Leadership Council
May 4, 2016; 9:00 am to 11:00 am

Jefferson Health Conference Room
2500 W. Sims Way, Port Townsend

Chair: Roy Walker

Objectives

- Approve HCA Contract Deliverables
- Agree on next phase of governance structure
- Agree on next steps for regional health project planning and implementation

AGENDA (Action items are in red)

Item		Topic	Lead	Purpose	Attachments
1	9:00-9:15	Welcome & Introductions	Roy		
2	9:15-9:30	Consent agenda	Roy	INFORMATION & ACTION	1. Director's report 2. HMA memos 3. Framework for the Project Toolkit 4. HCA Contract Summary 5. Contract deliverables
3	9:30-9:40	Three-year OCH budget	Eric	DISCUSSION & ACTION	6. Budget deliverable
4	9:40-9:50	OCH Readiness Proposal comments	Elya	DISCUSSION	7. Summary of the review 8. OCH Readiness Proposal review
5	9:50-10:20	Moving governance forward	Doug	PLANNING & ACTION	9. Governance SBAR 10. Charter template
6	10:20-10:35	Project planning and implementation	Elya & Siri	PLANNING & ACTION	11. Project Planning SBAR
7	10:35-10:45	Accountable Health Communities CMMI funding opportunity	Jennifer	INFORMATION & ACTION	12. Alliance AHC Overview 13. SBAR
8	10:45-11:00	Next steps	Elya	INPUT & ACTION	14. Next steps
9	11:00	Adjourn	Roy		

Glossary

ACH	Accountable Community of Health
ASSH	Alliance for South Sound Health (partnership between CHI and Multi-Care)
AHC	Accountable Health Communities
CMS	Center for Medicaid and Medicare Services
CMMI	Center for Medicaid and Medicare Innovation
HCA	Health Care Authority
HMA	Health Management Associates
KPHD	Kitsap Public Health District
SBAR	Situation, Background, Assessment, Recommendation

A message from your new director

Since this is my 1st director's report, I wanted to take the opportunity to share how fortunate I feel to be here. I already sense excitement about *what is possible* from people I have met in this community. This enthusiasm arms me with an even greater sense of commitment to our shared mission. With your guidance and wisdom, together we can do something truly transformational to improve health in our three counties. It will not happen overnight – and we will sometimes feel discouraged– but I hope we all agree that it will be well worth the journey. Our region got a bit of a late start and we have much to catch up on so **here we go…**

Communications

Between Healthier Washington and the Medicaid waiver are progressing rapidly. To keep you informed I will disseminate regular updates via email. I will be presenting a Communications and Engagement Plan for your review and approval in the coming months. Until then, we will launch an electronic newsletter platform that will link with our OCH website and social media (currently underway).

If you would like, I am always available for presentations and Q&A at your leadership or stakeholder meetings. We are working on an OCH overview PowerPoint presentation and other communications collateral to make publically available.

Financials

I will include financial tracking information in my director's report, at least until the OCH leadership elects a treasurer and/or establishes a finance committee. I am working with the finance team at the KPHD to develop a financial tracking report, inclusive of in-kind support. Financial tracking will be included in future materials.

Since April 2015 the HCA has awarded the OCH three funding allotments totaling $580,000, of which 55.4% remains as of February 29, 2016.

Design Grant	$100,000	April 2015
Amendment	$150,000	January 2016
Designation	$330,000	April 2016
TOTAL REVENUE	$580,000	
EXPENSES	$110,471	as of February 29, 2016
BALANCE	$469,529	

KPHD has been averaging a monthly burn rate of $10,042 dollars. The total funding for ACHs within the 2016-2018 SIM funding period is $660,000 (not including the $250,000 above). Therefore if we are unable to secure any additional funds, our average monthly burn rate should stay well below $18,333. This does not account for the balance leftover from 2015, which will have been largely unspent by the time the first allotment of $330,000 will be received. The remaining balance of any grants or contracts will stay in a designated reserve and move with the OCH if it becomes its own legal entity.

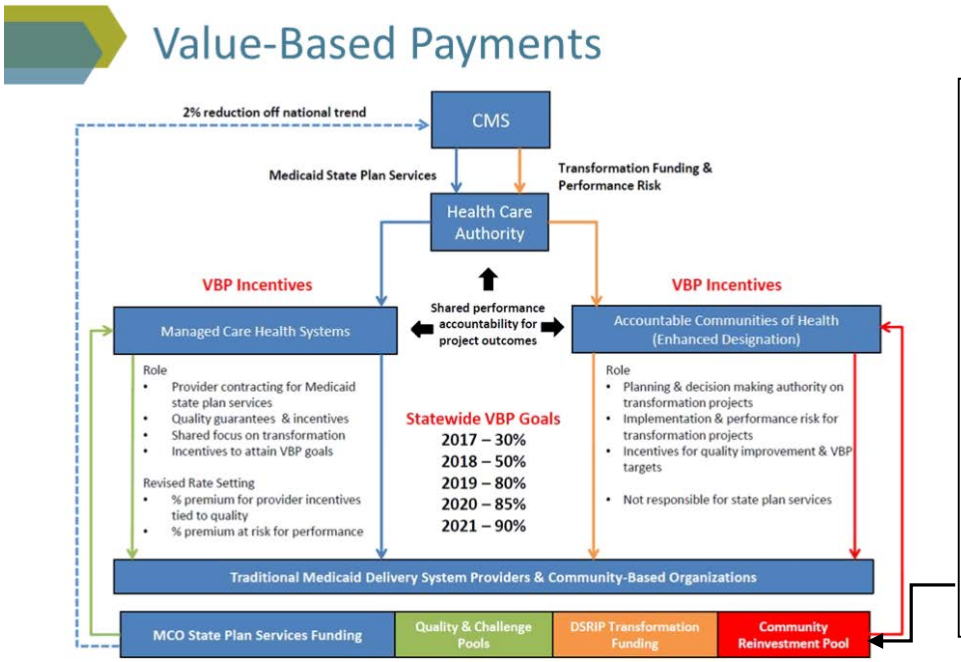
Waiver: In early March, HMA released two documents: the essential components of an ACH and a certification process for the waiver (see HMA memos). These documents are highlighted for your convenience and an executive summary is appended. These memos provide key background information to today's governance agenda item. We anticipate a decision from CMS's decision on the waiver by **July 2016** with a transformational project start date of **January 2017**. The State intends to support ACHs financially and with technical support (details TBD) in preparing to take on this role. In the meantime, a small waiver committee meets to discuss how this will roll out, emphasizing the ACHs role. Here is a summary of the committee's discussion:

- ✓ On the whole, the HMA documents do not represent finalized or negotiated requirements. **The one requirement is legal entity status.**
- ✓ Regarding the specific administrative capacities starting on page 4 of the HMA Essential Components Recommendations, there is an opportunity to use this outline to discuss and differentiate the role of the ACH and capacities that can be fulfilled by vendors. The goal is to align capacities with unique value provided by the ACH, while not focusing ACH energy on capacity development that may be duplicative or could just as easily be fulfilled by vendors.
- ✓ The HCA is looking at potentially providing the financial executor services for the ACHs under the waiver. There is a request to the HCA to provide a clearer description of how it's defining financial executor (e.g., bookkeeping or accounting versus oversight or decision making). There is a gaining consensus that this could (or should) be a single contracted statewide entity.
- ✓ Regarding the recommended governance requirements on page 4, the list represents a recommended minimum standard for balanced and diverse representation. ACHs are invited to consider how this list does or does not align with your current model.

The HCA released a Framework for the Project Toolkit (attachment 3).This is not the final project tool kit. It is the framework from which the final project toolkit will be built. Summary in table below:

Domain 1: Health systems Capacity Building	Domain 2: Care delivery redesign	Domain 3: Prevention and health promotion
- Primary care models - Workforce and nonconventional service sites - Data collection and analytic capacity	- Bi-directional integration of care - Care coordination - Care transitions	- Chronic disease prevention and/or management - Maternal and child health

**Tribal specific projects will have different investment strategies*

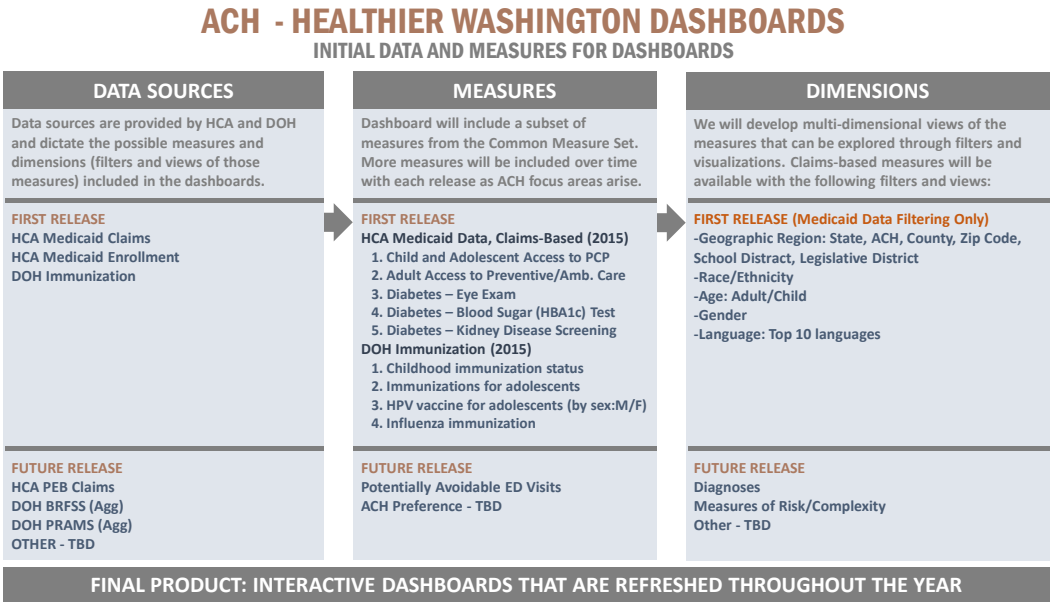


You have until May 27th to provide feedback on this framework on an online survey link.

Members from the HCA Medicaid Waiver Team will attend our next board meeting to discuss waiver developments in more detail.

Of particular interest is the Value-Based Payment figure below from the April 26th webinar. Note the little red box.

CORE: HCA is contracting with CORE as an interim solution during the implementation year of Analytics, Interoperability, and Measurement (AIM) to provide data and analytics about the Common Measure Set's 55 measures to all ACHs and to state agencies involved with AIM work (Health Care Authority [HCA], Department of Social and Human Services [DSHS] and the Department Of Health [DOH]). Data will be made available to ACHs via the CORE data dashboards, which will be delivered in aggregated, de-identified form and include information from the following data sources: Medicaid claims and encounters, DOH survey data sets: Pregnancy Risk Assessment Monitoring System (PRAMS), Behavioral Risk Factor Surveillance System (BRFSS) and Immunization Information System (IIS). The first release is scheduled for late May 2016. AIM is also working to include claims and encounters data from Public Employee Benefits (PEBB**). I am one of 3 ACH delegates selected work with the State on AIM.**



Personnel: CMS has awarded the Department of Health a Transforming Clinical Practices Initiative 16 million dollar four-year grant to improve care delivery in the pediatric setting. As will be the case with the Practice Transformation HUB, the State is asking each ACH to embed a practice coach into their backbone team. Interviews for the Olympic region candidate occurred on April 27th with a likely announcement next week.

*__NEW__*developments within each focus area of Healthier Washington:
ACH FAQ Sheet | Payment Redesign Webinars | Practice Transformation HUB RFPs | Performance Measurement meeting summary

Executive Summary Memo 1: Health Management Associates (HMA) – Recommendations on Essential Components for an Accountable Community of Health (ACH) related to the Medicaid Transformation waiver

Key Message: HMA asserts that the terms and conditions of the Medicaid Transformation waiver will require ACHs to be established as legal entities in order to serve as the single point of authority for the Transformation Projects funded through the Medicaid waiver, HCA has verbally reinforced this statement. HMA recommends the following *Five Essential Components* of an ACH. **Note, however, that with the exception of legal entity status, these are recommendations and are not formally adopted by the HCA.**

Five Essential Components of an Accountable Community of Health

1. **Legal Entity** such as a 501c(3) Non-Profit Organization; Public Corporation; or LLC. *Prohibited organizations: 501c(4) and 501c(6).*

2. Accountabilities: the responsibilities of the ACH must be clear in its bylaws.

- The ACH must: act as a convener of funded transformation projects; be accountable for demonstrating meaningful regional collaboration and engagement; be accountable for developing a Regional Health Needs Inventory (RHNI) for the region and a Regional Health Improvement Plan (RHIP); have the authority for setting transformation project plan focus areas, and transformation project recommendations (HCA retains final approval for transformation project funding), as well as financial and performance oversight of these projects.
- Membership of the ACH decision-making body must multi-sector, balanced, transparent, and demonstrate effective decision-making for transformation and value based payment projects.

3. Governance Requirements: Each ACH decision-making body should include a minimum sector balance such as:

- Primary care providers; Behavioral health providers; Medicaid managed care health systems; Hospitals or health systems; Local government; Local public health; Long term services and supports organizations; Medicaid Consumers; Representative from not for profit organizations and/or local government focused on human services, housing, criminal justice or other social determinants of health
- No more than 50% of Governance Board of an ACH should be represented by Medicaid managed care organizations and hospitals or health systems (combined seats).

4. Administrative / Management Capacity:

- Must demonstrate financial capacity to provide strong financial management and transparency, including budget development, the distribution of funds and financial reporting.
- Must demonstrate ability to manage ACH operations including date/information technology governance and management, transformations project oversight and performance monitoring, support for shared learning, stakeholder engagement, and development of a regional health needs assessment and reporting requirements. **Note, an ACH could build its own capacity through staffing or contract out for all or some pieces of the operations.**
- Create Transformation Project Advisory Committee (TPAC) to oversee the transformation project selection process. The TPAC would not be a decision-making body.

5. Demonstration of Regional Partnerships – ACHS must be able to develop Letters of Understanding (LOUs) with potential partners.

Executive Summary Memo 2: Suggested questions and required documentation for ACH certification for purposes of the Medicaid wavier

Key Message: HMA provided advice for Health Care Authority (HCA) as to what documentation they should require from ACH's in order to become certified as a single point of authority for waiver transformation projects. Note, HMA recognizes that not all ACHs have equal capacity and resources to meet the requirements outlined below. In recent conversations, HCA has stated that the State may fulfill some of the financial obligations and that a list of vendors will be made available to assist the ACHs with other back office services. The one non-negotiable is legal entity status. ACH's not able to meet Medicaid waiver certification requirements would be eligible to receive technical assistance support, financial and in-kind. **Medicaid Transformation waiver investment funds cannot be distributed to the ACH until it has met the Medicaid waiver certification requirements.**

Suggested Documentation (please refer to table in memo for specific documentation for each category):

1. Articles of Incorporation
2. Bylaws
3. Letters of Understanding (LoU) with key partners
4. List of Public Meetings/Communications Plan
5. Financial Policies
6. Staff List
7. Contracts
8. Data/IT Policies
9. Transformation Project Advisory Committee (TPAC) Membership List
10. List of Existing Data Sources
11. MOU with any practice hubs in region

Memorandum

To: Marc Provence, Washington Health Care Authority

From: Cathy Kaufmann, HMA

Date: March 2, 2016

Re: Recommendations on Essential Components for an ACH related to the Medicaid Transformation waiver

Health Management Associates (HMA) was engaged by the Washington Health Care Authority (HCA) from December 2015 through February 2016 to provide support and recommendations regarding the development of components of the state's Medicaid Transformation waiver. The recommendations outlined below are HMA's advice on the essential components of Accountable Communities of Health (ACHs) given the role they are to play in the implementation of the state's Medicaid waiver, namely the oversight and management of Transformation Projects (Waiver Initiative 1). These recommendations are based on HMA's experience in working with CMS on other states' waivers, review of documentation and similar Centers for Medicare and Medicaid Services (CMS) initiatives and feedback from HCA.

Recommendations for Essential Components for an ACH as the single point of accountability for Medicaid waiver Transformation Projects.

ACHs are an integral part of the transformation of Washington's delivery system, leveraging innovation and collaboration in local communities by bringing public and private entities together to work on shared health goals. Health Management Associates was tasked with recommending a set of essential components for ACHs to effectively participate in Washington State's anticipated Medicaid Transformation Waiver. HMA believes that the elements described in this document are also essential to ensure ongoing sustainability of delivery system reforms achieved during the course of the waiver.

A key function of ACHs will be to select and monitor transformation projects funded through the Medicaid waiver and to ensure that projects are successful. These projects will be a significant lever in achieving Medicaid transformation goals. While ACHs have a role that is broader than Medicaid, the initial federal investment under the Medicaid waiver will require that Medicaid funds are allocated to an entity that meets requirements agreed to by the state and defined by CMS in the terms and conditions of the waiver. ACHs should be prepared to serve as a single point of accountability for transformation projects. They will need to develop

(or obtain through contractual relationships) the necessary capacity to meet administrative, financial and operational requirements that the state and CMS specify to ensure adequate oversight of federal funds.

The Health Care Authority (HCA) initially proposed the term "coordinating entity" to encompass ACH capacity to support financial and administrative functions necessary for transformation decision making and project oversight. Given the extent of delivery system transformation anticipated and the substantial regional investment to accomplish the change, there must be a single entity that retains final decision-making authority, serves as the contract partner for the state, and is held accountable for fulfilling the terms of the contract. The earlier implication that a "coordinating entity" other than the ACH could be the single point of accountability for regional transformation projects is incompatible with the direction CMS has taken in other states and doesn't align with the level of direct empowerment and accountability envisioned for the ACHs in Washington. While an ACH may choose to contract with an external entity[1] for certain financial and administrative functions, we anticipate that the terms and conditions of the Medicaid Transformation waiver will require ACHs to be established as legal entities if they are to serve as the single point of authority and accountability for transformation project oversight. Hence, the term "coordinating entity" is no longer necessary; an ACH will fulfill this role for transformation achieved under the waiver to have regional credibility and sustainability.

That said, ACHs are in the early stages of development with varying levels of capacity. Some ACHs may be prepared to take on necessary requirements now while others will need more time for planning and implementation to support their Medicaid transformation role under the waiver. It will be critical for the state, as a component of initial planning assuming a waiver is approved, to support ACHs as they ready themselves for the delivery system transformation ahead.

Essential components of an Accountable Community of Health:

Based on CMS guidance for other programs and experience with other state 1115 waivers, it is highly likely that CMS will require that waiver funds be distributed to legal entities that can provide strong lines of accountability and oversight. Therefore, for ACHs to oversee Transformation Projects, they must become a single, legal entity with the ability to receive and distribute funds and report on and ensure transformation project compliance.

1. **Defined legal entity:** To act as a fiscal agent, critical for managing federal transformation investment funds, each ACH must be a legal entity. This can take many forms. The structure that makes sense should be decided by the local region in consultation with its own legal counsel. Depending on any federal guidance, options may include:
   - 501c(3) non-profit organization: a new or existing non-profit organization can provide the structure of the ACH.

[1] For example, an ACH decision-making body could choose to contract with an existing backbone organization (a relationship established under the State Innovation Models grant) to perform certain financial and administrative functions. However, the ACH must still maintain final decision making authority.

    - If created under an existing non-profit organization, that organization must conform to the governance requirements of ACHs.
- Public corporation or other public-private partnership.
- An LLC, business corporation or LLP.
- The only prohibited organizational structure is a 501c(4) or 501c(6).

In order to serve as a regional health leadership body with authority to make decisions about transformation projects and the distribution of federal funds, each certified ACH will have the following accountabilities:

2. **Accountabilities:** The responsibilities of the ACH must be clear in its bylaws. Responsibilities will also be stipulated in contracts with the HCA that formalize requirements for project investments funded under the Medicaid Transformation waiver. These include:

    - The ACH must act as a convener of funded transformation projects for the spread of learning. Each ACH will be expected to demonstrate how they will collaborate with other ACHs to disseminate information and share lessons learned from the Transformation Projects.
    - The ACH is accountable for demonstrating meaningful regional collaboration and stakeholder engagement in its activities.
    - The ACH is accountable for developing a Regional Health Needs Inventory (RHNI) for the region and a Regional Health Improvement Plan (RHIP). The ACH must collaborate with relevant partners in this process and utilize and compile existing community and regional reports and available data. It will need to be clear how this RHNI and the associated RHIP are used to inform the ACH's selection of transformation projects and the alignment of SIM projects. (See separate guidance)
    - The ACH has the authority for setting transformation project plan focus areas (see separate guidance) and transformation project recommendations (HCA retains final approval for transformation project funding), as well as financial and performance oversight of these projects.

    With the responsibility and accountability associated with the Medicaid Transformation waiver, the membership of the ACH decision-making body must guarantee:
    - *Multi-sector, balanced engagement across the region among organizations that can influence health and health care*
    - *Balanced membership between the health care system and organizations who focus on social determinants of health*
    - *Transparency in governance and strong commitment to local engagement*
    - *Demonstration of effective decision-making process for transformation and value based payment projects*

3. **Governance requirements:**
   Health Management Associates recommends that HCA require each ACH decision-making body to include *at least* one member representing *each* of the following entities:
   i. Primary care providers
   ii. Behavioral health providers
   iii. Medicaid managed care health systems
   iv. Hospitals or health systems
   v. Local government
   vi. Local public health
   vii. Long term services and supports organizations
   viii. Consumers (defined as a Medicaid beneficiaries or their legal guardians)
   ix. Representative from not for profit organizations and/or local government focused on human services, housing, criminal justice or other social determinants of health.

   - To ensure broad regional representation and participation in the ACH and prevent one group of ACH stakeholders from dominating governance and decision-making, no more than 50% of the Governance Board of an ACH should be represented by Medicaid managed care organizations and hospitals or health systems (combined seats).

CMS will require that waiver funds be distributed to legal entities that can provide strong lines of accountability and oversight. Therefore, for ACHs to oversee Transformation Projects, they must demonstration the following administrative/ management capacity.

4. **Administrative / Management Capacity:** ACHs must demonstrate capacity, structure and policies to make decisions and be accountable for:
   - **Financial:** The ACH must demonstrate financial capacity to provide strong financial management and transparency, including budget development, the distribution of funds and financial reporting.
   - **Operations:** The ACH must demonstrate its ability to manage ACH operations, including data/ information technology governance and management (if needed), transformation project oversight and performance monitoring, support for shared learning across transformation projects and with other ACH regions, stakeholder engagement, and development of a regional health needs assessment and reporting requirements. HMA recommends that the state's process for certifying an ACH for the purposes of the Medicaid waiver should require demonstration of how the ACH will perform these functions but allow each ACH flexibility to determine how best to fulfill operations requirements. For example, an ACH could build its own capacity through staffing or contract out for all or pieces of the operations.

- **Transformation Projects:** Washington's Transformation waiver application[2] proposes that the Health Care Authority (HCA) contract with ACHs to coordinate Medicaid transformation projects within their region. In this role, an ACH will oversee projects intended to further Medicaid Transformation goals. HMA recommends that each ACH accomplish this function through the creation of a **Transformation Project Advisory Committee (TPAC)** to oversee the transformation project selection process, development of the application for project investments, and implementation of selected projects. Transformation Projects will require a significant amount of work and oversight. A separate committee may be the best mechanism for accomplishing these tasks for an ACH. However, a TPAC should not undermine the role of the governance board as the decision-making body for the ACH. The TPAC would not be a decision-making body, but would submit recommendations to the governance board for final approval. An ACH may choose to use the governance board as the TPAC. Whether an ACH creates a separate subcommittee or uses the governance board to meet this requirement, it must ensure input from stakeholders, subject matter experts (clinical and social determinants expertise) and managed care health systems in the region.

5. **Demonstration of Regional Partnerships:** In order to be an effective leadership body for the region, an ACH must work collaboratively with regional partners. These partnerships cannot all be addressed through governance. In order to demonstrate that critical partnerships are in place or forming, HMA recommends that ACHs be required to develop Letters of Understanding (LOUs) with potential partners, beyond those represented on the ACH decision –making body. These letters are not binding agreements, but demonstrate and document a commitment to partnership that can prove beneficial to the ACH and the region.

[2] Available at http://www.hca.wa.gov/hw/Documents/waiverappl.pdf

Memorandum

Re: Suggested questions and required documentation for ACH certification for purposes of the Medicaid wavier

Health Management Associates (HMA) was engaged by the Washington Health Care Authority (HCA) to provide support and recommendations regarding the development of components of the state's Medicaid waiver. The recommendations outlined below are HMA's advice on the application questions and documentation HCA and/or its independent assessor should solicit from ACHs to certify them to serve as the single point of accountability for Medicaid waiver Transformation Projects. These suggested questions and documents are meant to serve as a starting point for the HCA and/or its independent assessor for the development of the certification application and are tied directly to the ACH Essential Components HMA has recommended in a separate deliverable. In addition to providing guidance to the HCA in developing the certification process, this document may help ACHs identify technical assistance needs or other resources or supports that will be needed to meet the Medicaid waiver certification requirements.

Recommended Essential Component	Suggested Application Questions	Suggested Documentation
Legal Entity	What type of legal entity (organization) is your ACH?	Articles of Incorporation Bylaws
Governance	Identify members of the board, roles and responsibilities and how members were selected. Describe how members provide adequate representation of the region. Describe the decision-making process, including how conflicts	List of Board members and their organizational affiliations Bylaws

Recommended Essential Component	Suggested Application Questions	Suggested Documentation
	will be resolved. Describe how conflicts of interest of members will be identified and managed/mitigated. Describe how sub-regions and/or populations within the region will be considered equitably in the work of the ACH. Describe how the ACH will ensure a transparent governing process (e.g., Will board meetings be public? How will Board decisions be shared?)	
Community Collaboration & Stakeholder Engagement	Demonstrate ACH strategy for partnering with regional organizations not directly represented on the board. Describe how the ACH engages stakeholders, representative of the geography and populations the ACH serves. Describe how consumers (e.g., Medicaid beneficiaries) provide feedback to the ACH about RHNI/RHIP and Transformation Project selection and	Letters of Understanding with key partners List of public meetings / communications plan (if available)

Recommended Essential Component	Suggested Application Questions	Suggested Documentation
	performance.	
Capacity for financial administration/management	Describe the processes that will be implemented to support financial success and sustainability. Describe the key financial functions that will be established by the ACH to ensure financial transparency and strong financial management, including: • Budgeting; • Funds distribution oversight; • Identify planned use of internal and/or external auditors. • Describe how the ACH will establish a financial compliance program in adherence with state law. • Shared savings determination and reinvestment; • Planning for financial sustainability	Financial policies
Operations Capacity, including Transformation project administration /management	Describe staffing / contractual relationships to meet the accountabilities of an ACH To the extent applicable,	Staff list Contracts

Recommended Essential Component	Suggested Application Questions	Suggested Documentation
	describe the processes that will be established to ensure data security and privacy. Describe how the ACH will select projects (If applicable) Describe Transformation Project Advisory Committee (TPAC) was formed; how were members selected; Describe how the Transformation Project selection process will ensure input from the clinical community and managed care health systems Describe how the ACH will monitor transformation project performance. Describe how the ACH will respond to projects that are underperforming/not meeting established performance milestones and/or metrics. Describe the process for removing projects that fail to address/remediate identified issues within a prescribed	Data/ IT policies (including data sharing agreements, performance management tools, and reporting capability) TPAC membership list (if applicable)

Recommended Essential Component	Suggested Application Questions	Suggested Documentation
	timeline	
Accountability for RHNI and RHIP	Describe the process for completing a Regional Health Needs Inventory (RHNI) and Regional Health Improvement Plan (RHIP)	List of existing data sources that will be used
Accountability for Spread of Learning	Describe mechanisms for supporting the transformation projects and spreading learning across projects and with other ACHs)	MOU with any practice hubs in region (should reference opportunities developed under the SIM grant to avoid duplication)

Recommendation for ACHs initially unable to meet requirements outlined above

HMA recognizes that not all ACHs have equal capacity and resources to meet the requirements outlined above on the same time frame. Therefore, we recommend that HCA establish a process by which an ACH can achieve an interim step towards Medicaid waiver certification through a "Development Plan" with milestones established to ensure that essential components will be in place within an agreed upon timeline. This plan should identify what requirements have been met and what work will be done (with clear milestones and plans for achieving them) to meet the remaining requirements. The ACH should also identify technical assistance needs it has for which the HCA may be able to provide support.

ACHs not yet able to meet Medicaid waiver certification requirements but with an approved development plan in place would be eligible to receive any planning grants or technical assistance support the state may offer and begin the process for Transformation Project selection, but no Medicaid Transformation waiver investment funds can be distributed to the ACH until it has met the Medicaid waiver certification requirements.

About the Framework for the Project Toolkit

Introduction

Transformation Projects, led by Accountable Communities of Health (ACHs)[1], are a key component of Initiative 1 of Washington's Medicaid Transformation waiver and a critical lever to help the state meet its Medicaid transformation goals. The Medicaid Transformation waiver will build upon and accelerate the foundational delivery system transformation work underway in Washington State.

Through this waiver demonstration, the state is asking our federal partners to allow Medicaid funding to be used to incentivize providers to pursue activities in support of delivery system reform. These incentives are structured through transformation projects that are intended to address the state's vision for Healthier Washington and to support the delivery system in meeting the needs of our Medicaid population. To provide guidance and parameters for the transformation projects, the state is developing a project toolkit.[2]

The **transformation project toolkit** provides guidance on the transformation projects eligible for funding under Initiative 1 of the waiver demonstration. It will reflect the strategies—inspired by the submitted project ideas, chosen by the state and ultimately approved by CMS—that ACHs will use to develop Medicaid transformation project plans. Funding will be available for projects in the toolkit upon completion of pre-determined milestones and metrics.

The following framework draws heavily from the transformation project ideas submitted to HCA in January, as well as input from our stakeholders and partners. This framework has also been informed by the project toolkits approved by CMS for New York and California.[3] This document is not meant to be a comprehensive or limiting list of project details within each of the domains, and is not the final project toolkit. Rather, it outlines the key strategies the state believes are necessary in order to achieve the Medicaid Transformation goals.

Transformation Projects must promote systems-based approaches to improving health by incorporating and addressing social determinants of health and increasing the efficiency and effectiveness of healthcare. By making improvements in care and health for our Medicaid clients, we can catalyze improvements throughout the entire health care delivery system. While there are many gaps in our health system that need and deserve further investment, the Medicaid Transformation waiver will focus on activities aimed at changing the structure and incentives in the health care system that affect our Medicaid clients to encourage quality and efficiency, and promote more cost-effective care.

[1] Our use of the term ACH throughout this document includes participants and partners. It is not intended to mean the organization that performs administrative functions for the ACH and is also not meant to imply a preferential status for some in the region over others.

[2] *Project toolkit* is a term used in other states that are undertaking major Medicaid Transformation efforts through Section 1115 waiver authority. It is often a waiver demonstration requirement requiring approval by the Centers for Medicare & Medicaid Services (CMS).

[3] For example; New York Toolkit: http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf; California Toolkit: http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_AttachmentQ_PRIMEProjectsMetrics.pdf.

Purpose of the Framework

This is not the final project toolkit. Rather, this framework document is an outline from which the final toolkit will be built. The final toolkit will serve as the guide for transformation projects after the waiver proposal is approved by CMS. This framework reflects the project elements we have prioritized for the toolkit, and the project-specific objectives and outcomes envisioned.

Value-based Payment

The movement toward value-based payment models is critical to the success and sustainability of this waiver demonstration. To ensure that progress toward a transformed care delivery system, funded through the waiver, is sustained well beyond the 5-year demonstration period, we must change the way we pay for services. The state and federal governments have an expectation that transformation projects will reinforce the shift to paying for value over volume. The transition to value-based payment models is an over-arching goal for Initiative 1. To that end, projects will need to support building provider and plan capacity to achieve systemic change in how services are reimbursed.

Project Idea Submissions

Consistent with our commitment to a process that is informed by our stakeholders and partners, we asked the community for project ideas to ensure that the transformation project toolkit reflects community needs as well as Medicaid Transformation goals. The level of interest and engagement in that exercise was astounding; we received over 180 project ideas from across the state. Those ideas are available on our website for viewing.

We appreciate the hard work that went into completing templates for those project ideas. In the course of developing the project framework and defining the project rationale, goals, and objectives, we drew heavily from the major themes present in the ideas that were submitted. Many of the core components that will be specified in the toolkit will be based on those identified in project ideas. It is important to note that, while many of the project elements are drawn from submitted ideas, *no project idea will appear in the toolkit in the same form as originally submitted*. We will continue to review the idea submissions as we build the project toolkit.

It is important to note that many of the details included in the idea submissions will not be reflected in the final toolkit. Some of the project ideas contained elements that would not be eligible for incentive payments under the Medicaid Transformation waiver because they included:

- Duplicate services funded under the Medicaid state plan.
- Activities that overlap with the Medicaid Alternative Care (MAC) and Targeted Supports for Older Adults (TSOA) benefits under Initiative 2 of the waiver proposal.
- Activities that overlap with targeted supportive housing and supported employment benefits under Initiative 3.
- Activities that do not support predominantly Medicaid-eligible populations.

We encourage community partners to continue to engage their Accountable Communities of Health (ACHs) in discussions about regional needs related to the project areas identified in this framework document. For ideas that are not reflected in this framework, regions may have other means to support the pursuit and achievement of those goals.

Project Toolkit Overview

The project toolkit will provides guidance on transformation projects and provide ACHs with the details necessary to develop transformation project plans. This framework document serves as the outline for the eventual project toolkit. In the toolkit, each project description will include:

- **Project** title denoting the key strategies and activities designed to support communities and provider organizations as they change care delivery to maximize health care value.
- **Rationale** for the proposed project (evidence base and reasoning behind the project).
- **Objectives and outcomes** of the project (the project-specific goals and expected project outcomes).
- **Core components**, or key project elements, to guide development and implementation.
  The core components will provide approaches or elements that participating providers will be expected to adopt as they develop and implement projects. Most of these elements will be necessary to achieve the required results. In this way, the core components will promote standardization across Medicaid Transformation activities, while allowing regional flexibility to tailor projects to meet local needs. For example, a core component of bi-directional integration of care might be to *implement an integration assessment tool to provide baseline information and annual progress measurement*.
- **Metrics** required for the project. Participating providers will earn incentive payments based on performance on the project metrics.

The **rationale** and **objectives and outcomes** of the projects are provided in this framework document.

The **core components** and **project metrics** are not included in this document but represent the critical next steps toward completing the project toolkit. We expect to use the common measure set because it is foundational to this work.

Tribal-specific Projects

The State takes seriously its government-to-government relationship with Tribes and its responsibility to seek advice from Indian Health Service, Tribally operated facilities, and Urban Indian Health Organizations (I/T/Us) on its waivers. While the Accountable Communities of Health (ACHs) are intended to lead the State's efforts with respect to Medicaid Transformation, the State has contracted with the American Indian Health Commission for Washington State (the Commission) to help determine whether and how the Tribes and I/T/Us in Washington State wish to engage with the ACHs and if the Tribes and I/T/Us would like a separate Tribal entity or entities with which to work on Medicaid Transformation. In connection with these efforts, the State and the Commission will gather information on what projects and activities are needed to encourage quality and efficiency and promote more cost-effective care.

Next Steps

This framework document will be shared with CMS as part of ongoing negotiation discussions. We also invite our stakeholders to participate in a short survey to help inform the next steps of this process. The survey will be posted on our website on Wednesday, April 27, 2016 and will be available until Friday, May 27, 2016. If you have questions or comments regarding this framework, please send them to medicaidtransformation@hca.wa.gov.

We plan to address questions during our next webinar in the Medicaid Transformation series on April 26, 2016 from 10 a.m. to 12 p.m. For more information and registration details, please visit our website: http://www.hca.wa.gov/hw/Pages/medicaid_transformation.aspx.

Thank you.

Framework for the Project Toolkit

Transformation Projects, led by Accountable Communities of Health, are a key component of Washington's Medicaid Transformation waiver and a critical lever to help the state meet its Medicaid transformation goals. Following is a draft project framework, drawing heavily from the transformation project ideas submitted in January, as well as input from our stakeholders and Tribal partners. This framework has also been informed by the project toolkits approved by CMS for New York and California.[4]

There are three domains and an over-arching expectation of support, across all of the domains, for the transition of Medicaid services to value-based payment. The domains for transformation projects are:

- Health systems capacity building
- Care delivery redesign
- Prevention and health promotion

The domains are not mutually exclusive. Projects in one domain may reference or support a project in another domain. This is particularly true for projects under Domain 1 which must directly reinforce other transformation projects. This means that projects related to workforce, primary care models, and data collection and analytic capacity must support and demonstrate a direct connection to activities undertaken in Domain 2 (Care Delivery Redesign) and/or Domain 3 (Prevention and Health Promotion).

The project framework is not meant to be a comprehensive or limiting list of project details within each of the domains, but rather an illustration of the key strategies the state believes are necessary in order to achieve the Medicaid Transformation goals.

Note that there is a placeholder section reserved for projects specifically targeted to American Indians/Alaska Natives (AI/ANs). The State has contracted with the American Indian Health Commission for Washington State to gather information on what projects and activities are needed to encourage quality and efficiency and promote more cost-effective care; these projects and activities will be incorporated later in the project toolkit development process.

[4] For example; New York Toolkit: http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf; California Toolkit: http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_AttachmentQ_PRIMEProjectsMetrics.pdf.

Support for the transition to value-based payment
Consistent with the Healthier Washington goal of having 80% of state payments tied to value by 2019, as well as CMS expectations for the Medicare and Medicaid programs, Medicaid transformation efforts must contribute meaningfully to moving Washington forward on value-based payment (VBP). Paying for value across the continuum of Medicaid services is necessary to assure the sustainability of the transformation projects undertaken through the Medicaid Transformation waiver. A transition away from paying for volume may be challenging to some providers, both financially and administratively. Because not all provider organizations are equipped at present to successfully operate in these payment models, providers may need assistance to develop additional capabilities and infrastructure. To that end, significant financial incentives will be established for attainment of VBP targets over the five-year demonstration at the regional ACH and managed care plan levels. Incentives will support provider and plan capacity in achieving systemic change in how services are reimbursed. In addition, there will be opportunities to explore the relationship of each of the project domains to value-based payment.

Domain 1: Health Systems Capacity Building
Health system capacity must be enhanced in order to support the level of delivery system change called for in Washington's Medicaid Transformation waiver. This domain focuses on strategies and projects to build that system capacity, including health information technology to support integration and collaboration among providers and systems; data analytics capacity to track and improve quality and cost; and projects to increase the capability and flexibility of the provider workforce to ensure health care teams have the necessary composition to deliver team-based coordinated care. To ensure funds for transformation projects are effectively leveraged, all projects in Domain 1 must demonstrate a direct connection to Domain 2 (Care Delivery Redesign) and/or Domain 3 (Prevention and Health Promotion), or must support providers in developing the capabilities necessary to operate in value-based payment models.

Project	Rationale	Objectives and Outcomes
Primary Care Models	Primary care teams are undergoing substantial changes in order to deliver whole-person care efficiently and effectively, and to transition to value-based payment models. This strategy focuses on supporting existing efforts for primary care practices undergoing transformation.	• Implement evolved models for primary care practices to provide whole-person care. • Ensure health systems have efficient and reliable access to community resources that address social and personal needs for effective treatment. • Develop advanced care planning materials for client education to support care and treatment consistent with clients' goals and values. • Improve client experience of care. • Provide educational and coaching sessions on how to provide effective palliative care. • Ensure provider teams are well equipped with resources to facilitate seamless specialty referrals or behavioral health referrals. • Promote early identification, diagnosis and disclosure of cognitive impairment and dementia.
Workforce and Non-conventional Service Sites	Provides support for changes in the workforce, including training and education, or facilities needed to evolve systems to team-based, patient-centered care and ensure the equity of care delivery across the population.	• Expand use of telemedicine in rural and underserved areas. • Expand Community Health Worker/Peer Support/Long-term Care workforce. • Provide clinical and staff training/technical assistance to successfully implement care delivery redesign and prevention and health promotion projects. • Improve care quality and increase health systems capacity to prepare for future increases in our aging population.
Data Collection and Analytic Capacity	Support the evolution of electronic health records and health information exchanges to improve the speed, quality, safety, and cost of care. This includes linkages to community-based care models.	• Identify and evaluate necessary technology and tools for information exchange. • Implement health information technology and/or health information exchange projects to support coordinated,

	Improve data and analytics capacity to support health systems transformation, including combining clinical and claims data to advance value-based payment models and to achieve the triple aim.	person-centered care while incorporating relevant social determinants of health. • Ensure interoperability of health data to support care delivery.

Domain 2: Care Delivery Redesign		
Health care delivery systems are critical to achieving the goals of Medicaid Transformation. This domain focuses on system-wide connections to improve the quality, efficiency and effectiveness of clients' care and includes investments in projects that are the foundation of delivery system change. Strategies emphasized under this domain include integration of behavioral and physical health care; ensuring effective care coordination, including client outreach and engagement, that reaches those who need it most; improving transitions of care to improve outcomes and reduce costs; and supporting care models that are person-centered while strengthening partnerships between clinics and community-based supports.		
Project	**Rationale**	**Objectives and Outcomes**
Bi-directional Integration of Care	The Medicaid system aims to support person-centered care that delivers the right services in the right place at the right time. Challenges remain in achieving coordinated care across complex healthcare systems; these can be a major obstacle to care. Primary care services are a key gateway to the behavioral health system, and primary care providers need additional support and resources to screen and treat individuals for behavioral health care needs, and make appropriate referrals. Similarly, for clients not easily engaged in primary care settings, behavioral health settings should be equipped to provide for effective primary care as needed. The key point is that physical and behavioral health problems often occur together. Integrating services to treat both will yield the	• Spread and sustain effective models of integrated physical and behavioral health care. • Improve physical and behavioral health outcomes, care delivery efficiency, and client experience by establishing or expanding fully integrated care teams—i.e., primary and behavioral health care providers delivering coordinated, comprehensive whole-person care. • Enhance and more effectively support existing state programs, including Health Homes, without duplicating programs or services. • Address the needs of clients not easily engaged in primary care settings and support individuals needing a more intensive level of behavioral healthcare. • Improve clients' adherence to treatment regimens. • Improve population management and multi-tiered/stepped care

	best results and be the most effective approach for those being served. Effective bi-directional models of integrated care will include the systematic coordination of physical and behavioral healthcare. Integrating mental health, substance use disorder, and primary care services has been demonstrated to deliver positive outcomes and is an effective approach to caring for people with multiple healthcare needs.	approaches that provide increasing levels of specialty care involvement when a client is not improving as expected.[5] • Improve communications and protocols between different provider types and organizations. Provide basic health screening, access to physical health information, active coordination with primary care providers, and team-based care. • Reduce avoidable intensive services and settings. • Improve client experience with health services. • Improve crisis systems and diversion programs, reducing avoidable institutionalization in emergency departments and jail settings.
Care Coordination	Care coordination is essential for the health management of defined populations, especially those living with chronic health conditions. It involves bringing together various providers and information systems to coordinate health services, foundational community supports, and information to better achieve the goals of treatment and care. Care coordination efforts must be well-integrated at the regional level and collaboratively focused on improving the quality and efficiency of care coordination. If various coordination efforts are not linked, these well-intentioned efforts may perpetuate a fragmented and confusing health system. Many care coordination efforts face challenges in outreach and engagement that negatively impact client	*This strategy focuses on the implementation and/or improvement of care management models that facilitate the appropriate coordinated delivery of health care services and foundational community supports. Although projects cannot duplicate care coordination currently provided under Medicaid, they can link to and support these efforts as well as ensure local coordination. These activities must meet the clients' needs and preferences and result in improvements in clients' health outcomes.* *Outreach and Engagement* • Develop programs for outreach, engagement and retention of clients who are either not utilizing the health care system or who are utilizing the system ineffectively or inappropriately; link to care management activities. • Reduce unnecessary emergency department utilization by

[5] http://aims.uw.edu/all-hands-deck

	retention. Clients who are unwilling or do not understand how to access and effectively use the health care system cannot be expected to engage in the services necessary to meet their health care needs or access appropriate, less costly services as alternatives to emergency room care.	identifying high EMS utilizers and engaging community paramedics in care management efforts. • Support clients in accessing health care and in gaining self-confidence in managing their health. • Ensure clients' active participation in decision-making. • Assure cultural sensitivity. *Care Management* • Provide strong care coordination that does not duplicate existing services to better meet the needs of higher-risk clients. • Facilitate enhanced collaboration and efficiency between care coordination programs by linking and aligning care coordination efforts and providers. • Promote shared learning across providers by identifying best practices, shared resources, and technology solutions. • Develop reliable, replicable systems for linking people with both clinical care and community-based sources. • Increase referrals and use of community supports and services by creating clinical-community linkages. • Develop dementia-capable resources so health care professionals can support care coordination efforts. • Develop advanced care planning materials for client education to support care and treatment that is consistent with clients' goals and values.
	Connecting clients to dental care is a key priority for many regions across the state. Medicaid clients account for a significant portion of all ED dental visits. The incidence of oral disease is also disproportionately high among low-income communities.	*Oral Health Coordination (optional project as part of care coordination efforts)* • Increase the network of dental providers accepting Medicaid. • Connect clients with appropriate dental appointments and provide coaching to ensure clients are ready for appointments.

Care Transitions	Transitions out of intensive services and settings and into the community are critical intervention points in the care continuum. While some readmissions are appropriate, many are due to events that could have been avoided. Individuals discharged from intensive settings may not have a stable environment to return to or lack access to reliable care. Transitions can be especially difficult on clients and caregivers when there are substantial changes in medications or routines, or an increase in care tasks. Robust transition plans provide opportunities to help individuals avoid readmissions and achieve whole-person health. This strategy identifies system-specific gaps in care transition. It takes a multi-disciplinary approach toward system redesign incorporating physical, behavioral, and social health needs and perspectives. Investment in care transition programs will support parallel care coordination efforts.	• Improve the coordination and continuity of care as high-risk patients, with chronic health conditions, behavioral health conditions, and/or housing instability move out of intensive services and settings. • Improve individuals' ability to care for themselves and providers' ability to effectively hand off health care responsibility to the appropriate provider, • Optimize an individual's course of chronic illness, ultimately reducing avoidable utilization of intensive services and settings. • Improve referral pathways to housing providers so those in need of medical respite are connected to permanent supportive housing. • Ensure that interruptions in client housing and/or employment as a result of hospital or institutional stays do not result in homelessness or long-term unemployment after discharge.

Domain 3: Prevention and Health Promotion		
This domain focuses on prevention and health promotion for Medicaid beneficiaries with a strong focus on improving health equity. These strategies will target clinical and community prevention that is coordinated and whole-person centered. A transformed delivery system design will contain improved approaches to engage individuals in personal health behavior change based on their needs and service preferences at the time.		
Project	**Rationale**	**Objectives and Outcomes**
Chronic Disease Prevention and/or Management	A wide array of chronic health conditions is prevalent among Washington's Medicaid clients, and the number of individuals with or at risk of chronic disease is increasing. Disease prevention and effective self-management is critical to individuals' quality of life and longevity. However, many individuals face cultural and linguistic barriers to accessing quality care, navigating the health care system, and understanding how to take steps to improve their health. Improving health care and health behaviors is only part of the solution. Washington State recognizes the impact that factors outside the health care system have on health and is committed to a "health in all policies" approach to effective health promotion and improved treatment of disease. This strategy will focus on supporting those living with chronic health conditions, engaging them in active management of those conditions, and preventing chronic health conditions by working across sectors.	• Support those living with chronic health conditions, such as asthma, depression, high blood pressure, and diabetes to effectively manage their conditions to improve their health and prevent complications. • Identify existing community resources that provide targeted services for clients with chronic health conditions, creating linkages and connecting or referring clients to those resources, including those that address the social determinants of health. • Take an interdisciplinary approach to identifying culturally competent, cost-effective, evidence-based approaches to the prevention of and/or care for clients with chronic disease. • Reduce disparities in receipt of targeted prevention services. • Increase rates of screening and completion of follow-up across targeted prevention services. • Expand the availability of chronic disease self-management programs and assist individuals in increasing their self-management skills. • Implement obesity and food insecurity screening tools and procedures for referral to treatment and community resources for pediatric and adult populations.

Maternal and Child Health	Maternal and child health is a focus for the Medicaid program since it funds more than half the births in the state and provides coverage to more than half of Washington's children. This strategy focuses on supporting and promoting better health for this population and targeting unmet health needs that contribute to high costs in the health system, including interventions to mitigate the prevalence of adverse childhood experiences for vulnerable populations.	*Promoting improved birth outcomes and early childhood health* • Promote a "no wrong door" approach to ensure that women can get their needs met wherever they come into contact with the health system. • Increase provider training on how to incorporate reproductive life planning into routine health screening to help women fulfill their pregnancy intentions. • Identify and offer health education and increased access to treatment or services for women at risk for poor health or birth outcomes. • Reduce avoidable poor pregnancy outcomes and improve maternal and child health through the first years of a child's life. • Increase support programs for maternal and child health. • Improve maternal and child health outcomes through home visits, pre-natal screenings, and postpartum health status assessments. • Combine case management and preventive services for mothers and children. *Promoting Trauma-Informed Approaches to Care* • Focus on interventions to mitigate the instances and intergenerational transition of Adverse Childhood Experiences (ACEs). • Expand outreach and engagement to children and families affected by ACEs. • Increase system awareness and skills for addressing trauma from ACEs. • Promote the uniform application of practice skills informed by trauma care principles.

Tribal Specific Strategies/Project(s)
Health care for American Indians/Alaska Natives (AI/ANs) presents different strengths and challenges and needs different investments to encourage quality and efficiency and promote more cost-effective care. The federal trust responsibility for AI/ANs applies to all federal agencies. While the Indian Health Service (IHS) is the primary agency to meet this trust responsibility with respect to health care, IHS has also suffered since its inception from severe underfunding. In contrast, over the years, Congress has expanded the ability of IHS to receive reimbursement from Medicaid—even clarifying that IHS is the payer of last resort. Within these historical developments, more and more Tribes have taken over the administration of their health care programs under the Indian Self-Determination and Education Assistance Act, as amended—enabling them to coordinate health care and social services. As a result of this complex history, IHS Service Units, Tribally operated facilities, and Urban Indian Health Organizations (together, the I/T/Us) have developed, to varying degrees, the very system-wide connections and whole person health care which the Medicaid Transformation Waiver is intended to help develop. The State takes seriously its government-to-government relationship with Tribes and its responsibility to seek advice from I/T/Us on its waivers. While the Accountable Communities of Health (ACHs) are intended to lead the State's efforts with respect to Medicaid Transformation, the State has contracted with the American Indian Health Commission for Washington State (the Commission) to help determine whether and how the Tribes and I/T/Us in Washington State wish to engage with the ACHs and if the Tribes and I/T/Us would like a separate Tribal entity or entities with which to work on Medicaid Transformation. In connection with these efforts, the State and the Commission will gather information on what projects and activities are needed to encourage quality and efficiency and promote more cost effective care. One likely candidate is infrastructure investment to improve the increasing number of data interfaces between the I/T/Us and the non-I/T/U providers and payers, including Medicaid.

HCA Contract #: K1434	**Amendment Start Date:** 2/1/2016
Grant Award Amendment No. 2	**Contract End Date:** 1/31/2017
Amendment Amount: $330,000 **received** 4/25/2016	

Domain of Work	Deliverable	Due date
Governance Structure and Administrative Capacity (estimated 60% of the work)	Budget Projections 2016-2018	May 9 (was due April 29)
	Clearly defined roles of the backbones, including accountability to the ACH structure	May 9 (was due April 29)
	Updates to governance structure, agreements, and policies	Ongoing
	Communication summary and engagement activities update	April - July
	Updated Budget Projections 2016-2018	Sept 30, 2016
	Communications and engagement plan	October 31, 2016
Health Improvement and Measurement Planning (estimated 25% of the work)	Updated Regional Health Needs Inventory (RHNI) and priorities	April - July
	Identify ACH Project(s)	April - July
	Action plan to address "Early Win" project	October 31, 2016
Health and Delivery System Transformation (estimated 15% of the work)	Partnering on the development and messaging related to the ACH in the context of other HW Investments (E.G., Early Adopter, P4IPH)	Ongoing
	Participation in evaluation effort	Ongoing
	Participation in the technical assistance effort led by Empire Health Foundation	Quarterly
General Reporting	Midway report capturing all completed updates/adjustments to-date.	October 31, 2016
	Final report capturing all completed updates/adjustments to-date.	January 31, 2017
	Financial report	February 28, 2017

Purpose: The HCA has given us an extension from April 29th to May 9th to submit five contract deliverables. These are:

1. 2016-2018 Budget
2. Updates on the backbone organization
3. Updates on the governance structure
4. Updates on communications and engagement activities
5. Other updates – Regional Health Needs Assessment and Improvement Plan

The narrative for deliverables two through five is presented below for Council approval. Deliverable 1, the revised three-year budget, is also an action item but it intentionally pulled out of the consent agenda and included as item 2 for today's meeting.

HCA contract deliverables due May 9th, 2016

Updates since the Olympic Community of Health (OCH) Readiness Proposal submission, November 2015

1. 2016 to 2018 Budget

Refer to agenda item 2.

2. Update on backbone organization

In February 2016, the OCH Interim Leadership Council dropped the word "Interim" from its name and became the OCH Leadership Council (Council). In February, the Council reaffirmed the Kitsap Public Health District (KPHD) as the OCH backbone organization and approved a revised 2016 operating budget. Revenues and expenditures for KPHD's backbone support of the OCH were included in KPHD's 2016 budget, which was approved in January 2016 by the Kitsap Public Health Board. KPHD has agreed to provide backbone support through the end of the ACH contract period (January 31, 2017) with the understanding that this could change as the OCH governance and structure evolves.

The Council conducted interviews on February 29th for an OCH Director. The interim Project Manager, Rochelle Doan, ceased work under her contract with KPHD effective March 31, 2016. The Director position was offered to Elya Moore, who accepted on March 18th and began full time on April 18th. Elya is an employee of KPHD and has an office in Bremerton. However, informal discussions are underway about a more central location for Elya pending future developments regarding ACH legal entity status and potential backbone subcontracts.

While Elya technically reports to the KPHD Administrator, there is an understanding that until the OCH becomes its own legal entity, she is the Director reporting and accountable to the Council. The OCH is also supported by a 0.4 FTE support staff assistant (hired in March) and a 0.5 FTE epidemiologist, all staff of KPHD. The KPHD Administrator continues to provide in-kind support for the backbone team. Additionally, the KPHD is donating in-kind indirect expenses.

Elya has initiated conversations with the HCA technical assistance contractor, Alisha Fehrenbacher at the Empire Health Foundation, to research available resources to assist with OCH becoming a legal entity and/or forming a fiscal sponsorship and services agreement between the OCH and a subcontractor. Elya also is beginning work to adopt OCH bylaws and is currently reviewing bylaws from other ACHs that are further along in this process.

Attachments to send to the HCA:

- ✓ OCH Director Job Description, January 11, 2016
- ✓ OCH 2016 Budget, February 29, 2016

3. Update on governance structure

On February 29, 2016, the Council made several changes to its governance structure.

1. All seven Tribes in the OCH region have a Council voting seat.
2. Removed the word "interim" from Interim Leadership Council.
3. Approved the 2016 OCH budget.
4. Agreed that KPHD will continue to serve as the backbone organization.

On May 4, 2016, the Council made several additional changes to the governance structure. (NOTE: The four points below may change pending decisions made at the May 4th Council meeting)

1. Established a Board of Directors (Board) of 19 voting members that is largely made of up of the existing Council.
2. Formed an Executive Committee of 5-7 individuals from within the Board.
3. Formed an ongoing Regional Health Assessment and Planning Committee with a core group of technical experts.
4. Employed the use of charters for all committees.

The next steps for governance include discussion of incorporation, legal entity type, bylaws and policies (e.g., conflict of interest, governance structure review, backbone review, executive director review, change in sector representation or retirement, and others).

Attachments to send to the HCA:

- ✓ Revised OCH Charter, February 29, 2016
- ✓ Governance Situation. Background. Assessment. Recommendation., May 4, 2016

4. Update on communications and engagement

At the February 2016 Council meeting, members authorized the creation of a formal OCH website. Currently our website is hosted by Kitsap County Human Services as an in-kind donation for around $20 dollars per month. The new website will be managed internally by KPHD and provide up-to-date information and materials, a calendar of events, a link to sign up for the newsletter, and an opportunity to provide input. Work will begin on the design and functionality of the new website in April/May 2016. The website will be connected with social media and an electronic newsletter or blog.

Regular electronic communications will be disseminated to a broad list of stakeholders (currently 126 people) at least once per month. Regular OCH Stakeholder meetings will continue to be held. Additionally, the director has initiated a conversation with Craig Nolte from the San Francisco Federal Reserve to hold large in-person community gatherings across the region.

OCH staff are compiling a brand book for the OCH with templates for PowerPoint, letterhead, reports, business cards and other communications collateral. The brand and logo were donated from the Olympic Medical Center for an in-kind donation of $250. The brand book and key communications collateral will be distributed to OCH stakeholders for broader dissemination within their sectors.

The new Director has begun to meet with stakeholders across the region, including elected officials.

All of these above activities will be integrated into a strategic Communications and Engagement Plan that will go to the OCH Board for approval and be submitted to the HCA as a contract deliverable in January 2017. We are currently exploring the Community Engagement Spectrum™ provided by the International Association for Public Participation as a framework for this plan.

5. Update on Regional Health Needs Assessment and Improvement Plan

The OCH Interim Leadership Charter identified four broad **focus areas**: access to care, population health, access to "whole person" support, and data management/region-wide infrastructure. At the March 22 OCH Stakeholder Group meeting, five **priority areas** were approved: access, aging, behavioral health, chronic disease, and early childhood.

Attachment to send to the HCA:

- ✓ Revised Regional Health Improvement Plan infographic

OLYMPIC COMMUNITY OF HEALTH

2016-2018 HCA BUDGET - Attachment 6

Leadership Council - Action Item

May 4, 2016

Grantee Name: Olympic Community of Health supported by Kitsap Public Health District
Contract #: K1434-02
Contact Person: Elya Moore **Phone:** (360) 633-9241 **Email:** elya.moore@kitsappublichealth.org

Instructions:

Initial budget projection are due by April 29, 2016 with an update anticipated in Quarter 3 of 2016. Please align with the following parameters and

Budget Line Item	2016	2017	2018	2016-2018 Total	Notes
1: Governance Structure and Administrative Capacity (SIM $)	$159,877.21	$102,972.94	$25,954.42	**$288,804.57**	Matched contributions expected from OCH partners. $10,000 pledged for 2016.
1.a. Match (if applicable):	$10,000.00	$80,000.00	$160,000.00	**$250,000.00**	
1.b. In-Kind Staffing:	$0.00	$0.00	$0.00	**$0.00**	Backbone agency tracked $4,000 in in-kind support for January 2016. Too soon to extrapolate this out for three years. In-kind contribution will be captured in updated September 2016 budget projection.
2: Health Improvement and Measurement Planning (SIM $)	$70,782.17	$76,238.73	$77,481.01	**$224,501.90**	
2.a. Match (if applicable):	$0.00	$0.00	$0.00	**$0.00**	
2.b. In-Kind Staffing:	$0.00	$0.00	$0.00	**$0.00**	
3: Health and Delivery System Transformation (SIM $)	$42,469.30	$45,743.24	$46,488.60	**$134,701.14**	Domain 1: est. 60% of total budget Domain 2: est. 25% of total budget Domain 3: est. 15% of total budget
3.a. Match (if applicable):	$0.00	$0.00	$0.00	**$0.00**	
3.b. In-Kind Staffing:	$0.00	$0.00	$0.00	**$0.00**	
Total	**$283,128.69**	**$304,954.90**	**$309,924.03**	**$898,007.62**	Refer to '16-'18 budget for more detail

Optional : Any match expenditures that do not fit within your budget line item categories can be projected under the "Other" line item. Please add a brief description

*** Also optional: Please provide in-kind resource or hour estimations based on staffing that supports the contract categories (i.e., this is meant to project a more*

OLYMPIC COMMUNITY OF HEALTH

2016-2018 DRAFT BUDGET - Attachment 6

Leadership Council

May 4, 2016

This budget provides the backend details for the 2016-2018 budget deliverable for the HCA and assumes that the OCH incorporates by 2017 and/or bids for a new backbone organization. The estimates herein are drawn from 2016 operational budget approved by the OCH Interim Leadership Council on February 24th, 2016. In-kind contributions have not yet been incorporated. Please note that the future is extremely uncertain; therefore the details provided in this budget may change, especially if the backbone or legal entity status of the OCH changes or if/when the waiver activity beging. The HCA confirmed that this is expected and would not have a negative impact on our contract.

REVENUES 2016

Description	Total
HCA ACH Phase 1 Grant	330,000
HCA Design Grant	150,000
Clallam County *(not yet received)*	10,000
TOTAL REVENUES	**490,000**

Note : Unexpended balance of HCA state funding from 2016 ($480,000) is reserved for 2017 and 2018.

REVENUES 2017

Description	Total
HCA ACH Phase 2 Grant	231,000
Designated reserve	206,871
Partner contributions (TBD)	80,000
TOTAL REVENUES	**517,871**

Note : This is a conservative revenue projection. It assumes no new revenue through the waiver, new contracts, or philanthropy.

REVENUES 2018

Description	Total
HCA ACH Phase 3 Grant	99,000
Designated reserve	212,916
Partner contributions (TBD)	160,000
TOTAL REVENUES	**471,916**

Note : This is a conservative revenue projection. It assumes no new revenue through the waiver, new contracts, or philanthropy.

2016

January 1, 2016-December 31, 2016

EXPENDITURES

Personnel	Salaries	Benefits[1]	Total
Director: 1.0 FTE for 9 months	79,362	23,809	103,171
Program Coordinator: ~~1.0~~ 0.5 FTE for ~~8~~ 4 months	14,923	4,477	19,399
Epidemiologist: 0.5 FTE for 11 months	37,279	11,184	48,463
Assistant 0.4 FTE for ~~12~~ 10 months	15,528	4,658	20,186
Subtotal Personnel Costs	**147,092**	**44,127**	**191,219**
Non-Personnel			**Total**
Professional Services:			
Interim Project Manager (Jan. - March 2016)			23,605
Communications Support (website)			3,500
Legal or other consultant[2]			5,000
Travel			4,000
Supplies			3,000
Event/Meeting Expenses			5,000
Other			0
Subtotal Non-Personnel Costs			**44,105**
Indirect Costs (25% of salaries & benefits)[1]			47,805
TOTAL EXPENDITURES[3]			**283,129**
DESIGNATED RESERVES[4]			**206,871**

2017

January 1, 2017-December 31, 2017

EXPENDITURES

Personnel	Salaries	Benefits[1]	Total
Executive Director: 1.0 FTE for 12 months	107,932	26,983	134,915
Assistant: 1.0 FTE for 12 months	47,516	11,879	59,395
Subtotal Personnel Costs	**155,448**	**38,862**	**194,310**
Non-Personnel			**Total**
Professional Services:			
Legal or other consultant[2]			2,000
Program Coordinator: 80 hrs/month for 12 months			52,800
Epidemiologist: 20 hrs/month for 12 months			15,698
Travel			4,500
Supplies			1,500
Event/Meeting Expenses			5,000
Other			0
Subtotal Non-Personnel Costs			**81,498**
Indirect Costs (15% of salaries & benefits)[1]			29,147
TOTAL EXPENDITURES[3]			**304,955**
DESIGNATED RESERVES[4]			**212,916**

2018

January 1, 2018-December 31, 2018

EXPENDITURES

Personnel	Salaries	Benefits[1]	Total
Executive Director: 1.0 FTE for 12 months	110,091	27,523	137,614
Assistant: 1.0 FTE for 12 months	48,466	12,116	60,582
Subtotal Personnel Costs	**158,557**	**39,639**	**198,196**
Non-Personnel			**Total**
Professional Services:			
Legal or other consultant[2]			2,000
Program Coordinator: 80 hrs/month for 12 months			52,800
Epidemiologist: 20 hrs/month for 12 months			15,698
Travel			5,000
Supplies			1,500
Event/Meeting Expenses			5,000
Other			0
Subtotal Non-Personnel Costs			**81,998**
Indirect Costs (15% of salaries & benefits)[1]			29,729
TOTAL EXPENDITURES[3]			**309,924**
DESIGNATED RESERVES[4]			**161,992**

NOTES

1. Assumes benefits and indirects reduce from 30% to 25% and 25% to 15% respectively from 2016 to 2017 under new organizational structure with back office service contract
2. Hoping to use in-kind donation for legal or policy consultant; or to use technical assistance offered by the State
3. The approved Feb 2016 budget was $360,000. This savings has been moved into the designated reserve.
4. Designated reserves move with the ACH, should it incorporate or change backbone agencies

Items in red in 2016 budget are revisions from the approved February 2016 budget

Assumes a 2% cost of living wage increase

SUMMARY: OCH Readiness Determination and Comments – Attachment 7

Leadership Council – Consent Agenda Item

May 4, 2016

Summary

Overall, the OCH Readiness Proposal was strong. However, the reviewers identified several areas to improve, none of which are insurmountable. The purpose of taking stock of these comments is to position ourselves to be a successful ACH and steward of the waiver transformation projects.

Below is a high-level summary of the key strengths and weaknesses of our proposal, including areas that Rochelle, and now I, have already begun to address.

Strengths *"Strong starting point"*

- Inclusive and transparent in our process with broad engagement and consensus building
- Clear transition plan for iterative governance development
- The differentiation and accountabilities between the backbone and the OCH are clear
- Creation of RHNI that did not exist prior to this work, and one of the better RHNI examples. Includes the formation of a subcommittee that pulls from diverse expertise within the region. "*Potentially the most thorough inventory and planning process*"
- Broadening Tribal participation
- Proposed budget for 2016 and with identified tasks

Weaknesses

- Lack of formal, approved policies (e.g., conflict of interest policy) and other key governing documentation (e.g., bylaws, contract with backbone agency)
- Need a comprehensive communication and engagement strategy
- Broaden sector engagement

Weaknesses with that are already being addressed!

- Hired a director for long term OCH development
- Work with Tribal ACH staff and next round of contract for increased Tribal linkage
- Need a smaller group size to move recommendations and decisions forward
- Schedule regular stakeholder meetings
- OCH website

Review Team ACH Readiness Determination and Comments:
Olympic Community of Health ACH Designation

Purpose: The intent of the ACH Readiness Proposal (to be submitted by each emerging ACH) is to assess (through minimum requirements and outputs) the initial development of a functional ACH that exhibits a strong foundation for regional health improvement efforts and collaborative partnership with the State. This assessment is based on ACH readiness for the next phase of development and activity, highlighting initial considerations and infrastructure surrounding governance, engagement, and sustainability frameworks.

Process: The review team consists of the HCA, DOH and DSHS "ACH Project Team," along with the Center for Community Health and Evaluation partners. In reviewing the submitted portfolio, the review team considered the examples associated with each category to assess if the ACH applying is ready for designation and the next phase of activity.

Designation decisions must be based on if the ACH has met or surpassed the minimum threshold by submitting materials in-line with the examples and if those materials correspond with the previously identified requirements for each category. While not anticipated prior to designation, a gap between the documentation provided and the minimum requirement will result in a request for more information to clarify the intent or work completed to-date.

Critical feedback will accompany the designation decision to allow for additional discussion and continued improvement. Feedback will be outlined in three sections: Promising Practices, Opportunities, and Questions for Follow Up.

A. Applicant: Olympic Community of Health ACH

B. PDF Contains Required Material (check as fulfilled):

- Required: Introductory cover letter (including summary of content and contact information)
- Required: Table of contents (including the list of supporting documents organized by category)
- Required: Narrative for each category and supporting documentation meet the category requirements (total: 6; including description of how each document matches category requirements)

C. Categorical Requirements

Categories 1-3

Category 1: Operational Governance Structure
Based on the materials supplied for Governance Structure, the emerging ACH should be designated and continue to build on this foundation.

X Agree (although more information may be required)
□ More information required prior to designating

Please take the time to provide critical feedback on particular strengths and opportunities for growth in this area.

Review Team's Determination:
The governance structure meets the requirements outlined in category 1. Comments from the review team are outlined below:

- **Strengths:**
  - Historical context and supporting documentation strong
  - Forward thinking and balanced plan for iterative approach
  - Mention of work with other ACHs and Healthier WA at-large
  - Inclusion of when subcommittee work will be completed and process for annual evaluation
  - Building on what others have developed and starting with a planning group before bringing a model to the steering committee.
  - Clear transition plan for the ILC to be replaced by the permanent Governing Board.
  - Very clear and thorough decision making process, including the intent behind consensus and plan for addressing disagreements.
  - COI speaks to the inherent tension that will exist with meaningful and collaborative work. Good recognition of the importance of transparency and communication.

- **Opportunities:**
  - Discuss how other sectors will be engaged in 2016 and beyond. While mentioned, it was unclear of the next steps to follow this work prior to the finalization of the Board in March 2016.

- **Questions:**
  - Any work done to date to expand subcommittee membership for social determinant of health inclusion more broadly?

- How will Olympic select/include a single Tribe? Has Olympic spoken to SPIPA and considered a similar approach?
- The OCH has relied on a steering committee thus far. Is there any plan to continue using a steering committee or smaller board to move any recommendations and/or decision forward other than the three mentioned committees?
- Regarding the COI, has the OCH considered the potential consequences of an issue-by-issue process to address or manage potential conflicts?

Category 2: Balanced Multi-Sector Membership

Based on the materials supplied for Governing Body Membership, the emerging ACH should be designated and continue to build on this foundation.

X Agree (although more information may be required)

☐ More information required prior to designating

Please take the time to provide critical feedback on particular strengths and opportunities for growth in this area.

Review Team's Determination:

The governing body membership meets the minimum requirements outlined in category two. Comments from the review team are outlined below:

- **Strengths:**
  - Recognition that everyone must fit in with the vision of the ACH, and balanced thinking around what work has been done and what needs to be done based on the communities engagement/interest.
  - Appreciate the acknowledgement regarding the evolving tribal representation recommendation based on AIHC efforts. Good recognition of the need to be inclusive in the interim.
  - MCO caucus and rotation test (single vote), while recognizing consensus is the goal anyway.

- **Opportunities:**
  - Work with Tribal ACH staff and next round of contract for increased Tribal linkage.

- **Questions:**

- What consideration has been given to having individuals/consumers represented in some capacity within the ACH structure/governing board?

Category 3: Community Engagement
Based on the materials supplied for Community Engagement, the emerging ACH should be designated and continue to build on this foundation.

X Agree (although more information may be required)
☐ More information required prior to designating

Please take the time to provide critical feedback on particular strengths and opportunities for growth in this area.

Review Team's Determination:
The community engagement activities meet the minimum requirements outlined in category three. Comments from the review team are outlined below:

- **Strengths:**
  - Broad engagement strategies and audience-specific good; acknowledgement that this is a two-way process.
  - Website and open public meetings established and functional.

- **Opportunities:**
  - Intent to move to more frequent stakeholder meetings other than quarterly (or does this happen through the county-based forums?)
  - Clarity regarding ACH stakeholder/member engagement vs. community/consumer engagement activities.
  - Glenn Baldwin listed as "evaluator" – should change to DSHS ACH connector

- **Questions:**
  - Who is responsible for implementing the communication tools?
  - The IAP2 spectrum might benefit from some context. Is this suggesting individual members of the public will be informed, consulted, involved, collaborated with and empowered? Or is this limited to the audiences mentioned on page 65? If limited to those audiences, to what degree or through what mechanisms can members of the public be informed and involved?

Category 4: Backbone functions/roles identified and documented, whether fulfilled by one or multiple organizations. This documentation should also include a process for the governing board to select and/or reaffirm the backbone organization(s), allowing for adjustments as necessary.

Category 4: Backbone Functions Established

Based on the materials supplied for Governing Body Membership, the emerging ACH should be designated and continue to build on this foundation.

X Agree (although more information may be required)

☐ More information required prior to designating

Please take the time to provide critical feedback on particular strengths and opportunities for growth in this area.

Review Team's Determination:

The backbone structure meets the minimum requirements outlined in category four. Comments from the review team are outlined below:

- **Strengths:**
  - Timeline for January 2017 review and updated structure linkage to HCA contract.
  - Strong backbone accountability and updates for function called out.
  - Connection with HCA and other ACHs mentioned.
  - Clear backbone responsibilities, accountability to the OCH is documented along with the review/confirmation process. Really appreciate the matrix documenting OCH responsibilities compared to backbone responsibilities by function/category.

- **Opportunities:**
  - N/A, see questions.

- **Questions:**

- Will other community members be involved in the evaluation of the backbone organization?
- Long term plan for project management capacity?

Category 5

- Draft or final inventory developed and highlights initial priority areas (i.e. explanation of what services/resource gaps and assets exist across the region, such as transportation, housing, education, insurance, health care access, etc.)
- Work plan in place to reflect the iterative development of the inventory and future or ongoing development for the Regional Health Improvement Plan (including potential support from ACH TA team) with goals, deliverables, a timeline, and roles and responsibilities

Category 5: Initial Priority Areas and Strengths Identified

Based on the materials supplied for Governing Body Membership, the emerging ACH should be designated and continue to build on this foundation.

X Agree (although more information may be required)

☐ More information required prior to designating

Please take the time to provide critical feedback on particular strengths and opportunities for growth in this area.

Review Team's Determination:

The Regional Health Needs Inventory meets the minimum requirements outlined in category 5. Comments from the review team are outlined below:

- **Strengths:**
  - Pg. 92 and 101 explanations of work done, alignment potential and assets/gaps/priorities exercise.
  - Creation of RHNI that did not exist prior to this work, and one of the better RHNI examples.
  - Formation of the assessment and planning subcommittee that pulls from the diverse expertise within the region.
  - County discussion results theming common assets, gaps, and opportunities. In addition, thorough inventory of existing plans/priorities and initiatives across all three counties. Potentially the most thorough inventory and planning process.

- **Opportunities:**
  - Link the 4/2016 expected activity for dashboard with Core, Alliance, AIM, CCHE work
  - Inclusion of the broad group as "plan by concern" good, but how will data continue to be populated for these organizations/sectors for chart on pg 143-144
  - More clear explanation/next steps on how the data on pg 143-144 will be utilized in refining priorities after the 12/8 meeting as explained on pg 116-117

- **Questions:**
  - Will the focus areas in the ILC charter potentially change based on the planned synthesizing and cross walking exercise?

Category 6: Pathway for sustainability planning developed, including considerations around financial and social capital (i.e. considerations regarding potential savings characterization, additional grant sources, community matching funds, social impact bonds, membership dues, etc.)

Category 6: Initial Pathway to Sustainability
Based on the materials supplied for Governing Body Membership, the emerging ACH should be designated and continue to build on this foundation.

X Agree (although more information may be required)
☐ More information required prior to designating

Please take the time to provide critical feedback on particular strengths and opportunities for growth in this area.

Review Team's Determination:
The initial pathway for sustainability meets the minimum requirements outlined in category 6. Comments from the review team are outlined below:

- **Strengths:**
  - Utilization of TA and subcommittee work on thinking ahead for plans – especially being purposeful about membership dues in a 501c3 structure.
  - Connection to Healthier WA payment models good.
  - Proposed budget for 2016 and matching the tasks with the allotment.
  - Strong starting point represented in the six-step pathway.

- **Opportunities:**
  - Thinking ahead to the 2016 amount being 220 versus 330 as outlined.

- **Questions:**
  - Good call out of the competing sustainability priorities – any thoughts on how to balance these efforts moving forward?
  - Does the value proposition mentioned equate to the non-fiscal sustainability efforts?

Category 7 (Optional): The emerging ACH has likely completed other activities that the above outline does not reflect (i.e. public commentary provided to HCA, participation in regional and national health improvement initiatives, investment in regional health improvement projects, regionally developed measurement systems, etc.). It is appropriate, although not required, for this portfolio to reflect the various activities and investments by the emerging ACH.

Category 7: Additional Activities
Based on the materials supplied for Optional Activities, the emerging ACH should be designated and continue to build on this foundation.

Please take the time to provide critical feedback on particular strengths and opportunities for growth in this area.

Review Team's Determination:
This category includes supporting documentation and evidence of additional regional activity and progress. This category does not represent a designation requirement but allows the region to highlight recent efforts that go beyond the minimum requirements for designation. Additional comments from the review team are included below:

- **Strengths:**
  - Not a specific category, but overarching connection to the meetings with HCA/other ACHs at-large.

Overall Designation Status:

X Designated (although more information may be required)
☐ More information required prior to designating

Situation | Background | Assessment | Recommendation

Situation

To be a successful ACH, our governance structure must accommodate the following functions:

1. Selection and strategic oversight of a regional health improvement project, and
2. Becoming the single point of authority for transformation project implementation and oversight for the Olympic region under the Medicaid waiver. (See HMA memos, attachment 2)

Over the next 3 months, the state will ask the OCH to submit deliverables and make decisions on both of the above counts.

Background

The approved governance structure in the *Interim Leadership Council Charter* and the *Pathway to Governance Decision-Making* provides a solid foundation:

- ✓ Moving from the Interim Leadership Council to a Governing Body
- ✓ Forming a Steering Committee
- ✓ Employing a balanced, multi-sector composition with one vote per sector
- ✓ Inviting all 7 Tribes to participate
- ✓ Deploying subcommittees
- ✓ Calling out term limits
- ✓ Beginning conversations on becoming a legal entity

Assessment

The OCH assembled its current governance structure for the first phase of ACH development. In March of 2016 it became clear that the functions asked of the ACHs will be substantially more sophisticated than originally thought. Health Management Associates (HMA) (See HMA memos, attachment 2) recommended to the state that "*there must be a single entity that retains final decision-making authority, serves as the contract partner for the state, and is held accountable for fulfilling the terms of the contract*." **From this, the HCA has confirmed that the OCH must have certain essential components, including: defined legal entity, accountability written into bylaws (convener, needs assessment, project planning and others), multi-sector representation, financial administration and management capacity, and operations capacity (e.g., transformation projects).**

Recommendations

Below are a set of recommendations offered for discussion and decision. Each recommendation can be treated individually; however, careful consideration should be given to ensure a holistic governance structure is created.

Recommended Action 1. Establish a **board of directors** that is largely made of up of the existing Leadership Council, with a few caveats.

To keep the board to a manageable size, minimize duplication of sector representation wherever possible. There are three sectors that may be considered over-represented: 1) primary care (represented in federally qualified health center), 2) chemical dependency (represented in county-

based human services and mental health services) and 3) housing (represented in community action agency). If agreed, by removing these redundancies the Board will consist of 19 voting members. As stated in the charter, only members of the Board may vote**.** Here would be the current voting members by sector:

#	Name and Affiliation of <u>VOTING</u> member	County	Service Area	Sector(s)
1	**Doug Washburn** Director Kitsap County Human Services	Kitsap	Clallam Jefferson Kitsap	**1. Behavioral Health Organization** **2. Chemical Dependency** (Medicaid Provider) **3. Housing/Homelessness**
2	**Peter Casey** *(Retiring in August)* Executive Director Peninsula Behavioral Health	Clallam	Clallam	**Mental Health** (Medicaid Provider)
3	**Michael Anderson, MD** (*to be replaced by David Schutz CEO)* Chief Medical Officer CHI Franciscan Harrison Medical Center	Kitsap	Clallam Jefferson Kitsap	**Private/Not for Profit Hospital**
4	**Eric Lewis** Chief Executive Officer Olympic Medical Center	Clallam	Clallam	**Public Hospital**
5	**Hilary Whittington** Chief Financial Officer Jefferson Healthcare	Jefferson	Jefferson	**Rural Health**
6	**Jennifer Kreidler-Moss, PharmD** Chief Executive Officer Peninsula Community Health Services	Kitsap	Kitsap	**1. Federally Qualified Health Clinic** **2. Mental Health** **3. Primary Care**
7	**Kat Latet** Community Health Plan of WA	Statewide	Statewide	**Medicaid Managed Care** (rotating chair by MCOs)
8	**Thomas Locke, MD** County Health Officer, Jefferson CEO, Jamestown Family Health Clinic Board President, Washington Dental Service Foundation	Jefferson	Statewide	**1. Oral Health** **2. Public Health** **3. Philanthropy** **4. Tribe**
9	**Katie Eilers** Assistant Director, Community Health Kitsap Public Health District	Kitsap	Clallam Jefferson Kitsap	**Chronic Disease Prevention Across the Lifespan**
10	**Chris Frank, MD** Health Officer Clallam County Public Health	Clallam	Clallam	**Public Health**
11	**Roy Walker** Executive Director Olympic Area on Aging	Clallam Jefferson	Clallam Jefferson	**Long Term Care/Area Agency on Aging/ Home Health**
12	**Larry Eyer** Executive Director Kitsap Community Resources	Kitsap	Kitsap	**1. Community Action Program/ Social Service Agency** **2. Housing/Homeless**
13	**Maria Lopez*** Tribal Chairwoman Hoh Tribe	Clallam		**Tribe**
14	**Andrew Shogren***	Clallam		**Tribe**

	Health Director Quileute Tribe			
15	**Timothy Green Sr.*** Tribal Chair Makah Tribe	Clallam		**Tribe**
16	**Frances Charles*** Tribal Chairwoman Lower Elwah Klallam Tribe	Clallam		**Tribe**
17	**Ron Allen*** Tribal Chair Jamestown S'Klallam Tribe	Clallam		**Tribe**
18	**Jeromy Sullivan*** Tribal Chair **Kelly Sullivan*** Executive Director, Tribal Services **Kerstin Powell*** Health Center Business Office Manager Port Gamble S'Klallam Tribe	Kitsap		**Tribe**
19	**Leonard Forsman*** Tribal Chair Suquamish Tribe	Kitsap		**Tribe**
	Justin Seville Director, Operations Harrison Health Partners	Kitsap	Kitsap	**Primary Care**
	Robin O Grady Executive Director West Sound Treatment Center	Kitsap	Kitsap	**Chemical Dependency**
	Kurt Weist Executive Director Bremerton Housing Authority	Kitsap	Kitsap	**Housing/Homelessness**

**Tribal representative identification is still under development*

Postpone adding the two newly identified sectors by HMA as part of the minimum set of sectors. These are *Medicaid consumer* and *government official*. HCA has not yet endorsed these as a mandate for ACHs.

Postpone adding the additional sectors called out in section 1.15 of the *Leadership Council Charter* until the next round of governance iterations. This is partly due to our challenging timeline, but more so due to the nice balance that is currently in our existing Leadership Council.

Recommended Action 2. Form an **executive committee** of 5-7 individuals from within the Board. The primary responsibilities of the executive committee are: 1) working with the director on ongoing issues regarding the business of the OCH, 2) listening and deciding on pressing matters of business which may arise between regularly scheduled board meetings, and 3) receiving tasks delegated by the board on a case-by-case basis.

	Form an *ad hoc* nominating committee of at least three board members who are not interested in serving on the executive committee. Call out for executive committee nominees for vetting and recommend a slate to the board. Vote on the slate of nominees at the June board meeting.
Recommended Action 3.	Convert the current assessment and planning subcommittee into an ongoing **regional health assessment and planning committee** that is accountable to the board and whose primary responsibility is to 1) continually assess and build the OCH regional health assessment and 2) advise the board on planning and project selection. (More discussion in agenda item 6)
Recommended Action 4.	The **governance committee** will meet one more time to recommend next steps for the governance of the OCH, and then transfer its duties to the executive committee.
Recommended Action 5.	The work of the **sustainability committee** will become the responsibility of the OCH director, with the support of the executive committee as needed. The director will meet with the chair of this committee for a warm hand off.
Recommended Action 6.	Each committee will use the same (or similar) **charter** (see charter template) that clearly defines membership, objectives, responsibilities and timeline. All charters will be approved by the board.
Recommended Action 7.	When a board member **retires or changes employment into a new sector**, that member must caucus with his or her sector to declare a replacement on the board. In the event this cannot or does not happen, an *ad hoc* nominating committee will be established to call for nominees from that sector.
Next steps	Amend the OCH charter to reflect the changes decided today. The Director will research and work with the board, state, and other ACHs about the process, risks and benefits of becoming a legal entity. Based on the information available at present, pages 5&6 illustrate a potential a potential evolution of our governance structure over the next several years.

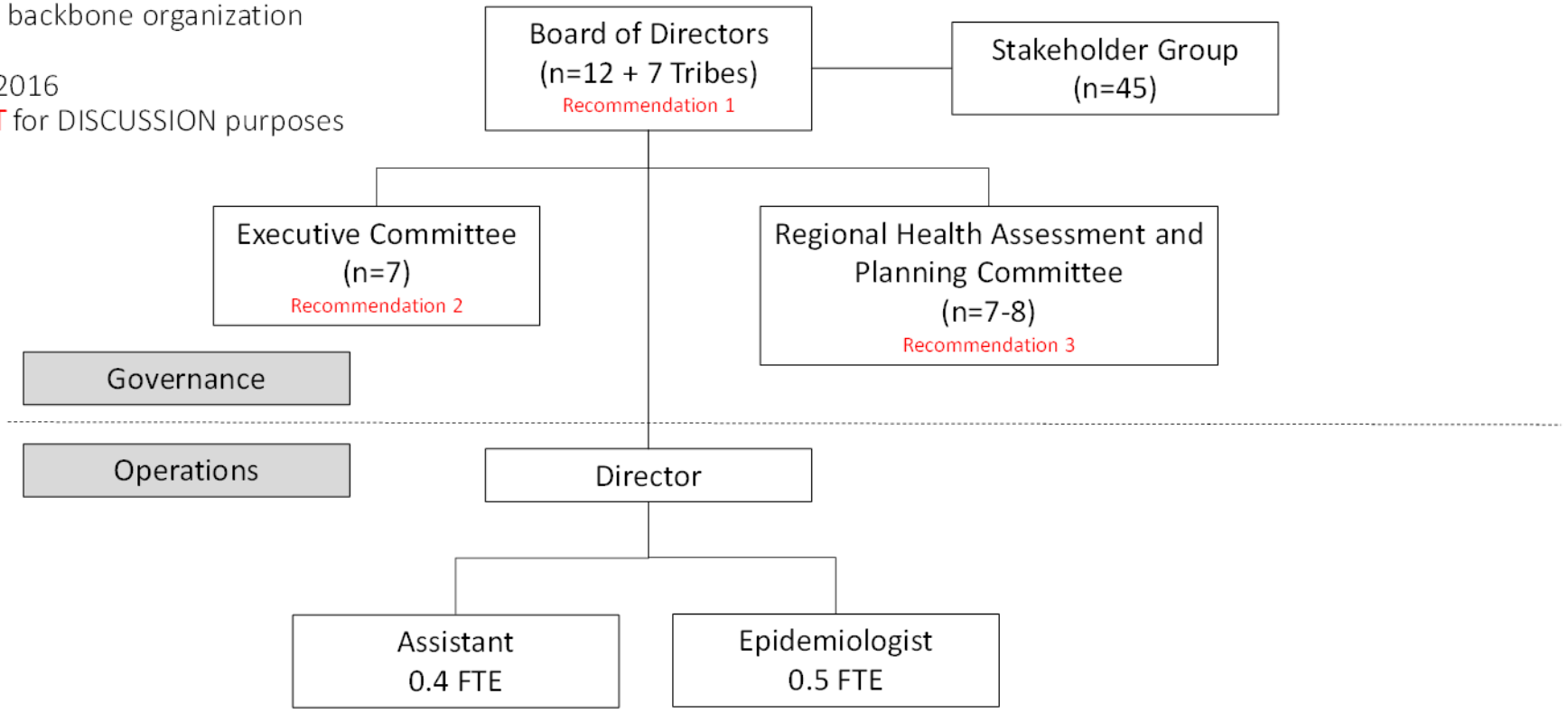
Olympic Community of Health

Proposed structure for Phase II of iterative governance process

Assumes Kitsap Public Health District is operating as the backbone organization

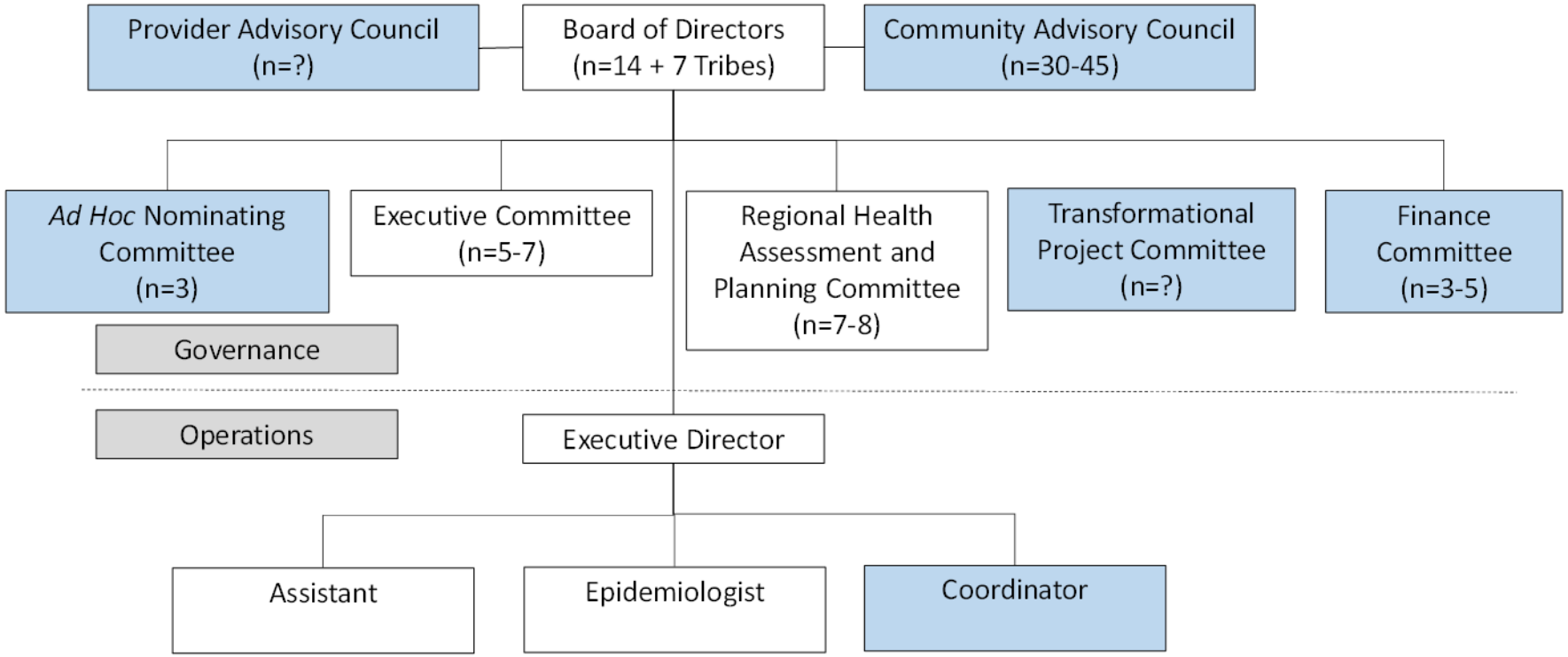
4/20/2016

DRAFT for DISCUSSION purposes



Olympic Community of Health

Possible structure for Phase III of iterative governance process
Assumes OCH is (or is close to) operating as its own legal entity
4/20/2016
DRAFT for DISCUSSION purposes



Name of Committee

Committee Members	
1	5
2	6
3	7
4	8

Overview

Objective

Responsibilities

-
-
-
-

Timeline (for time-limited committees or committees with concrete deadlines)

Olympic Community of Health

Regional Health Assessment & Planning SBAR – Attachment 11

Leadership Council – Action Item

May 4, 2016

Situation | Background | Assessment | Recommendation

Situation

- ✓ Assessment and planning are core functions of the OCH: they keep us grounded and focused on addressing the health needs of our communities.
- ✓ To meet our contractual obligations, the OCH must continually develop our Regional Health Needs Assessment (RHNA) and Regional Health Improvement Plan (RHIP). We must identify one or more "early win" projects by July and submit an action plan by October 2016.

Background

- ✓ OCH stakeholders selected five regional health priority areas: access, aging, behavioral health, chronic disease and early childhood.
- ✓ The HCA has disseminated a Framework for the Project Toolkit (attachment 3) with guidance on the transformation projects that will be included in the toolkit for the Medicaid waiver. Waiver projects are slated to begin January 1, 2017.

Assessment

- ✓ Health assessment and planning is an ongoing process and is a core activity for the OCH.
- ✓ Kicking off an "early win" project will show HCA how our region can collaborate and that we have the capacity to coordinate waiver projects.
- ✓ The "early win" project can build off of existing projects in the region that address our regional health priority areas.
- ✓ There are organizations within our OCH region that do routine assessment and planning as part of their scope of work.

Recommendation

Form a Regional Health Assessment and Planning Committee (RHAPC) that consists of a core minimum set of technical experts from organizations with an internal assessment component:

1. local health jurisdiction
2. area agency on aging
3. hospital
4. community action agency
5. Tribe
6. behavioral health organization

Members on this committee are not necessarily board members; however at least one board member is on this committee. Given the tight contract timelines, the RHAPC is formed immediately and frontloaded with the work necessary for project selection, implementation and oversight ahead of the waiver start date and in line with our HCA contract.

The RHAPC will have the following responsibilities:

- ✓ Update the RHNA as new information comes available.
- ✓ Develop a RHIP.
- ✓ Submit the RHNA and RHIP to the board for adoption at regular intervals.
- ✓ Vet potential project proposals using a template provided by the HCA and criteria developed by the RHAPC, with an eye towards the potential waiver projects.
- ✓ Submit the most promising project ideas to the board for discussion and approval.
- ✓ Share developments on the RHNA and RHIP with the OCH Stakeholder Group for feedback.

Alliance for South Sound Health Network (ASSHN) ~ Accountable Health Communities Model Overview

Project Overview: This multi-county initiative (Pierce, S. King, and Kitsap Counties) brings together two community based health systems, three Federally Qualified Health Centers and various community organizations to create a community-based learning system that will address the unmet health-related social needs of our residents. Funds will be requested up to the $4.5M funding limit to support work through the ASSHN.

Partnership Roles:

Bridge Organization: In 2014 MultiCare Health System (MHS) and CHI Franciscan Health (CHI) joined together to form the Alliance for South Sound Health "ASSH". MHS and CHI have served the Puget Sound Community for over 125 years and today, these health systems serve an area of 2.1 million people, employ over 22,000 people and have 3,000+ medical staff. Through this partnership, the ASSH will build a new psychiatric hospital to provide behavioral health services to area residents in the coming years. The ASSH will serve as the Bridge organization and will work with clinical delivery sites, community based organizations, and community service organizations to implement strategies to identify and address the unmet health related social needs of Medicare and Medicaid populations (community dwelling beneficiaries) and provide referral and navigation to high-risk participants.

Clinical Delivery Sites: Together, MHS and CHI have 14 hospitals and 1 designated children's hospital that will be participating in this project. Specific areas where we will engage community dwelling beneficiaries include Emergency Departments, Labor and Delivery and Inpatient Psychiatric Facilities. In addition, Good Samaritan Behavioral Health, Tacoma Family Medicine and East Pierce Family Medicine Clinics will be clinical delivery sites in Pierce County. Federally Qualified Health Centers are also engaged in our project. HealthPoint has agreed to participate and will include their S. King County sites which serve approximately 4,000 Medicare and 35,000 Medicaid patients. In addition, Sea Mar and Community Health Clinic have recently joined our consortium.

Community Partner Organizations:

WithinReach will work collaboratively in this project to support screening, referral and lay navigation for the community dwelling beneficiaries. They have over 28 years of experience connecting vulnerable Washington State residents with community resources that help to build healthy, resilient communities. In 2016, they anticipate serving 300,000 families through our statewide hotlines, coalitions, website and one-to-one hands-on navigation support for low income individuals and families seeking nutrition, health care, transportation, child development and early learning, intervention, and other concrete supports.

Global to Local (G2L), created through a partnership between Health Point, Public Health—Seattle & King County, Swedish Health Services, the Washington Global Health Alliance and the cities of SeaTac and Tukwila, will also be a partner in this project and will support screening and referral for the community dwelling beneficiaries specifically related to the Connection Desk model. Launched in partnership with HealthPoint in 2013, the Connection Desk deploys volunteer university students to address the underlying social issues that often drive poor health—things like access to food, transportation, language training, and employment. To-date the Connection Desk has provided over 7,000 referrals, including over 3,000 people enrolled in health insurance under the Affordable Care Act. G2L is now working with other health care systems, including Harborview (Seattle) and Providence (Portland) to replicate and scale this program.

Community Service Organizations:

We are currently mapping out strategies to engage community service organizations that offer direct services related to housing, food insecurity, utility needs, interpersonal violence, and transportation throughout our three county region.

In ***Pierce County,*** we offer direct community services through WIC & SNAP ED programs and have many existing partnerships with community service organizations. We are also exploring other potential collaborations. We will work with the Tacoma Pierce County Health Department and the Pierce County ACH to create key alliances and partnerships,

identify specific social determinants of health impacting this community, and address gaps in health care delivery and services.

In ***King County***, we will focus specifically in providing services to S. King County residents. We will also work with the King County Health Department and the King County ACH to create key alliances and partnerships, identify specific social determinants of health impacting this community, and address gaps in health care delivery and services.

In ***Kitsap County***, Harrison Medical Center provides care to residents in Bremerton and Silverdale and Hospice of Kitsap County recently became part of MHS. We are also exploring other potential collaborations in the areas and will work with the Olympic ACH to create key alliances and partnerships, identify specific social determinants of health impacting this community, and address gaps in health care delivery and services.

Projected community-dwelling beneficiary participants: The population in our geographic areas of focus is very racially and ethnically diverse and many residents are from minority or underserved communities. There are many social determinants of health that impact area residents including food insecurity, access to healthcare and social services, safe communities and affordable housing, local employment, access to education, and public safety. Through our partnerships we anticipate serving 51% of community dwelling beneficiaries.

Intervention Track & Project Goals: The ASSHN is pursuing to Track #3 – Alignment to create synergy and between partners and ensure the needs of beneficiaries are met and community services are available. In coordination with partners, we will implement the prescribed AHC model intervention workflow:

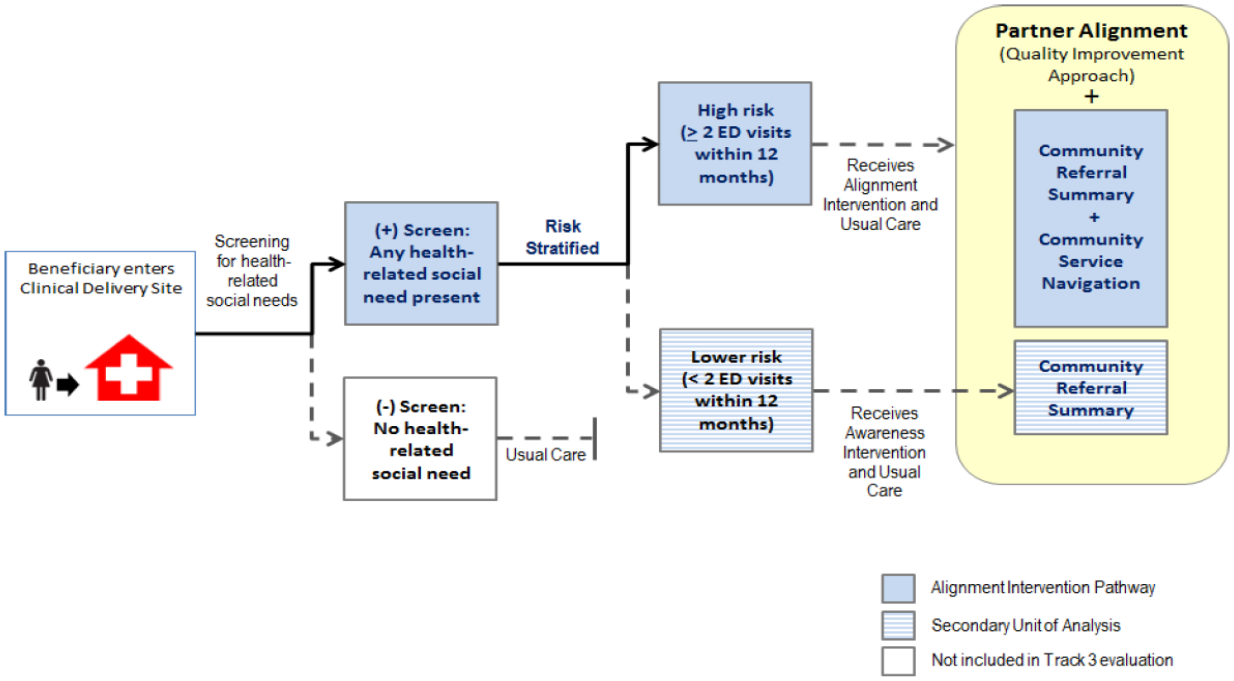


Figure 11. Track 3 – Alignment Evaluation Diagram

1) ***Screen.*** All eligible community dwelling beneficiaries at participating clinical delivery sites will be screened for non-medical needs which include food insecurity, housing, transportation , interpersonal violence, utility needs
2) ***Referral.*** Each community dwelling beneficiary screening positive for a social unmet need will receive a tailored community resource referral from the shared project database.
3) ***Navigation.*** High risk beneficiaries will receive lay navigation of community services.
4) ***Alignment.*** Create partner alignment through all area clinical delivery sites, health providers, community partners and implement an intervention in two matched comparison groups

Shared Project Database: Health Leads is the shared database that will track community dwelling beneficiary status as they complete the screening , referral and navigation processes. Information from this shared database can be integrated into the EMR.

Advisory Board: The Advisory Board will be comprised of all Alliance partners, direct community service providers, community leaders, and insurers. The Advisory Board and will meet on a quarterly basis and will guide the Bridge organization in overall project implementation, assist with the annual gap analysis and ongoing QI initiatives.

Olympic Community of Health

Accountable Health Communities CMMI Grant SBAR – Attachment 13

Leadership Council – Action Item

May 4, 2016

Situation | Background | Assessment | Recommendation

Situation

Should the OCH submit a Letter of Support to the Health Care Authority (HCA) for an application from the Alliance for South Sound (ASSH) (a partnership between Catholic Health Initiative (CHI) and Multi-Care hospital systems) to CMS for the Accountable Health Community (AHC) funding opportunity?

Background

The AHC is a new testing model under CMS/CMMI to examine whether systematically identifying and attempting to address health-related social needs of Medicare and Medicaid beneficiaries -- including Medicare Advantage, children, and duals -- through referral and community navigation services can impact the Triple Aim.

The ASSH is applying for Track 3 of the grant: *Encourage alignment to ensure that community services are available and responsive to needs of beneficiaries*. The funding for this award is $4.51 million over 5 years and 20 sites will be awarded in the United States. Funds will not pay directly or indirectly for provision of community services. The grant is due May 18th.

The ASSH will serve as the Bridge Organization and will work with clinical delivery sites, community based organizations, and community service organizations to implement strategies to identify and address the unmet health related social needs of Medicare and Medicaid populations and provide referral and navigation to high-risk participants. (See attachment 11, the ASSH grant overview)

To be considered, the ASSH must:

- ✓ Screen at least 75,000 "community-dwelling" beneficiaries (e.g., not in jails or nursing homes).
- ✓ Reach 51% of community-dwelling beneficiaries in South King, Pierce and Kitsap counties.
- ✓ Use a screening tool provided by CMS and submit data to CMS.
- ✓ Have an MOU in place with the HCA, clinical delivery sites (hospital, primary care and behavioral health), and community service providers (housing, food insecurity, utility needs, interpersonal violence and transportation)
- ✓ Have letters of support from each of the three ACHs in the service area: S. King, Pierce and the OCH. *Note: that this is a requirement from the HCA, not CMS.*

At ASSH's request, on March 2, 2016 Rochelle Doan asked Interim Leadership Council members to electronically vote whether or not to support ASSH's application with a letter. Only five members responded: 3 no's, 1 abstention, and 1 yes. On April 25, 2016 several OCH members met with members of ASSH to discuss the potential partnership.

Assessment

+ CHI Harrison Medical Center is a key hospital partner for the OCH, serving 34,500 patients in Kitsap, 1,400 patients in Jefferson and 690 patients in Clallam counties. If awarded this grant, they will be providing a screening and referral service to over 15,000 members of our community, predominantly in Kitsap County.
+ If successful, this grant will serve to support the work of the OCH by creating stronger alignment between community partners and developing better coordination of care among our most vulnerable members of our communities.
+ If the OCH does not vote to support ASSH's bid, then the HCA will restrict their MOU to beneficiaries in South King and Pierce counties only.
+ Both King County and Pierce County have submitted Letters of Support.
+ Roles the OCH may play: advisory, identifying key community service providers, assessment of duplication, identifying community dwelling beneficiary population/subpopulations
+ There is nothing as formal and structured going on like this that we are aware of. There is great service being provided, but not necessarily such structured care coordination across the healthcare and service sectors.
+ Although the method is highly prescribed, the level of engagement is slightly variable for most (e.g. a healthcare organization can opt in for one site or one year only.)
+ There is a good faith effort to expand the project into Clallam and Jefferson counties in the second year of the project. More discussion on this from partners in these two counties is needed.

- There was not much local engagement and we were not asked to participate in the grant planning and design until late in the process
- The grant activity will add additional administrative burden onto community providers
- At this point only one of the three counties in the OCH is included, making this seem very Kitsap-centric and potentially undermining the solidarity of our three county region.
- The roles of the Bridge Organization can be seen as potentially duplicative of the OCH
- The activities in the grant may be seen as duplicative of existing services at the local level.
- ASSH is a partnership between two major hospital systems that may drown out local community voice.

Recommendation

The letter is nonbinding and there is little downside risk to supporting the application. If awarded, this grant stands to serve over 15,000 members of our community by connecting them to the resources that they need to live well.

Recommendation: The director submits a letter of support on behalf of the OCH board of directors. Two board members who are not currently listed on the application volunteer to review the letter before submission.

Scheduling (*please check your calendars*)
Recommended **ACTION**

1. The **board** will meet in-person monthly – the 1st Wednesday of each month from 9 am to 11 am. [NOTE: HCA has requested to personally present waiver updates at the next Board meeting, ASAP]
2. The **executive committee** will meet in-person monthly – at least 8-10 business days before the board meeting to assist in setting the board agenda strategy. For urgent issues, the Director may convene the executive committee, or its members, on a case by case basis.
3. The **stakeholder group** will gather quarterly, at least through the grant period, which ends February 1, 2017, at which point we can reassess the frequency of these meetings and structure of this group. If approved, the next stakeholder meeting will be scheduled the 3rd week of June. This timeline will allow input into the formative governance development and project selection.

Input and discussion (*if time allows, otherwise please send Elya or Angie an email)*

1. How was the **length** (two hours) of this meeting? Location?
2. How did you like the way the **materials** were organized?
3. Is anybody willing to **donate space** or **catering** on behalf of your organization for future meetings?