Pierce County ACH

# Phase I Certification Submission Template

| ACH Certification Phase I: Submission Contact | |
|---|---|
| **ACH** | Pierce County Accountable Community of Health (PCACH) |
| **Name** | Alisha Fehrenbacher, Executive Director |
| **Phone Number** | (253) 302-5508 |
| **E-mail** | alisha@piercecountyach.org |
| **Alternate:** | |
| **Name** | Alisa Solberg, Associate Director |
| **Phone Number** | (253) 381-0067 |
| **E-mail** | alisa@piercecountyach.org |

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| Theory of Action and Alignment Strategy |
| --- |
| Pierce Count ACH is a group of fierce pioneers, committed to health systems change. We engage with community volunteers and partners to learn, share, and act because we believe that better health is a cornerstone of community and economic vitality. The newly rebranded PCACH is taking a community driven approach to shared learning and action that allows the entire region, in partnership, to see how mutual outcomes are interconnected. (Attachment A).<br><br>PCACH will align with and utilize the Demonstration in the following ways:<br>**Advance the financial integration of physical and behavioral health** to provide additional funding and support to clinical providers when the region implements financial and clinical integration. To include a potential focus on **oral health, opioid clinical guidelines, and chronic disease prevention and mitigation** (Attachment B).<br>• **Support community-based care coordination**, Pathways Hub model. We refer to this model as our anchor strategy to drive payment-for-outcomes that successfully identify, treat, and measure for those at risk. We see this as an opportunity to take a systems approach to all the projects proposed under the Demonstration toolkit, as well as related social determinants of health. To date the RHIP Council[1] has identified a **potential emphasis on opioid users, maternal child and health, specific chronic diseases, and/or jail re-entry populations.**<br>• **Align community conditions that support health** across sectors so that both traditional and non-traditional healthcare sectors (housing, transportation, education, etc.) understand their contributions to health outcomes and what those implications are for value-based purchasing. To include a **regional opioid response** strategy to identify necessary policy and systems changes and required resources.<br>• Bring together data experts and community leaders **to connect local cross-sector data to act as the "central pillar" of regional health care outcomes data**. This transformational data asset supports the full continuum of ACH activities: from assessing needs to planning and launching interventions to monitoring, evaluating, and reinvesting.<br><br>Our priorities are still under development, but the initial slate has been supported by strategic visioning and listening sessions. Strategies are being designed to show which outcomes are being improved and where potential savings are happening, so partners who seek to improve those outcomes and save money will be compelled to invest back into community priorities (Attachment C).<br>▪ Find common target populations across sectors and develop better coordinating strategies;<br>▪ Understand how impacts in one sector ripple into the outcomes of the others;<br>▪ Find common upstream drivers of everyone's poor health outcomes;<br>Build collective strategies that thread cross-sector funding toward "common leverage points". |

[1] Regional Health Improvement Plan Council, See page 4 for description of RHIP Council

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

We will solidify priorities and strategies in the coming month with a detailed framework that supports the attached driver diagram (Attachments D, E, and F). We will also roll out the anchor strategy and a detailed project plan. With strong measurement and processes by which programs are continually refined and improved, the community will have information needed to sustain and spread effective programs.

PCACH will use data on distributions of outcomes and financial burden, and will listen to the Community Voice in decision-making. To fully implement an effective, relevant community-led and shared learning system, community engagement must be intentionally cultivated. Community members help system partners understand what data means at a grassroots level. PCACH staff attend other community led groups and meetings and meet with people working on initiatives and projects throughout Pierce County. We have and will continue to work closely with complementary health efforts and identify opportunities to align/braid funding, initiatives, and partnerships. To ensure a health equity lens is applied to all decisions and recommendations made by the Board, Councils, and Committees, PCACH will use a decision-making criterion described in the Governance section, page 5 (Attachment T).

PCACH believes the Demonstration is one opportunity, a catalyst and incentive to bring the necessary people to a common table. The Demonstration will not only support a new system of health, it will also improve community conditions that support health. Co-creating the strategic plan will take all partners, and will require data for decision-making, community input for lasting change, and provider input and buy-in to ensure feasibility. Additionally, we are working with the county to identify ways the Demonstration can be leveraged to support housing and employment efforts. The shared learning and action approach will intentionally create an environment that encourages continuous workforce development and builds new competencies that promote workforce flexibility to respond to demands inherent in health reform efforts.

PCACH has been financially supported by several of the large healthcare delivery systems. We are having exploratory conversations with the Health Resources and Services Administration and Substance Abuse and Mental Health Services Administration, who have expressed interest in partnering locally. We have also had early partnership discussions with Washington Department of Health, Department of Early Learning, and Department of Social and Health Services.

## Attachments

A. Community Driven Strategy for Shared Learning and Action
B. What Healthcare Providers Need
C. Service to the Region
D. Care Delivery Redesign
E. Driver Diagram
F. Investment Strategy

## Governance and Organizational Structure

### ACH Structure

PCACH is a non-profit organization with a stakeholder-heavy organizational structure (Attachment G). The final decision-making body, or single point of accountability, is the Board of Trustees (the Board), who serve in a traditional non-profit board capacity. The term "trustee" was selected before the non-profit was established. It was important to the community to use a term that implies stewardship of the sector or community perspective rather than the individual board member's perspective. The non-profit recognizes we do not have a board of trustees in the legal sense of the word, but a board of directors in terms of a traditional non-profit. The bylaws reflect this historical context (Attachments H and I).

PCACH governance structure is composed of the following bodies:

**Board:** The Board is responsible for assuring the work of PCACH is financially sound, legal, and in service to the collective vision of the community. Committees of the Board include the Executive Committee, Finance Committee, Nominating Committee, Tribal Collaboration and Communication Committee. Board Roster and Executive Committee Bios are attached (Attachments J and K).

**Regional Health Improvement Plan Council (RHIP):** A 25-member body comprised of members from the health care delivery system, including physical, behavioral, and oral health, MCOs, early childhood, K-12, and post-secondary education, housing, criminal justice, public health, and community stakeholders. Provides recommendations to the Board for workgroups to be established as necessary. Workgroups, which cover topics such as care coordination, bi-directional integration of care, opioid interventions, etc., are made up of councilmembers and community-at-large members alike to capture local expertise, work already happening in Pierce County, and a cohesive view of the broader picture. Through this model, PCACH will provide multiple avenues for input from the diverse populations in Pierce County. The RHIP receives input from the CVC, PIP, DLT and workgroups and moves forward recommendations to the PCACH Board for approval. Draft RHIP Charter and Roster are attached (Attachments L and Ll).

**Community Voice Council (CVC):** The CVC has a direct line to the Board, separate from the RHIP Council. The council is a diverse group of people who receive Medicaid, Medicare, and Veteran's Administration benefits, those who have private insurance, and those who are uninsured. CVC members are chosen for their experience with social conditions of health, the health and human services network in Pierce County, and understand firsthand the difficulties in navigating a fractured healthcare system. They contribute their expertise into the shared learning and action structure in the same way providers share their perspective and expertise, ensuring a more complete vision of whole person health. For additional information on the community capacity of PCACH, review the Community and Stakeholder Engagement section of this document. Draft CVC Charter and Roster are attached (Attachment M and Mm).

**Provider Integration Panel (PIP):** Currently in development, this panel will provide clinical direction and engagement into the ACH. The Clinical Director, who will support the work of the PIP and the PCACH, is anticipated as a mid-summer hire, with the following preferred qualifications: clinical license, understanding of hospitals/clinics, provider-level work, understanding of the financial modeling of health care and experience with the Triple Aim. For additional information on the clinical capacity of the PCACH, review the Clinical Capacity and Engagement section of this document. Draft PIP Charter and Roster are attached (Attachment N and Nn).

**Data and Learning Team (DLT)**: PCACH has convened a Data & Learning Team (DLT) to provide data and analytic expertise, and shared learning support to the ACH's governance committees, projects, and initiatives. The DLT is comprised of key stakeholders, including providers, health systems, MCOs, behavioral health, public health, social services, and community groups representing multiple sectors. The DLT supports data driven decision-making by reviewing and interpreting existing data and reports, identifying data gaps and data sharing needs, and making recommendations to ACH staff and governance committees regarding project focus areas and target populations, data collection, and analysis. The DLT will leverage multiple data sources to assess community health needs, select and implement projects, monitor progress, and evaluate impact. These may include: RHNI data, Medicaid beneficiary data, and other reports from HCA; data from transformation projects, including community care coordination, bi-directional integration, and opioid use; public health data from TPCHD; county social services data; data from cross-sector partners, such as housing, education, and criminal justice. To address the data needs of the community care coordination project, PCACH plans to contract with a vendor to develop and implement a data platform to manage and facilitate care coordination, collect data, and track payment. Draft DLT Charter and Roster are attached (Attachment O and Oo).

**Decision-making**

The final decision-making body is the PCACH Board. The Board follows Robert's Rules of Order. They are responsible for approving the budget, setting executive limitations (Attachment P), establishing full governance (Attachments Q, R, S), hiring and managing the executive director, final decisions on project adoption and implementation, and are responsible for oversight of the audit process of the organization. The Board is no longer involved in daily operations and have evolved to a full governance board. The term limit is 2 years, with a 3-term limit. Individual sectors are responsible for putting forth nominations to the Nominating Committee, who make recommendations to the Board. The Board elects new members based on recommendations from the nominating committee. Applicants are put forth to the nominating committee by the community and/or the various sectors with support from PCACH staff.

Under this required and technical decision-making body, is a robust model which favors content experts and community voice. This model centers on the RHIP Council, which acts as the receiving body for information from the PIP, CVC, and DLT. All moving parts of the organization will use the following criteria for decision making: need; impact; health equity; data and measurement feasibility; political/legal feasibility; social and practical factors (Attachment T).

To ensure a shared learning and action approach appointed liaisons carry information and learning between the councils and from the councils to the Board. CVC liaisons have one vote on the RHIP Council, PIP, and Board of Trustees. A PIP liaison will have one vote on the RHIP Council. The Pierce County ACH developed this model after the Board voted on the establishment of a non-profit in June 2016. Karen Rasmussen of Bennett, Bigelow & Leedom P.S., along with in-kind support from MultiCare general counsel, developed the Articles of Incorporation and initial Bylaws, which were submitted and accepted by Washington State in August 2016 (Attachments H and I).

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**Staffing and Capacities**
Current PCACH staff is 4 FTEs, with additional support from consulting firms, including Uncommon Solutions, Providence CORE, Foundation for Healthy Generations, Accounting Systems and Procedures, and StarPoint Consulting Group.

### Staff
Executive Director, Alisha Fehrenbacher (Attachment U)
Associate Director, Alisa Solberg (Attachment V)
RHIP Council Director, Lena Nachand (Attachment W)
Operations Coordinator, Vanessa Perdomo
Executive Assistant & Governance Coordinator, Anticipated June 2017
Community Voice Council Coordinator, Anticipated June 2017
Communications Coordinator, Anticipated June 2017
Community Care Coordination HUB Manager, Anticipated July 2017
Director of Clinical Integration, Anticipated July 2017
RHIP Project Manager, Anticipated August 2017
Improvement Advisor - Practice Coach (interim), Anticipated August 2017

### Potential Shared Services
Human Resources, Anticipated June 2017
Tribal Liaison, Anticipated June 2017

### Consultants
StarPoint Consulting Group, Meg Taylor, Chief Financial Officer (Attachment X)
Uncommon Solutions, Robbi Kay Norman, Jeremy Rolfer, Vic Colman
Providence CORE, Stacy DeLong, Nikki Olson, Sarah Bartlemann
Foundation for Healthy Generations, Kathy Burgoyne, Gretchen Hansen
Accounting Systems and Procedures, Minda Hevly

### Financial
Alisha Fehrenbacher, Alisa Solberg, Meg Taylor, and Minda Hevly support the Finance Committee, chaired by Anne McBride who served as the CFO of Evergreen Healthcare for 13 years. PCACH Financial Policies were approved by the Finance Committee on 3/13/2017 and the Board on 4/17/2017. For additional information on the financial capacity of the PCACH, review the Budget and Funds Flow section of this document (Attachments P, Q, R, S, T).

### Program Management and Strategic Vision
The program management and strategic vision for PCACH is overseen by Executive Director, Alisha Fehrenbacher. She is supported by Robbi Kay Norman, Uncommon Solutions; Associate Director, Alisa Solberg; and RHIP Director, Lena Nachand. Together, this team is responsible for implementation of the direction set by the Board, CVC, PIP, and RHIP Councils.

**Executive Director**

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|---|---|
| **Name** | Alisha Fehrenbacher |
| **Phone Number** | (253) 302-5508 |
| **E-mail** | alisha@piercecountyach.org |
| **Years/Months in Position** | 4 months |

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## Data Capacity, Sharing Agreement and Point Person

**Data Point Person**

| **Name** | Stacy DeLong and Jeremy Rolfer |
|---|---|
| **Phone Number** | (971) 347-5970 and (360) 789-4590 |
| **E-mail** | Stacy.delong@providence.org, jeremy@uncommonsolutionsinc.com |
| | |

While PCACH has not yet signed a data sharing agreement (DSA) with the HCA, we did receive a draft on 4/27/17, which Providence CORE provided commentary on. We have submitted the document for legal review.

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

PCACH recognized immediately that there would be gaps in its capacity for data driven decision making. The strategy for shared learning and action requires a multi-sector Data and Learning Team to ensure proper systems and structures for data collection, analysis, and reporting. This robust team[2] has met several times and are exploring opportunities to further support PCACH and the Pierce County Community. We understand the need to partner with HCA in order to be affective with our data driven strategy and are greatly anticipating this partnership.

## Attachment(s) Required

G. Organization and Staffing Structure
Gg. Decision-making flowchart
H. Bylaws
I. Articles of Incorporation
J. Board of Trustees and Committee Roster
K. Executive Committee Bios
L. Regional Health Improvement Plan Council (RHIP) Charter
Ll. Regional Health Improvement Plan Council (RHIP) Charter
M. Community Voice Council (CVC) Charter
Mm. Community Voice Council (CVC) Roster
N. Provider Integration Panel (PIP) Charter
Nn. Provider Integration Panel (PIP) Roster
O. Data and Learning Team (DLT) Charter
Oo. Data and Learning Team (DLT) Roster
P. Financial Policies-Executive Limitations
Q. Compensation Policy
R. Whistleblower Policy
S. Document Retention Policy
T. Decision Making Criteria
U. Executive Director Bio
V. Associate Director Bio
W. Regional Health Improvement Plan Council (RHIP) Director Bio
X. Chief Financial Officer Bio

[2] See attachment Oo, Data and Learning Team (DLT) Roster

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## Tribal Engagement and Collaboration

Tribal engagement has been a challenge for PCACH. While there has always been one seat reserved for Tribal members on the PCACH Board of Trustees, this seat has been left open for more than two years. Current staff lack understanding about how and when Tribal engagement was done under the direction of the Tacoma Pierce County Health Department. PCACH's approach has been to work with state partners to piece together this history, including how PCACH has been perceived by Tribal entities, if there are successes or challenges to collaboration specific to our region, and to learn from other ACHs.

PCACH will follow the Tribal Protocol and Model ACH Tribal Collaboration and Communication Policy to encourage Tribal representation on the PCACH Board. PCACH has also reached out to Jessie Dean, Libby Watanabe, and Vicki Lowe at the Health Care Authority for guidance on the best path forward for Pierce County. We have a meeting scheduled May 30, 2017 to discuss Tribal collaboration training for the PCACH Board, Staff, and Council Members. In addition to the information HCA has provided in the Tribal Protocol and Model ACH Collaboration and Communication Policy, we will seek guidance regarding who to contact within each Tribal agency, how the communication should be crafted, and what kinds of engagement would be welcome (e.g. proposing to hold meetings at times and locations that would encourage Tribal participation).

PCACH is working to put together an accurate picture of the engagement and communication efforts that happened prior to establishment of the 501c3. To date, we have discovered email attempts by Tacoma Pierce County Health Department to invite Tribal members to the steering committee table. These efforts were unsuccessful and did not align with the recently drafted Tribal Protocol and Model ACH Tribal Collaboration and Communication Policy. Plans moving forward include providing information sessions and trainings for the PCACH shared learning and action structure and creation of guidelines and procedures to ensure PCACH is adhering to the Tribal Protocol and Model ACH Tribal Collaboration and Communications Policy.

One key lesson PCACH has learned from fellow ACH partners is the importance of approaching local ITUs in a manner that is respectful and appropriate for the status tribes hold as sovereign nations. This approach is very different from the approach PCACH may take with other local CBOs, agencies, or County officials to engage them into the work of the ACH.

### Policy Adoption

The PCACH BOT adopted the State's Model ACH Tribal Engagement and Collaboration Policy on 4/17/17. We anticipate hiring new staff and ramping up our capacity in the coming months. Two of the new hires planned for early summer are the Communications Coordinator and Tribal Liaison. These two positions will be responsible for fleshing out the guidelines and procedures associated with the Tribal Protocol and Model ACH Tribal Collaboration and Communication Policy, ensuring communication with the correct Tribal representative(s), and building relationships in the community that foster Tribal engagement. The Tribal Liaison will work closely with the Community Voice Council Coordinator and the Tribal Collaboration and Communication Committee to ensure overlap and alignment as PCACH builds its Tribal and Community engagement system.

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**Board Training**

PCACH will establish a Tribal Collaboration and Communication Committee of the Board made up of the Executive Director and Associate Director, PCACH Board members, and Tribal, HIS, and UIHP designees. This committee will be responsible for oversight of the Tribal Protocol and Model ACH Collaboration and Communication Policy, including ongoing training for the Board, shared learning structure, and the Staff. The committee will also give input regarding the impact of proposed decisions and projects on Tribal interests.

PCACH recognizes the need for support and guidance in this area. We are interested in receiving feedback from HCA Tribal Liaisons regarding a joint training with King County ACH if applicable. Additionally, we are interested in education about how to approach Tribes that have land within Pierce County, and the American Indian/Alaskan Native populations who live and work within the region.

**Attachment(s) Required:**

A1. Model ACH Tribal Collaboration and Communication Policy

**Attachment(s) Recommended:**

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## Community and Stakeholder Engagement

Authentically engaging community members in choosing, designing and implementing ACH Transformation projects is vital for success. Communities are made up of many different elements including community members, health and human service organizations, schools, faith communities and businesses. These elements are all part of the community's history and culture which may include income or racial segregation, poverty, crime and other barriers caused by systems or policy. To understand all the elements of a community including the ways in which our systems and policies create barriers to health for Medicaid recipients, the PCACH will support elevating the community's voice in identifying what the community views as their own strengths, needs and potential solutions to their challenges. We need the community to help us understand the meaning behind the data, find locally informed solutions and shape community feedback the policy makers, organizations and system leaders of the PCACH to act on. What we are designing with our community is a community engagement system that will enable us to learn and act together with the community, not only to choose, design and implement our Transformation Demonstration Projects, but to do all the work of the ACH. PCACH has created a Community Voice Council (CVC)[3] made up of people who receive Medicaid, Medicare, and Veteran's Administration benefits, those who have private insurance, and those who are uninsured. The community engagement system is embedded into all our work. If done well, it will build trust with community members, provide continuity and give a place for policy and system leaders to receive community informed solutions and feedback.

The pace at which the work must move forward is a challenge to meaningful community engagement as relationships and trust take time to build. One of PCACH's priorities is to achieve diversity throughout the learning structure. To ensure an organizational culture that promotes and encourages diversity, the PCACH team has scheduled equity and diversity training with Beroz Ferrell to occur in July or August 2017. Ms. Ferrell has over 25 years in leadership and organizational development and has worked extensively with Ms. Fehrenbacher. Her website www.thepointintl.com.

Our structure is intended to foster bi-directional communication and has been successful thus far in creating synergy between the RHIP[4] and CVC. We have tested this with progress to-date on the community-based care coordination model. We learned about how our communication is perceived and ways to make sure we are communicating in an effective and respectful fashion. We will continue to test and evolve through the coming months. We incorporate input and reflect that input back through our iterative decision-making process[5]. Partnering providers, both clinical and non-clinical, participate through the Board, the PIP, the RHIP and the DLT.

### Partnering Provider Engagement

With the on-set of the new non-profit, PCACH made a commitment to authentic community engagement, as evidenced by the contract with Foundation for Healthy Generations and the work of Gretchen Hansen, Kathy Burgoyne, and several community health workers. These individuals were chosen to help develop PCACH's community engagement system because they are trusted members of the diverse geographic, ethnic, and racial communities that exist within the Pierce County region. Gretchen and her staff have traveled throughout the county, attending local and community meetings to talk about PCACH and recruit applicants for the CVC. Their recruitment strategy is three-fold. They

[3] Attachment M and Mm, Community Voice Council (CVC) Draft Charter & Roster
[4] Regional Health Improvement Plan (RHIP) Council
[5] Attachment x, Decision-Making Flow Chart

attend already established community events where multi-ethnic and racially diverse communities gather. They identify interested council candidates using a simple presentation and low-threshold application. Finally, they interview interested candidates in a conversational style for a more personal, in-depth process. Gretchen's work has resulted in 15 CVC applicants and 9 applicants for other councils and workgroups. CVC applicants include people who speak English as a second language, have personal experience with violent crime, jail or prison, disabilities, homelessness, and/or substance use disorder. Members also have experience with a mix of payers including Medicaid, Medicare, Veteran's Administration, and private insurance. A few of the members are uninsured. To appropriately support the CVC, PCACH plans to hire a CVC Coordinator in June. This position will be responsible for outreach to the broader community, as well as targeted work to community members who experience the greatest disparities in health outcomes. The first CVC meeting occurred April 20, 2017.

In addition to this individual and targeted approach of recruiting and supporting members for the CVC, PCACH participated in an event on March 24, 2017 at the Star Center, a community center on South Tacoma Way. Twenty-three people participated in a group discussion, in which two questions were posed: "How do you and your family stay healthy?" and "What makes it hard for you and your family to stay healthy?" (Attachment D2) This event allowed PCACH to gain insight about what community members consider to be the essential components of and barriers to good health. Plans are underway to continue this community conversation in locations throughout Pierce County. We are also considering ways to incorporate this feedback into the shared learning structure and eventually back out to the community (e.g. storytelling, qualitative research, etc).

**Transparency and Communications**

All meetings, except for Board committee and Data and Learning Team meetings, are open to the public, and time is dedicated on the agenda to public input. We now have a brand-new website www.piercecounty ach.org with an interactive calendar that allows us to notify all community partners instantly about schedule changes and upcoming events. If decisions are required between meetings, the executive committee convenes and follows up with the councils and panels that need the information to further the work of the PCACH. Furthermore, all committees or workgroups of the PCACH will use collective decision making criteria to ensure a health equity lens and honoring community members as partners.[6]

Decision-making filter examples: Does the project reduce health disparities and/or advance health equity? Does it address social determinants of health? Does it support the health outcomes of Medicaid beneficiaries? Is there a clear connection to improved quality of life, community health, and community values? Is the project multi-sector? Is there a clear community engagement strategy? We challenge ourselves, as well as our colleagues and partners to ask; Who benefits from this decision? Who will be left out? What are the unintended consequences of this decision?

To support the iterative nature of PCACH's decision-making flow, a cascading schedule of monthly Council and Board meetings has been established so that recommendations made by CVC and PIP, which meet earlier in the month, can be incorporated into the recommendations and decisions made later in the month by the RHIP Council and the Board. DLT meets the end of the month so it can collect feedback and data requests from all bodies and push information back out for the next round of meetings. This is depicted in the attached Decision-Making Flow Chart.[7]

[6] PCACH Governance and Organization, Attachment T, Decision Making Criteria

[7] PCACH Bylaws and Articles of Incorporation are attached (Attachments H and I).

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| **Attachment(s) Required:** |
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| B2. Community Engagement Approach |
| C2. Community Voice Council Outreach |
| D2. Star Center Report |
| E2. PCACH Info Sheet |

## Budget and Funds Flow

PCACH is approaching the budget and finances from both an operational standpoint, as well as a strategic planning and long-term vision standpoint. The Finance Committee, Executive Director, and Associate Director are currently preparing the expanded operational budget for this year, as well as a 5-year budget with fiscal oversight and strategic support from Chief Financial Officer, Meg Taylor, and current accounting support from Minda Hevly of Accounting Systems and Procedures (ASAP). This includes Demonstration funds, SIM funds, and local contributions. Using QuickBooks, we attribute all expenditures to specific funding streams, ensuring that funds are used in accordance with the restrictions placed on each stream. Ms. Taylor will support the Executive and Associate Directors in exploring shared services with another ACH for accounting/bookkeeping functions. The Finance Committee reviews a detailed budget once a month, followed a week later by the Finance Chair presenting a high-level budget to the Board.

The Finance Committee approved the PCACH Financial Policies in February 2017, the Executive Committee approved them in April 2017, as did the Board.[8] The Executive and Associate Directors have expenditure authority up to $15,000. After that, two signatures are required. Additional authorized signatures include Anne McBride, Mike Curry and Federico Cruz-Uribe.

PCACH recently contracted with Ms. Taylor, Chief Financial Officer of StarPoint Consulting Group. She will aid the Executive and Associate Directors in creating the strategic vision for PCACH's accounting and funds flow approach. Meg recently consulted on the establishment of an inpatient mental health facility and joint-venture between MultiCare and CHI Franciscan and has a depth of knowledge regarding financial integration of medical systems.[9]

### Project Design Funds

An immediate need of the PCACH is additional staff capacity.[10] This is shown in the staff budget line increasing over June-July-August of this year. We will use this staff to increase our work on tribal engagement, communications/transparency, clinical integration, and care coordination. Phase I Demonstration funds do not represent 100% of our staff/personnel costs.

### Fiscal Integrity

Budget and accounting support is provided by Minda Hevly, Accounting Systems and Procedures; Meg Taylor, CFO, StarPoint Consulting Group; and a Finance Committee of the Board chaired by Anne McBride. Ms. Hevly, with oversight from Ms. Taylor, tracks the various accounts and funding streams through QuickBooks. The QuickBooks file is reconciled monthly to the bank statement. Financial statements are reviewed in detail by the Finance Committee and Board of Directors.

### Attachment(s) Required:

F2. High-level Budget Plan for Project Design

[8] PCACH Governance and Organization, Attachment P, Financial Policies-Executive Limitations
[9] PCACH Governance and Organization, Attachment X, Chief Financial Officer Bio
[10] PCACH Governance and Organization, Attachment G, Organization and Staffing Structure

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## Clinical Capacity and Engagement

To appropriately and effectively engage providers, PCACH has created the Provider Integration Panel (PIP)[11], a provider specific engagement group. This panel will be responsible for clinical components of the PCACH Medicaid Transformation Plan, ensuring Community Voice is incorporated into the decision-making, and giving direction and clarity in making final recommendations to the Regional Health Improvement Plan Council and ultimately the Board of Trustees. This panel serves two purposes, one to ensure engagement of our regional providers, but also to ensure that the plan and work coming out of PCACH are clinically and operationally feasible. This group is made up of practicing providers and will have several work groups: The Opioid Task Force, Care Coordination Workgroup, Quality Improvement Workgroup, Interoperability Workgroup, and others as the work evolves.

### Provider Engagement

Ms. Fehrenbacher has done extensive work within the community, meeting with provider groups and one-on-one with individual providers, learning about community-based and regional systems, and providing information about the PCACH, Healthier Washington Initiative, Medicaid Demonstration, the toolkit, and seeking alignment with the above goals. This engagement has included interaction with doctors (MD and DO), nurse practitioners, physicians assistants, behavioral health consultants, nurses as well as medical directors, multi-specialty providers, paramedics, community health workers, social workers, peer support specialists, substance use providers, clinic administrators, the regional physicians network, quality assurance specialists, and more. We are currently scheduling meetings with dentists and pharmacists. Many providers in Pierce County have expressed a keen interest in the collaborative care model linking with primary care medical home and community care coordination efforts. We have leveraged our administrators who participate at the board level to identify and vet key providers within their systems.

We will convene focus groups, taskforces, and work sessions under the Provider Integration Panel to complete check-ins before and after hours with clinic based providers and clinic administrators and provide ongoing opportunities for feedback and input while plans are under development as described earlier in this document on our structure of Councils and Provider Integration Panel. We have developed a thorough recruitment process for the PIP and have secured broad sector representation after only two rounds of recruitment. There will be a third recruitment phase to fill in any gaps that remain in the subject matter expertise of the panel. These taskforces will ensure clinical expertise in the plan development and will encourage these clinicians to become champions for and ambassadors to the broader clinical community.

### Partnerships

We have developed partnerships with Northwest Physicians Network, Pierce County Medical Society, Washington State Hospital Association, and the local health systems and providers. Ms. Fehrenbacher is building a partnership with Washington Association of Community and Migrant Health Centers and is scheduled to present to their association meeting the end of May or beginning of June. We plan to connect with Washington Academy of Family Physicians and Washington State Public Health Association. Ms. Nachand has extensive volunteer experience with Planned Parenthood of Central Washington and PP Votes, a 501c4. Ms. Solberg is on the board of directors for Pierce County AIDS

[11] PCACH Governance and Organization, Attachment N, Provider Integration Panel (PIP) Charter & Roster

Foundation, is a participant on the Bree Collaborative Opioid Prescribing Task Force and the Washington State Hospital Association and Washington State Medical Association Opioid Recommendations Task Force. Ms. Fehrenbacher, a Fellow with the American Academy of Healthcare Executives, is a member of the Washington State Healthcare Executive Forum.

**Attachment(s) Required:**

G2. Samuel J. Huber MD, MS Curriculum Vitae
H2. Dimitry Davydow MD, MPH Curriculum Vitae
I2. Sarah Redding MD, MPH Bio
J2. Francis Mercado MD Curriculum Vitae
K2. Megha Rao, MD, Medical Director, PIP Application
L2. Scott Kronlund MD, MS Resume
M2. Marjorie Page, Behavioral Health Lead CHC, Application
N2. Melissa Haney MA, LMFT, CCM, PIP Application
O2. Laura Morris, Tacoma Fire, PIP Application
P2. Elizabeth Hickman, Probation Supervisor, PIP Application
Q2. Julie Lindberg LICSW Molina, PIP Application
R2. Bill Barber, EMS Battalion Chief, PIP Application
S2. Phoebe Mulligan LICSW, PIP Application
T2. Joe Huang MHS, Application
U2. Qudsia Khan MD, PIP Application
V2. Jose Mendoza, MD PIP Application
W2. Rick MacCornack NPN Curriculum Vitae *Senior advisor to PCACH leadership.