

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 executor. 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. Funding¹ 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

ACH Certification Phase I: Submission Contact	
ACH	Greater Columbia Accountable Community of Health (GCACH)
Name	Carol Moser, Executive Director
Phone Number	(509) 851-7601, (509) 546-8933
E-mail	cmoser@greatercolumbiaach.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

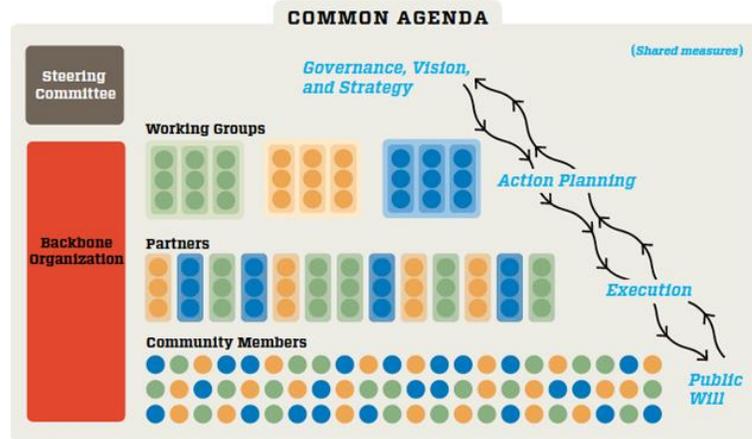
Please ensure that your responses address of the questions identified below. Total narrative word-count range for entire section is 400-800 words.

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?
- 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?

Greater Columbia Accountable Community of Health (GCACH) is a collaboration of community leaders from a variety of sectors with a common interest in improving population health. GCACH developed the following vision statement to guide our work: “The Greater Columbia Region is a vibrant, healthy community in which all individuals, regardless of their circumstances, have the ability to achieve their highest potential.” Our mission is “to advance the health of our population by decreasing health disparities, improving efficiency of health care delivery, and empowering individuals and communities through collaboration, and community engagement.” To make this happen, the region has come together using the Collective Impact Model to align community strategies, and implement evidence based approaches to health issues. Collective Impact is premised on the belief that no single policy, government department, organization or program can tackle or solve the increasingly complex social problems we face as a society. The approach calls for multiple organizations or entities from different sectors to abandon their own agenda in favor of a common agenda, shared measurement and alignment of effort. Unlike collaboration or partnership, Collective Impact initiatives have centralized infrastructure – known as a backbone organization – with dedicated staff whose role is to help participating organizations shift from acting alone to acting in concert.

Cascading Levels of Collaboration



In 2014, the Southeast Washington Community of Health (later the GCACH) began using the National Association of County and City Health Officials [Mobilizing for Action through Planning and Partnerships \(MAPP\)](#) framework to develop a regional health improvement plan. In a series of meetings and retreats, the GCACH reviewed many sources of data and assessments to identify regional health needs. In addition, local health jurisdictions, a community action agency, and the Eastern Washington University Institute for Public Policy and Economic Analysis presented community health needs assessments, social determinants of health, County Health Rankings, and population health data. The process took approximately 18 months, and the following issues emerged as the region’s most pressing health priorities: Care Coordination, Diabetes/Obesity, Behavioral Health, Healthy Youth & Equitable Communities, and Oral Health.

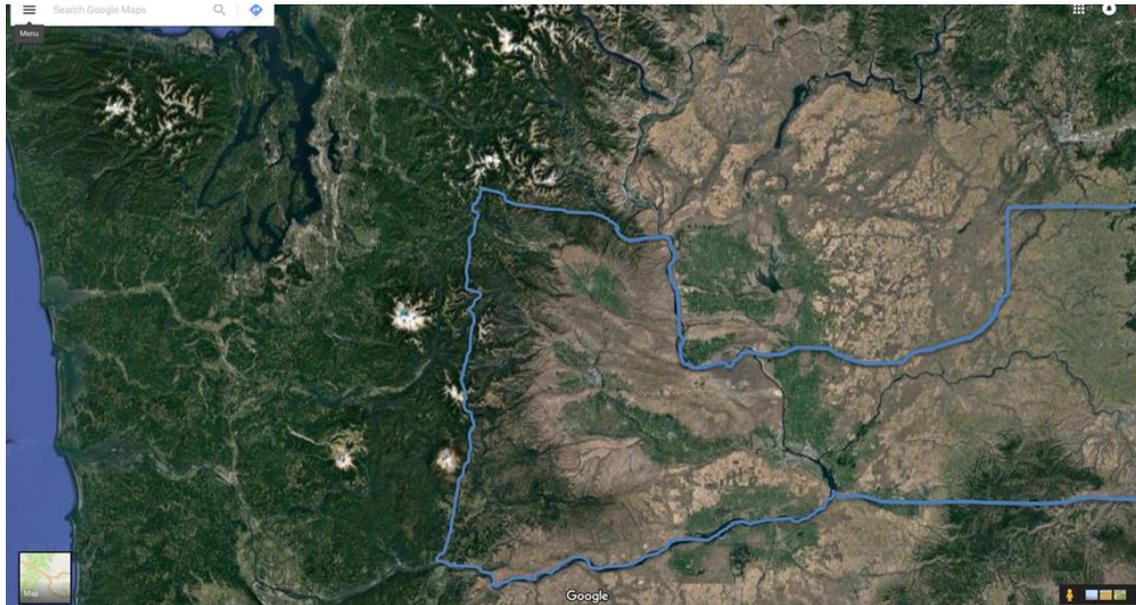


Based on the data and assessments, the GCACH formed five Priority Work Groups to address these priorities, and created a strong governance structure to implement the regional health improvement plan.

The governance structure includes a Board of Directors representing 17 sectors, and a Leadership Council that brings the community, stakeholders, and subject matter experts to the same table. In addition, GCACH has created a myriad of communication tools to inform, involve, and engage our partners that keep them apprised of our actions.

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

Health equity is a strong priority for GCACH because of the large numbers of children and adults receiving Medicaid benefits. Of the 732,000 people in our regional service area, nearly 254,000 receive Medicaid, equating to 34.7% of our population. Health disparities in the GCACH's service area arise from high rates of poverty, a large Hispanic and Native American population, lack of education, job opportunities, high rates of uninsured, limited English proficiency and lack of access to health insurance. Much of this is driven by the region's geographic features which support one of the regions' main industry, agriculture. A map of the Greater Columbia Accountable Community of Health geographic area is shown below, outlined in blue.



Greater Columbia by County Population & Medicaid %**				
County Population	OFM 4-1-16	% GCACH Pop	Population on Medicaid*	% of GCACH Pop on Medicaid
Asotin	22,150	3%	6,497	2.6%
Benton	190,500	26%	55,853	22.0%
Columbia	4,050	1%	1,145	0.5%
Franklin	88,670	12%	34,916	13.8%
Garfield	2,200	0.3%	599	0.2%
Kittitas	43,710	6%	9,974	3.9%
Klickitat	21,270	3%	6,588	2.6%
Walla Walla	60,730	8%	16,568	6.5%
Whitman	47,940	7%	7,822	3.1%
Yakima	250,900	34%	113,780	44.8%
Total GCACH Pop	732,120	100%	253,742	100%
Comparison to WA State			13.9%	
Comparison to GCACH Population			34.7%	

Greater Columbia ACH Differentiations		
Characteristics	Statewide	GCACH
Rural	18%	23.3%
Hispanic/Latino	11.2%	26.4%
American Indian/Alaska Native	1.2%	14.3%
Less than high school graduate	10%	19.2%
Non-Citizen	7.1%	10.0%
Limited English proficient	7.9%	13.5%
Migrant Seasonal Farmworker	4.1%	19.6%
Uninsured	13.5%	18.2%
Medicaid Insured	26%	34.7%
Below Poverty	12.9%	19.5%

** <https://fortress.wa.gov/l/51/views/HealthierWashingtonDashboard/PopulationExplorer>

Employment Security Department, Quarterly Census of Employment & Wages		2015 Annual Averages			
	Firms	Total Wages	Average Emplmt	Average Wages	% of Emplmt
Yakima County					
Retail trade	615	\$289,565,953	10,384	\$27,886	9.5%
Agriculture, forestry, fishing and hunting	1,050	\$824,510,422	30,191	\$27,310	27.7%
Franklin County					
Manufacturing	54	\$144,749,603	3,802	\$38,072	11.5%
Agriculture, forestry, fishing and hunting	356	\$183,435,224	6,730	\$27,256	20.3%
Benton County					
Agriculture, forestry, fishing and hunting	265	\$154,923,258	6,020	\$25,735	7.3%
Walla Walla County					
Agriculture, forestry, fishing and hunting	231	\$97,559,932	3,489	\$27,962	13.0%
Manufacturing	132	\$175,073,788	3,520	\$49,737	13.1%
Garfield County					
Retail trade	9	\$1,280,148	49	\$26,125	6.7%
Agriculture, forestry, fishing and hunting	38	\$1,453,735	55	\$26,432	7.6%
Whitman County					
Agriculture, forestry, fishing and hunting	294	\$12,675,233	489	\$25,921	2.7%
Retail trade	92	\$35,837,356	1,443	\$24,835	8.0%
Asotin County					
Retail trade	52	\$31,761,426	1,050	\$30,249	18.0%
Columbia County					
Agriculture, forestry, fishing and hunting	43	\$4,473,416	147	\$30,431	11.6%
Kittitas County					
Accommodation and food services	148	\$45,866,988	2,548	\$18,001	18.2%

- 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.

GCACH’s identified priority areas align with the project categories in the Medicaid Demonstration Project Toolkit, our vision, and our regional health improvement plan. Therefore, GCACH is well-positioned to take the next steps to determine which approaches and strategies can be leveraged to find common solutions that can go upstream to address root causes and health equity. For example, Community Health Workers could provide home visiting services that are culturally sensitive in rural areas that lack transportation and access to health services.

- 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.

GCACH has taken a regional approach to determine common solutions, shared measures, reinforcing activities supported by continuous communication to leverage DSRIP projects. As a result, GCACH has a regionally focused process to build a coalition that can synthesize multi-sector and cross-geographic voices to shape decisions that inform our health improvement efforts. As a region, our collective voice has more influence to support policy changes leading to the achievement of the triple aim. Adoption of these policies within the delivery system will create lasting change and sustainability.

Healthier communities must consider all the social determinants of health, including housing, education, job opportunity, food insecurity, and cultural differences; every attempt will be made to take an integrated approach when selecting strategies. For example, programs that can be scaled regionally and demonstrate clinical-community linkages will be chosen over programs with a singular focus and geographic area.

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

GCACH has developed strong partnerships in the community to provide meeting spaces, technological and financial support, and lunches for monthly meetings and retreats. Our monthly meetings have grown to include over 60 people, many who donate a full day to attend monthly meetings.

Attachment(s) Required

Not Applicable

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

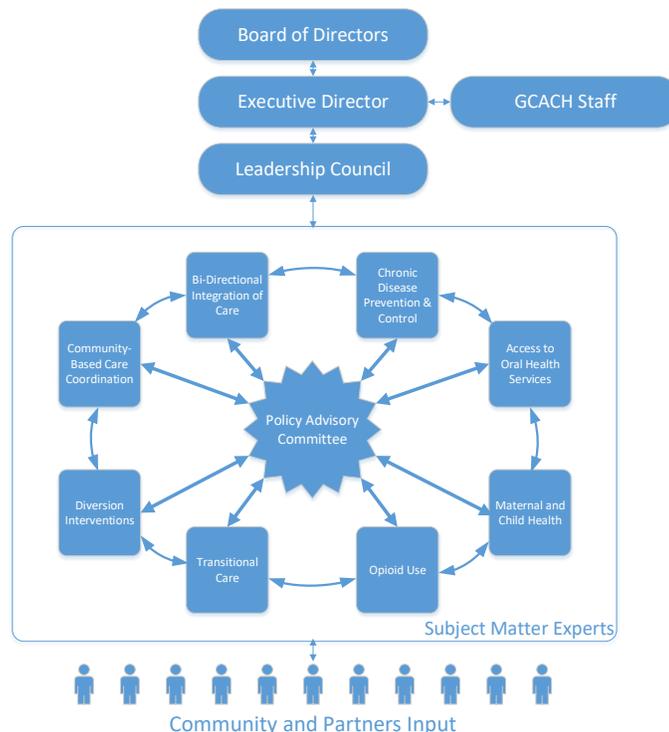
Instructions

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.)?

GCACH has a two-tiered governance structure; a Leadership Council and a Board of Directors. The Leadership Council includes anyone from our regional service area who shares a common interest in improving health. The Board of Directors provide the strategic direction and oversight of the organization and work in partnership with the Leadership Council on determining processes, projects, and priorities. The primary role of the Leadership Council is to provide the creative energy that gives voice to priority issues, and brings subject matter expertise to the Policy Advisory Committee.



The Leadership Council has formed 8 Project Teams to align with the Medicaid Transformation Demonstration Project Toolkit: Bi-Directional Integration, Opioid Use, Community-Based Care Coordination, Transitional Care, Diversion Interventions, Reproductive and Maternal/Child Health, Access to Oral Health Services, and Chronic Disease Prevention and Control.

The Board of Directors has representatives from 17 sectors as illustrated below. The Board also maintains five standing committees: Executive Committee, Nominating Committee, Finance Committee, By-Laws Committee, and the Communications Committee.

BACKBONE ORGANIZATION

Greater Columbia Accountable Community of Health

Carol Moser, Executive Director

Aisling Fernandez, Communications Coordinator

Wes Luckey, Program Manager

BOARD OF DIRECTORS

Public Health Walla Walla County Department of Community Health Meghan Debolt	Hospital Yakima Memorial Hospital Eddie Miles	FQHC Tri-Cities Community Health Martin Valadez, President	Healthcare Provider Sunnyside Community Hospital Brian Gibbons, Treasurer	Mental Health Provider Comprehensive Mental Health Ed Thornbrugh	CBO/FBO Catholic Family and Child Services Darlene Darnell	Social Services SE WA Aging and Long Term Care Lori Brown	Local Gov't Greater Columbia Behavioral Health Vacant	
Education Educational Service District 123 Les Stahlnecker	Philanthropy Three Rivers Community Foundation Carrie Green	Managed Care United Healthcare Amina Suchoski	Housing Yakima Neighborhood Health Rhonda Hauff, Vice-President	Workforce Dev Washington State Allied Health Center of Excellence Dan Ferguson	Tribes Yakama Nation Frank Mesplie	Public Safety Kittitas Valley Fire and Rescue John Sinclair, Secretary	Consumer Northwest Justice Project Vacant	Transportation People for People Madelyn Carlson

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

The GCACH Board began discussions with the Benton-Franklin Community Health Alliance (BFCHA) a community 501(c)(3) managed by the same Executive Director at their December 15th, 2015 meeting. Since that time, both BFCHA and GCACH have evolved together through a Fiscal Sponsorship Agreement. A fiscal sponsorship is a formal arrangement in which a 501(c)(3) public charity sponsors a project that may lack exempt status. This arrangement allowed GCACH to receive funding under BFCHA's tax exempt status, but specified the terms, fiscal accountability, administrative support, restrictions, relationship, and reporting requirements of the agreement.

The GCACH received its Certificate of Incorporation as a Nonprofit Corporation in June of 2016. In March of 2017, the GCACH received tax exemption status by the IRS as a 501(c) 3 public charity.

Decision-making

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

Management of all affairs, assets, property and goodwill of the GCACH are vested in the Board of Directors who have delegated the management of the day-to-day operation of the business to an Executive Director. Ultimately, however, the activities and affairs of the

corporation are managed and all corporate powers are exercised under the direction of the Board. The Board provides strategic direction and works in partnership with the Executive Director, Leadership Council, and workgroups on approved projects. The Board has adopted Robert's Rules of Procedure as the method of conducting meetings and making decisions. The Bylaws dictate that a quorum of "a simple majority of the Directors then in office at the beginning of each meeting" shall constitute a quorum for the transaction of business" (Article IV, Section 7. Meetings, 7.8 Quorum.).

The Bylaws also stipulate that expenditures exceeding \$2500, and not in the budget have to come before the Board for approval. Contracts policy #2017-001 requires contracts and agreements exceeding \$4999 to be approved by the Board. The same policy further requires that all contracts, agreements, memorandum of understanding and similar documents that are legally binding are subject to any federal or state grant contracting laws and requirements.

- 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 decisions leading up to the selection of a governance structure was a very inclusive and transparent process. A 10-county retreat was held in December 2014 to determine the composition, roles, and process of choosing the Board, Leadership Council and backbone organization.

Ultimately, a subcommittee of the Leadership Council recommended using a distributed model of governance consisting of many stakeholders with cross geographic and cross sector representation. It was also determined that there should be one Leadership Council for the ten county area, (now nine), and one Governing Board. At the retreat, the participants voted to use BFCHA as the interim backbone organization, and be authorized to hire an interim director for the GCACH, subject to approval from the BFCHA Executive Board.

Over the course of six months, the subcommittee proposed, interviewed, and vetted candidates for 16 Board positions representing the following sectors: Public Health, Hospitals, Healthcare Providers, Behavioral Healthcare Providers, Food Systems/Community Based Organizations/Faith-based Organizations, Social Services, Local Government, Education, Philanthropy, Managed Care, Housing, Business, Tribes, Public Safety, Consumers, and Transportation. The first Board meeting was held on May 21, 2015 at which time a Federally Qualified Health Center sector position was added bringing the total to 17 members. The initial term of these Board members was one year, however for the purpose of staggering the terms after the initial year, fifty percent (50%) of the Board served a one-year term and the remaining Directors will serve a two-year term. The initial group was determined by a lottery. Thereafter, each Director's term of office is 2 years. The MCOs self-determine their representative which rotates on a yearly basis.

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

Board vacancies follow a procedure outlined in the bylaws; the Leadership Council recommends a new representative for the open sector Board position, the President appoints a Nominating committee to vet the candidate, and the Board approves the position.

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

The official vehicle for informing GCACH members of decisions of the Board and the recommendations of the Leadership Council is through the meeting minutes. Because the Board meetings happen after the Leadership Council, the minutes go out in draft form to the membership, and then again after the minutes have been approved by the board. The minutes are posted to the GCACH website so that the public can read them; this also allows for its accessibility to all GCACH members.

Board members frequently attend the Leadership Council meetings, providing the opportunity for bi-directional communication that can happen in real time, however we recently began a practice of taking key messages from the Leadership Council to the Board to ensure that bi-directional communication remains fluid. Similarly, we are asking the Board for key messages to be communicated to the Leadership Council.

According to the Bylaws, the Leadership Council is advisory to the Board with the Board ultimately making the decisions on behalf of the organization.

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

GCACH maintains a website with current information received from the WA HCA, minutes and materials from the Board and LC meetings. We also maintain a calendar on the website listing our meeting dates and time. Agendas and materials are sent out to organizations and individuals who have requested to be on our mailing list (at latest count approximately 250). We also maintain a larger distribution list for initiatives like the Regional Survey to inform the community of opportunities to shape decision making which includes over 700 members.

To date, the recommendations from the Leadership Council have been accepted by the Board. The biggest issue, however, was the recommendation of the project required under the State Innovation Model grant. While the Strategic Issues Committee had met and determined a path forward for the project, and recommended its approval to the Board, the process was rushed to meet the deadline.

The Board felt that they did not have enough time to process the project selection. Ultimately, the Board took the recommendation of the Leadership Council, but more time should be allowed for decisions involving funding in the future. The Board President and Vice-President met with the Executive Director to understand how the process could be improved.

- Describe how flexibility and communication strategies are built into the ACH’s decision-making process to accommodate nimble decision-making, course corrections, etc.
- Describe any defined scope, financial accountability or other limits placed on staff or the Executive Director regarding decision-making outside of board approval.

The structure of the Leadership Council provides a great deal of flexibility to the Board who rely on this body for specific actions which are detailed in the Bylaws. These specific items include: developing a list of priority issues and strategies to address them, monitoring indicators of population health, and evaluating the performance of the regional healthcare delivery system. The Board can also request specific individuals to become members of the Leadership Council, or appoint standing or temporary committees that require additional subject matter expertise. In this manner, the Leadership Council acts as the recommending body for strategic directions for the Board which the Board can then consider.

The Bylaws call for an Executive Committee who can be empowered to make decisions on behalf of the Board between regular Board meetings should that authority be expressly given to them by the Board.

The limits placed on the Executive Director regarding decision-making have been described in the previous section.

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	Carol Moser, MBA, Executive Director
Phone Number	(509) 851-7601, (509) 546-8933
E-mail	cmoser@greatercolumbiaach.org
Years/Months in Position	3 years – Started in May of 2014

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?

GCACH has contracted a facilitator, Dr. Patrick Jones, who has provided data and analytic support since the organizations’ inception. Dr. Jones is an economics professor from Eastern WA University, and is the Executive Director of the Institute for Public Policy & Economic Analysis. His support has enabled GCACH to make informed decisions regarding regional priorities and issues based on data analysis, trends, and reports in addition to providing subject matter expertise and experience.

Recently, GCACH hired a Program Manager who has extensive background in data analysis and research. GCACH has no gaps in this program area, and is very fortunate to have such qualified and capable people on the team.

A data committee of the Leadership Council also provides feedback and support to GCACH staff.

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

Data Sharing Agreement with HCA?			
YES		NO	X

A draft data sharing agreement was released, reviewed, and revised by the Executive Director and Program Manager for GCACH on May 5, 2017. Pending approval of the revisions, GCACH will have an agreement with the HCA for sharing data that is categorized as public and sensitive, but not identifiable to specific individuals.

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

Data Point Person	
Name	Wes Luckey, Program Manager
Phone Number	(509) 546-8931, (509) 851-7784
E-mail	wluckey@greatercolumbiaach.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

Instructions

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

- 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.
- Describe whether and how the ACH has reached out to regional ITUs to invite their participation in the ACH.

During the initial stages of discussing Governing Board representation, and using guidance from the Washington State Health Care Authority, the Yakama Indian Nation was recognized as an important partner to GCACH. Andre Fresco, the Public Health Administrator for the Yakima County Health District volunteered to set up a meeting with the Yakama Nation and representatives of the GCACH to invite their participation on the Board of Directors, and encourage their participation. Mr. Fresco had worked with the Yakama Tribe on some Public Health issues, so he was a trusted pathway. During the Spring of 2015, the Executive Director and Mr. Fresco met with three members of the Yakama Tribe: Frank Mesplie, Member of the Tribal Council, and Chairman of the Health, Employment, Welfare, Rec., Youth Activities Committee, (HEW), Raymond R. Smartlowit, Tribal Council and member of the HEW, and Phillip L. Ambrose III, with Tribal Administration, Special Projects Manager – Retrocession. Although Councilman Mesplie has not been able to attend the Board meetings, he has designated Katherine Saluskin, MSW and Program Director of Behavioral Health and Tonya Kreis, MED, Behavioral Health Therapist II, to officially represent him on the Board.

Ms. Kreis and Ms. Saluskin have participated in several GCACH meetings, and receive communications and meeting materials for the Leadership Council and Governing Board meetings.

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

As stated above, the Yakama Nation has had a seat on the GCACH Board of Directors since the inception of the organization, and there have been several occasions to collaborate with them. The Executive Director observed a Tribal Consultation meeting on May 11, 2016 along with the other ACH Directors at Suquamish House of the Awakened Culture in Suquamish. This was a very instructional meeting, and the American Indian Health Commission (AIHC) wanted to discuss the minimum requirements to be placed on the ACHs on governance structure, and the requirements of consultation and engagement. In August of 2016, 32 members of the Leadership Council participated in an AIHC training at the Yakama Nation Legends casino in Toppenish. This training included information about the history of health care law, and tribal issues concerning Indian Health Services. The presentation also highlighted health concerns of the Yakama Tribe. GCACH members noted that we share common health issues of diabetes, obesity, oral health, behavioral health, and health equity. This training was highlighted in our first monthly newsletter, September 2016, and in the September 2016 Director’s Report.

On April 14, 2017, the Program Manager and the Executive Director drove to Toppenish to meet with Tonya Kreis to learn more about the Yakama’s Behavioral Health Programs, and to discuss the Medicaid Demonstration toolkit. Ms. Kreis shared valuable information regarding their Behavioral Health programs and challenges, and helped us connect with Bonnie Pimms, WIC Program Manager, and Angelique Williams, the Administrative Assistant for the Yakama Nation Area Agency on Aging. The trip was very enlightening, and created a better understanding of the challenges shared by both GCACH and the Yakama Nation, and was highlighted in the April 2017 Director’s Report.

- 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.

The May Tribal Consultation in Suquamish was an informative experience, and there were many lessons learned about appropriate engagement with the Tribes as a sovereign nation, their desire to be considered partners, not stakeholders, the requirements of consultation, and understanding the importance of consultation prior to implementation of ACH policies and actions that have tribal implications. The August workshop was a good lesson in understanding the various agencies that serve Native Americans, and a history lesson in how certain treaties and promises have undermined the trust between the United States government and tribal nations.



The Yakama Nation is the largest Indian Tribe in the State of Washington, and as a sovereign nation operates and funds departments, agencies, and services. Their Governing Body is a 14-member Tribal Council with 13 Standing Committees. Decisions must follow

certain protocols and may take longer to make than decisions made by local and state government agencies.

GCACH is taking steps to make engagement with the Yakamas more meaningful by learning about their challenges and needs, and ensuring that they are receiving all of the meeting materials for the Leadership Council, Board, and Project Work Teams as far in advance as possible to allow them time for decision making.

Engagement with the Yakama Tribe has been more frequent since Councilman Frank Mesplie designated Tonya Kreis and Katherine Saluskin to represent him on the Board. In-person meetings on the reservation are ideal due to some technical, transportation, and communication challenges. The Nation is also challenged in providing services to a large regional area (their reservation is over 1 million acres), so time spent away from the reservation is difficult, and travel is challenging.

A recent trip to Toppenish to meet with Tonya Kreis in the Behavioral Health office was informative, and gave the Program Manager and Executive Director a strengthened appreciation for the challenging work of their program, and the people they serve. We hope to follow-up with them on programs for the Medicaid Demonstration project application, and collaborating to solve some of their communication needs.

Policy Adoption and Board Training

- 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?
- 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.

GCACH has not yet adopted the ACH Tribal Collaboration and Communication Policy, but the policy will be on the May 18th Board agenda for discussion. Yakama representatives have been sent the policy to review, and are sending a representative to attend the meeting. GCACH Staff will work with Libby Watanabe, Jessie Dean, Vicki Lowe, Tonya Kreis and Katherine Saluskin to schedule a follow-up training for the Board of Directors by the end of 2017. In the meantime, the May 18th Board meeting will carve out time on the agenda to discuss the Collaboration and Communication Policy, and review highlights of the presentation given on August 16, 2016.

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.

There is a saying in Public Health, "Nothing about us without us." This is especially true for the approach GCACH is taking with the Medicaid Demonstration. While GCACH is fortunate to have robust participation from stakeholders at their Leadership meetings, the need to touch base with the very lives that will be affected is extremely important to the organization. This means working through existing networks of community-based organizations that serve these populations, developing an awareness of the racial and economic disparities in our region, and why they exist, going out into the community to experience and engage with consumers of the system, and empowering them in helping us shape the type of system that improves the health of their populations. It is our vision to create a Consumer Council comprised of Medicaid beneficiaries. While we have a designated Board position for Consumers, it was recently vacated providing GCACH with an opportunity to find a Medicaid consumer who can offer their perspective and represent communities with the greatest needs for health improvement.

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

The type of community engagement that reaches the Medicaid population varies from community to community, and is really dependent on being at the right place at the right time. Traditional forms of marketing don't always reach the audiences we are seeking, so it requires understanding how to get meaningful input. Language and other cultural barriers have to be overcome as well. In addition, until the approval of the Medicaid Demonstration, there has not been certainly about the ACHs' future, so staffing up to fund a consumer engagement program

has been lacking. Given the region's demographic makeup with over 26% of the population identifying as Hispanic, and 14% identifying as American Indian, meaningful community engagement must include a bi-lingual approach and be culturally appropriate. GCACH must find trusted pathways to engage Medicaid consumers.

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

GCACH has a very robust Leadership Council with stakeholders that represent low-income communities who are very good about speaking up for their interests. However, more could be done to engage marginalized populations, and to include partners that work with systems that interface with the social determinants. Getting the word out to our housing partners, social service agencies, early education, social justice and advocacy groups, and faith-based organizations are opportunities for more bi-directional communication. While the GCACH website contains meeting materials, minutes, a calendar and resources, this information is only provided in English. It would be our desire to have the website translated into Spanish, and to produce a marketing brochure about GCACH in both English and Spanish. Eventually, we would like to dedicate more resources to communications in general to better engage with the community, and open up more channels for bi-directional communication. Sites such as SharePoint makes it possible for an organization with hundreds of members spread across the region to work with the same level of agility and coordination as a company with ten people working out of a single office. Built into our decisions for the project application are a series of health fairs that will engage the Medicaid population to gather input on our strategies and approaches that will be factored into the final programs decided by the Board.

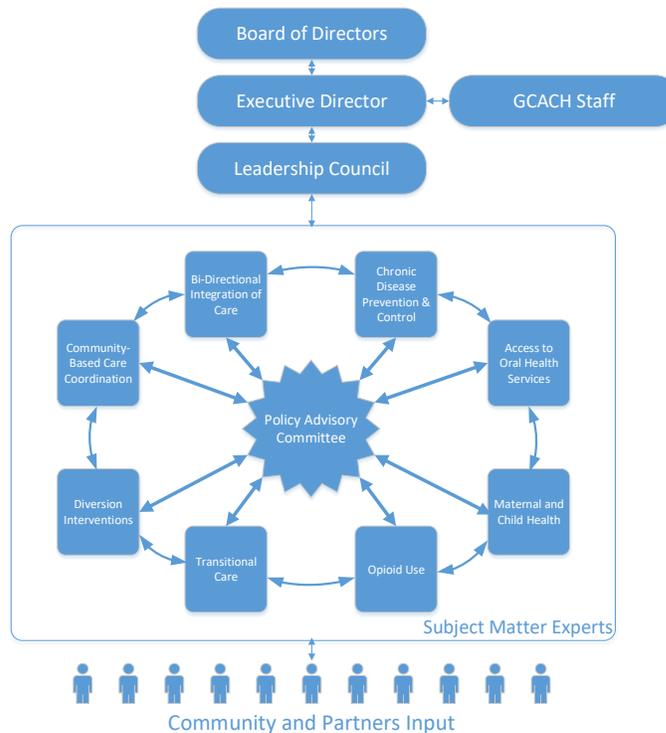
- How is that input then incorporated into decision making and reflected back to the community?

Decision making takes place at the Board level, and those decisions are reflected in the official minutes, documents, and reports, and policies of the Board, and placed on the GCACH website. The minutes are sent out to all members of the GCACH approximately two weeks following the meeting, and sent out again with the meeting materials. The Communications Coordinator takes great care in providing a narrative of the discussion of each agenda item which provides the reader a better understanding of how the decision was made, and who participated in the discussion.

Major decisions are also reflected in the monthly newsletter which directs people to our website, and contains emails of the staff members for questions, concerns, and ideas.

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?



GCACH employs a robust structure for partner engagement. Beyond the Governing Board, GCACH enjoys active participation from the Leadership Council, and has expanded its 5 Priority Workgroups into 8 Project Teams. The Project Teams are aligned with each of the project categories of the Medicaid Demonstration toolkit, and draws subject matter experts (SME) from across the region. One of the roles of the Project Teams is to bring in new SME where appropriate, and an open invitation is extended to the community through the newsletter. Other strategies include stakeholder engagement, community presentations, and outreach. GCACH staff have been meeting with stakeholder groups, and doing community presentations across the region. We provide a sign-in sheet at each of these outreach events, or obtain them through the organizer, and include attendees in subsequent invitations to attend our monthly meetings, and receive our communications.

A Policy Advisory Committee which includes the Project Team Facilitators from each Project Team, the Program Manager, Communications Coordinator and Executive Director has been formed to advise the GCACH Board on program approaches and strategies for the Medicaid Demonstration Project Plan.

- What barriers/challenges has the ACH experienced or anticipate experiencing toward meaningful engagement of a broad spectrum of partnering providers?
What opportunities are available for bi-directional communication to ensure that partnering

providers can give input into planning and decision?

The biggest challenge to meaningful engagement of our partnering providers has been the geographic region of our service area. The size of our area includes 9 counties encompassing over 15,000 square miles, the largest ACH geographic region of the state. In person meetings occur on a monthly basis in Pasco, with some members traveling 2 ½ hours one way to attend. Many of the rural communities do not have internet service on a consistent basis, and the Yakama Nation frequently experiences interruption to their phone service. Fortunately, there are many opportunities for our partners to have input into planning and decisions through GoToMeetings, conference calls, stakeholder gatherings, trainings, and on-site visits.



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.

All Governing Board meetings are open to the public, all actions of the Board are recorded in the official minutes of each meeting, and all meeting minutes are posted to our publicly facing website. If a decision is needed between public meetings, the description of that action is recorded in the minutes along with the electronic vote taken by each Board member. As a precaution, the Executive Director sends the President the electronic record of each Board member after voting.

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

The Communications Coordinator of GCACH has developed a communications matrix to illustrate the various communication tools that GCACH uses for intended audiences that is based on The International Association for Public Participation (IAP2). The Public Participation Spectrum demonstrates the possible types of engagement with stakeholders and communities. The spectrum shows the increasing level of public impact as you progress from ‘inform’ through to ‘empower’. The matrix is Attachment B under Community and Stakeholder Engagement.

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.

GCACH has been a very lean operation employing 1.5 FTEs until Washington's request for a Medicaid Demonstration project was approved on January 9, 2017 by the Centers for Medicare and Medicaid Services (CMS). Until that time, 2 GCACH staff were housed at the Benton-Franklin Health District which restricted adding staff positions, but gave staff the benefit of sharing office space, phone systems, meeting space, and supporting other operational needs.

Once the Demonstration project was approved, the Board authorized staff to seek other office options. GCACH approached several community partners, and was fortunate to locate space at Community Action Connections, a community based organization that serves the Medicaid population.

Since March of 2017, GCACH has added a Program Manager position, contracted for a Finance Manager, and has had to purchase computers, office supplies, and subscriptions to support utilities for phone service, wireless internet, internet based meeting software, and financial accounting software. Printing costs have substantially increased to support monthly meetings, and travel for training and stakeholder engagement has risen markedly.

Project Design funds will support these additional costs, and will allow GCACH to add a full-time Administrative Assistant position, and support a sub-contract for a healthcare data and financial consultant to development the Demonstration project application. These funds will also be used to hire a Chief Financial Officer, support convenings, facilitation, travel, training, marketing and outreach, consumer engagement, and health fairs.

Investments in IT infrastructure such as SharePoint, eConvene, and upgrades to our existing website will be needed to improve communications and transparency. It is anticipated that investments in IT infrastructure may be necessary in some of our more rural areas, especially on the Yakama Indian reservation. More training will be necessary as part of scaling up programs and expanding capacity, and possible upfront investments in other programmatic areas such as the Pathways Hub will require hiring and training staff.

Fiscal Integrity

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

GCACH has contracted a Contracts and Finance Manager to provide accounting and financial services, and Human Resource Support. This position will transition to a full-time Chief Financial Officer after the certification funding is approved. The Board of Directors has a standing Finance Committee that provides financial oversight for GCACH, and develops an annual budget with the Executive Director. They are also tasked with establishing long-term financial goals that will provide for the sustainability of the corporation.

The Treasurer has been given certain responsibilities under the Bylaws, and is accountable for all funds belonging to GCACH. The Treasurer assures that policies and procedures regarding the disposition of assets and all related financial transactions are followed as prescribed by the Board or the Bylaws and G.A.A.P.

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

The Executive Director has authority to expend up to \$4999 without Board approval, as long as the expenditure has been identified in the budget. The Bylaws stipulate that expenditures exceeding \$2500, and not in the budget have to come before the Board for approval. Contracts policy #2017-001 requires contracts and agreements exceeding \$4999 to be approved by the Board. The same policy further requires that all contracts, agreements, memorandum of understanding and similar documents that are legally binding are subject to any federal or state grant contracting laws and requirements, and must be approved by the Board.

The Board of Directors has full authority over all assets of the corporation, however, they are bound by a Conflict of Interest policy to assure there is no gain to them or their organizations in the program selection process, or jeopardizes GCACH's tax exempt status.

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

General ledger accounts are established and utilized for each funding stream via QuickBooks Online. In addition, the Contracts and Finance Manager classifies expenditures within the system as a checks and balance for proper coding to the general ledger. This allows more flexibility with reporting and analyzing figures. QuickBooks Online has an edit tracking feature so that all transactions and movement of funds is tracked by log on for audit purposes.

- 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.

GCACH employs a full-time Executive Director, Program manager, a .75 FTE for communications and administrative support, contacts for a Contracts and Finance Manager, and contacts for data analytics and facilitation through Eastern WA University. We anticipate transitioning the Contracts and Finance Manager to a full-time Chief Financial Officer after the certification funds have been distributed. Our current Program Manager has nearly 20 years' experience in data analysis with a managed care organization and a Federally Qualified Health Center. The current Contracts and Finance Manager is the CFO of a rural community hospital residing in our service area. Depending on the number of programs in the project application, GCACH may find it necessary to add additional expertise on funds flow and incentive payments once the programs are implemented.

The Executive Director has broad experience in community engagement in the healthcare and public policy sectors, and an MBA with an emphasis in marketing. Efforts to plan, organize and attract the Medicaid community to the health fairs will require travel, targeted messaging and media. We would also like to offer incentives to participate in the program selection process.

Understanding the complexity of the project application, GCACH is contracting with a consulting firm experienced in funds flow management, delivery system incentive payments, value-based purchasing, modeling, project management, claims analysis, and utilization measures. This consultant will have experience with other state Waivers such as New York or New Hampshire.

Because of our broad geographic service area, it is contemplated that a Program Manager will serve in sub-regions within the GCACH eventually requiring 2 new positions. The Project Teams that have been formed to develop the project application will assist in monitoring the program performance, while GCACH will maintain oversight of this process.

It may be necessary to contract for clinical expertise, although currently, GCACH has robust support from clinical providers in each Demonstration project category.

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.

Most of the providers engaged in Greater Columbia ACH are in clinical practice, making it difficult to attend our monthly meetings, however, with the recent formation of the Project Teams, we have experienced more engagement. Each team has a project facilitator who is responsible for bringing the group together to make decisions about program selection. Several of the project facilitator chairs are clinicians.

- 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.

Greater Columbia ACH started under the guidance of the Benton-Franklin Community Health Alliance, a non-profit organization led by the hospitals in Benton and Franklin Counties in 2014. As the GCACH organization has matured and developed, the hospital network has expanded to include the 12 other hospitals and 39 federally qualified health centers (FQHC) in the service area. The hospitals and FQHCs employ the majority of providers in the GCACH service area, so engaging these systems has been critical to linking with provider champions. This expansion has come through personal contact with the hospital CEOs, presentations to their Boards, retreats, personal visits, emails, attending WSHA, WSMA, and regional stakeholder meetings. As the GCACH organization has matured, its distribution list has included these provider organizations who receive communications through newsletters, minutes, meeting materials, and meeting invites. As a result, many hospitals are encouraging their clinicians to participate in the Project Teams. Presently, the Project Teams have at least 3-4 providers engaged in program review and selection, and Dr. Koday, Carla Prock, RN, Dr. Neven, Becky Grohs, RN, Mandy McCollum, RN, Heidi Desmarais, RDH are chairing or co-chairing Project Teams.

Our Board is well represented by the Provider sector, having 4 seats representing the hospitals, medical providers, behavioral health providers, and FQHCs. The Leadership Council has had many provider champions working on the Priority Work Groups, and now Project Teams are attracting new providers to the table to help with project selection. The process of project selection has been another opportunity to reach out to new providers, making personal contact, and plugging them into Project Teams.

Another aspect of provider engagement will come with workforce training. As these projects are implemented, it is anticipated that access issues will provide opportunities for more integration at the community level. Pacific Northwest University of Health Sciences has formed an Inter-professional Practice & Education Committee (IPEC) in order to train a new generation of physicians who get clinical experience in a variety of health pathways which expands their clinical knowledge. Other opportunities are expanding dental assistant training through apprenticeships, and offering a Masters in Social Work through Heritage University. GCACH will work closely with our educational institutions as part of the workforce development plan.

GCACH is partnering with WSU-Tri-Cities College of Nursing, Trios, and Kadlec hospitals for the State Innovation Model pilot project, a hospital readmission program. Should this program be chosen as the Care Transition project, it is anticipated that we would use RN-BSN nursing students in other communities that need clinical experience for their students.

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).

The Executive Director and Program Manager have been working with the Washington State Hospital Association, and the Northwest Rural Health Network to find areas for collaboration within the hospital system, and is arranging consumer health fairs at selected FQHCs as part of its consumer engagement strategy. The Executive Director is working with the Behavioral Health Organization, Greater Columbia Behavioral Health to find a mutually acceptable path for fully integrated managed care. We have engaged with the Washington Dental Service Foundation to find alignment with our program selection process, and the project facilitator for the Opioid Project Team is working with the State's Opioid Task Force to help inform her Project Team.

One of the advantages to the large geographic region of GCACH is the number of educational institutions, and opportunities to partner for clinical training. The State Innovation Model care transitions pilot project includes a partnership with WSU-Tri-Cities College of Nursing, and Columbia Basin College which uses RN to BSN nursing students for visiting patients in their home following an in-patient stay. This experience is providing the students with clinical training, and expands the capacity of Consistent Care Services.

Another opportunity for provider engagement has been through Pacific Northwest University of Health Sciences (PNWU). The Executive Director has met with Dr. Keith Watson, PNWU president and Victoria Keetay, Executive Director of IPEC to discuss opportunities to provide training for team-based care for students and providers within the GCACH region. PNWU is part of the Yakima Valley IPEC, working with the physician assistant and nursing programs at Heritage University; nursing and pharmacy programs with Washington State University; and paramedicine and dietetics programs at Central Washington University. Dan Ferguson, GCACH Board member representing Workforce Development is the Executive Director of the Yakima Valley Centers of Excellence. Mr. Ferguson is helping link clinical training with the provider gaps in the healthcare system, and is a member of IPEC. Our gap analysis has also shown a need for more behavioral health specialists, dental assistants and hygienists in SE Washington, and Mr. Ferguson has been asked to explore ways to engage more students in the dental field.

The Washington State Hospital Association has played an important role in keeping the ACHs in front of their membership through presentations and joint meetings.

The Executive Director and Program Manager have been giving presentations to various clinical provider organizations since 2015. Presentations on the ACH have been given to Trios Health, the South Central & Southeast WA Hospital Councils, Kadlec Regional Medical Center, Kittitas Valley Healthcare, Greater Columbia Behavioral Health Organization, the Whitman County Health Network, and the SE WA Health Network. GCACH has been attending meetings of the Washington State Hospital Association, the Northwest Rural Health Network, the Inter-professional Practice & Education Collaborative, and Washington State Medical Association.

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	<ul style="list-style-type: none"> A. Demonstration of adoption of Model ACH Tribal Collaboration and Communication Policy, either through bylaws, meeting minutes, correspondence, or other written documentation 	<ul style="list-style-type: none"> B. Statements of support for ACH certification from every ITU in the ACH region
Community & Stakeholder Engagement	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> A. High-level budget plan (e.g. chart or excel document) for Project Design funds to accompany narrative required above. 	None
Clinical Capacity & Engagement	<ul style="list-style-type: none"> A. Bios or resumes for identified clinical subject matter experts or provider champions 	None