

Phase I Certification Submission Template

ACH Certification Phase I: Submission Contact	
ACH	North Central Accountable Community of Health
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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 how the ACH will consider health disparities to inform regional priorities.
- 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?
- 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.
- 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.
- 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.

Narrative (796 words):

North Central Accountable Community of Health (NCACH) works with clinical and community partners to implement Whole Person Care for Medicaid recipients through the bi-directional integration of behavioral and medical care, and through the creation of better connections between clinical care and community resources which assist patients in dealing with the impacts of the social determinants of health outside the walls of clinics. The point is not to pay for new services during the life of the Demonstration but to transform our region's delivery system so that this vision is realized in a manner that is sustainable after the Demonstration is over.

North Central Washington is a rural community with many provider organizations whose financial viability is at risk as we transform how we deliver and pay for care. The vision of the North Central Accountable Community of Health is to have community members reach a state of the best possible physical, mental, and social well-being while creating a health care system that is sustainable and meaningful to all provider organizations. This vision of change will be achieved through 4 regional principles:

1. Use Demonstration resources to create sustainable systems inside and outside of the clinical setting to connect Medicaid patients with services that achieve whole person care. Involvement of front-line providers is a critical element in this work.
2. Include our community based organizations in the work of care delivery redesign, and ensure their work is compensated in the new payment delivery models developed under the Demonstration
3. Share the goal of financial viability that provider organizations have as they pursue the new value-based payment model
4. Distribute resources and funding to our partnering organizations to develop care transformation while minimizing the creation of additional administrative overhead in the ACH.

To ensure this consistent message is delivered to our partner groups, the NCACH will develop and adopt an Alignment Strategy for Health System Transformation prior to Phase 2 certification that will be shared with our community partners.

NCACH will align our goals with the regional priorities defined by our Community. To better understand those priorities, the Board focused on the results of our Community Health Needs Assessments (CHNAs). This intensive process brought community members from the entire region together to identify key health issues. The assessment revealed the following regional priorities: Mental Healthcare Access, Access to Care, Education, Obesity, Affordable Housing, Drug and Alcohol Abuse, Access to Healthy Foods, and Diabetes. NCACH also incorporated information from our Community Input survey which identified Care Coordination, Transitional Care, Diversion Intervention, and Chronic Care as the 4 projects that community members felt provided the biggest impact on the above health disparities. These priorities were reviewed at our recent board retreat and were used by the Board in Demonstration project selection. As we develop project proposals, we will structure projects to address these priorities. We will incorporate Mental Health Care Access and Access to Care into bi-directional integration (project 2A), and emphasize care coordination (Pathways HUB) to improve the way Medicaid addresses social determinants of health such as education and affordable housing.

To achieve the NCACH vision and address regional priorities, it is critical to align the priorities of our clinical and community support systems in the region. A prime example of this is the current community partnerships occurring within three regional opioid workgroups. The NCACH will assist these workgroups to find common alignments under the Demonstration project that can enhance their work. As well, community organizations (i.e. housing specialist) will see an increase in the need for services under this new model. Moving forward, it will be important to identify how we will pay for those services through new payment delivery models.

Though a majority of work is completed at the local level, it is important that the NCACH influence extends to the State level. NCACH can act as a collective community voice to the Health Care Authority throughout the course of the Demonstration project and as new payment models are developed between providers (Medical and Community Service Organizations), Managed Care Organizations (MCOs), and the Health Care Authority. The NCACH can also act regionally to educate local and state elected officials and other State agencies on the health priorities specific to our region.

Lastly, sustainability of this work will not be achieved without the support our region receives from local organizations. A specific example is the in-kind support and contract support we have received from our region's Local Health Jurisdictions, support from community partners around website hosting and meeting set-up, and the clinical expertise we have received from our local Health Centers and Hospitals. Our regional partners constantly come forward to support the goals of Healthier Washington, and as we progress through the Demonstration project, NCACH needs to ensure our partners involved are able to establish a mutual benefit.

Attachment(s)

- A. Community Health Needs Assessment Summary
- B. Medicaid Demonstration Project Selection Community Input Results
- C. Press Release – NCACH Project Selection

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

Decision-making

- What decisions require the oversight of the decision-making body? How are those decisions made? (E.g. simple majority, consensus, etc.)
- 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.
- If a board seat is vacant, how will the ACH fill the vacancy?
- How is decision-making informed? What are the documented roles and communication expectations between committees and workgroups to inform decision-making?
- 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?
- 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.

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	Information provided on page 8
Phone Number	
E-mail	
Years/Months in Position	

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

Information provided on page 9

Data Sharing Agreement with HCA?			
YES		NO	

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

Data Point Person	
Name	Information provided on page 9
Phone Number	
E-mail	

Narrative (1,465 words):

The NCACH Governance structure consists of two principal components, The Governing Board (“Board”), and the Coalitions for Health Improvement (CHIs).

The Board is the principal and ultimate decision-making authority for the NCACH. The North Central Accountable Community of Health (NCACH) is currently comprised of 17 board seats that are elected based on sector representation. Two Board members are currently non-voting members representing what was termed the Leadership Council (referenced below). At full representation, we have 47% of our membership representing providers and payers while 53% represents community based organizations, tribal authorities, governmental agencies, and consumers. The Board has an executive committee that is composed of a Chair, Vice-chair, Treasurer, and Secretary. As work arises, the Board will develop workgroups with defined charters that will provide the scope of work to be completed by the workgroups.

Included in the original charter and bylaws of the NCACH, there is a provision to develop a Leadership Council that would act as an advisory council to the Board. The leadership council has not been developed but does have two filled non-voting seats on our Board. Since the original bylaws were

developed the CHIs have become vibrant and active vehicles for community engagement and we believe it makes more sense to support and empower the CHIs than to create a separate Leadership Council, which would in many ways be redundant. As part of a NCACH Governance restructure, the Board voted at our May 1st meeting to forgo establishing the leadership council and develop a formalized structure that will allow the CHI's to provide direct feedback to the Board. This will remove the current 2 non-voting member seats of the leadership council and add a voting seat for each CHI. The Board also voted to increase the board membership from 17 to 20 members by adding a Consumer seat and one additional At-Large seat. At full representation, this will change our board makeup to have 35% representing providers and payers and 65% representing community and governmental agencies.

To become a legal entity, The Board voted to become a Washington State not-for Profit Entity and was officially incorporated on March 22nd, 2017. The NCACH currently has a resolution with the Chelan-Douglas Health District to provide administrative services. With incorporation, the resolution will be changed into a formalized contract. This is currently in process and a new contract will be established and submitted during Phase 2 Certification.

The NCACH's future plan is to maintain the administrative backbone structure with the Health District. In alignment with our Theory of Action and Alignment Strategy, the Board does not plan to build an organization that will need future funding to be sustainable, and therefore chooses to contract our administrative functions with the Health District.

The CHIs are the formalized structure on how the Board will provide bi-directional communication for community and consumer input. The NCACH has three Coalition of Health Improvement (CHI) groups that are located in each of the region's Local Health Jurisdictions (Chelan-Douglas, Grant, and Okanogan). Each CHI is intended to engage a wide variety of partners in the mission and work of the NCACH, and provide input to the Board on significant issues directly related to NCACH mission and activities. The interaction between the Board and the CHIs will be developed in a charter and/or policy, and each CHI will also have a voting representative on the Board.

The decision making process of the Board is outlined within the NCACH Bylaws. Unless otherwise specified in the Bylaws, decisions of the Board are made at a public meeting and require a >50% vote of approval from a quorum of board members. Decisions that require oversight from the Board include but are not limited to: the financial approval of large purchases, funding for staff positions, contracts with state and local entities, and other decisions that may affect the long term vision of the organization. The Board will delegate duties through both workgroups and the Executive Director. The Executive Director will be responsible for the management of the day-to-day operations including hiring and oversight of NCACH staff. The Workgroups will have defined charters that will outline responsibilities and reporting requirements to the Board.

Any documentation related to that decision is posted on the NCACH webpage (mydocvault.us) and shared at the Board meeting during the decision making process. The Board follows Roberts Rules of Orders and allows time for a discussion period to occur prior to a Board vote. Once the Board votes and approves the decision, it is documented in the meeting minutes and posted on the NCACH webpage.

The decision making body is selected to represent specific sectors. To fill current board vacancies, the representatives of the board seat sector, executive committee members, and members of the nominating committee work together to nominate a replacement member. Vacancies of the Board may be voted on and ratified at any regular or special board meeting by the remaining board

members. Currently, the Board is actively identifying and recruiting members to join its open board seats.

To inform decision making of our Board, the NCACH makes every effort to collect data and feedback from community partner engagement. The formalized process to communicate Board decisions is through the local CHI. NCACH will encourage interested parties to actively engage in their local CHI to ensure they can provide a voice in the work of the Demonstration. If the Board makes a decision that is different from recommendations presented by committees, CHI, and/or workgroups, the Board will provide rationale of the change to the group that made the initial recommendation. The Board is responsible to ensure decisions enhance the quality of care throughout the whole region and fall into alignment with the overall vision of the ACH. Final decisions of the Board may not always fall in alignment with the recommendation brought forth by the workgroup, CHI, or Committee. If members of a group have questions around the decision making process, they are able to attend governing board meetings and provide input, or directly address their concerns to the Board Members.

To ensure a nimble decision making process, the Board has established an executive committee that has been delegated powers and duties that can be made between Board meetings. The Board has also established mid-month board phone call (3rd Wednesday of the month) to allow board members to stay educated on the demonstration work. Currently, the Board will not vote on these calls and board members are able to provide a proxy representative to gather information if they are unable to attend. Any decisions of the executive committee or the Board made between meetings will be addressed and ratified by the whole board at the next scheduled board meeting.

In the instance that the board will have to amend a previous decision voted on at a meeting, the Board will review the new data available to justify the change and provide recommendations. Documentation on rationale for the change in direction will be clearly outlined in the Board minutes.

To maintain the fiduciary requirements of the Board members, the board has established the following limitations on spending without a board vote: Any non-budgeted expenditure in excess of \$5,000 dollars made by the executive director shall require prior approval by the board. The Executive committee shall not authorize a single occurrence of \$5,000 and an annual accumulation of \$10,000 without vote of the full board. Any additional clarification on the roles and responsibilities of Board Members, their committees/workgroups, and the Executive Director are outlined in the NC ACH Bylaws.

Executive Director

Senator Linda Parlette has been in the position since July 2016. Senator Parlette was also a member of the governing board representing the Elected Office position prior to accepting the position of Executive Director.

Name	Linda Parlette
Phone Number	509 – 886 - 6439
E-mail	Linda.parlette@cdhd.wa.gov
Years/Months in Position	10 Months

Data Capacity, Sharing Agreement and Point Person

NCACH does not currently have a contract in place with the HCA. Over the next few weeks, we will reach out to the HCA to determine and complete the needed contracts we need to establish.

Data Sharing Agreement with HCA?			
YES		NO	x

Data Point Person	
Name	John Schapman
Phone Number	509 – 886 -6435
E-mail	john.schapman@cdhd.wa.gov

As an organization, we have been focused on reviewing data from community partners around project selection and the RHNI. Moving forward, we will work with our Technical Assistance to identify data we need to collect and analyze to ensure we are able to meet project goals and progress our region towards value based payment. As we complete this analysis, we will address the current gap we have in data collection by either contracting with an agency or hire a data manager internally. We plan to have a better structure in place when we submit details for Phase 2 certification.

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. (i.e. Example Charter and CHI Contract)
- 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.
- G. Conflict of Interest Policy
- H. Proposed update to Governing Board Roster (Approved at May 1st Governing Board Meeting)

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.
- 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.
- 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.

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?

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.

Narrative (795 words):

The NCACH has prioritized outreach and engagement efforts to achieve full participation of our region's sovereign tribal nations and communities, and will continue to do so throughout the Demonstration. Even prior to the adoption of the Model Tribal Communication and Engagement Policy, our region has consistently followed the principles and processes outlined in the policy.

The first step in the process of tribal engagement has been to reach out to leaders of the sovereign tribal nations and communities to fill the voting Tribal Representative Seat on the Governing Board. The Board does not nominate the tribal seat themselves, but recognizes sovereign tribes' right to determine their own representation. Throughout the past 2 years, Board members have made it a priority to reach out to sovereign tribal nations and communities to inform tribal leaders of their right to appoint a person to this seat and engage them in the NCACH. The NCACH learned through this process the additional steps needed to build relationships and authentic engagement with tribal leaders. The current accomplishments to reach out to sovereign tribal nations and communities has been realized by using the personal relationship held between our Executive Director (Linda Parlette) and Tribal leaders.

Our Executive Director reached out to the Colville Tribal Council Vice Chair (Mel Tonasket) to request an in person meeting in Omak, WA (March 24th). At that meeting, our Executive Director asked Vice Chair Tonasket for his recommendation for tribal member Board participation. On his recommendation, our Executive Director reached out to the Colville Health and Human Services Director to continue the discussion. The Director (Alison Ball) recommended that the Deputy Director (Carmella Alexis) join us for a Board meeting to learn more about the NCACH and determine if she would like to serve on the Board. Our Executive Director invited Deputy Director Alexis to the May 1st Governing Board meeting to listen in by phone. She was unfortunately unable to attend. To ensure that we grow this partnership, our Executive Director again contacted Director Ball and Deputy Director Alexis on May 3rd to schedule a meeting at their offices and discuss how they envision future tribal engagement with the NCACH. Our Executive Director continues to maintain contact with Vice Chair Tonasket, and on May 3 sent him a status update of her outreach to Director Ball and Deputy Director Alexis. On May 4th, our Executive Director met with Vice Chair Tonasket in person. We will continue seek his guidance and assistance in achieving full ACH participation by our sovereign tribal nations and communities.

Knowing that this continues to be a challenge for ACH's across the state, NCACH will prioritize working with the HCA, with Manett for TA support, and/or the American Indian Health Commission to enhance engagement with our sovereign tribal nations and communities. Our Executive Director has initiated this process by contacting Jessie Dean (HCA) on May 3rd to request his assistance in outreach to the sovereign tribal nations and communities in our region. NCACH will request best practices from our TA support to help us move forward in an effective and appropriate way. If we are unable secure a dedicated tribal representative at this time, NCACH's board will continue to maintain an open board seat for tribal representation. We will also continue to pursue tribal engagement outside of the board. If a sovereign tribal nation and community approaches the NCACH to collaborate on one project, we will honor our policy of collaboration and engage them in the development and implementation of that project.

The NCACH recently adopted the State’s Model ACH Tribal Collaboration and Communication Policy at the May 1st meeting. NCACH board members reviewed the policy at the April Governing Board retreat and decided that it would provide the best level of engagement with our sovereign tribal nations and communities to adopt the statewide policy instead of developing a region specific policy. As part of this process, the NCACH will initiate discussion with leaders of the sovereign tribal nations on the establishment of a committee of ACH and Tribal/HIS/UIHP designees. If the sovereign tribal nations and communities are not interested in establishing a committee at this time, the NCACH governing Board commits to regularly evaluate how the NCACH decisions will impact of AI/ANs, tribes, HIS, or UIHPs and provide information to those entities of specific decisions.

To ensure ongoing training on the Indian Health Care Delivery System, The Governing Board will work with our Tribal Board Member, our sovereign Tribal nations and communities (i.e. Colville Tribe), and/or the American Indian Health Commission to ensure we schedule and complete routine training to Board Members. Once we have developed a relationship with these groups, we will determine the best time to schedule an initial board education and then continue with ongoing training throughout the demonstration.

Attachment(s):

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

Attachment(s) Recommended:

- A. 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.
- What barriers/challenges has the ACH experienced or anticipate experiencing toward meaningful community and Medicaid beneficiary engagement?
- What opportunities are available for bi-directional communication, so that the community and stakeholders can give input into planning and decisions?
- How is that input then incorporated into decision making and reflected back to the community?

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?
- 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 decisions?

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

Narrative (1,472 words):

Community members and partnering providers have four main venues to directly engage in the work of the NCACH. These are through direct voting representation on the Governing Board, participation in workgroups, engagement in local Coalitions for Health Improvement (CHIs), and attending open Governing Board meetings.

Each member of the Governing Board represents a specific sector of the community. That member is elected by both sector representatives and members of the Board Executive Committee. Each Board member is expected to report back the current work and decisions of the NCACH to their assigned sector to ensure we continue to update the larger community.

Workgroups are developed under the direction of the NCACH Board to complete tasks and provide recommendations on specific projects related to the Demonstration. Though these are workgroups of the Board, every effort is made to ensure community partners that provide meaningful input to the workgroup deliverables are represented. A current example of this work is the NCACH Whole Person Care Collaborative. This is a workgroup of physical health, behavioral health, MCO, and community based partners who are providing input on how partnering providers can adapt their clinical processes to deliver whole person care.

The Coalitions for Health Improvement (CHIs) located within each Local Health Jurisdiction are composed of a broad-base of local stakeholders. The CHIs are intended to engage a wide variety of partners in the mission and work of the NCACH. Each Coalition will provide input to the Governing Board on significant issues directly related and material to NCACH's mission and activities, including needs assessment and local health data; community health improvement plans and priorities; health improvement initiatives; and delivery system transformation. To ensure this group has a strong voice, each Coalition has one voting seat on the Board.

The Board will gather input and recommendations from both workgroups and CHIs. That input will be summarized for the NCACH Governing Board and will be incorporated into the decision making process of the Board. Once a decision is made a report will be provided back to the group with additional details/rational on why the decision was made (including supporting data if applicable). Lastly, Governing Board meetings are open to the public to encourage community partners to stay engaged and informed on the work of the NCACH. All meeting materials are on our public webpage and a meeting reminder is sent via email to our partner list one week prior with the meeting with call-in details and meeting agenda. This is beneficial to those individuals who need to understand the bigger direction of the ACH, but are still determining how their organization aligns directly with our work

This format has proven very effective in engaging partnering providers, both healthcare and community partners. We have an average Governing Board attendance of 25 individuals, excluding board members. We have also utilized this mechanism for bi-directional engagement into the selection of our Medicaid Demonstration Projects. NCACH staff and Board members provided six public presentations (2 in each Local Health Jurisdiction), and one presentation to the North Central Hospital Council on the Demonstration project. Members of the community were able to provide input on project selection by completing paper surveys or online surveys (Survey Monkey) that were distributed to all partners on our distribution list. NCACH compiled survey results and shared the

overall results with both the Board members and with community partners. As our board finalizes project selection, our NCACH will utilize our distribution list and local newspapers to send press releases to the community to notify our partners about the Demonstration Projects selected by the NCACH.

As we move forward into the demonstration project, we must recognize we are at risk of losing this engagement. This is because time, resources, and money are limited in all our rural organizations. Specific to community based organizations, we must find them an active role in the demonstration that will help them align the services they provide with the new delivery systems and payment models of Medicaid beneficiaries. In relation to medical providers, we need to ensure we align our work with current workflows occurring in their organizations. With so many competing quality improvement initiatives occurring in the medical sector, provider organizations do not have the resources available to them to manage one more competing change process.

Though we know that this model provides ample ability to engage partnering providers, the barriers for Medicaid beneficiaries have been different and the NCACH will enhance our engagement strategies to ensure we receive meaningful engagement from consumers.

As we move toward Fully Integrated Medicaid Contracting and development of Demonstration proposals, our NCACH recognizes the urgency to proactively reach out to Medicaid consumers. This will formally be done through a variety of venues. First, the Board has approved adding a voting consumer representative on the Board. The NCACH will formalize our relationships with the CHIs to include an emphasis in consumer involvement. Finally, NCACH staff will develop a communication and engagement plan that includes a focus on Medicaid beneficiaries. As part of this plan, NCACH recognizes that we must consider limiting factors to participation such as meeting times, locations, childcare, and other factors that may influence an individual's ability to participate. We plan to work with our Manatt technical assistances team and local experts to utilize evidence –based approaches that will help us connect and engage with Medicaid Beneficiaries. This plan will also include a strategy to include bi-directional feedback to Medicaid consumers. Assigned workgroups and/or NCACH Staff members will share consumer input at Board meetings. After Board decisions are made, the NCACH will make a concerted effort to report back those decisions to the participating entities/individuals who provided input through both the CHI, board announcements, and local outreach.

One area that will ensure continued engagement of both community and partnering providers is to continually strive to be transparent as an organization. To ensure transparency, the NCACH holds open Governing Board meetings and posts all documents online (www.mydocvault.us). Any decision that is made in between meetings will be in alignment of the NCACH Bylaws and will be ratified by a full vote of the Board at the next Board Meeting.

NCACH recognizes that transparency is only good if someone has the ability to access the information. This is why we have a current focus to share information through website updates, email communication, presentations to local organizations, and local newspaper articles. The current NCACH website provides a location where all community partners can access meeting materials and view a calendar of all NCACH meetings, however it is lacking in usability. Over the next 2 months, NCACH has contracted with a web design vendor (Firefly) to create a new website (New domain: www.ncach.org) that has an enhanced layout, is more user friendly, and that will be utilized as a marketing tool for the organization.

NCACH's main form of direct communication is through our partner distribution list (email). This is where we directly notify community partners of upcoming meetings, important documents, and any board decisions that should be shared with the greater community. NCACH staff routinely updates this list (494 participants: 44% of which are from the healthcare sector and 56% from other community sectors) to ensure we have correct information and include all community members who want to be involved in this work. Any interested community member is able to email a NCACH staff member to have their name added to the distribution list to receive updates (List is not provided in certification as an attachment to maintain privacy of partner member's individual emails).

To promote public events and to share the work of the Demonstration, NCACH continues to communicate with our local newspaper reporters. Two prime examples of this is when HCA went on their statewide tour to share the work of the Whole Demonstration, and recently when both our Governing Board Chair and Executive Director interviewed with a reporter to discuss the work being done locally with the demonstration.

Lastly, to ensure we reach the community, NCACH's Executive Director and Board Chair have been going to community groups directly (i.e. Rotary Clubs, Coalition for Children and Family, and North Central Hospital Council), to share NCACH's story and the work of the Demonstration. As we connect with these local community leaders, we will encourage them to become actively engaged in the work of the NCACH, and provide them with the contact information they need to provide meaningful input into the work of the demonstration.

Overall NCACH recognizes the current successes and barriers we have had around meaningful engagement and will develop a more comprehensive communication plan by Phase 2 Certification. NCACH recognizes that in order for this this work to be successful we will need significant involvement of the whole community and will continue to make it a priority to reach out to representatives of all community members affected by this work.

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.
- B. New Website Quote and Report
- C. NCACH Wenatchee World Newspaper Articles

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.

Fiscal Integrity

- Provide a description of budget and accounting support, including any related committees or workgroups.
- Define the levels of expenditure authority held by the Executive Director, specific committees (e.g., Executive Committee), and the decision-making body.
- Provide a description of the tracking mechanisms to account for various funding streams (e.g., SIM and Demonstration).
- 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.

Narrative(1,090 words):

The NCACH strategy related to the expenditure of funds is to minimize direct administrative expenses and ensure we allocate a portion of the funding we receive to support the capacity needs of our community partners. With that theory, we plan to utilize up to 65% of our design funds (7% of overall Demonstration funds) to support the direct cost of the organization while utilizing the remaining funds to support our community partners in the development of project planning and implementation.

For financial support, the NCACH will continue to contract with the Chelan Douglas Health District (CDHD) to be the backbone organization. The CDHD has received annual state audits that include federal fund audits. For several years, the CDHD has had zero findings and recommendations from those audits. The CDHD has qualified accounting staff and allocated budget codes within their finance department to ensure all funding is coded appropriately for both Demonstration and State Innovation

Model (SIM) dollars. All expenditures that are not staff related are done through an invoice process utilizing purchase orders (PO) to track payments and code dollars to the correct account. Staff timesheets are tracked through Microsoft Access and each hour is coded to the department and funding source (i.e. SIM) that the staff worked. Currently NCACH tracks expenses under SIM funding, but as demonstration dollars become available, coding will be created to designate funding and expenditures to Demonstration related projects.

To ensure the board meets its fiduciary responsibility, the overall budget is approved by the NCACH Governing Board annually and as needed to approve non-budgeted expenses. Budget updates are provided by the CDHD on a quarterly basis to both the Executive Director and the Board Treasurer. The Treasurer reviews the organization's financials and provides an update to board members at the next available Governing Board meeting.

The NCACH Bylaws outlines the financial requirements of the Executive Director and the Governing Board. The Executive Director is required to receive prior approval by the board of any non-budgeted expenditure in excess of \$5,000. The Executive Committee cannot incur any single monetary obligation in excess of \$5,000 or cumulatively up to \$10,000 annual, or bind the NCACH to an obligation exceeding 1 year, whether budgeted or not. Any non-budgeted expenditure decisions made by either the Executive Director and/or Executive Committee will be shared and ratified by the whole Board at the following Board meeting.

Design funds will be utilized to develop project proposals and build NCACH capacity. To support the initial development of project planning, NCACH will hire a Program Development Specialist position to act as the lead author for project proposals. In collaboration with community partners and other NCACH Staff, the Program Development Specialist will compile the supporting documents and contracts for each project plan and ensure timely submission of all proposals. After project proposals are submitted, this individual or another designated NCACH staff member will act as the main contact between partnering organizations, the Health Care Authority, and the NCACH to coordinate the collection of data, submission of progress reports, and measurement of our progress towards project outcomes.

To build community engagement capacity, we will fund both direct NCACH staff time for community outreach and contract with a Local Health Department/District to support the Coalitions for Health Improvement (CHI). NCACH staff will ensure direct community engagement occurs by providing ongoing support to the NCACH webpage, ensuring community and consumer input is gathered through local outreach to Medicaid beneficiaries, and assisting in developing and scheduling presentations for community partner groups.

Financial support for the NCACH Coalitions for Health Improvements (CHIs) is established by contracts between the Local Health Jurisdictions (LHJ) and the NCACH. Each LHJ will receive a deliverable based contract that will provide funding to support staffing, room rental, and other administrative expense needed to organize and convene the CHI in each LHJ. Chelan-Douglas does the work of the CHI through its current contract as an administrative backbone organization and therefore a separate contract is not in place. If the local LHJ is unable to support the deliverables outlined in the contract, the Board will be able to select an alternate organization within that LHJ that can fulfill the contract requirements. The NCACH will also provide direct support and oversight to each CHI to ensure contract deliverables are met and address issues that arise throughout the course of the contract.

Furthermore, in-kind support will be provided by having Board members take an active role in their local CHI.

The NCACH is reviewing the option to develop a similar model with the local tribal organizations. This model could provide funding for the tribe to support a position that would be the liaison between NCACH and the local tribal nations.

Clinical capacity will be supported through the Whole Person Care Collaborative. The NCACH is establishing a Director of Whole Person Care who will guide our partnering providers through the process of change management. This part of the demonstration work will be very time intensive and additional staff will be provided to support the director in this work as needed. To encourage providers to get involved and assist them in building capacity to make changes in their own organization, a portion of design funds will be utilized for provider engagement in the work of the collaborative.

The NCACH does not currently have a specific plan to address data management. As we select demonstration projects and evaluate the data requirements of the Health Care Authority, we will determine if this function is best suited by contracting with another entity or developing the needed infrastructure and staff support to house this expertise within our organization.

Finally, Program Management and Strategic development will be provided by the Executive Director and the Governing Board. The Board is responsible for the overall alignment and direction of the NCACH. As need arises, the Governing Board will create a standing committee to review the strategic needs of the organization and provide recommendations back to the whole Board. The Executive Director will ensure that the daily operations of the organization continues to align with the direction approved by the Board.

Lastly, a portion of design funding will be reserved to support and/or incent our partner agencies to participate in the work of the Demonstration. This includes both traditional medical providers and Community Based Organizations. This funding will be spread out throughout the course of the demonstration project and the exact funding mechanics related to this work will be determined in greater detail after we have made our project selections and prepare to submit documentation for Phase 2 certification.

Attachment(s) Required:

- A. High-level budget plan (e.g., chart or excel document) for Project Design funds to accompany narrative required above.
- B. Resume, Chelan-Douglas Health District Accounting Lead Kandis Boersema

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.
- 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.

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).

Narrative (916 words):

Since the start of Healthier Washington, NCACH has known that value based purchasing and Fully Integrated Medicaid Contracting were two key projects that would occur in Washington State. With that knowledge, NCACH made it a priority to engage clinical providers in a forum to discuss how we will provide “Whole Person Care (WPC)” for the Medicaid patients in our region. This has led to the strong partnership NCACH has with providers through the collaborative, connections with local and state organizations, and active participation on our Governing Board. Currently, NCACH has consistent communications with the Federally Qualified Health Centers, Hospitals, and Behavioral Health Providers in the region.

The main vehicle to achieve this vision has been through the establishment of the NCACH Whole Person Care (WPC) Collaborative. To set the framework for this group of primary care, behavioral health, and hospital providers, the WPC Collaborative first developed the Whole Person Care Vision Statement document. This document outlines the tools needed for providers to deliver whole person care and a picture of what it will look like once operational.

To engage more providers in the vision of Whole Person Care, the WPC Collaborative held the Whole Person Care Workshop in January 2017. This workshop brought together 100+ individuals from the region to learn about NCACH’s vision of Whole Person Care and the components involved in implementing the vision. Through that process, the WPC Collaborative gathered feedback from participants on both the vision statement and the different components of Whole Person Care (i.e. Advanced Primary Care and Care Coordination) that the Collaborative used to help define its next steps. This input was later shared with workshop participants with additional details on how they can better engage in the NCACH.

The WPC Collaborative is now in the process of developing a functional work plan that will give more concrete steps to achieve our vision. Two main goals of this work plan are to engage provider organizations to develop a change process for their specific clinic, and to establish the WPC Collaborative as a “Learning Collaborative” with a formalized membership process. This process is still in draft version, but will be the foundation on how we engage our clinical providers through the demonstration project. To accelerate our ability to accomplish the objectives of the Collaborative, the Board approved hiring a Director of Whole Person Care (0.5 FTE). This individual will work with

local providers and state resources to ensure providers receive the technical assistance and funding needed to develop the changes needed to deliver new models of care in their organization.

A key first step in this work is the completion of practice assessments for all primary care and behavioral health providers. NCACH is working directly with Qualis Health, in partnership with the Pediatric – Transforming Clinical Practice (P-TCPI) Initiative and the National Rural Accountable Care Consortium (NRACC) to coordinate transformation efforts into one regional evaluation. These assessments will provide NCACH with an understanding of our current region’s state in achieving Whole Person Care, and provide each individual provider with a comprehensive report on the steps needed to enhance care at the clinic level. This spring, NCACH Leadership and Qualis Health reached out directly to every major provider in the region to encourage them in both the assessments and the collaborative.

Outside of the collaborative, the NCACH continues to reach out to our local provider organizations. In April, our Executive Director met with the North Central Hospital Council to gather input on the projects we will select through the Demonstration. In the future, our Executive Director will continue to attend these meetings to ensure alignment in the work of both groups through the demonstration. Our ACH has also maintained a strong partnership with our North Central Behavioral Health Organization (NCBHO) and its workgroups. This has been an integral forum in which we have engaged our region’s Behavioral and Substance Use Disorder providers in the work currently being completed to prepare for Fully Integrated Medicaid Contracting.

Finally, even small organizations in rural communities can get lost in this work. We have engaged with the Quality Improvement Focus Group (Leavenworth, WA) and the Methow Valley HealthCare Network (Twisp, WA) to stay connected with the work of our rural providers and ensure they have input on the NCACH work.

On a statewide level, NCACH continues work with state associations and workgroups to connect with regional providers and find areas of collaboration on local projects. Specifically in North Central, both the Washington State Hospital Association and NCACH are interested in the ability of our Critical Access Hospitals to survive under value based payment. This partnership has lead NCACH to review the Washington Rural Health Access Preservation Project (WRHAP) to determine if it can be incorporated into the work of the Demonstration. NCACH has connected with Washington State Medical Association to determine how we can enhance our partnership, and hope to have a stronger collaboration with this association in the future. Finally, NCACH recognizes the need to define how we engage in statewide collaborative such as the Bree Collaborative and the Clinical Accelerator committee. Both workgroups bring a number of these partners to the table, and will be good resources to maintain connections and foster new ones in the future.

Even with strong collaboration, we realize the demonstration will not be successful without a robust engagement of direct service line providers. With that in mind, we will continue to reach out to those providers through local networks, committees, and through direct contact with our provider organizations.

Attachment(s) Required:

- A. Bios or resumes for identified clinical subject matter experts or provider champions
- B. Whole Person Care Vision Statement and Overview [Draft]
- C. Discussion Draft #2: Functions of the Whole Person Care Collaborative
- D. Whole Person Care Workshop – January 2017

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

