data collection and reporting systems. They will be able to interpret quality requirements and report conclusions to stakeholders and other interested parties. In addition, the data team will be able to perform root-cause analyses for quality metrics and recommend quality improvement plans using evidence-based methodology.

Additionally, we are contracting with Providence CORE to provide support related to identifying project-level measures and the CPAA's planned data infrastructure. CORE may also provide help with CPAA partners' data needs and infrastructure as related to CPAA initiatives, identifying priority populations or tailoring project selection based on available data, interpretation of State or provider data, benchmark setting for CPAA projects and partners, and reporting infrastructure.

**Clinical**

We will expand our capacities to include appropriate expertise and strategies for monitoring activities of clinical providers by incorporating clinical leadership, which will reflect both large and small providers and urban and rural providers, by identifying subject matter experts from partner organizations, and hiring appropriate clinical staff to support this work.

We plan to hire the following positions in support of clinical capacity:

1. Chief Medical Officer (CMO) (Contracted)
2. Clinical Program Director
3. Clinical Educator (Contracted)

The Chief Medical Officer and Clinical Program Director will both have clinical backgrounds, and provide expertise that will be helpful to clinicians. The director will provide clinical oversight and quality oversight to program managers, providers, and others as needed as well as educate other CPAA participants to increase clinical capabilities within the team. The Clinical Educator will provide clinical support and education for providers to improve clinical outcomes.

The CPAA has identified clinical subject matter experts from partner organizations, including chief medical officers from the seven counties who are willing to serve as provider champions to help guide and implement the Demonstration projects. Please refer to the attached clinical bios for additional information.

**Financial**

The financial domain includes making decisions about allocation methodology, identifying roles and responsibilities of each partner organization, and developing a budget. The CPAA meets the capacities of this domain by working with the CHOICE Operations Director, our accounting firm, the CPAA

finance committee, and the Technical Assistance vendor Manatt, to explore the best examples of payment methodologies for contracts with providers. The team will have the ability to develop financial reports to support incentive payments to providers, and they will also submit reports to the state on the actual distribution of transformation project payments, fund balances and reconciliations, and other financial reports upon request (subject to auditing by state).

**Community Engagement**
We will conduct community engagement with an emphasis on health equity by hiring a Community and Tribal Liaison. This person will foster relationships with community members and tribal authorities to understand community interests as they relate to projects. They will follow the Model Tribal Engagement and Collaboration Policy, and receive ongoing training on the Indian health care delivery system, and share training and methods with other ACH staff and partners. The liaison will collaborate with CPAA's tribal leader committee. Additionally, the liaison will engage the public through electronic communications, "town-hall" style meetings, social media, and other forms of communication in collaboration with program managers.

**Strategic Development**
The Executive Director works with the CPAA Council and Board of Directors to develop the strategic plan and provide strategic leadership. The Regional Health Improvement Plan Compass lists our goals, priorities, and strategies to improve community health and safety while advancing the Triple Aim.

**Program Management**
To provide organizational capacity and administrative support, we will establish two program directors under the executive director's leadership. These directors will be responsible for the oversight of the demonstration projects. Additionally, several program managers will be hired to support the projects, assuming the CPAA is moving forward with all mandatory and optional projects under Domains 2 and 3:

1. Bi-Directional Integration of Care Program Manager
2. Oral Health Program Manager
3. Transitional Care Program Manager
4. Community Based Care Coordination Program Manager
5. Diversion Program Manager
6. Maternal Child Health/Chronic Disease Program Manager
7. Opioid Program Manager

The program managers will be responsible for planning and implementation of each specific program. Some of these activities include:

- Serving as coordinator and single point of contact for all related program activities.
- Assessment, planning, and development of workforce needs in the region or affected area for each program
- Providing related analysis and reporting to meet statewide requirements for project demonstration
- Monitoring and continuous improvement of programs to evolve the health services workforce through transformation efforts, the provision of training and education services, hiring and deployment processes, and integration of new positions to support transition to team-based, patient-centered care to ensure equity of care delivery across populations.

- Provide oversight related to implementation of the program, collaboration with data analyst(s), and community and tribal liaison in addition to external resources needed for specific program implementation.

We are also exploring the need for a business analyst that could provide business and process improvement facilitation for providers, communities, and any other stakeholders as needed to achieve better results in process-based programs.

**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.*

**Provider Engagement**

**Provide a summary of current work or plans the ACH is developing to engage clinical providers. Include a summary of input the ACH has already received from clinical providers or subject matter experts regarding the mechanisms and strategies to engage providers.**

CHOICE Regional Health Network is a nonprofit healthcare collaborative with the mission to improve health across our region through the collective planning and action of health care leaders. CHOICE board members include independent and critical access hospitals, health systems, federally qualified health centers, primary care clinics, behavioral health providers, and public health departments. We have engaged in conversations with these providers to receive guidance on how best to engage with clinical staff. These clinical systems suggest engaging with clinical line staff is essential, but support and buy-in from organizational leadership (such as Chief Executive Officers, Chief Medical Officers, and Chief Clinical Officers) will be needed first.

We have begun to set up meetings with lead administrators and chief medical staff to review the Project Toolkit and obtain guidance on project selection and project design. For instance, we recently met in Grays Harbor to speak with the clinical and administrative leaders of two hospitals and affiliated clinics to discuss Demonstration project options. There is great interest in providing guidance and direction in matters that are related to clinical operations. We are now scheduling similar meetings with the leaders of hospitals and affiliated clinics and other providers throughout the CPAA region. We will build from that foundation to reach out to clinical line staff.

CPAA also has a Care Coordination Work Group that includes clinical providers who are engaged in project research, selection, and development. There are different types and levels of providers participating, such as a primary care physician who is co-chairing the group, pediatricians, nurse practitioners and behavioral health therapists. Additionally, many local forums have clinical providers included at the local level as well. Having these clinical perspectives from different practice levels is vital to developing the work of the ACH.

Initial feedback we have received from providers about the toolkit is that improvements in care coordination, care transitions, and diversion are complimentary and interconnected. There is great interest in all three areas as well as in chronic disease management. Additionally, the clinical and administrative leadership is very interested in the business implications of implementing the project toolkit strategies. There is a need to determine the costs and benefits of the various projects to see if the transformation efforts will be sustainable. This includes understanding where the Medicaid beneficiaries are located and what providers are serving them. Lastly, there is a strong desire to align

the Medicaid Transformation Demonstration with other transformation efforts to achieve the broad systems transformation envisioned by the Demonstration.

**Describe how the ACH is approaching provider engagement, as well as identification of provider champions within the ACH. Include any targeted committees, panels or workgroups.**

As mentioned above, we have great connectivity with clinicians due to the relationships CHOICE has built over the last 20 years. The CEOs of area hospitals and clinics have agreed to be a gateway to provider champions. We are now engaging with these administrative leaders to connect with their top-level clinical staff (CMOs and CCOs) who are willing to either serve as provider champions and/or subject matter experts or connect us with clinicians that are able to fulfill this function. Their expertise will be crucial in the design of the Demonstration projects. We are still exploring how we will systematically engage providers across the region beyond these clinical leaders. This could take the form of specific planning work groups or a review panel. Providers will provide CPAA guidance on how best to engage them. Please see the attached bios for provider champions confirmed to date.

**Partnerships**

**Demonstrate how the ACH is partnering with local and state clinical provider organizations (e.g., local medical societies, statewide associations, and prospective partnering providers).**

CHOICE has worked with clinical provider organizations in a five-county region and statewide for over 20 years. Within our region, we are able to leverage the local provider organizations who serve the majority of patients and clients in the region, including hospitals, federally qualified health centers, behavioral health providers, and primary care that are coming together within CHOICE. Over the last two years, we have expanded these relations to clinical providers with services in Cowlitz and Wahkiakum counties. We have also developed strong relationships with clinical provider organizations outside of CHOICE, including Physicians of Southwest Washington, Washington Rural Healthcare Collaborative, Washington State Hospital Association (WSHA), and the Washington State Medical Society. We have presented to each of these organizations at different meetings this past year to share information about the CPAA's work and invite their collaboration. Most recently, we have been involved in regular meetings with WSHA to explore how we can align our efforts with health systems that cross multiple ACH regions and coordinate the work of ACHs across regions.

**Attachment(s) Required:**

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

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## Attachments Checklist

| Application Section | Required Attachments | Recommended Attachments |
|---|---|---|
| **Theory of Action & Alignment Strategy** | None | None |
| **Governance & Organizational Structure** | A. Visual/chart of the governance structure<br>B. Copy of the ACH's By-laws and Articles of Incorporation<br>C. Other documents that reflect decision-making roles, including level of authority, and communication expectations for the Board, committees, and workgroups<br>D. Decision-making flowchart<br>E. Roster of the ACH decision-making body and brief bios for the ACH's executive director, board chair, and executive committee members<br>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 (Chehalis & Skokomish) |
| **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 |