North Central Accountable Community of Health

Governing Board Meeting
1:00 PM–3:30 PM, November 4, 2019

Location	**Call-in Details**
Confluence Technology Center 285 Technology Center Way #102 Wenatchee, WA 98801	Conference Dial-in Number: (408) 638-0968 or (646) 876-9923 Meeting ID: 429 968 472# Join from PC, Mac, Linux, iOS or Android: https://zoom.us/j/429968472

TIME	AGENDA ITEM	PROPOSED ACTIONS	ATTACHMENTS	PAGE
1:00 PM	Introductions – **Barry Kling** • Board Roll Call • Declaration of Conflicts • Approve Consent Agenda • Public Comment • Board Expirations	• Approval of Consent Agenda - o Sept Minutes o Monthly Financial Report o Exec Director Report o Workgroup Updates	• Agenda, Acronyms & Decision Funds Flow Chart • Consent Agenda • Board roster with December expirations highlighted	*1-3* *4-24* *25*
1:15 PM	CHI Update – **Sahara Suval**	• Approval of small project payments	• Board Decision Form	*Sep Attach*
1:30 PM	Tribal Updates – **Molly Morris**		• Tribal Update	*26-35*
1:50 PM	Draft 2020 Budget – **NCACH Staff**		• Draft 2020 Budget • Presentation • Board Information Forms o Tribal Investments o Community Info Exchange o Health Equity Innovation o Capacity Building Rapid Cycle Fund o CPTS Recovery Coach	*Sep Attach* *36-63* *64-66* *67-69* *70-72* *73-75* *76-77*
2:50 PM	Summary of October Board Retreat – **John Schapman** • Next steps		• Summary • Presentation	*78-85* *86-95*
3:10 PM	• Opioid – **Christal Eshelman** • WPCC – **Wendy Brzezny** • Data – **Caroline Tillier**	• Approval of Opioid Prescriber Coaching • Approval of Revision to WPCC Stage 2 Funding Framework • Approval of Data Support Contract Increase	• Board Decision Forms	*96-98* *99-100* *101-102*

North Central Accountable Community of Health

A Handy Guide to Acronyms within the Medicaid Transformation Project

ACA: Affordable Care Act

ACH: Accountable Community of Health

ACO: Accountable Care Organization

AI/AN: American Indian/Alaska Native

BAA: Business Associate Agreement

BH: Behavioral Health

BH-ASO: Behavioral Health - Administrative Service Organization

BLS: Basic Life Skills

CBO: Community-Based Organization

CCHE: Center for Community Health and Evaluation

CCMI: Centre for Collaboration Motivation and Innovation

CCS: Care Coordination Systems

CHI: Coalition for Health Improvement

CHW: Community Health Worker

CMS: Centers for Medicare and Medicaid Services

CMT: Collective Medical Technologies

COT: Chronic Opioid Therapy

CP: Change Plans

CPTS: Community Partnership for Transition Solutions

CSSA: Community Specialist Services Agency

DOH: Department of Health

DSRIP: Delivery System Reform Incentive Program

EDie: Emergency Dept. Information Exchange

EMS: Emergency Medical Services

FIMC: Fully Integrated Managed Care

FCS: Foundational Community Supports

HCA: Health Care Authority

HIT/HIE: Health Information Technology / Health Information Exchange

MAT: Medication Assisted Treatment

MCO: Managed Care Organization

MH: Mental Health

MOU: Memorandum of Understanding

MTP: Medicaid Transformation Project(s)

NCACH: North Central Accountable Community of Health

NCECC: North Central Emergency Care Council

OHSU: Oregon Health & Science University

OHWC: Okanogan Healthcare Workforce Collaborative

OTN: Opioid Treatment Network

OUD: Opioid Use Disorder

P4P: Pay for Performance

P4R: Pay for Reporting

PCS: Pathways Community Specialist

PHSKC: Public Health Seattle King County

RFP: Request for Proposals

SDOH: Social Determinants of Health

SSP/SEP: Syringe Services Program / Syringe Exchange Program

SMI: Serious Mental Illness

SUD: Substance Use Disorder

TCDI: Transitional Care and Diversion Interventions

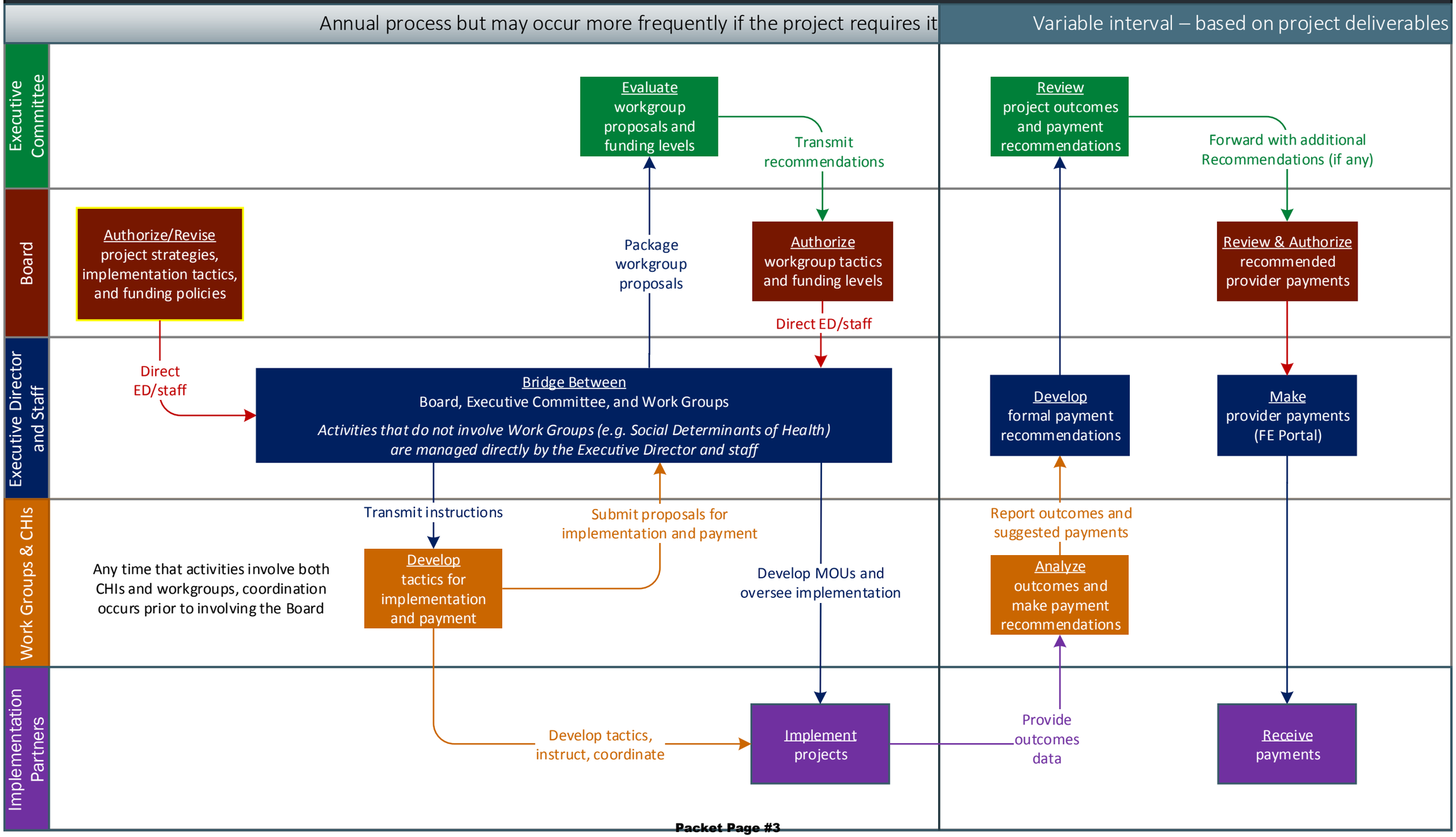
TCM: Transitional Care Management

VBP: Value-Based Payment

WPCC: Whole Person Care Collaborative

Decision Flow for Funding Design and Allocation

[This process is utilized when a budget amendment is requested to the Annual Budget]



North Central Accountable Community of Health

Governing Board Meeting
September 9, 2019 1:00 PM – 3:30 PM

Location	Attendees
Family Health Centers 1003 Koala Dr Omak, WA 98841	**Governing Board Members Present:** Rick Hourigan, Blake Edwards, Rosalinda Kibby, Scott Graham, David Olson, Carlene Anders, Cathy Meuret, Ken Sterner, Nancy Nash-Mendez, Courtney Ward, Molly Morris, Ray Eickmeyer, Daniel Angell, Brooklyn Holton, Kyle Kellum, Mike Beaver **Governing Board Members Absent:** Barry Kling, Doug Wilson, Senator Warnick **Public Attendance:** Kelsey Gust, Laurel Lee, Amelia Davis, Lisa Apple, Deb Miller, Melodie White **NCACH Staff**: John Schapman, Caroline Tillier, Wendy Brzezny, Christal Eshelman, Tanya Gleason, Sahara Suval, Mariah Brown, Teresa Davis – Minutes
Agenda Item	**Minutes**
• Review of Agenda & Declaration of Conflicts • Public Comment	Conflicts of Interest: None Public Comment: None
• Approval of Minutes	❖ David Olson moved, Nancy Nash seconded the motion to approve the August minutes, motion passed.
• Treasurers Report	• Brooklyn Holton went over the monthly financial report, does not have any concerns. • Brooklyn noted that we are looking at the option of creating a consent agenda for future meetings to save time, Board was in general agreement of this. ❖ **Ken Sterner moved, Molly Morris seconded the motion to approve the July monthly financial report, motion passed.** • John Schapman went over the 2020 budget planning timeline. Staff has started the planning process and has met with Brooklyn. We plan on introducing new budget items / ideas for 2020 at the October 7th Board retreat. Staff will present a draft 2020 budget at the November Board meeting for feedback, then present the budget for a final approval in December at the annual meeting. John Schapman asked how the Board wanted to handle some items that were budgeted for but not expended in 2019 - Examples: • $450K approved for CHI but we will only spend $150K this year / we will have a holdover of $300K to next year because the application scoring will not be finalized before the end of the year. How does the Board want to see it for next year's budget? • $5M budgeted for HUB, we will not be using that much due to the slower ramp up and lower enrollment numbers. The Board wants items already approved highlighted on the budget. Regarding project money that was not used, do you want us to keep the money in the bucket or reallocate the money to other projects? Courtney asked if there are ideas in those buckets. If not, why would we keep it in there? Rick noted that it should be handled case by case, if you know what you are spending it on then keep it there, but if it is extra, we need to move it and it should be discussed with the Board. John asked about a time limit to spend money for approved funding. Example: If we approve funding for a group to do a project but nothing ever comes of it, how long do we need to keep that money allocated to that group? Again, this is case by case, but staff needs to check back with the group, put them on notice to take action or we move on and reallocate the money.

	• **990 Tax Filing** – John reviewed the 990 Tax Filing. There were a few questions regarding membership which were answered. Question regarding not having paid members and employees – NCACH does not officially have any employees as they are all employees of the Chelan Douglas Health District under the hosting agreement. ❖ **Scott Graham moved, Rosalinda Kibby seconded the motion to approve the NCACH 2018 990 document for filing with the Internal Revenue Service (IRS), motion passed.**
• Staff Updates	**Opioid – Christal Eshelman** • School based opioid prevention awardees have started having monthly calls. They will be doing an assessment and producing 2020-2021 project plan • Recovery Coach Training is set for October and we currently have almost 20 applicants. These participants will also participate in the Train the Trainer course later in the month. A requirement of that course will be that they each lead a recovery coach training to build capacity in our region. • Opioid Response Conference – Looking at doing a spring conference instead of another conference in the fall as it was too soon for all of the volunteers that made the last one happen. Looking into doing a module that will have a video with a discussion piece that educators can use. **2019 Opioid Project Plan Budget Update:** $44,000 left in the 2019 budget. During the workgroup meeting, the group decided that they would like to allocate some money in the 2019 budget towards technical assistance for physicians that are overprescribing. The workgroup asked Dr. Julie Rickard to submit a proposal for this work. ❖ Carlene Anders moved, Nancy seconded the motion to allocate up to $44,000 to conduct and assessment of opioid prescribers and if necessary, provide technical assistance to the prescribers who are outside of recommended prescribing limits (based on Bree Collaborative and CDC Prescribing Guidelines) - ***Motion not passed*** *Discussion:* • David asked if we could get this information about overprescribing from MCO's? The MCO representatives in the room said that they probably have that information, but they are not sure that they are comfortable giving that information out. • Nancy believes that having a neutral person doing the work could benefit our region for future grants. • Kyle asked if there is an estimated amount of hours she expects to complete this work. We talked about setting the contract up as 100 hours of travel and 10 hours each for 15 providers. • Rick would like to see written data, before we approve this type budget request. We could put this into next year's budget. Would also like to see a more detailed proposal. ****Motion did not pass. Board feels that it is a good idea overall, but would like to see a more detailed proposal and data to support the need presented at a future meeting before approving.*

	CPTS – Christal Eshelman • Okanogan County CPTS is supporting the new Oxford House, Chelan Douglas is developing a strategic plan. **WPCC – Wendy Brzezny** • Caroline put together a Collective Medical Webinar • Mariah led a Centricity Webinar • We are getting ready to introduce a Population Health LAN that will be a yearlong learning activity • Learning Symposium is October 4th in Wenatchee **TCDI – John Schapman** • Hospital Report – Q2 reports submitted in July. This work has allowed them to share best practices. • EMS Report – Q2 EMS reports submitted. Looking at a treat and referral project. Q3 & Q4 will be looking at implementing the projects. Trying to get orgs reporting into WEMSIS. Looking into providing additional funding to EMS providers for 2020. Will be meeting with NCECC to determine plan for 2020 and will bring back proposal for 2020. **CHI Evaluation Update – Caroline Tillier** • Goal is to check in with the 3 CHI's for a midpoint evaluation to find out how we can better support them. Survey will go out sometime this week. Final report will be done in November.
• Capacity Building	Tanya Gleason gave an update on her research around asset mapping and developing a referral network. (See meeting packet for presentation) Community Recommendations from Regional Provider interviews: • Interoperability • Complete and accurate resource lists to which to refer patients • Electronic referral capability • User friendly referrals with tracking capability (closed-loop) • Full regional inventory • Need more SDOH connections than already referred to • Unclear how WIN211 can or should be interacted with Topics that came from the Community interviews: BSN Student Interns from Wenatchee Valley College: 40 in-person interviews conducted across Chelan and Douglas Counties Key themes: • Access—38 mentions • Follow-up or further coordination—24 mentions • Availability—16 mentions • Quality/Appropriate care—8 mentions • Communication—6 mentions What this means: • The broader community wants a connected service network that can quickly exchange and track accurate referral information that can be integrated into current systems and workflows.

	Tanya suggested that we enter into a small contract with Julota to create a blueprint and create a workgroup to develop a CIE (Community Information Exchange) that would work for our region. She is not asking for Board action right now, she is still doing some research, she wanted to provide an update. **Discussion:** • Is there a demo of San Diego 211 on the Website? Tanya will check • Didn't Community Choice start out as a CIE? Deb doesn't think that they started that way. There was the Health Record Bank, which is what Health Home is using as their platform, but would not classify that as a CIE. • Cathy Meuret said to also collect information from school district staff as well. • Rick noted that the state should be doing this or at least we should be partnering with larger areas. • Deb feels that we would be wise to partner with other Eastern Washington ACH's. Tanya plans to attend a CIE forum to work on partnering with them.
• Pathways HUB	• Deb Miller – Attended statewide Care Coordination Meeting with Senator Parlette. Conversations are continuing around how to align the existing care coordination. • Working on getting the last of the CCHE interviews done on the qualitative evaluation on the HUB. • HIPAA Security Assessment is complete and started the process to implement any changes. A presentation can be presented to the Board at a future date.
• CHI Update	• Okanogan CHI – Focusing on the Opioid work • Chelan Douglas CHI - Working on connecting non-housing partners to support housing partners to help with the unseen homeless. • Grant CHI – Working with the Homeless Task Force and Suicide Prevention Coalition to see how they can support the great work that is already happening. **Sahara Suval gave an update on the CHI Community Investment Funding:** The funding is to be allocated through a community investment process developed by the CHI Community Initiatives Advisory Group. The community investment process was originally designed to be flexible in both the sizes and the types of projects that could receive funding. Project sizes were broken into tiers and the project focus areas remained broad to encourage innovation and unconventional approaches from nontraditional partners. The Advisory Group believed that by keeping the parameters flexible, it would help inform NCACH and the Advisory Group of the true 'need' of the region for future funding opportunities. • In July 2019, the community investment process opened and partners were invited to submit Letters of Intent to Submit an Application. Letters of Intent were due on August 16, 2019 and have since undergone an eligibility review to determine if they met the criteria to advance to the full application stage. • 63 Letters of Intent were submitted, with over $3.75 million in requests for funding. • After undergoing review, 50 Letters of Intent are eligible to advance to the application stage, with over $2.76 million in requests for funding. • Some of the submitted proposals demonstrate significant or direct overlap with (or expansion of) other work within NCACH's project portfolio, which has prompted staff to evaluate whether or not these proposals (>$25,000) could be redirected or funded

	through other NCACH funding streams. • **Ask: NCACH staff developed proposed criteria to evaluate proposals that demonstrate significant overlap and would like to ask the Board to consider allocating funding in the 2020 Budget to fund some of the submitted CHI Community Initiatives proposals through other funding streams.** Discussion: • Rick: Would doing this require a new funding path in the budget? Yes, we would need to bring a Board decision form. • Brooklyn: Would this decision prevent the applications from moving forward in the CHI process. Brooklyn thinks that they should still go through the scoring process. We would be assuming that we would want to fund before they were even scored. Feels that if they score high and there is crossover, then we can present it as a budget amendment. • David would feel most comfortable giving $450K, then look at requests later • Carlene says it makes sense that if it is something that we were looking at funding anyway, that she would like to see some of the other projects funded under the initiative funding. • Brooklyn said that she wants to base it off of the application process, not off of the letter of intent. • Rosalinda sees this as changing criteria midstream, which we should not do. • David noted that we need to remember that in October we are going to talk about the future of this organization. We can't fund every good request. We need to balance the benefits of doing something right now and the benefits of having an organization that could do good work for years to come. ❖ **Motion to approve the proposed criteria to evaluate proposals submitted through the 2019 CHI Community Initiatives funding that could be supported in the 2020 NCACH Budget under a different priority/project area, ***Motion Not Approved*****.** *Rick suggested Sahara **"*"** any projects with crossover but keep them in the rankings and bring them back to the Board for consideration of funding from other streams. Board agreed with this approach.*
• Strategic Planning / Visioning Update	• It's the Board's fiscal responsibility to plan for the future. • How do Board Members want to provide feedback? Overall, would like the opportunity to provide both written and verbal feedback. • Chris will send a survey for Board to provide open ended answers. • Chris OHSU – Facilitating style – Board agrees that pushing with challenging questions is what this group needs. • Staff involvement – Send a poll to Board members on how they would like staff to participate.

NCACH Funding & Expense Summary Sheet

	CDHD ACCOUNT			FINANCIAL EXECUTOR FUNDS		
Funding Source	**SIM/Design/Misc Funds Received**	**SIM/Design/Misc Funds Expended**	**SIM/Design/Misc Funds Remaining**	**NCACH Funds @ FE**	**FE Funds Expended**	**FE Funds Remaining**
SIM Funding*	**$ 115,329**	**$ 115,329**	$ -			
Transformation Project Funding						
Original Contract K2296 - Demonstration Phase 1	$ 1,000,000					
Original Contract K2296 - Demonstration Phase 2	$ 5,000,000					
Transfer from FE Portal	$ 226,961					
Interest Earned on Demo Funds	$ 191,019					
Transformation Total	**$ 6,417,980**	**$ 2,413,729**	**$ 4,004,250**			
Workshop Registration Fees/Misc. Revenue*	**$ 15,370**	**$ 13,720**	**$ 1,650**			
			$ -			
Financial Executor Funding						
Project Incentive Funds				$ 13,863,063	$ 5,573,390	$ 8,289,673
Integration Funds				$ 5,781,980	$ 58,422	$ 5,723,558
Bonus Funds				$ 1,455,842		$ 1,455,842
Value Based Payment (VBP) Incentives				$ 300,000		$ 300,000
DY1 Shared Domain 1 Funds**				$ 4,350,278	$ 4,350,278	$ -
Totals	**$ 6,548,679**	**$ 2,542,778**	**$ 4,005,901**	**$ 25,751,163**	**$ 9,982,090**	**$ 15,769,073**

**A portion of funds in this category were collected when CDHD held the SIM Contract*

***Automatically paid out through FE Portal from Health Care Authority and therefore not reflected on Financial Executor budget spreadsheet*

TREASURER NOTES:

1. The $1,650 from "workshop registration fees/misc revenue" stems from our conferences and is not specific to any one project.
2. The $300,000 from "value based payment (VBP) incentives" is funding above and beyond what the board assumed we would receive. This funding category was conservatively estimated at $0 by the board so it's great that we are already seeing these dollars earned.

2019 NCACH Budget: Monthly Summary

CDHD Account Expenses

Fiscal Year: Jan 1, 2019 - Dec 31, 2019

Budget Line Item	Total Budgeted	Aug-19	Sep-19	Totals YTD	% Expended YTD to Budget
Salary & Benefits	**$ 983,205**	$ 74,696	$ 75,007	$ 692,597	70%
Supplies					
Office	**$ 9,420**	$ 233	$ 57	$ 3,050	32%
Drugs and Medicines	**$ 15,100**			$ 9,594	64%
Furniture < $500	**$ 2,400**	$ 143		$ 1,554	65%
Books, References, & Videos	**$ -**	$ 268		$ 551	
Software	**$ 3,000**			$ 681	23%
Computer Hardware	**$ 6,000**			$ 3,487	58%
Services					
Legal Services	**$ 8,400**			$ 877	10%
Computer	**$ 16,140**			$ 4	0%
^Misc. & Contracts	**$ 27,500**			$ 5,000	18%
Mileage	**$ 81,760**	$ 1,744	$ 1,477	$ 14,433	18%
Professional Travel and Training	**$ 16,800**	$ 1,300	$ 401	$ 5,203	31%
^Conference - Program Meals/Lodging	**$ 38,250**	$ 234	$ 292	$ 8,890	23%
Other (Train/Plane/Boat/Parking)	**$ 10,200**	$ 166		$ 4,994	49%
Advertising - Newspapers	**$ 3,800**			$ -	0%
Advertising - Other	**$ 7,900**	$ 3,500		$ 10,975	139%
Insurance	**$ 5,700**			$ 5,702	100%
Printing - Office	**$ 7,900**	$ 2,520		$ 3,050	39%
^Printing - Copier	**$ 12,200**	$ 565	$ 581	$ 6,881	56%
Dues and Memberships	**$ 3,300**	$ 173	$ 139	$ 3,202	97%
Subscriptions	**$ 658**		$ 54	$ 736	112%
^Other Expenditures	**$ 139,349**	$ 8,291	$ 2,664	$ 84,187	60%
CDHD Hosting Fee 15%	**$ 212,322**	$ 14,075	$ 12,101	$ 129,847	61%
Grand total	**$ 1,611,305**	**$ 107,906**	**$ 92,774**	**$ 995,495**	62%
				% of Fiscal Year	75%

TREASURER NOTES:

1. The 139% of Advertising other is likely to reduce by the $3,500 expense in August as it should be reclassified as a "Computer" expense.
2. The 112% from "Subscriptions" includes website support and we will see the $54 expense continue through the remainder of the year.
3. We are at 62% of budget expended while 75% through the year and expect to remain on par through the end of the year if not closer.

FE Portal Account Expenses

Fiscal Year: Jan 1, 2019 - Dec 31, 2019

Budget Line Item	Total Budgeted	Aug-19	Sep-19	Totals YTD	% Expended YTD to Budget
Operations					
^ OHSU	**$ 100,000**		$12,525	$77,753	78%
Program Evaluation (TBD)	**$ 60,000**			$0	0%
Program Evaluation (Pathways Hub)	**$ 60,000**			$0	0%
Public Health Seattle King County(Data)	**$ 24,000**			$4,215	18%
Xpio	**$ 20,000**			$350	2%
Feldsman Tucker Leifer Fidell LLP	**$ 40,000**			$7,500	19%
** Asset Mapping (TBD)*	**$ 52,800**			$0	0%
^ Workforce Development	**$ 48,125**	$2,183	$1,856	$6,664	14%
Communications and Outreach					
Training (TBD)	**$ 10,000**			$0	0%
Lead Agencies (CHIs)	**$ 150,000**	$6,477	$12,500	$102,719	68%
** CHI Partner Payments*	**$ 450,000**			$0	0%
Whole Person Care Collaborative					
^ Comagine Health (Qualis Health)	**$ 215,710**	$7,198	$3,845	$50,463	23%
Shift Results	**$ 53,820**			$36,898	69%
CCMI - Advising	**$ 186,000**		$26,000	$56,000	30%
Learning Activities	**$ 246,640**		$64,921	$151,174	61%
CSI - portal & TA	**$ 75,992**		$1,250	$15,923	21%
Learning Community - fixed	**$ 1,080,000**		$270,000	$810,000	75%
Learning Community - variable	**$ 2,080,000**			$70,000	3%
Pathways Hub					
Community Choice - Hub Lead Agency	**$ 1,426,612**		$126,040	$398,540	28%
Transitional Care and Diversion Intervention					
Confluence Health (TCM Trainer)	**$ 55,000**			$0	0%
Add Hospital Contractor Payment (TBD)	**$ 20,000**			$0	0%
EMS Contractor Payments(NCECC)	**$ 60,000**	$11,569		$22,042	37%
TCDI Hospital Partner Funds	**$ 234,626**	$116,882		$233,763	100%
EMS Partners Payments	**$ 240,000**	$61,000		$113,500	47%
Emerging Initiatives Approval (CCOW)	**$ 20,000**			$0	0%
** Other TCDI Initiatives*	**$ 370,000**			$0	0%
Opioid Project					
Rapid Cycle Applications	**$ 100,000**		$10,380	$59,599	60%
Public Awareness Contract	**$ 30,000**			$2,100	7%
^ School Based Prevention Contracts	**$ 60,000**	$40,000	$20,000	$60,000	100%
*^ * Other Opioid Initiatives (TBD)*	**$ 35,000**			$0	0%
Grand total	**$ 7,604,325**	**$245,309**	**$549,318**	**$2,279,203**	**30%**
				% of Fiscal Year	75%

Total Budget	**$ 9,215,630**	**$ 353,216**	**$ 642,092**	**$ 3,274,698**	**36%**

"*" asterisks - This means a line item will need to go back to the Board in 2019 for further approval prior to any funds being expended.

"^" Budget Amendment Occurred in 2019

TREASURER NOTES:

1. Info for low percentage budget items
   a. Program Eval. at 0% is a delayed use and remains an expected expense.
   b. Public Health King Cnty at 18% has submitted late billing and in October will see Q1 and Q2 expenses.
   c. Xpio at 2% was underutilized and will be removed in 2020 budget.
   d. Asset Mapping at 0% has seen direct staff time though no expenses for project.
   e. Workforce Dvlpmnt at 14% is a delayed through expected expenditure that will be seen in the 2020 budget.
   f. Training (TBD) at 0% is a not expected to be spent in 2019
   g. CHI partner Payments at 0% will see around $100,000 expended in 2019 and the remaining $350,000 in 2020 due to extended application/ scoring process.
   h. Comagine Health (Qualis Health) at 23% was over-budgeted
   i. CCMI Advising at 30% was over-budgeted and will be reduced in 2020
   j. CSI Portal & TA at 21% is from a contract transition from flat rate fee to a pay-for-use/hour and is seeing less need.
   k. Learning Community - variable at 3% will see these payments in October
   l. Comm Choice - HUB at 28% due to extended time for expansion
   m. Confluence Health at 0% due to delayed contract execution
   n. Hospital Contractor at 0% as it did not come to fruition
   o. EMS Cont. at 37% will expended to about 50%
   p. Emerging Initiatiave & Other TCDI both at 0% will not be happening.
   q. Public Awareness Contract at 7% is under review by staff for potential payments
   r. Other Opioid at 0% was tied to PMP

Budget Amendments - 2019

Date	Amendment
01.07.19	Motion to approve an increase of $116,425 to the current 2019 budget amount allocated to the Qualis Health Contract to include contracting for HIT technical assistance, This will bring the total budgeted amount for the Qualis Health contract to a maximum (up to) amount of $215,710 in 2019.
03.04.19	Motion to approve $13,500 to allocate for a contracted vendor to support Executive Director coordination and support between the nine ACHs in 2019.
05.06.19	Approval of the adjusted Opioid Project Budget as presented at the Board meeting.
7.3.2019	Motion to increase the 2019 budgeted amount for the OHSU contract by $28,000 (from $72,000 to $100,000) to support current initiatives through the end of 2019.
7.3.2019	Motion to increase the 2019 budgeted amount for workforce development by $7,125 (from $41,000 to $48,125) to support current initiatives through the end of 2019.

North Central Accountable Community of Health

Executive Director's Report – November 2019

It has been busy since I last shared one of these updates! My vacation was wonderful; it is hard to believe I have been home for at least seven weeks. Time flies when you are having fun!

A few updates beginning late September:

- Legislative Rural Health Tour – hosted September 23-24, 2019: Representative Cody and her team came for a two-day visit and tour, which concluded with a three-hour meeting in Brewster with the Regional Hospital Council. Dr. Peter Rutherford (Confluence Health) began a discussion on the evolution of healthcare in the region over the last ten years. Representative Cody left impressed with the level of collaboration that is occurring between partners in our region – she commented on how partners have made great strides, compared to when she and I started these rural health care tours nearly twenty years ago!
- Parkside: I have been working with the City of Wenatchee, the Governor's office, the Department of Commerce, and NCACH staff to search for funding to help with the structural deficiencies in the building. Sadly, the criteria outlined in the 2019 Capital budget for behavioral health facilities does not allow funding to be given to Parkside. I remain committed to work on this issue, as it is so vital for our region.
- NCACH hosted its 2nd Annual Whole Person Care Collaborative Learning Symposium on October 4, 2019, which brought together fourteen organizations and faculty for a full day of learning and discussion. While most all attendees gave the event high marks in their evaluations, a few specific successes from the event included: a frank discussion around value-based purchasing and practical solutions for implementation; the opportunity for organizations to learn from one another directly, and to learn that many organizations are facing the same challenges; and many commented on how useful the hands-on content was. Overall, a successful event!
- An ACH Executive-Directors meeting was hosted on October 8, 2019, which included Managed Care Organization (MCO) representatives and the Health Care Authority in the afternoon. My "take away" was the Health Care Authority's (HCA) announcement that while they are not requiring or asking ACHs to discontinue Pathways, the HCA has decided to no longer support the Pathways HUB program. It was reported that the HCA is more interested in optimizing Health Home enrollment/engagement and program capacity. We will work with Action Health Partners for our strategy moving forward regarding community based care coordination in the North Central Region. Following the ACH

Executive Director's meeting, was the Health Care Authority's Annual Symposium on October 9. Our staff joined me in this one day presentation. My take away was admiration of the keynote speaker's ability to engage members in the audience to have critical conversations, particularly about the Medicaid Transformation Project, with all in the room.

- On October 16, NCACH learned that we earned 100% of total possible points on the third Semi-Annual Report that was submitted for January – June 2019. The Semi-Annual Report is a detailed account of all activities and milestones that each of the ACHs must submit twice annually, and is used to measure our progress on the Implementation Plans that were submitted in 2018.
- Lastly, I joined all of our staff in an interview done by the Independent Assessor for the Mid-Point Assessment (MPA) of the Medicaid Transformation Project on October 18. Myers and Stauffer, a Certified Public Accounting firm, will submit the initial MPA findings to the Health Care Authority on November 1. We anticipate receiving the final MPA Report with by the end of December.

I look forward to continuing these discussions with you all at the next Governing Board meeting.

Charge on!

Linda Evans Parlette

Executive Director

North Central Accountable Community of Health

NCACH Project Workgroup Update

Regional Opioid Stakeholders Workgroup

November 2019

Key Updates

- **MAT Waiver Training:** NCACH is partnering with the Washington State Department of Health to provide a MAT Waiver Training in Wenatchee in early February. More details and a registration link will be available soon.
- **Recovery Initiatives:** NCACH sponsored a Recovery Coach Training Academy and Training of Trainers in October. There were 14 participants from North Central Washington and three from the Tri-Cities area. NCACH staff worked with Greater Columbia Accountable Community of Health to secure support for these participants from the Tri-cities area. Each trainee is committed to providing a minimum of one Recovery Coach Training in North Central Washington within one year of completing the training. We are exploring contracting with the trainer to provide technical assistance in 2020 to the newly certified Recovery Coach Trainers. Read more here: https://ncach.org/extending-hand-recovery/

- **Narcan Trainings:** NCACH staff provided two Narcan Trainings to the Colville Confederated Tribes in October, including the Police Department. These were Train-the-Trainer trainings to build capacity and ensure continuity of skills for new hires and turnover.
- **Facilitated Community Discussions:** Instead of holding an Opioid Response Conference in the fall of 2019, the Planning Committee has been exploring developing a module that could be deployed to communities or organizations which would include an educational component and a facilitated discussion. The Planning Committee identified an existing video and facilitation guide that can be used for this purpose. The Planning Committee is currently working to pilot this format in the next couple months and if successful will utilize this format to provide training opportunities in 2020.
- **Spring 2020 Opioid Response Conference:** The Planning Committee is continuing to meet to make plans for the Spring 2020 Opioid Response Conference. We are currently exploring the theme: The Intersection of ACEs, Resilience, and Opioid Use and the potential to combine this conference with the Annual Summit since NCACH staff are exploring a similar theme for the Summit. If this is done, an attempt will be made to maintain the distributed conference model format.
- **2019 Opioid Project Plan Update:** There is currently $43,826 of unallocated and under budget funds in the 2018 Opioid Project budget (see chart below) and it is expected that about 50% of the currently Committed but not expended funds will not be expended. The Opioid Workgroup is recommending to utilize those funds to provide targeted technical assistance to providers who are overprescribing opioids. This proposal was previously brought to the Board in September and the Board requested more information before moving forward. See Board Decision Form for further information.

Strategy	Budgeted	Expenses	Committed	Remaining
Rapid Cycle Opioid Application	$100,000	$96,258		**$3,742**
NCW Opioid Response Conference	$10,000	$7,052		**$2,948**
NCW Opioid Response Summit	$12,000		$12,000	$0
Dissemination of Dental Prescribing Guidelines	$15,000	$10,864		**$4,136**
Increase Awareness of Opioid Use and Addiction	$30,000		$30,000	$0
School-based Opioid Prevention	$60,000	$60,000		$0
Naloxone Training and Distribution	$20,000	$9,500	$10,500	$0
Recovery Initiatives and Events	$20,000	$19,643	$357	$0
Unbudgeted	$33,000			$33,000
TOTAL	**$300,000**	**$205,417**	**$50,757**	**$43,826**

- **Steering Committee:** The Steering Committee held its first meeting on September 16th. The Steering Committee endorsed the following 2020 Opioid Project Plan and budget recommendations.

Prevention	Treatment	OD Prevention	Recovery	Strategy	Budget
■	■	■	■	Rapid Cycle Opioid Awards	$100,000
■	■	■	■	North Central Opioid Response Conference (DCM) and support for conference site teams	$95,000
■				Provide training opportunities	$15,000
■				Increase Awareness of Opioid Use and Addiction & Reduce Stigma	$30,000
■				School-based Prevention	$120,000
		■		Naloxone Training and Distribution	$20,000
			■	Recovery Initiatives and Events	$34,000
TOTAL					**$414,000**

Upcoming Meetings

November 15, 2019	Regional Opioid Stakeholders Workgroup
February 21, 2020	Regional Opioid Stakeholders Workgroup

North Central Accountable Community of Health

NCACH Project Workgroup Update

Whole Person Care Collaborative
October 2019

Key Updates

Learning Activities Update

- The Team-Base Care LAN concluded in September. Overall evaluations were well received. LAN was attended mostly by clinical staff, which several reported that they would like their leadership to hear the messages so they understand the psychological safety issues and change fatigue the staff are feeling.
- We hosted an Access webinar which was also well attended. Participants felt that the information was timely and practical for decisions being made within their organizations.
- The year-long Population Health LAN will begin on November 12th. We have 10 organizations and 13 clinical teams participating. We have had a few other organizations express interests, however the timing did not work for their organizations. When they are prepared to participate the WPCC staff and faculty will work diligently to include them so that they are successful.

General Updates

- There was no WPCC meeting in October.
- The Population Health Learning Symposium was attended by 14 of the 17 organizations and multiple individuals representing all three MCOs. Total attendance was 99 individuals. Morning and afternoon evaluations reveal workshops that were practical, offered many opportunities for peer sharing and very engaging.
- Quarter 3 Progress to Date and Measurement Reports were due September 30th. We hope to have a full analysis to the board by the December meeting, if time permits.
- WPCC organizations also submitted their 2020 Change Plans on November 2st.

For more information on the WPCC Meetings, please visit https://ncach.org/wpcc/ where you will find, minutes, presentation slides and the recorded meeting.

North Central Accountable Community of Health

NCACH TCDI Workgroup Updates

September and October 2019

Key Highlights (September/October):

- September 26th workgroup meeting:
  - Lake Chelan Community Hospital and Coulee Medical Center presented on current work.
  - Approved 2020 budget recommendations for hospital and EMS partners
  - Myers and Stauffer (Medicaid Transformation Project Independent Assessor conducted a focus group
- Quarter 3 reports were submitted by hospital and EMS on October 15th. Detailed reports will be shared with Board as a December Board meeting update.
- NCACH staff have worked with implementation partners to develop final implementation plans and deliverables for 2020 based on the TCDI workgroup approve budget.

2020 Project and Budget recommendations from TCDI Workgroup meeting:

On September 26th, 2019 the Transitional Care and Diversion Intervention workgroup reviewed budget plans for 2020 and approved the following below for hospital and EMS professionals:

Payment Type	Funding Amount
TCDI Hospital Partner Payments	$520,000
EMS Partner Payments	$395,000
Training/Consultants	$65,000
Total TCDI Workgroup Budget	$980,000

This recommendation is broken down into two main focus areas (Hospital and EMS Partners) with their specific scope of work. Those primary focuses are included below.

Hospital Partner Project:

Project Focus Area: The Hospital partners will focus on the key issues below

- Focus funding and process improvement work on maintaining current efforts with an emphasis on collaboration across sectors and within organization's service areas (e.g. primary care, behavioral health, and community based organizations)
- Have each partner demonstrate how they are working with another agency outside of their own organization (clinical and non-clinical)
- Partners would focus on two areas:
  - Better connection with outpatient providers
  - Engage community-based partner (if applicable)

Partners will go through a project update process that outlines their plans for 2020. Those updates will be reviewed by NCACH staff for approval. The funding amount will align with the table below. All amounts below are considered up to amounts.

Partner Payment Type	Funding Amount
Transitional Care (Inpatient)	$25,000
ED Diversion	$25,000
Partnership with Community Partner *(Supports Community Partner work)*	$15,000
Total (Each)	**$65,000**
Total Project (8 Organizations)	*$520,000*

EMS Partner Project

Project Focus Area: The EMS partners will focus on the key issues below:

- Invest in additional Certified Ambulance Documentation and WEMSIS trainings.
- Offer additional funding for those providers who would like to develop more robust community paramedicine programs (separate funding stream).
- Support training to EMS providers and NCECC to support providers that need to adapt reporting processes to comply with SSB 5380 (WEMSIS training and expansion for all EMS).
- Continue to support partners to expand their treat and referral programs.
- Offer additional technical assistance to providers as requested (e.g. Quality Improvement and Motivational Interviewing).

Partners will go through a project update process that outlines their plans for 2020. Those updates will be reviewed by NCACH staff for approval. Anyone who wants to apply for the additional community paramedicine funds ($40,000 each) will need to go through an additional formal application process. The funding amounts will align with the table below. All amounts below are considered up to amounts.

Payment Type	Funding Amount
NCECC Project Management	$20,000
Partner Funding *Develop expansion plans for current EMS proposal work*	$215,000
Community Paramedicine Project Funds *Partners who are ready to expand to a more robust Community Paramedicine model (4 providers - $40,000 each)*	$160,000
Overall Total	**$395,000**

North Central Accountable Community of Health

NCACH Project Workgroup Update

Pathways Community HUB

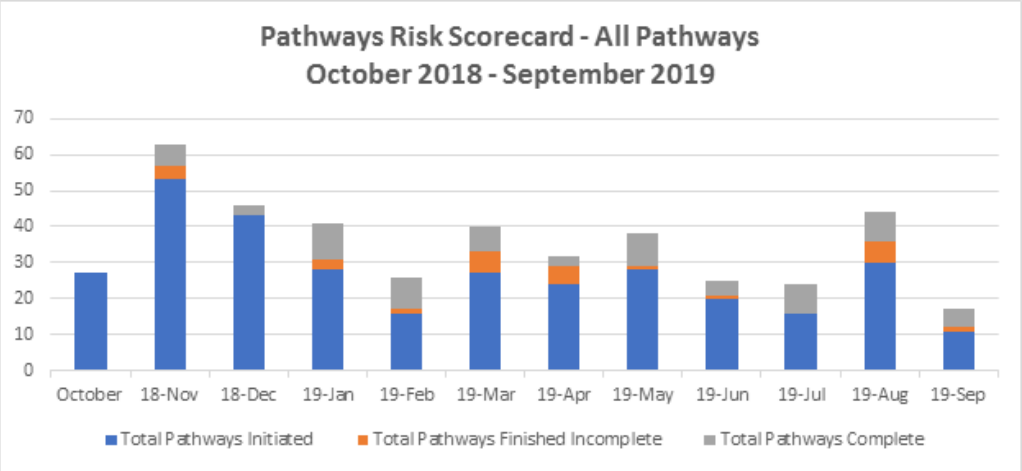
September 2019

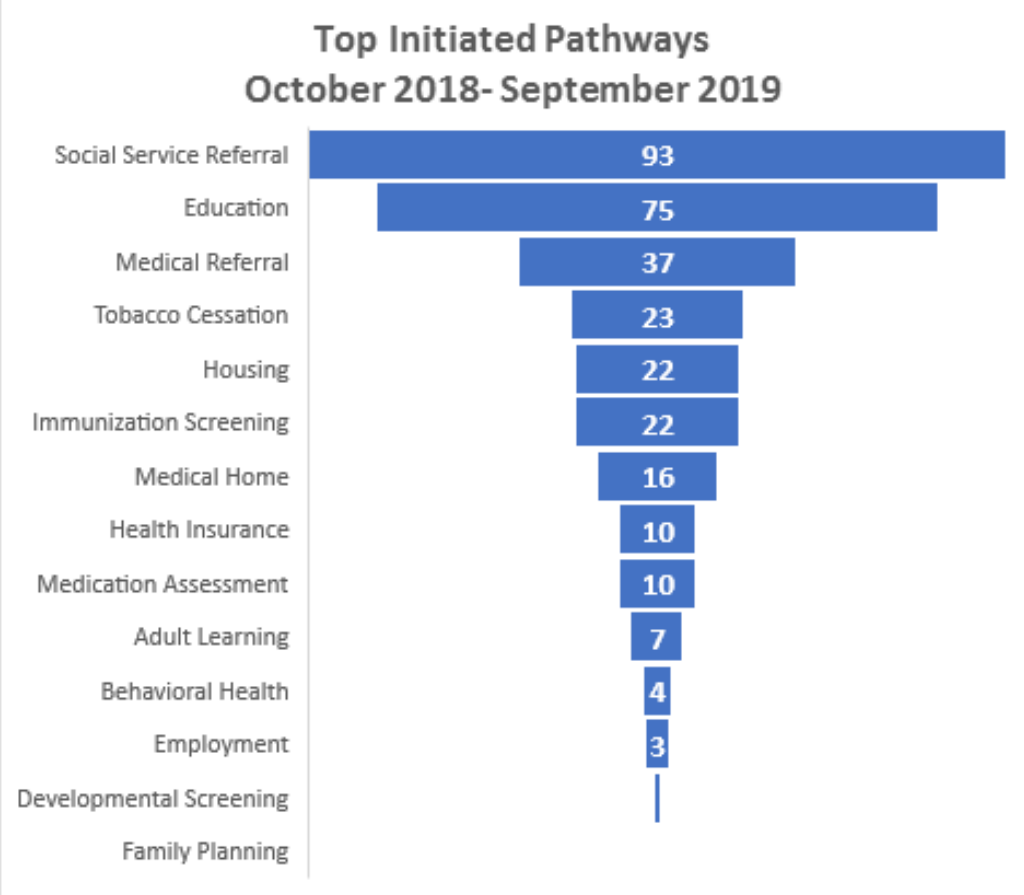
Key Updates-September Activities

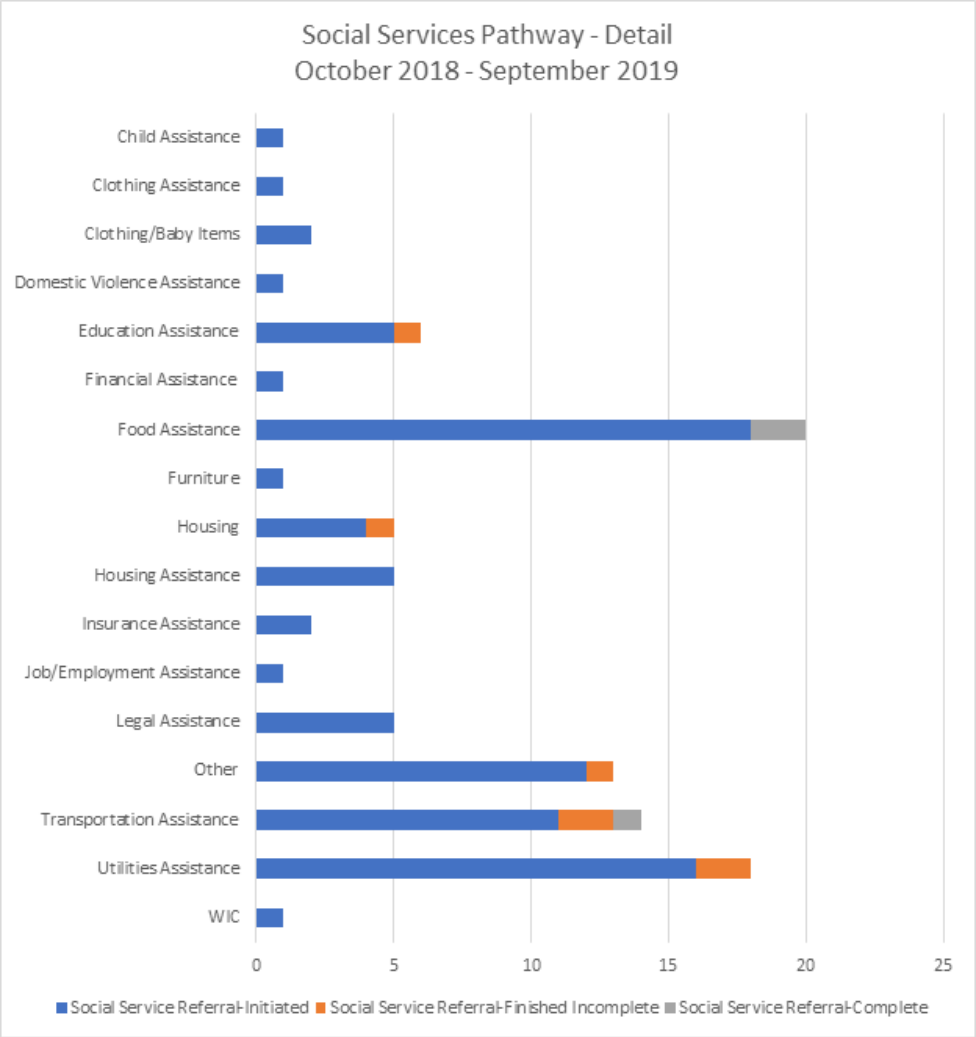
- HUB team worked with Allen Cheadle on finalizing the Pathways HUB Qualitative Evaluation Report
- HUB team continues to participate in regular Cross-ACH HUB calls. The primary focus of the meetings is to work on standardization of common processes. SWACH created a *X-ACH Care Coordination Collaborative Portal* for document sharing across HUB partners.
- HUB Referral Partner packet has been created that includes detailed process steps for submitting referrals.
- Attended the HCA Medicaid Transformation Public Forum
- Provided HUB outreach at the following events:
    - Grand Coulee Pow Wow
    - Columbia Basin Health and Wellness Fair
    - Hands Across the Bridge

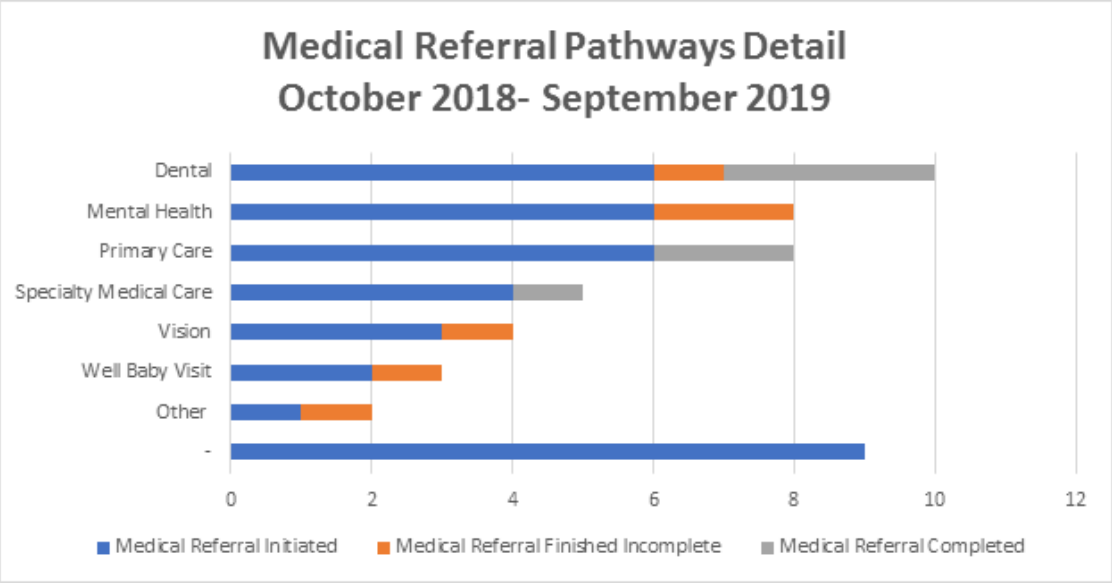
Program Metrics-August Data

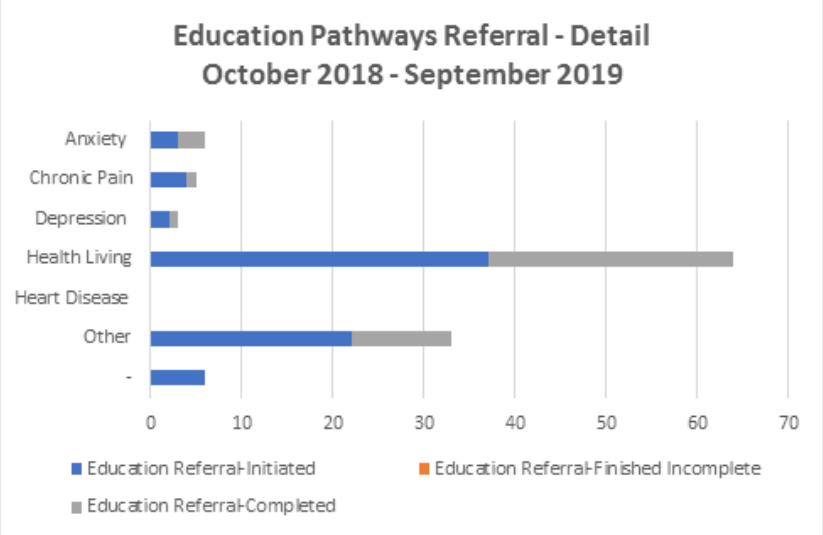
Client Caseload - 10/01/2018 - 09/30/2019			
Total Client Caseload			
Client Type	**Assigned***	**Enrolled****	**Enrollment Rate**
Adult	227	36	16%
Pediatric	6	3	50%
Pregnant	0	0	0%
Senior	12	0	0%
Total	**245**	**39**	16%
Current Client Caseload by PCS			
PCS	**Total Clients Assigned**	**Total Clients Enrolled**	**Total Enrollment Percentage**
1	118	23	19%
2	127	16	13%


Pathways Risk Scorecard - All Pathways
October 2018 - September 2019
70
60
50
40
30
20
10
0
October
18-Nov
18-Dec
19-Jan
19-Feb
19-Mar
19-Apr
19-May
19-Jun
19-Jul
19-Aug
19-Sep
Total Pathways Initiated
Total Pathways Finished Incomplete
Total Pathways Complete


Top Initiated Pathways
October 2018- September 2019
Social Service Referral
93
Education
75
Medical Referral
37
Tobacco Cessation
23
Housing
22
Immunization Screening
22
Medical Home
16
Health Insurance
10
Medication Assessment
10
Adult Learning
7
Behavioral Health
4
Employment
3
Developmental Screening
Family Planning


Social Services Pathway - Detail
October 2018 - September 2019
Child Assistance
Clothing Assistance
Clothing/Baby Items
Domestic Violence Assistance
Education Assistance
Financial Assistance
Food Assistance
Furniture
Housing
Housing Assistance
Insurance Assistance
Job/Employment Assistance
Legal Assistance
Other
Transportation Assistance
Utilities Assistance
WIC
0
5
10
15
20
25
Social Service Referral-Initiated
Social Service Referral-Finished Incomplete
Social Service Referral-Complete





Upcoming Meetings

November 13, 2019	HUB Advisory Board Meeting
November 27, 2019	PCS/Supervisor Meeting
December 11, 2019	HUB Advisory Board Meeting
December TBD	PCS/Supervisor Meeting

2019 NCACH Board

Sector Represented	Board Member Name	Term End Date	Term #
Behavioral Health	Blake Edwards	12/31/2021	2
Confluence Health (primary Care)	Doug Wilson	12/31/2020	2
Confluence Health (CWH)	Rick Hourigan	12/31/2019	1
Public Hospitals	Rosalinda Kibby	12/31/2019	1
Public Hospitals	Scott Graham	12/31/2020	1
Federally Qualified Health Clinic	David Olson	12/31/2019	1
Business Community	Carlene Anders	12/31/2020	1
Elected Official	Senator Warnick	12/31/2019	1
Education	Cathy Meuret	12/31/2019	1
Public Health	Barry Kling	12/31/2020	2
Area on Aging	Ken Sterner	12/31/2021	1
Hispanic Community	Nancy Nash Mendez	12/31/2019	1
MCO	Courtney Ward	12/31/2019	1
Tribal Representative	Molly Morris	12/31/2021	2
Consumer	Daniel Angell	12/31/2019	1
At-Large Seat	Ray Eickmeyer	12/31/2020	2
At-Large Seat	OPEN	12/31/2019	
Grant County CHI	Kyle Kellum	12/31/2020	1
Okanogan County CHI	Mike Beaver	12/31/2019	1
Chelan-Douglas CHI	Brooklyn Holton	12/31/2020	2

Officers				
Seat	**Name**	**Date Elected**	**Expiration**	**Term #**
Chair	Barry Kling	12/3/2018	12/31/2020	2nd Term
Vice Chair	Rick Hourigan	3/5/2018	12/31/2019	1st Term
Treasurer	Brooklyn Holton	6/4/2018	12/31/2019	1st Term
Secretary	Blake Edwards	12/3/2018	12/31/2020	1st Term

COLVILLE CONFEDERATED TRIBES
COLVILLE BUSINESS COUNCIL

Special Session
September 19th, 2019
Resolution Index

Condensed by, Naomi Yazzie, Executive Office Assistant

Present: Rodney Cawston, Jack Ferguson, Joel Boyd, Karen Condon, Margie Hutchinson, Janet Nicholson, Roger Finley, Richard Moses, Joseph Somday, Richard Swan Sr., Jarred-Michael Erickson, Marvin Kheel

Delegation: Norma Sanchez, Darnell Sam

Resolution No.	Condensed Recommendation Information	Colville Business Council Vote Tally
2019-548.fish **10-Signature**	To approve new award for Bureau of Reclamation Invasive Species in the amount of $89,639 and the dates are from September 15, 2019 thru December 31, 2020, and authorize the Chairman or his/her designee to sign all pertinent documents. Attached is new award. No Tribal dollars associated.	**10 FOR (DS, JB, MK, JF, JS, NS, RF, JME, RS, RM)** **0 AGAINST** **0 ABSTAINED** **Rationale: Timelines**
2019-549.fish	To approve new award for National Park Service P19AC01058 Agreement in the amount of $235,000 and the dates are from September 15, 2019 thru September 24, 2024, and authorize the Chairman or his/her designee to sign all pertinent documents. Attached is new award. No Tribal dollars associated.	**10 FOR (DS, JB, MK, JF, JS, NS, RF, JME, RS, RM)** **0 AGAINST** **0 ABSTAINED** **Rationale: Timelines**
2019-550.nrc.m&b.cdc	To approve a contract for Drone Seed Co. for $250,000.00 for Conifer Seedling/Planting. Chairman or designee to sign all pertinent documents.	**10 FOR (JF, RF, JN, DS, RS, JME, JB, MH, RM, MK)** **0 AGAINST** **0 ABSTAINED** **Rationale: Timelines**
2019-551.hhs.m&b.cdc	To accept funding from Better Health Together as earned income from the Medicaid Transformation funding in the amount of $107,000.00. Chair or designee authorized to sign all pertinent documents.	**11 FOR (JF, JB, KC, MH, JN, RF, RM, JS, RS, JME, MK)** **0 AGAINST** **0 ABSTAINED**
2019-552.hhs	To approve the FY 2020 Annual Funding Agreement (AFA) and Scope of Work (SOW) identified as IHS Contract Number 248-96-0001. Chair or designee authorized to sign all pertinent	**11 FOR (JF, JB, KC, MH, JN, RF, RM, JS, RS, JME, MK)**

	documents.	**0 AGAINST** **0 ABSTAINED**
2019-553.hhs	To accept Amendment Number Five (5) increasing the 638 IHS Contract, Health Education, in the amount of $12,000 in non-recurring funds. The purpose of these funds are for Child Health Physical Education in the amount of $8,500 and travel expense for Health Educator to attend the IHS sponsored Clinical and Community based Partnership Conference. Chair or designee authorized to sign all pertinent documents.	**11 FOR (JF, JB, KC, MH, JN, RF, RM, JS, RS, JME, MK)** **0 AGAINST** **0 ABSTAINED**
2019-554.m&b.cdc	To approve the attached 2019 Investment Objective Letter to be submitted to the Office of Special Trustee for American Indians. Chair or designee to sign all pertinent documents.	**11 FOR (JF, JB, KC, MH, JN, RF, RM, JS, RS, JME, MK)** **0 AGAINST** **0 ABSTAINED**
2019-555.m&b.cdc	To approve a continuing resolution through October 31, 2019 for the FY20 Budget. Budget appropriations will be determined by the final approval of the FY20 budgets and adjustments made accordingly and cover the following: (1) Higher Education: 1st quarter/semester tuition; (2) Forest Management Deductions: continuing projects underway; (3) Land Purchase: October fee transactions closing in October and the payment for second half property taxes to Okanogan & Ferry Counties; and (4) Other budgeted projects currently underway. Budget will be 1/12 at 80% of FY19 Budget.	**11 FOR (JF, JB, KC, MH, JN, RF, RM, JS, RS, JME, MK)** **0 AGAINST** **0 ABSTAINED**
2019-556.m&b.cdc.hhs	To approve the attached modification to the organizational chart of Children and Family Services to eliminate three positions and create a new position of Social Worker Supervisor. The Chairman or designee is to sign all pertinent documents.	**9 FOR (JF, JB, JN, RF, RM, JS, RS, JME, MK)** **2 AGAINST (KC, MH)** **0 ABSTAINED**
2019-557.m&b.cdc	To approve the attached modification to the Executive Director's Contract, extending it to FY 2023. Chairman or designee to sign all pertinent documents.	**8 FOR (JF, JB, JN, RF, RM, RS, JME, MK)** **1 AGAINST (KC)** **2 ABSTAINED (MH, JS)**
2019-558.m&b.cdc	To approve the attached amendment to current Cingular Wireless PCS LLC (AT&T) business communications lease to allow for modifications at the Omak Butte site. All other terms of the underlying lease shall remain in effect. Chairman or designee to sign all pertinent documents.	**11 FOR (JF, JB, KC, MH, JN, RF, RM, JS, RS, JME, MK)** **0 AGAINST** **0 ABSTAINED**
2019-559.m&b.cdc.hhs	To submit the attached Washington State Department of Health Construction Review Services Application Packet with associated fees. Chairman or designee is authorized to sign all pertinent documents. Funds to come from account #81.	**11 FOR (JF, JB, KC, MH, JN, RF, RM, JS, RS, JME, MK)** **0 AGAINST** **0 ABSTAINED**
2019-560.m&b.cdc.hhs	To submit a 'Pre-Application' to Indian Health Services "FY 2020 Joint Venture Program", for purposes of constructing a	**11 FOR (JF, JB, KC, MH, JN, RF, RM, JS, RS, JME, MK)**

	new Omak Health Facility in Omak, Washington on the Colville Indian Reservation. Chairman or designee to sign all pertinent documents.	**0 AGAINST** **0 ABSTAINED**
219-561.m&b.cdc.l&j	To approve budget modification for 1801/101916 Natural Resource Enforcement Lake Roosevelt Management bringing the contract total to $2,199,677 for dates 2016 to 2019 and identifying carry over amount. Chairman or his/her to sign documents. Attached is BIA modification #17. No Tribal dollars associated. Indirect $120,980.	**11 FOR (JF, JB, KC, MH, JN, RF, RM, JS, RS, JME, MK)** **0 AGAINST** **0 ABSTAINED**
2019-562.m&b.cdc	To approve the attached Memorandum of Agreement between the Tribes Planning Department and the Tribes DOT. The purpose of this agreement is to coordinate a funds transfer to Planning from DOT for the purpose of matching grant funds for the Keller San Poil Boat Launch project and to facilitate the collaboration between the departments for purposes of development, implementation, and completion of the Project. The Chairman or designee is authorized to sign the attached Agreement.	**11 FOR (JF, JB, KC, MH, JN, RF, RM, JS, RS, JME, MK)** **0 AGAINST** **0 ABSTAINED**
2019-563.m&b.cdc	To approve the attached Project Agreement between the Colville Tribes and the Washington Recreation and Conservation Office (RCO). The purpose of this agreement is to set out the terms and conditions by which a grant was made from the RCO to the Colville Tribes. The Agreement includes a limited waiver of sovereign immunity. The Colville Tribes hereby waives its sovereign immunity for suit in federal and state court for the limited purposes of allowing the State to bring and prosecute to completion such actions relating to the performance, breach, or enforcement of this Agreement and to bring actions to enforce any judgment that may arise. This waiver is not for the benefit of any third party and shall not be enforceable by any third party or by an assignee of the parties. The Chairman or designee is authorized to sign the Agreement.	**10 FOR (JF, JB, MH, JN, RF, RM, JS, RS, JME, MK)** **1 AGAINST (KC)** **0 ABSTAINED**
2019-564.m&b.cdc	To carryover consolidated funds FY18 to FY19 for the completion of the 12 Tribes Fiber Project in the amount of $1,584,886. No additional dollars needed.	**11 FOR (JF, JB, KC, MH, JN, RF, RM, JS, RS, JME, MK)** **0 AGAINST** **0 ABSTAINED**
2019-565.m&b.cdc	To approve the Chairman/designee to approve the appointment of Damon Day as the Colville Tribes' delegate to the Federal Communications Commission.	**11 FOR (JF, JB, KC, MH, JN, RF, RM, JS, RS, JME, MK)** **0 AGAINST** **0 ABSTAINED**
2019-566.m&b.cdc.l&j	To approve Gaming Commission's Background Screening Contract C18-025, Change Order Request #3 to extend contract date until September 30, 2022, by the amount of $135,000 ($45,000 per annum) and modify the screening package options from the original contract with no change to the a la carte	**11 FOR (JF, JB, KC, MH, JN, RF, RM, JS, RS, JME, MK)** **0 AGAINST**

COLVILLE CONFEDERATED TRIBES
COLVILLE BUSINESS COUNCIL

Regular Session
October 10th, 2019
Resolution Index

Condensed by, Naomi Yazzie, Executive Office Assistant

Present: Jack Ferguson, Karen Condon, Norma Sanchez, Janet Nicholson, Roger Finley, Richard Moses, Joseph Somday, Jarred-Michael Erickson, Darnell Sam

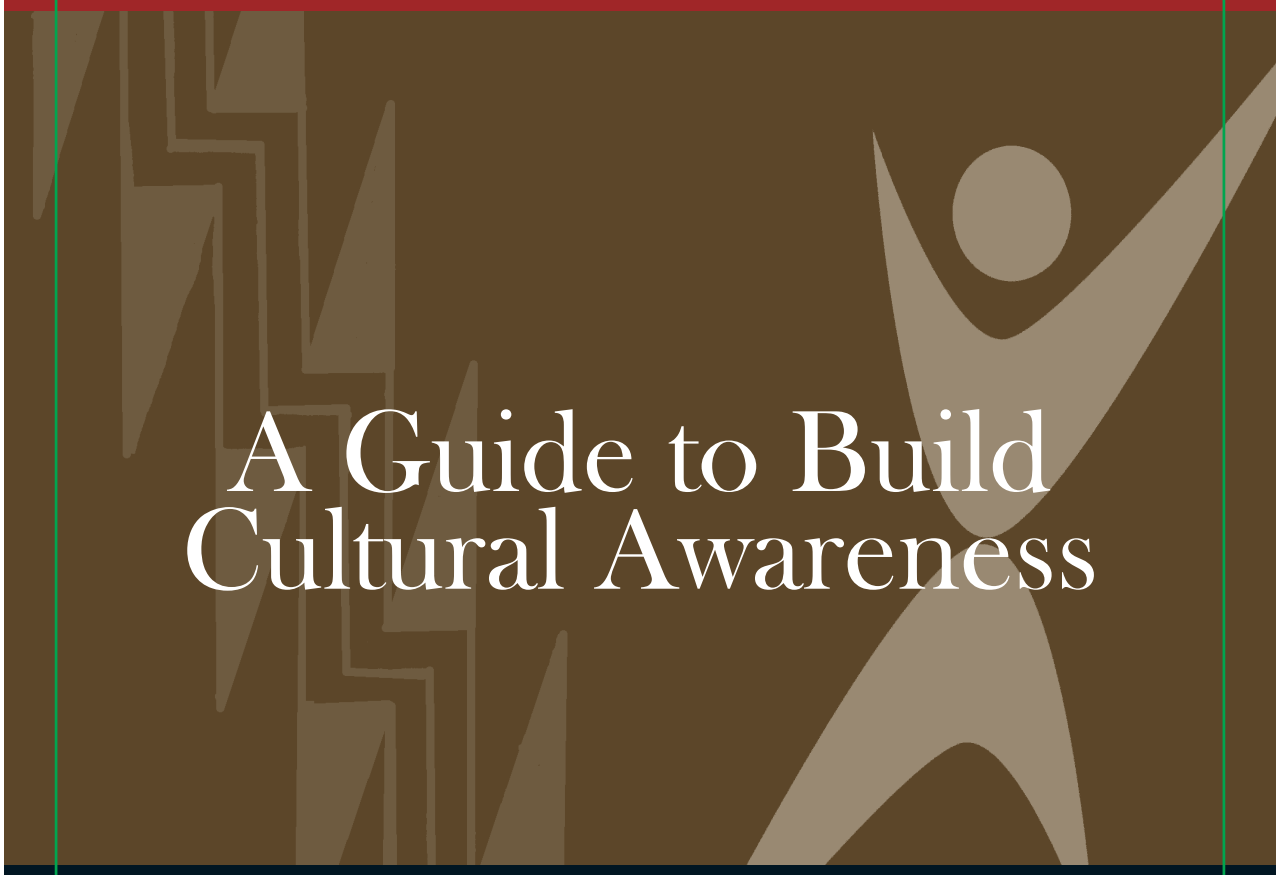
Delegation: Rodney Cawston, Joel Boyd, Margie Hutchinson, Richard Swan Sr., Marvin Kheel

Resolution No.	Condensed Recommendation Information	Colville Business Council Vote Tally
2019-618.nrc ***10-Signature***	To approve the attached road use permit for Hancock Forest Management. Contractors would improve, use and maintain forest roads as necessary during the life of the Williams Flats salvage timber sale contract. Chairperson or designee has the authority to sign all pertinent documents.	**10 FOR (JS, MK, JN, KC, MH, JB, RF, JF, DS, RM)** **0 AGAINST** **0 ABSTAINED** **Rationale: Timelines**
2019-619.hhs.m&b.cdc ***10-Signature***	To approve SF-424 Grant Application for FY2020 in the amount of $407,690.00 to be submitted to USDA FNS Federal Agency for approval. Chairman or designee is authorized to sign all pertinent documents.	**10 FOR (JN, MK, JS, NS, RC, KC, DS, JME, MH, JB)** **0 AGAINST** **0 ABSTAINED** **Rationale: Timelines**
2019-620.nrc ***10-Signature***	To approve change order #7 extending the contract with Wood Environmental & Infrastructure Solutions, Inc. to September 30, 2022, adding additional tasks and funding per Contract A16AV00299 Amendment 38 in the amount of $450,000.00, for a new contract total of $998,651.00. Funding is provided by the BIA Safety of Dams for the environmental survey and assessment, and permitting services necessary for the replacement of Owhi Lake Dam. Chairman or designee authorized to sign all pertinent document(s).	**10 FOR (JF, RF, MH, DS, JME, RS, NS, JS, RM, JN)** **0 AGAINST** **0 ABSTAINED** **Rationale: Timelines**
2019-621.hhs.m&b.cdc ***10-Signature***	To approve the Low Income Home Energy Assistance Program SF-424 Grant Application for FY 2020 in the amount of $500,855.00. Chairman or designee is authorized to sign all pertinent documents.	**10 FOR (JF, JS, JME, NS, JB, KC, MK, DS, RM, JN)** **0 AGAINST** **0 ABSTAINED** **Rationale: Timelines**
2019-622.l&j ***10-Signature***	To accept the contract funding for the Tribal Traffic Safety	**10 FOR (RF, JB, MK, JF, JME, JS, NS, RS, DS, JN)**

	Coordinator position. The period of performance will be Oct. 1, 2019 through Sept. 30, 2022. The budget within this agreement will only cover FY20 because FY21 and FY22 budgets will need to be renegotiated each year. The Washington Traffic Safety Commission will provide $67,297.00 in FY20 to support salaries, fringe, and indirect costs. The contract will require a match for direct costs in FY 20 in the amount of $5,907 from the Public Safety Director's budget in salaries and fringe to meet the requirement. The project total is $73,204. Chairman or designee authorized to sign.	**0 AGAINST** **0 ABSTAINED** **Rationale: Timelines**
2019-623.hhs ***10-Signature***	To submit the attached letter of support in regard to the State Health Care Authority's (HCA) Indian Nation Agreement on behalf of the American Indian Health Commission. Chairman or designee to sign pertinent documents.	**10 FOR (JN, MK, JS, JF, RF, JME, RM, NS, JB, DS)** **0 AGAINST** **0 ABSTAINED** **Rationale: Timelines**
2019-624.m&b.cdc ***10-Signature***	To approve Cates & Erb Inc. final payment for the Benton Street Rehabilitation Project. At this time the Construction Phase services will not exceed $164,583.50. No Tribal dollars, Chairman or designee to sign all pertinent documents.	**11 FOR (JF, MK, NS, JME, RS, JS, JB, DS, MH, RF, KC)** **0 AGAINST** **0 ABSTAINED** **Rationale: Timelines**
2019-625.e&e.m&b.cdc ***10-Signature***	To approve the Five Year Non-Competing Continuation Grant FY 2020, Office of Head Start Grant Application in the amount of $1,380,780 Federal Funds and $345,195 required non-federal cash match. Tribal Chairman or Designee to sign all pertinent documents.	**10 FOR (JB, JS, MK, DS, MH, JME, RF, KC, JN, RM)** **0 AGAINST** **0 ABSTAINED** **Rationale: Timelines**
2019-626.m&b.cdc ***10-Signature***	To approve the purchase and installation of a stainless sander, wet line kit and snow plow on the 2018 Freightliner for the Keller District for snow and ice control in the amount of $75,257.66 from the vendor Titan Truck. No Tribal dollars, Chairman or designee to sign all pertinent documents.	**10 FOR (JF, RF, MK, JS, RS, JB, DS, MH, KC, RM)** **0 AGAINST** **0 ABSTAINED** **Rationale: Timelines**
2019-627.hhs ***10-Signature***	To approve the following: AAOA 2020-2023 Area Plan and Budget in the amount of $990,330 (State & Federal Funds). Chairman or designee authorized to sign all pertinent document(s).	**10 FOR (JF, RF, RS, MK, JS, DS, MH, MK, RM, RC)** **0 AGAINST** **0 ABSTAINED** **Rationale: Timelines**
2019-628.m&b.cdc	The term of the representative of the Tribes, as appointed by the Business Council expires on October 4, 2019. It is the recommendation of the Management & Budget/Community Development Committee to approve the appointment of Tanya K. Steele as Director of the Colville Tribal Credit Board of	**8 FOR (KC, NS, JN, RF, RM, JS, JME, DS)** **0 AGAINST** **0 ABSTAINED**

	Directors for a two year period by the Colville Business Council.	
2019-629.m&b.cdc	To approve the Planning Department Budget - money rollover from FY19 budget to FY20 budget for grant matching dollars to meet requirements of the resolution approved MOA 2019-372 (Okanogan County & CCT Planning) and 2019-373 (Ferry County & CCT Planning).	**8 FOR (KC, NS, JN, RF, RM, JS, JME, DS)** **0 AGAINST** **0 ABSTAINED**
2019-630.m&b.cdc	To approve the three year EPA 104(k) Brownfields Multi-Purpose Assessment Grant award not to exceed $300,000 for funding for the Brownfield sites on the Colville Indian Reservation in Fiscal year 2019-2022. The award will be split between two accounts (1) Hazardous Substance, total $154,337 and (2) Petroleum Sites, total $145,663. The Tribal Chairman or his designee is authorized to sign all relevant documents. No Tribal dollars required.	**8 FOR (KC, NS, JN, RF, RM, JS, JME, DS)** **0 AGAINST** **0 ABSTAINED**
2019-631.m&b.cdc	To approve EPA 128(a) Tribal Response Program Grant award not to exceed $326,357 for funding surveys and inventory of Brownfields site, HSCA (4-16) oversight and enforcement activities, meaningful public involvement; mechanisms for approval of cleanup plans, and verification of complete responses for FY2019. The Tribal Chairman or his designee is authorized to sign all relevant documents. No Tribal dollars required.	**8 FOR (KC, NS, JN, RF, RM, JS, JME, DS)** **0 AGAINST** **0 ABSTAINED**
2019-632.m&b.cdc	To approve the Colville Tribal Convalescent Center to move monies from budgeted salaries and fringe line items to Agency Nursing line items to provide adequate nursing department staff. The Convalescent Center is moving monies within their approved budget so no additional monies are needed.	**8 FOR (KC, NS, JN, RF, RM, JS, JME, DS)** **0 AGAINST** **0 ABSTAINED**
2019-633.m&b.cdc.e&e	To enact the attached amendments to the EPM effective immediately upon CBC approval.	**8 FOR (KC, NS, JN, RF, RM, JS, JME, DS)** **0 AGAINST** **0 ABSTAINED**
2019-634.tg	To nominate Janet WakWak Nicholson for the National At-Large Position on the Department of Health & Human Services Secretary's Tribal Advisory Committee (STAC). Chairman or designee authorized to sign the attached nomination letter.	**7 FOR (KC, NS, RF, RM, JS, JME, DS)** **0 AGAINST** **1 ABSTAINED (JN)**
2019-635.tg	To appoint Richard Moses as the delegate to the Healing Lodge of the Seven Nations Board. This resolution shall supersede all previous resolutions. Chairman or designee to sign all pertinent documents.	**7 FOR (KC, NS, JN, RF, JS, JME, DS)** **0 AGAINST** **1 ABSTAINED (RM)**
2019-636.tg	To appoint Norma Sanchez as the alternate delegate to the Healing Lodge of the Seven Nations Board. This resolution shall supersede all previous resolutions. Chairman or designee to sign all pertinent documents.	**7 FOR (KC, JN, RF, RM, JS, JME, DS)** **0 AGAINST** **1 ABSTAINED (NS)**
2019-637.tg	To appoint Rodney Cawston as the delegate for the National	**8 FOR (KC, NS, JN, RF,**

CultureCard



A Guide to Build Cultural Awareness

American Indian and Alaska Native

About this Guide

The purpose of this guide is to provide basic information for Federal disaster responders and other service providers who may be deployed or otherwise assigned to provide or coordinate services in American Indian/Alaska Native (AI/AN) communities.

This guide is intended to **serve as a general briefing to enhance cultural competence** while providing services to AI/AN communities. (Cultural competence is defined as the ability to function effectively in the context of cultural differences.) A more specific orientation or training should be provided by a member of the particular AI/AN community.

Service providers should use this guide to ensure the following Five Elements of Cultural Competence* are being addressed:

1. Awareness, acceptance and valuing of cultural differences
2. Awareness of one's own culture and values
3. Understanding the range of dynamics that result from the interaction between people of different cultures
4. Developing cultural knowledge of the particular community served or to access cultural brokers who may have that knowledge
5. Ability to adapt individual interventions, programs, and policies to fit the cultural context of the individual, family, or community

*Adapted from Cross, T., Bazron, B., Dennis, K., and Isaacs, M. (1989). Towards A Culturally Competent System of Care Volume I. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Myths and Facts

Myth: AI/AN people are spiritual and live in harmony with nature.
Fact: The idea of all AI/ANs having a mystical spirituality is a broad generalization. This romantic stereotype can be just as damaging as other more negative stereotypes and impairs one's ability to provide services to AI/ANs as real people.

Myth: AI/AN people have distinguishing physical characteristics, and you can identify them by how they look.
Fact: **Due to Tribal diversity, as well as hundreds of years of inter-Tribal and inter-racial marriages, there is no single distinguishing "look" for AI/ANs.**

Myth: Casinos have made AI/ANs rich.
Fact: Out of more than 560 Federally recognized tribes, only 224 operate gaming facilities. About three-fourths of those tribes reinvest revenue in the community. In 2006, only 73 tribes distributed direct payments to individual Tribal members.

Myth: The Bureau of Indian Affairs (BIA) and the Indian Health Service (IHS) are the only agencies responsible for working with tribes.
Fact: The U.S. Constitution, Executive Orders, and Presidential memos outline policy requiring that ALL executive departments have the responsibility to consult with and respect Tribal sovereignty.

Myth: AI/ANs have the highest rate of alcoholism.
Fact: While many tribes and AI/AN villages do experience the negative effects of alcohol abuse, what is less known is that AI/ANs also have the highest rate of complete abstinence. When socioeconomic level is accounted for in a comparison group, alcoholism rates are no different for AI/ANs than for other ethnic or racial groups. Most AI/AN-sponsored events ban the use of alcohol and even "social" drinking is often frowned upon.

Myth: AI/AN people all get "Indian money" and don't pay taxes.
Fact: Few Tribal members receive payments from the BIA for land held in trust and most do not get significant "Indian money." AI/ANs pay income tax and sales tax like any other citizen of their State while the U.S. Alaska Natives may get dividend payments from their Native Corporation or the State of Alaska as State citizens.

Tribal Sovereignty

Presently, there are more than 560 Federally recognized AI/AN tribes in the United States. Over half of these are Alaska Native villages. Additionally, there are almost 245 non-Federally recognized tribes. Many of those are recognized by their States and are seeking Federal recognition.

There is a unique legal and political relationship between the Federal government and Indian tribes and a special legal relationship with Alaska Native Corporations.

The U.S. Constitution (Article 1 Section 8, and Article 6), treaties, Supreme Court decisions, Federal laws, and Executive Orders provide authority to the Federal government for Indian affairs with Federally recognized tribes.

As sovereign nations, Tribal governments have the right to hold elections, determine their own citizenship (enrollment), and to consult directly with the U.S. government on policy, regulations, legislation, and funding.

Tribal governments can create and enforce laws that are stricter or more lenient than State laws, but they are not subservient to State law. State laws cannot be applied where they interfere with the right of a tribe to make its own laws protecting the health and welfare of its citizens, or where it would interfere with any Federal interest.

Criminal legal jurisdiction issues are very complex, depend on a variety of factors, and must be assessed based on the specific law as applied to a specific tribe. In general, the Federal law applies.

The Indian Self-Determination Act (Public Law 93-638) gives the authority to Tribal governments to contract programs and services that are carried out by the Federal government, such as services provided by the BIA or IHS.

The Alaska Native Claims Settlement Act was signed into law on December 18, 1971. Settlement benefits would accrue to those with at least one-fourth Native ancestry, and would be administered by the 12 regional corporations within the State.

Regional and Cultural Differences

Prior to European contact, AI/AN communities existed throughout various areas of North America. Federal policies led to voluntary and forced relocation from familiar territory to the current day reservation system.

When the reservation system was formed in the late 1800s, some bands and tribes were forced by the U.S. government to live together. In some instances, these groups were related linguistically and culturally; in others, they were not closely related and may even have been historic enemies.

On reservations where different AI/AN groups were forced to co-exist, repercussions occurred that still can be experienced today in those communities. **Historic rivalries, family or clan conflicts, and "Tribal politics" may present challenges for an outsider unaware of local dynamics who is trying to interact with different groups in the community.**

While there is great diversity across and within tribes, there are within-region similarities based on adaptation to ecology, climate, and geography (including traditional foods); linguistic and cultural affiliations; and sharing of information for long periods of time.

Differences in cultural groups are closely related to regional differences and may be distinguished by their language or spiritual belief systems. They are also a result of the diversity of historic homelands across the Nation and migration patterns of Tribal groups.

Cultures developed in adaptation to their natural environment and the influence of trade and interaction with non-Indians and other AI/AN groups.

Urban Indian communities can be found in most major metropolitan areas. These populations are represented by members of a large number of different tribes and cultures that have different degrees of traditional culture and adaptation to Western culture norms. They form a sense of community through social interaction and activities, but are often "invisible," geographically disbursed, and multi-racial.

Cultural Customs

Cultural customs can be viewed as a particular group or individual's preferred way of meeting their basic human needs and conducting daily activities as passed on through generations.

Specific cultural customs among AI/AN groups may vary significantly, even within a single community.

Customs are influenced by: ethnicity, origin, language, religious/spiritual beliefs, socioeconomic status, gender, sexual orientation, age, marital status, ancestry, history, gender identity, geography, and so on.

Cultural customs are often seen explicitly through material culture such as food, dress, dance, ceremony, drumming, song, stories, symbols, and other visible manifestations.

Such outward cultural customs are a reflection of a much more ingrained and implicit culture that is not easily seen or verbalized. **Deeply held values, general world view, patterns of communication, and interaction are often the differences that affect the helping relationship.**

A common practice of a group or individual that represents thoughts, core values, and beliefs may be described by community members as "the way we do things" in a particular tribe, community, clan, or family. This includes decision-making processes.

Respectful questions about cultural customs are generally welcomed, yet not always answered directly.

Any questions about culture should be for the purpose of improving the service provider's understanding related to the services being provided.

Many AI/AN people have learned to "walk in two worlds" and will observe the cultural practices of their AI/AN traditions when in those settings, and will observe other cultural practices when in dominant culture settings.

Sharing food is a way of welcoming visitors, similar to offering a handshake. Food is usually offered at community meetings and other gatherings as a way to build relationships.

Spirituality

A strong respect for spirituality, whether traditional (prior to European contact), Christian (resulting from European contact), or a combination of both, is common among all AI/AN communities and often forms a sense of group unity.

Many AI/AN communities have a strong church community and organized religion that is integrated within their culture.

Traditional spirituality and practices are integrated into AI/AN cultures and day-to-day living.

Traditional spirituality and/or organized religions are usually community-oriented, rather than individual-oriented.

Spirituality, world view, and the meaning of life are very diverse concepts among regions, tribes, and/or individuals.

Specific practices such as ceremonies, prayers, and religious protocols will vary among AI/AN communities.

A blend of traditions, traditional spiritual practices, and/or mainstream faiths may coexist. It is best to inquire about an individual's faith or beliefs instead of making assumptions, but be aware that many AI/AN spiritual beliefs and practices are considered sacred and are not to be shared publicly or with outsiders.

Until passage of the Indian Religious Freedom Act in 1978, many traditional AI/AN practices were illegal and kept secret.

Social/health problems and their solutions are often seen as spiritually based and as part of a holistic world view of balance between mind, body, spirit, and the environment.

It is a common practice to open and close meetings with a prayer or short ceremony. Elders are often asked to offer such opening and closing words and given a small gift as a sign of respect for sharing this offering.

Communication Styles

Nonverbal Messages

- **AI/AN people communicate a great deal through non-verbal gestures.** Careful observation is necessary to avoid misinterpretation of non-verbal behavior.

  • AI/AN people may look down to show respect or deference to elders, or ignoring an individual to show disagreement or displeasure.

- A gentle handshake is often seen as a sign of respect, not weakness.

Humor

- **AI/AN people may convey truths or difficult messages through humor**, and might cover great pain with smiles or jokes. It is important to listen closely to humor, as it may be seen as invasive to ask for too much direct clarification about sensitive topics.

- It is a common conception that "laughter is good medicine" and is a way to cope. The use of humor and teasing to show affection or offer corrective advice is also common.

Indirect Communication

- **It is often considered unacceptable for an AI/AN person to criticize another directly.** This is important to understand, especially when children and youth are asked to speak out against or testify against another person. It may be considered disloyal or disrespectful to speak negatively about the other person.

- There is a common belief that people who have acted wrongly will pay for their acts in one way or another, although the method may not be through the legal system.

Storytelling

- **Getting messages across through telling a story (traditional teachings and personal stories) is very common** and sometimes in contrast with the "get to the point" frame of mind in non-AI/AN society.

This guide was developed by an ad hoc group of U.S. Public Health Service Commissioned Officers, American Indian/Alaska Native (AI/AN) professionals, and family advocates working together from 2006-2007. The abbreviation AI/AN is used for American Indian/Alaska Native in the interest of space and consistency.

The authors of this guide wish to thank the many AI/AN professionals and community members across the country who contributed their thoughts and comments to this guide. The challenge in developing a basic guide for an incredibly diverse group of people such as AI/ANs cannot be understated. The authors hope the result is accurate, respectful to the communities, and helpful for the users.

January 2009

Historic Distrust

Establishing trust with members of an AI/AN community may be difficult. Many Tribal communities were destroyed due to the introduction of European infectious illnesses. Similarly, many treaties made by the U.S. government with Tribal nations were broken.

From the 1800s through the 1960s, government military-style boarding schools and church-run boarding schools were used to assimilate AI/AN people. Children were forcibly removed from their families to attend schools far from home where they were punished for speaking their language and practicing spiritual ways in a stated effort to "kill the Indian, save the child." Many children died from infectious diseases, and in many schools physical and sexual abuse by the staff was rampant. Boarding school survivors were taught that their traditional cultures were inferior or shameful, which still affects many AI/AN communities today.

The Federal "Termination Policy" in the 1950s and 1960s ended the government-to-government relationship with more than 100 Federally recognized tribes. The result was disastrous for those tribes due to discontinued Federal support, loss of land held in trust, and loss of Tribal identity. Most of the tribes terminated during this time were able to re-establish Federal recognition through the Congressional process in the 1980s and 1990s.

The Federal "Relocation Policy" in the 1950s and 1960s sought to move AI/AN families to urban areas, promising jobs, housing, and a "new life." Those that struggled and stayed formed the core of the growing Urban Indian populations. Ultimately, many families returned home to their reservation or home community. Today, many families and individuals travel between their home community and urban communities for periods of time to pursue education and job opportunities.

Churches and missionaries have a long history of converting AI/AN people to their religions, and in the process often labeled traditional cultural practices such as songs, dances, dress, and artwork as "evil." Today there is a diverse mix of Christian beliefs and traditional spirituality within each AI/AN community.

Cultural Identity

When interacting with individuals who identify themselves as AI/AN, **it is important to understand that each person has experienced their cultural connection in a unique way.**

An individual's own personal and family history will determine their cultural identity and practices, which may change throughout their lifespan as they are exposed to different experiences.

The variation of cultural identity in AI/AN people can be viewed as a continuum that ranges between one who views himself or herself as "traditional" and lives their traditional culture daily, to one who views himself or herself as "Indian" or "Native", but has little knowledge or interest in their traditional cultural practices.

Many AI/AN families are multicultural and adapt to their surrounding culture.

From the 1950s to the 1970s, the Federal government, adoption agencies, state child welfare programs, and churches adopted out thousands of AI/AN children to non-AI/AN families. The Indian Child Welfare Act was passed in 1978 to end this practice. There are many AI/AN children, as well as adults, who were raised with little awareness or knowledge of their traditional culture; they may now be seeking a connection with their homelands, traditional culture, and unknown relatives.

When asked "Where are you from?" most AI/AN people will identify the name of their tribe/village and/or the location of their traditional or family homeland. This is often a key to self-identity.

It is important to remember that most Alaska Natives do not refer to themselves as "Indians."

Age is another cultural identity consideration. Elders can be very traditional while younger people can either be multicultural or non-traditional. In many communities, leaders and elders are worried about the loss of the use of the traditional language among children and young adults. Still, in other communities, young people are eagerly practicing the language and other cultural traditions and inspiring older generations who may have felt shame in their identity growing up as AI/AN.

Historical trauma and grief events, such as boarding schools or adoption outside of the tribe, may play a dramatic role in shaping attitudes, sense of identity, and levels of trust.

Role of Veterans and Elders

Elders play a significant role in Tribal communities. The experience and wisdom they have gained throughout their lifetime, along with their historical knowledge of the community, are considered valuable in decision-making processes.

It is customary in many Tribal communities to show respect by allowing elders to speak first, not interrupting, and allowing time for opinions and thoughts to be expressed.

In group settings, people will often ask the elder's permission to speak publicly, or will first defer to an elder to offer an answer.

Elders often offer their teaching or advice in ways that are indirect, such as through storytelling.

When in a social setting where food is served, elders are generally served first, and in some traditional Alaska Native villages, it is the men who are served first by the women. It is disrespectful to openly argue or disagree with an elder.

AI/AN communities historically have high rates of enlistment in the military service. Often, both the community and the veteran display pride for military service.

Veterans are also given special respect similar to that of elders for having accepted the role of protector and experienced personal sacrifice. AI/AN community members recognize publicly the service of the veteran in formal and informal settings.

AI/AN community members who are veterans are honored at ceremonies and pow wows, and by special songs and dances. They have a special role in the community, so veterans and their families are shown respect by public acknowledgment and inclusion in public events.

The AI/AN community's view of Uniformed Service members being deployed to an AI/AN community in times of crisis or disaster (such as the U.S. Public Health Service Commissioned Corps or National Guard) will vary greatly. There may be respect for the uniform similar to that shown to a veteran, but there may also be feelings of distrust related to the U.S. government's and the military's historical role and presence in AI/AN communities.

Strengths in AI/AN Communities

It is easy to be challenged by the conditions in AI/AN communities and to not see beyond the impact of the problems or crisis.

Recognizing and identifying strengths in the community can provide insight for possible interventions. Since each community is unique, look to the community itself for its own identified strengths, such as:

- **extended family and kinship ties;**
- **long-term natural support systems;**
- **shared sense of collective community responsibility;**
- **physical resources (e.g., food, plants, animals, water, land);**
- **indigenous generational knowledge/wisdom;**
- **historical perspective and strong connection to the past;**
- **survival skills and resiliency in the face of multiple challenges;**
- **retention and reclamation of traditional language and cultural practices;**
- **ability to "walk in two worlds" (mainstream culture and the AI/AN cultures); and**
- **community pride.**

Health and Wellness Challenges

Concepts of health and wellness are broad. The foundations of these concepts are living in a harmonious balance with all elements, as well as balance and harmony of spirit, mind, body, and the environment. Health and wellness may be all encompassing, not just one's own physical body; it is holistic in nature. AI/ANs define what health and wellness is to them, which may be very different from how Western medicine defines health and wellness.

Many health and wellness issues are not unique to AI/AN communities, but are statistically higher than in the general population. It is important to learn about the key health issues in a particular community.

Among most AI/AN communities, 50 percent or more of the population is under 21 years of age.

Health disparities exist with limited access to culturally appropriate health care in most AI/AN communities.

Only 55 percent of AI/AN people rely on the Federally funded IHS or Tribally operated clinics/hospitals for care.

Suicide is the second leading cause of death among AI/AN people age 10-34. The highest rates are among males between the ages of 24 and 34 and 15 and 24, respectively.

Following a death by suicide in the community, concern about suicide clusters, suicide contagion, and the possibility of suicide pacts may be heightened. A response to a suicide or other traumatic occurrence requires a community-based and culturally competent strategy.

Prevention and intervention efforts must include supporting/enhancing strengths of the community resources as well as individual and family clinical interventions.

Service providers must take great care in the assessment process to consider cultural differences in symptoms and health concepts when making a specific diagnosis or drawing conclusions about the presenting problem or bio-psychological history.

Every effort should be made to consult with local cultural advisors for questions about symptomology and treatment options.

Self-Awareness and Etiquette

Prior to making contact with a community, **examine your own belief system about AI/AN people related to social issues, such as mental health stigma, poverty, teen suicide, and drug or alcohol use.**

You are being observed at all times, so **avoid making assumptions and be conscious that you are laying the groundwork for others to follow.**

Adapt your tone of voice, volume, and speed of speech patterns to that of local community members to fit their manner of communication style.

Prefered body language, posture, and concept of personal space depend on community norms and the nature of the personal relationship. Observe others and allow them to create the space and initiate or ask for any physical contact.

You may experience people expressing their mistrust, frustration, or disappointment from other situations that are outside of your control. **Learn not to take it personally.**

If community members tease you, understand that this can indicate rapport-building and may be a form of guidance or an indirect way of correcting inappropriate behavior. **You will be more easily accepted and forgiven for mistakes if you can learn to laugh at yourself and listen to lessons being brought to you through humor.**

Living accommodations and local resources will vary in each community. Remember that you are a guest. Observe and ask questions humbly when necessary.

Rapport and trust do not come easily in a limited amount of time; however, don't be surprised if community members speak to you about highly charged issues (e.g., sexual abuse, suicide) as you may be perceived as an objective expert.

Issues around gender roles can vary significantly in various AI/AN communities. Males and females typically have very distinct social rules for behavior in every day interactions and in ceremonies. **Common behaviors for service providers to be aware of as they relate to gender issues are eye contact, style of dress, physical touch, personal space, decision making, and the influence of male and/or female elders.**

Careful observation and seeking guidance from a community member on appropriate gender-specific behavior can help service providers to follow local customs and demonstrate cultural respect.

Etiquette – Do's

Learn how the community refers to itself as a group of people (e.g., Tribal name).

Be honest and clear about your role and expectations and be willing to adapt to meet the needs of the community. Show respect by being open to other ways of thinking and behaving.

Listen and observe more than you speak. Learn to be comfortable with silence or long pauses in conversation by observing community members' typical length of time between turns at talking.

Casual conversation is important to establish rapport, so be genuine and use self-disclosure (e.g., where you are from, general information about children or spouse, personal interests).

Avoid jargon. An AI/AN community member may nod their head politely, but not understand what you are saying.

It is acceptable to admit limited knowledge of AI/AN cultures, and invite people to educate you about specific cultural protocols in their community.

If you are visiting the home of an AI/AN family, you may be offered a beverage and/or food, and it is important to accept it as a sign of respect.

Explain what you are writing when making clinical documentation or charting in the presence of the individual and family.

During formal interviews, it may be best to offer general invitations to speak, then remain quiet, sit back, and listen. Allow the person to tell their story before engaging in a specific line of questioning.

Be open to allow things to proceed according to the idea that "things happen when they are supposed to happen."

Respect confidentiality and the right of the tribe to control information, data, and public information about services provided to the tribe.

Etiquette – Don'ts

Avoid stereotyping based on looks, language, dress, and other outward appearances.

Avoid intrusive questions early in conversation.

Do not interrupt others during conversation or interject during pauses or long silences.

Do not stand too close to others and/or talk too loud or fast.

Be careful not to impose your personal values, morals, or beliefs.

Be careful about telling stories of distant AI/AN relatives in your genealogy as an attempt to establish rapport unless you have maintained a connection with that AI/AN community.

Be careful about pointing with your finger, which may be interpreted as rude behavior in many tribes.

Avoid frequently looking at your watch and do not rush things.

Avoid pressing all family members to participate in a formal interview.

During a formal interview, if the person you are working with begins to cry, support the crying without asking further questions until they compose themselves and are ready to speak.

Do not touch sacred items, such as medicine bags, other ceremonial items, hair, jewelry, and other personal or cultural things.

Do not take pictures without permission.

NEVER use any information gained by working in the community for personal presentations, case studies, research, and so on, without the expressed written consent of the Tribal government or Alaska Native Corporation.

This publication may be downloaded or ordered at www.SAMHSA.gov/shin. Or, call SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

DHHS Publication No. (SMA) 08-4354

A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

January 2009

North Central Accountable Community of Health

Governing Board Meeting

2020 Budget Overview

2020 Budget Approval Timeline

- **September 6th:** Introduced budget timeline with Board
- **September – October:** Staff worked with their workgroups, contractors, and partners to develop draft budget recommendations
- **November 4th (TODAY):** Staff is presenting a initial DRAFT budget for 2020 and providing additional context/narrative to main budget items
- **November:** Staff will incorporate Board feedback into budget and share updated version with Board members
- **December 4th:** Staff will present 2020 Budget for approval by Board

Goal of Today's Budget Presentation

1. **Provide DRAFT 2020 Budget and additional information that helped develop the up to amounts for new budget line items.**

2. **Review of DRAFT 2020 budget includes:**
   - High level review of all 2020 budget line items
   - Highlight of key changes to any budget items from the 2019 budget
   - Provide details to new budget items that staff and workgroups are proposing in 2020

3. **Get feedback/questions from the Governing Board to make adjustments to budget spreadsheet for December Board meeting**

2020 Budget Format Details

- **"*" =** Signifies budget items that would need to go back to the Board for final approval prior to funds being expended in 2020
- **Green =** Carry over budget items approved in 2019 that will be expended in 2020
- **Purple =** New project proposal in MTP FE Portal category
- **Supplemental – MTP work:** New proposals to support MTP toolkit objectives. Aligns with candidate strategies developed at October 7th Board Retreat.
- **Board Information Forms:** Any new 2020 budget item is accompanied with a Board information form with additional details
- **All line items:** Considered up to amounts.

2020 and 2019 Budget Comparisons

Payment Category	2020 Budget	2019 Budget	Difference	Rationale
Operations & Projects (CDHD Account)	**$1,437,560**	$1,611,304	↓ $173,744	• Reduction in 1.0 FTE (Practice Facilitator) • Adjusted line items based on 2019 actuals
MTP Toolkit Work (FE Portal Account)	**$6,596,494**	$7,604,325	↓ $1,007,831	• Reduction in number of contractors and contract amounts • Decrease in WPCC Learning Community – variable payments • Includes any new proposals directly associated to MTP toolkit objectives
Supplemental – MTP Work (FE Portal Account)	**$550,000**	NA	↑$550,000	• These are staff project proposals that support MTP toolkit objectives (Health Equity and Capacity Building). • These proposals could be developed into additional candidate strategies for the Board to consider.
NCACH Reserves for Future ACH (FE Portal Account)	**$500,000**	NA	↑$500,000	• This is to allocate reserves to support NCACH operations into 2025.
Total	**$9,084,054**	$9,215,630	↓$131,576	

North Central Accountable Community of Health

2020 Budget

2020 Tribal Investment – *up to* $500,000

- Opportunity to support Colville Confederated Tribes' health improvement efforts and address significant health disparities in our region.
- Up-to estimate based on project ideas that have been submitted by CCT, or discussed with CCT leadership (still under development).
- Specific funding recommendations and project plans will be brought to the Board for final approval.

Community Information Exchange

CIE Definition:

An ecosystem comprised of multi-disciplinary network partners that use a shared language, a resource database, and technology platform to deliver enhanced community care planning.

Community Information Exchange

Funding a Community Information Exchange (CIE) Workgroup

Goal: create and implement a sustainable process and interconnected network of clinical systems and community-based providers of SDOH

2020 funding for Consulting and Technical Assistance Contract

- Up-to $50,000 for:
  - Support with CIE workgroup creation and partnership building
  - Blueprints and work plan for community engagement and process development
  - Comprehensive landscape assessment of systems and their relationships to tech vendors (past, current, potential)

Community Information Exchange

Potential Timeline

Dec 2019- Feb 2020—Workgroup Creation
Request funding for CIE Workgroup creation and recruitment strategies; set initial monthly meeting schedule; create Workgroup Charter with input from community members and ACH staff

Feb-Dec 2020—Building Year and Sustainability Planning
Recruitment of workgroup members in four-county region; select consultant for blueprint creation of CIE through 2021/2022; full landscape assessment of systems and their relationship to preferred tech vendors provider buy-in and marketing of workgroup intent; sustainability planning

2021—Full Scale Implementation
Integration of previously silo-ed EHR systems with preferred vendor(s) to include funding necessary API building activities; technical assistance; payments to preferred vendor(s) for met scope of work deliverables.

2022 and Beyond—Handoff
TBD depending on scope of NCACH post-MTP funding. Will need to create processes to maintain and fund TA needs and/or select new backbone organization to act as the administrator of TA or vendor contracts.

Community Information Exchange

Benefits

- Touches diagnosis points as identified by the board
- CIEs are currently at the forefront of the clinical-community linkage discussion
- Work alongside care coordination systems (such as the HUB) to serve non-Medicaid community member
- Matches projection of NCACH's role as addressing the SDOH in the 2nd half of the MTP and beyond
- HCA believes a CIE model is a top priority for care coordination in the State

Health Equity Innovation Fund

Regional fund to support health equity innovation in TRANSPORTATION and HOUSING

Goal: to support intentional health equity efforts (ex. policy development, outreach, translation, etc.)

- $450,000 allocated in 2020
- Open to all partners and sectors
- Could support the infrastructure-building needed for potential future NCACH capital investments.
- Potential to establish an multi-year or annual fund in years 2021 and 2022

Health Equity Innovation Fund

Funding Models

Community Investment Model	Traditional Grant with Collaboration Requirements
2020 • *Creation of an advisory group to be self-governed with NCACH support to develop the RFP geared toward housing and transportation* • *Group develops process, RFP, and marketing and communications strategy* • *450,000 distributed across 4 counties*	2020 • *RFP NCACH developed by ACH with partner input* • *Funding opened and disbursed* • *As required by RFP applicants work to convene a group of stakeholders to plan project work* • *450,000 distributed in 4 counties*
2021, 2022 • *Partnerships made in County or Counties funding in 2020 continue post-grant or,* • *Funding possible for multiyear funded projects* • *New strategies for HE across sectors* • *Internal evaluation of past funded projects*	2021, 2022 • *Partnerships made in County or Counties funding in 2020 continue post-grant or,* • *Funding possible for multiyear funded projects* • *New strategies for HE across sectors* • *Internal evaluation of past funded projects*

Health Equity Innovation Fund

Benefits

- Touches diagnosis points as identified by the board
- Adds a necessary building block for SDOH focus.
- Ability to help address local disparities in communities that will continue to exist in SDOH if HE is not intentionally built.
- Financially engaging communities currently addressing health equity to bolster efforts
- Addressing HE with specified funding will improve the health of all people in communities

Capacity Building Rapid Cycle Fund

Training-Specific Funding Stream

Goal: Support internal capacity building for community-based organizations through creating local partnerships (such as with SME who provide capacity building services) with whom to match NCACH SDOH dollars.

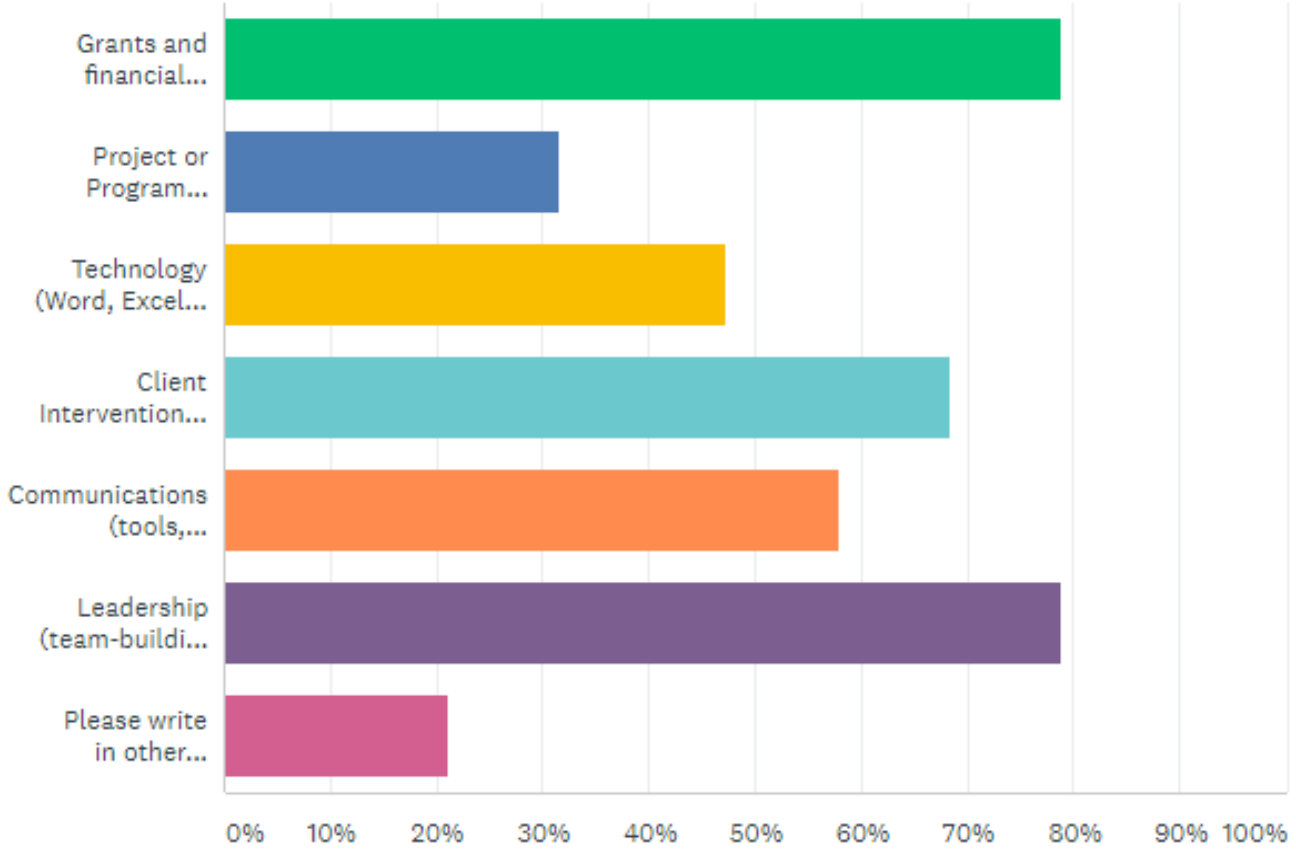
Early 2020—Focus on building partnerships and training programming; funded only disbursed if partnership building is successful

- 100,000 total allocation to support:
    - NCACH/Partner-Funded, CBO Hosted, Trainings
    - NCACH/Partner-Hosted Trainings in the Community

Capacity Building Rapid Cycle Fund

Training survey sent out to partners to assess:

- Scope: *see graph*
- Format: 90% for mix of tech-based, in-person
- Length: 80% want shorter, concise trainings
- Host-preference: 42% want ACH-hosted; 32% receive funding to train; 42% no preference



Capacity Building Rapid Cycle Fund

Benefits

- Touches diagnosis points as identified by the board
- Broadening the conversation around Trauma-Informed Care
- Synergize efforts

Operations and Projects (CDHD Account) Highlights

- **Changes from 2019:**
  - Salary & Benefits: ↓1.0 FTE in 2020
  - Drugs and Medicine: ↑ for additional Narcan Trainings (Part of Opioid Project – Plan to do additional Narcan trainings in 2020)
  - Overall, 12 Items saw a ↓ of up to 50% of 2019 budgeted amounts
    - Adjusted to closer align with 2019 actual expenditures.

Operations (FE Portal)

- **Program Management and Organizational Development:** Continued work with Chris Kelleher from Oregon Health and Science University
- **Program Evaluation:** Condensed down into one Budget line item in 2020
- **Feldsman Tucker Leifer Fidell LLP:** Budgeted to use for Behavioral Health Providers in 2020 (last year in budget)
- **Workforce Development (2020):** Funds reserved for a cohort of individuals to go through CDP apprenticeship when created

Whole Person Care Collaborative

Budget Line Item	Total Budgeted 2019	Total Budgeted 2020
Comagine (Coaching TA and SME)	$215,710	$50,000
Shift Results (Coaching TA)	$53, 820	-
CCMI - Advising	$186,000	$78,000
Learning Activities	$246,640	$280,000
CSI Portal and TA	$75,992	$36,000
Learning Community - fixed	$1,080,000	$1,080,000
Learning Community - variable	$2,080,000	$800,000
Grand Total	**$3,938,162**	**$2,324,000**

Pathways HUB

Assumptions

- Pathways HUB Staffing

2018	2019	2020	2021
2.4	2.8	3.5	4

- Pathways Community Specialists
  - **3** CSSA's per area (9 total)
  - **1** PCS's per CSSA (9 total)
  - **0.2** FTE Supervisor per PCS

- Areas Served
  - Moses Lake – October 2018
  - Wenatchee – October 2019
  - Omak – January 2020
- Active monthly clients 2020

Q1	Q2	Q3	Q4
196	252	308	392

- Percent expenses of HUB funding by other sources

2020	2021	2022	2023	2024
10%	20%	30%	65%	100%

Pathways HUB

5 Year Projections

	2018	2019	2020	2021	2022	2023	Total
In 2018	$380,000	$1,426,612	$1,526,957	$908,743	$302,914	$0	$4,545,234
In 2019	$380,000	$715,000	**$1,051,794**	$1,100,000	$1,100,000	$550,000	$4,971,794

Payment Categories

Pathways Community HUB Operations	$392,414
CCS Platform	$118,000
HUB CSSA Payments	$541,380
Total 2019 Pathways HUB Funding	**$1,051,794**

2020 TCDI Hospital Project

Partner Payment Type	Funding up to Amount
Transitional Care (Inpatient)	$25,000
ED Diversion	$25,000
Partnership with Community Partner	$15,000
Total (Each)	**$65,000**
Total Project (8 Organizations)	*$520,000*

2020 TCDI EMS Project

Payment Type	Funding up to Amount
NCECC Project Management	$20,000
Partner Funding Continuation of current EMS proposal work (With new goals Identified)	$215,000
Community Paramedicine Project Funds Partners who are ready to expand to a more robust Community Paramedicine model (4 providers - $40,000 each)	$160,000
Overall Total	**$395,000**

2020 CPTS Project

Recovery Coach Network

- Through the North Central Community Partnership for Transition Solutions, jail release has been identified as a point in time where there is a need for greater support to help individuals transition out of jail, reduce recidivism, and reintegrate into the community.
- We propose supporting a network of Recovery Coaches that would meet individuals at release to provide needed supports.

Expense	Amount
Contracted full-time Recovery Coach Network Coordinator (salary and benefits)	$60,000
Equipment, training, overhead, etc.	$10,000
Recovery Coach Stipends ($50/day; ~3-4 hr shift)	$54,750
Supports for clients (e.g. bus token, meals, clothing, etc.)	$5,250
TOTAL	**$130,000**

TCDI 2020 Budget

Payment Type	Funding Amount
TCDI Hospital Partner Payments	$520,000
EMS Partner Payments	$395,000
Training/Consultants Reserved funds for both EMS and Hospital partner TA	$65,000
Community Partnership for Transition Solutions (Recovery Coach Network)	$130,000
Total TCDI Budget	$1,110,000

2020 Opioid Workgroup Budget:

Prevention	Treatment	OD Prevention	Recovery	Strategy	Budget
■	■	■	■	Rapid Cycle Opioid Application	$100,000
■	■	■	■	North Central Opioid Response Conference – DCM	$15,000
■	■	■	■	Support Opioid Conference Site Teams and Follow-up	$80,000
■				Provide sector training opportunities (educators and coaches)	$15,000
■				Increase Awareness of Opioid Use and Addiction & Reduce Stigma	$30,000
■				School-based Prevention	$120,000
		■		Naloxone Training and Distribution	$20,000
			■	Recovery Initiatives and Events	$34,000
TOTAL					**$414,000**

North Central Accountable Community of Health

Governing Board Retreat

2020 Budget Spreadsheet & Discussion

North Central Accountable Community of Health

Board Information Form

TOPIC: ***2020 Budget - Tribal Investment for Colville Confederated Tribes***

PURPOSE: *To preview a new project/idea and funds allocation that staff would like to include in the 2020 Budget Proposal for Board Approval.*

Based on recent tribal engagement activities, staff propose allocating funds to support health improvement opportunities prioritized by the Colville Confederated Tribes in 2020.

BOARD ACTION:

☑ Information Only

☐ Board Motion to approve/disapprove

BACKGROUND:

As a sovereign nation, Colville Confederated Tribes (CCT) manages a complex tribal health services system despite significant underfunding[1]. Their system includes two tribally-operated community health centers (in Ferry County which is geographically part of another ACH), two Indian Health Service (IHS) clinics in Okanogan County, and tribal BH services. CCT's non-tribal health care partners operate in five different counties. CCT has reported significantly higher-than-average health disparities (compared to other non-American Indian/Alaska Native populations in the North Central region), and they are charging forward with health improvement investments including constructing a new Omak health facility, constructing a Substance Use Treatment Center in Keller, increasing capacity for Medication Assisted Treatment, and working on Tribal Behavioral Health Integration efforts with their Medicaid Transformation funding from HCA.

NCACH staff have recently revamped our strategy for engaging CCT as a partner in their work to improve health outcomes for residents of the North Central region. A staff group formed in August, including NCACH staff and the tribal representative from NCACH's Board, to work on aligning NCACH goals in support of CCT's priorities. Recent efforts include several meetings with leadership from CCT's Health and Human Services to better understand needs and opportunities for partnership and potential support from NCACH. Potential strategies identified from these meetings include:

[1] *"Tribal Sovereignty and Indian Health Care Delivery" – Jesse Dean, Washington State Health Care Authority, 2019 NCACH Annual Summit*

- Building capacity for much-needed Chemical Dependency Professional (CDP) staff, including use of a CDP apprenticeship program
- Supporting CCT human resource management as it relates to recruiting healthcare professionals
- Meeting training needs of CCT healthcare professionals (e.g. *The Golden Thread* approach in clinical document management and care)
- Supporting CCT's efforts to improve access to population health data

In addition to these ideas, NCACH has also increased our work with CCT departments through initiatives such as the *Okanogan Workforce Collaborative* and the *North Central Washington Opioid Response Conference: Pathways to Prevention*, hosted in March 2019. CCT and NCACH signed a memorandum of understanding in June 2019 to provide naloxone training and opioid overdose kits to the Tribe following the Opioid Response Conference. NCACH staff believe that many of these initiatives will provide continued opportunities for engagement and collaboration for the post-Medicaid Transformation Project period.

CCT has also submitted a Letter of Intent for the 2019 CHI Community Initiatives funding for $300,000 to support a variety of wellness and health initiatives for tribal members. Proposed strategies range from food access to traditional healing to chronic disease management skills for members. NCACH staff believe that investing in proposals that support the delivery of culturally-appropriate care while building local capacity are the best way to help close the gap in health disparities for AI/AN members across our region.

PROPOSAL:

Historically, promises outlined in treaties in the 1800's promised CCT hunting and fishing rights, as well as healthcare. These promises were not kept, resulting in the detrimental health disparities seen in CCT today. NCACH's Tribal Engagement Planning Team believes that a significant and sustained investment for our tribal partners is the best way to support their efforts to foster a system of interconnected, culturally-responsive, whole person health for members of the Colville Confederated Tribes. Providing opportunities for shared learning will build local capacity while respecting traditional modes of healing and closing the gap in our region's health disparities.

If approved, staff will work with tribal partners to identify strategies and develop scopes of work that meet the same criteria used for all MTP project plans and funding (e.g. demonstrated need, sustainability leading to lasting change/impact, etc). Like any other emerging initiative (per the Emerging Initiatives Guidelines Document approved by the Board in June 2018), the Board will be informed of all proposals. Specific funding

recommendations and an overview of projects tied to the *up-to* budget allocation will be brought to the Board for final approval per the Board's Decision Flow for Funding Design and Allocation.
IMPACT/OPPORTUNITY (fiscal and programmatic): NCACH has a unique opportunity to support CCT's health improvement efforts in order to address Tribal health disparities in our region.
TIMELINE: • December 2019: Board approves Tribal Investment funds • December 2019 and beyond: NCACH Staff continue working with CCT to identify strategies and develop scopes of work that meet the same criteria used for all MTP project plans and funding. • When available in 2020: Any specific funding recommendations and an overview of projects tied to this up-to budget allocation will be brought to the Governing Board for final approval.
RECOMMENDATION: NCACH staff recommends that NCACH invest *up-to* $500,000 in 2020 to support the Colville Confederated Tribes' health improvement efforts.

Submitted By:	**Tribal Engagement Team** (Linda Evans-Parlette; Molly Morris; Caroline Tillier; Christal Eshelman; Sahara Suval; Tanya Gleason)
Submitted Date:	10/25/2019
Staff Sponsor:	**Tribal Engagement Team** (Linda Evans-Parlette; Molly Morris; Caroline Tillier; Christal Eshelman; Sahara Suval; Tanya Gleason)

North Central Accountable Community of Health

Board Information Form

TOPIC: ***2020 Budget - Community Information Exchange Workgroup***

PURPOSE: *To preview a new project/idea and funds allocation that staff would like to include in the 2020 Budget Proposal for Board Approval.*

Staff propose allocating funding to create a Community Information Exchange (CIE) Workgroup to implement a sustainable process and interconnected network of clinical systems and community-based providers of SDOH.

BOARD ACTION:

- ☑ Information Only
- ☐ Board Motion to approve/disapprove

BACKGROUND:

Improvement in cross-sector linkages require approaches that improve access to preventive and medical care through connecting public health, health care, and community-based organizations and leveraging their individual and collective strengths. The Capacity Development and Grants Manager has been involved in conversations around CIE work for the last six months, collecting narrative data across the clinical and social service spectrum in order to secure a broad understanding of challenges to referrals and follow-up care as well as the challenges that NCW experiences in clinical to community linkages (i.e. Social Determinants of Health). The results of these conversations and data collection framed the solution, rather than circling around the problem, in that the broader service community wants a connected service network that can quickly exchange and track accurate referral information that can be integrated into current systems and workflows.

Definition—A CIE is an ecosystem comprised of multi-disciplinary network partners that use a shared language, a resource database, and an integrated technology platform to deliver enhanced community care planning. Our region has the benefit of already working toward a common language for health care change, as the NCACH has been a catalyst for uniting sectors and working toward bidirectional information exchange since its inception.

CIEs are currently at the forefront of the clinical-community linkage discussion across ACHs and are being considered as effective interventions that work alongside care coordination systems (such as the HUB) to serve non-medicaid community members. The CDGM is currently communicating with Greater Columbia ACH to potentially create a peer-based group for CIE challenges and approaches in rural communities as strategies for effective implementation vary greatly across the state.

In addition, HCA is aware of, and supportive of, the CIE model as a way to unify healthcare systems and processes across all ACH regions in Washington State, however, very limited information is available on where the HCA will go with the discussion in terms of concrete steps.

PROPOSAL:
This is a proposal to allocate an initial investment of up to $50,000 for 2020 consultant costs to create and maintain a CIE Workgroup to inform and implement a regional information and service highway by the end of the MTP.

IMPACT/OPPORTUNITY (fiscal and programmatic):
CIEs operate under the guidelines of the Collective Impact Approach, which serves to unite people, systems, and processes in a shared vision and focus to solve the issue at hand. In this way, CIE efforts have the ability to positively affect most, if not all, of the diagnoses as identified at the Governing Board retreat on 10.7.19. In addition, a CIE model can work synergistically with Pathways HUB and Health Homes, while addressing silos and redundancy.

This allocation of up to $50,000 for the CIE Workgroup in 2020 will allow NCACH to bring in experts of the CIE model to help facilitate the merger of systems previously seen as competitive despite relatively similar functionality with the purpose of addressing SDOH (e.g technologies such as EHRs and off-the-shelf referral platforms, internal processes, org-specific resource lists). With the current projection of NCACH's role as addressing the SDOH in the 2nd half of the MTP, our organization exists in a critical opportunity zone to assist in getting partners to the table to work toward a truly integrated system of care.

TIMELINE:

Dec 2019- Feb 2020—Workgroup Creation

- Request funding for CIE Workgroup creation and recruitment strategies; set initial monthly meeting schedule; create Workgroup Charter with input from community members and ACH staff

Feb-Dec 2020—Building Year and Sustainability Planning

- Recruitment of workgroup members in four-county region; convene and begin monthly meetings; select consultant for blueprint creation of CIE through 2021/2022; strategize around steps indicated in the prior blueprint; full landscape assessment of systems and their relationship to preferred tech vendors (such as Julota, an under-the-hood functionality builder); provider buy-in and marketing of workgroup intent; sustainability planning

2021—Full Scale Implementation

- Integration of previously silo-ed EHR systems with preferred vendor(s) to include funding necessary API building activities; technical assistance; payments to preferred vendor(s) for met scope of work deliverables.

2022—Handoff

- TBD depending on scope of NCACH post-MTP funding. Will need to create processes to maintain and fund TA needs and/or select new backbone organization to act as the administrator of TA or vendor contracts.

RECOMMENDATION:

In order to further the discussion and convene key partners in creating an effective, efficient, interconnected, and adequately resourced community, staff recommends the funding of consultant costs to assist in the creation of a CIE Workgroup meant to collectively address the issue and implement a truly regional approach.

Submitted By: Tanya Gleason, NCACH Capacity Development/Grants Manager
Submitted Date: 11/04/2019

North Central Accountable Community of Health

Board Information Form

TOPIC: ***2020 Budget - Health Equity Innovation Fund***

PURPOSE: *To preview a new project/idea and funds allocation that staff would like to include in the 2020 Budget Proposal for Board Approval.*

Staff propose the creation of a Health Equity Innovation Fund to invest in regional health equity innovation around transportation and housing.

BOARD ACTION:

- ☑ Information Only
- ☐ Board Motion to approve/disapprove

BACKGROUND:

A truly equitable health system ensures that all people have access to quality, culturally competent, appropriate, and individualized care across the care spectrum. The momentum from NCACH's 2018 Summit helped to broaden the discussion for our providers and community partners on Health Equity as a necessary part of health care in terms of outcomes and challenges and has paved the way for NCACH to more intentionally embed Health Equity principles in its operations, communications, and funding development. Additionally, the summit prompted staff to revisit feedback from the multiple focus groups and community conversations around the organization's focus on SDOH, seeing this work through a more intentional equity lens.

As the board considers NCACH's future state, working concomitantly on SDOH, specifically transportation and housing, as well as health equity would be valuable. Health Equity as a priority moving forward into 2019 and beyond will ensure a high-quality and comprehensive focus on all SDOH-focused efforts by our organization.

As an info-only proposal, there is ample time to bring this back to the board, amending the budget to take into account underspending that could occur in 2020.

PROPOSAL:

While health equity and SDOH are inseparable parts of the same whole, it is necessary to intentionally build an equitable system through targeted health equity processes, policies, and an open feedback loop between the community and the healthcare provider.

Given that no NCACH staff are true subject matter experts on housing and transportation solutions, the Health Equity Innovation fund could help NCACH fund local and regional

health equity initiatives to support under-funded equity work in NCW. Funding would be open to all partners and sectors to advance health equity work in whatever is defined as most impactful by communities, for communities, and would support the necessary infrastructure-building needed for potential future NCACH capital investments.

The Health Equity Innovation Fund could be a unique opportunity to directly and incrementally invest in health equity support strategies as the building blocks of an overall SDOH focus. As of this date, the proposed funding would only be for the 2020 calendar year with potential to establish an annual or multi-year funding process in years 2021 and 2022. If approved, this fund could be created and administered in one of the following ways:

Option 1—Community Investment Process

2020

- Creation of an advisory group to be self-governed with NCACH support to develop the RFP geared toward housing and transportation
- Group develops process, RFP, and marketing and communications strategy
- $450,000 distributed across 3 counties

2021, 2022

- Partnerships made in County or Counties funded beyond 2020
- Funding possible for multiyear funded projects
- New strategies for health equity across sectors
- Internal evaluation of past funded projects

Option 2—Traditional Grant with Collaboration Requirement

2020

- RFP NCACH developed by ACH with partner input
- Funding opened and disbursed
- As required by RFP, applicants work to convene a group of stakeholders to plan project work
- $450,000 distributed across 3 counties

2021, 2022

- Partnerships made in County or Counties funded beyond 2020
- Funding possible for multiyear funded projects
- New strategies for HE across sectors
- Internal evaluation of past funded projects

IMPACT/OPPORTUNITY (fiscal and programmatic):

Health equity is a core tenet of addressing the SDOH. The impact of a dedicated Health Equity Innovation Fund, as it has the capability to address local disparities in communities, is wide reaching. Financially, engaging new partners that are currently addressing health equity

through a more focused or under-resourced model has the potential to make a difference in the short and long term.
TIMELINE: **2020—**Partnership building, process creation, community-buy in; marketing and promotion. If approved and successful, this fund could be well suited to multi-year projects if requested by community partners OR re-allocated for new projects moving into 2021 and 2022. No determinations have been made about timeline past 2020, just projections of impact as evidenced by like-projects.
RECOMMENDATION: NCACH staff recommends an allocation of $450,000 for 2020 for the Health Equity Innovation Fund, to fund organizations across NCW to advance equitable solutions to transportation and employment.

Submitted By: Tanya Gleason, NCACH Capacity Development/Grants Manager
Submitted Date: 11/04/2019

North Central Accountable Community of Health

Board Information Form

TOPIC: 2020 Budget - Capacity Building Rapid Cycle Fund
PURPOSE: *To preview a new project/idea and funds allocation that staff would like to include in the 2020 Budget Proposal for Board Approval.* *Staff propose creating local partnerships (such as with local entities who provide capacity building programming) for matching NCACH SDOH dollars to support internal capacity building for community-based organizations. This would create a synergistic collaborative relationship, bolstering current capacity-building efforts, and help NCW become known as a region of excellence around topics identified by the community.*
BOARD ACTION: ☑ Information Only ☐ Board Motion to approve/disapprove
BACKGROUND: Through community conversations, coalition work, and qualitative data collection, NCACH has identified local trainings needs across the region. As of 9/27/19, 19 people have responded to the community-based training survey sent to our broad three-CHI stakeholder list. Though many training needs were identified, the greatest number of responses were for trainings around grants and financial mgmt., communications, and leadership training, tools that are imperative for healthy, thriving organizations and their boards. NCACH-sponsored efforts are only one piece of the puzzle when it comes to understanding the most important capacity challenges to our region and we cannot do it alone. Though partnership discussions have not yet happened, potential to collaborate is seen in local Subject Matter Experts vested in strengthening North Central Washington nonprofit and the community. It is not necessary to reinvent the wheel. NCACH dollars can meaningfully do the greatest good in a collaborative venture, paired with institutions that currently do, and will continue to do, important capacity building work in NCW.
PROPOSAL: Create formal partnership with local capacity-focused organizations or entities, and allocate $100,000 for a Capacity Building Rapid Cycle Fund to serve community-based organizations.

IMPACT/OPPORTUNITY (fiscal and programmatic):
NCACH has the unique opportunity to be the fulcrum for capacity improvement across all partner groups. Capacity building for NCW requires a multi-tiered approach to meet the differing needs across NCW's partners. As NCACH works to assist clinical systems in the transition to value-based payment, it is clear that also focusing on the fundamentally different needs of community-based organizations to better equip the nonprofit workforce will also be a measure of success for NCACH, especially as NCACH thinks about its future state addressing the SDOH.

This funding is an innovative opportunity to meaningfully invest in our communities while limiting administrative burden. Probable benefits of this fund could include, but aren't limited to:

- The potential to touch all diagnosis points as identified by the board at the October 2019 board retreat, especially around combining of funding sources to contribute more robustly to a thriving network of CBOs doing front-line work around the SDOH.

- Broadening the conversation around Trauma-Informed Communities and Community Resilience models through drawing in major players in community investment and strategic sustainability efforts.

- Enabling NCACH and potential partner funds to operate greater than the sum of their parts, expanding both the breadth and scope of training or information that may have lacked necessary funding (SME, rural health experts, etc.).

If approved, it would be preferable to break out this funding two ways:

$50,000 NCACH/Partner-Funded, CBO-Hosted Trainings
Up to 2k will be offered through a simple RFP process, for roughly 25 total awards in 2020

Eligibility

- Funding will not be limited to organizations according to size or scope, however preference will be given to orgs that focus on or primarily refer to SDOH.

$50,000 NCACH/Partner-Hosted Trainings in the Community
A collaborative creation and/or coordination of a targeted menu of free or low-cost, community-based trainings focused on a variety of topics such as inclusivity, leadership, communications, technology, or client interventions.

POTENTIAL TIMELINE:

- **2019—Funding Allocation Approved**
  Request necessary capacity building funding for internal trainings for currently unfunded partners and/or currently non-NCACH engaged community-based organizations

- **Early 2020— Formal Partnership Agreement:** partnership building and priority alignment; contract development to include scope of work and deliverables
- **Mid-Late 2020—RFP development and review; award**
- **Late 2020-Early 2021—Evaluation of goals and impact of the program.**

RECOMMENDATION:
NCACH staff recommends an allocation of $100,000 from the Board to fund currently identified training needs for organizations in two potential funding pots:

$50,000 NCACH/Partner-Funded, CBO Hosted, Trainings
$50,000 NCACH/Partner-Hosted Trainings in the Community

Submitted By: Tanya Gleason, NCACH Capacity Development/Grants Manager
Submitted Date: 11/04/2019

North Central Accountable Community of Health

Board Information Form

TOPIC: ***2020 Budget – Community Partnership for Transition Solutions (CPTS)***

PURPOSE: *To preview a new project/idea and funds allocation that staff would like to include in the 2020 Budget Proposal for Board Approval.*

Staff propose allocating funds to support a CPTS initiative; the formation of a Recovery Coach Network that would promote successful reentry for individuals transitioning from incarceration.

BOARD ACTION:

- ☑ Information Only
- ☐ Board Motion to approve/disapprove

BACKGROUND:

During the summer of 2019, members of the Community Partnership for Transition Solutions (CPTS) engaged in strategic planning. This involved identifying existing resources and gaps for people reintegrating into their communities after a period of incarceration, and selecting Action Items that CPTS members could drive forward to address gaps. Seven Action Items were identified by the group. The CPTS Action Plan is currently being finalized and will be shared with the Board in December.

Support for individuals immediately upon release, which is typically at 5AM, was identified as a key need. Individuals need to take critical steps at release in order to promote their successful transition back to the community; **navigating these steps alone is a significant challenge**.

The recovery community in North Central Washington is growing and gaining momentum, and NCACH can leverage our existing relationship with this grassroots movement to meet this critical need. In October, through the Opioid Project, NCACH sponsored the training of 17 Recovery Coaches, who also became certified Recovery Coach Trainers (which means they will be able to grow the capacity for additional recovery coaches locally). Since a majority of people experiencing incarceration have struggled with mental health and/or addiction issues, Recovery Coaches are well poised to provide support at release and post-release.

PROPOSAL:

NCACH has an opportunity to help develop and pilot a Recovery Coach Network in North Central Washington, which could support a number of CPTS action plan goals. Funding primarily would support a full-time Recovery Coach Network Coordinator and stipends for Recovery Coaches providing peer support on a per diem basis. This pilot would give our

community a chance to demonstrate impact and outcomes. If proven successful, other CPTS partners have indicated that they would consider sustaining the program.

IMPACT/OPPORTUNITY (fiscal and programmatic):
There is an opportunity for NCACH to pilot an innovative program that will address a unique challenge for individuals released from incarceration. Supporting this program would also address several objectives of the Medicaid Transformation, including workforce development, transitional care, diversion interventions, and addressing the opioid epidemic. There is substantial community and stakeholder support through the Community Partnership for Transition Solutions and the Central Washington Recovery Coalition.

Funding and piloting a coordinated recovery coach network could be a game changer. A tentative budget for the pilot is as follows:

Expense	**Amount**
Full-time Recovery Coach Network Coordinator (salary and benefits)	$65,000
Equipment, training, overhead, etc. (~15%)	$10,000
Recovery Coach Stipends ($50/shift)	$54,750
Supports for clients (e.g. bus passes, meals, clothing, etc.)	$5,250
Total	**$130,000**

TIMELINE:

- December – Board budget Approval
- January-February – Selection of lead agency
- March-May – Hire Recovery Coach Network Coordinator, establish network, develop procedures with the County Jail(s), select metrics to track
- June – Begin services and track metrics
- December – Annual report on program

RECOMMENDATION:
NCACH staff recommends an allocation of $130,000 for 2020 to form a Recovery Coach Network. Community Partnership for Transition Solutions has endorsed this proposal. In accordance with NCACH's Emerging Initiatives guidelines, this proposal will be presented to the TCDI Workgroup in November for approval and inclusion in the 2020 TCDI Workgroup Budget.

Submitted By: Community Partnership for Transition Solutions
Submitted Date: 11/04/2019
Staff Sponsor: Christal Eshelman

October 2019 NCACH Board Retreat
Summary and Proposed Actions

Background

At its January retreat, the NCACH Governing Board began an evaluation of the organization's future. Members reached consensus at the meeting that the ACH should continue to operate after the end of the Medicaid Transformation Project (MTP).

In July, the Board and staff completed surveys that assessed potential future configurations. At that month's retreat, the Board reached broad agreement that the future ACH should address the social determinants of health. Many important questions remained unresolved, however, including the precise mission of the post-MTP organization and the approach that would be used for strategic planning.

Board members completed a second survey in September that aimed to elicit opinions about the ACH's future directions and to establish criteria for evaluating candidate strategies. The survey results guided the Board's October 7th retreat, which was facilitated by Chris Kelleher.

At the outset of the discussion, the Board agreed to a baseline assumption that it would create a workgroup (hereafter identified as the Strategy Workgroup) to analyze candidate strategies and develop proposals for Board review.

This document summarizes the results of the retreat and presents a series of proposed next steps.

Criteria

Survey Results

To promote consistency in decision making, each Board member had the opportunity to rank twelve proposed criteria in order of preference. The results of the ranking exercise are presented below. Because members ranked criteria from 1 to 12, with 1 being the highest, *a lower score meant a better ranking.*

Criteria: Survey Results

Rank	Proposed Criteria	Score
1	To make a meaningful impact on the social determinants of health and health equity	29
2	To promote sustainable change, rather than fleeting investments	30
3	To connect partners and encourage information sharing	52
4	To advocate for and drive system change	56
5	To strengthen the engagement of marginalized groups	57
6	To be developed into a region wide agenda	60
7	To fill a gap needed in the community (value added)	67

8	To improve clinical-community connections	69
9	To leverage state initiatives and existing partnerships with state agencies	79
10	To generate sustained support from philanthropic funders	86
11	To support the needs of social service organizations	91
12	To support the needs of health organizations	104

Criteria Selection

The facilitator reviewed these results with the Board and initiated a discussion to select approximately four criteria that would guide future decision making. Because two criteria scored much better than other choices, they were presumed to be selected. The facilitator put aside the six criteria with the worst scores. The Board's discussion thus focused on four "finalists" (i.e. those criteria that ranked 3-6 on the survey).

The Board elected to drop the proposed criteria "to advocate for and drive system change," deeming that it was more of a method for achieving aims than a criteria for evaluating choices. Most of the remaining discussion focused on the proposed criteria "to strengthen the engagement of marginalized groups." In the end, members agreed that there was significant risk that the goal would be neglected in practice if it were not applied as a core criteria. The following five criteria were therefore selected:

Criteria Adopted by the Board

Rank	Proposed Criteria	Score
1	To make a meaningful impact on the social determinants of health and health equity	29
2	To promote sustainable change, rather than fleeting investments	30
3	To connect partners and encourage information sharing	52
5	To strengthen the engagement of marginalized groups	57
6	To be developed into a region wide agenda	60

It is important to note those proposed criteria that were *not* selected for prioritization by the Board. Their omission represents a statement of values. To maintain focus and consistency, they should not be applied as criteria when making strategy decisions.

Proposed Criteria Not Adopted

Rank	Proposed Criteria	Score
4	To advocate for and drive system change	56
7	To fill a gap needed in the community (value added)	67
8	To improve clinical-community connections	69
9	To leverage state initiatives and existing partnerships with state agencies	79
10	To generate sustained support from philanthropic funders	86

11	To support the needs of social service organizations	91
12	To support the needs of health organizations	104

Criteria → Vision

In selecting five criteria (and *not choosing* seven others), the Board has identified its guiding principles.

> North Central ACH is dedicated to developing a region-wide agenda focused on the social determinants of health and health equity. It prioritizes promoting sustainable change, rather than fleeting investments, and seeks to connect partners, increase information sharing, and strengthen the engagement of marginalized populations.

These criteria should inform the evaluation and selection of strategies for NCACH to focus on, which will ultimately shape NCACH's future mission and vision.

Discussion

Pre-Retreat Discussion

On the September survey, Board members responded to a number of open-ended questions. The responses have been collated in the attached document.

Mission

At its July retreat, the Board sketched a preliminary mission statement: "A regional Coalition for all community health influences, primarily intended to enable or facilitate action on the social determinants of health and the things that contribute to the sustainability of the rural system of care."

The Board revisited the statement on October 7th. There was agreement that facilitating action on the social determinants of health (SDoH) should be central to NCACH's mission. Discussion focused on whether "contributing to the sustainability of the rural system of care" should be an equivalently weighted goal or whether it should be seen as an *effect* of achieving success in addressing SDoH. The group arrived at a rough consensus in favor of the latter.

Strategy Development

Philosophy

The Board discussed strategic philosophy and agreed on additional principles:

- Because problems associated with the social determinants of health are large and deeply entrenched, and because NCACH's resources are comparatively modest, it is essential that the organization focus its efforts on one or two points where it has optimal leverage.
- There are many useful things that *could* be done, but the ACH must exercise discipline and avoid "something for everyone" plans that divide its attention and dilute its resources.

- It is not practical to follow one strategy for the remainder of the MTP period and then switch to a different strategy when the MTP ends. Success requires developing a coherent long-term plan that begins during the MTP and follows a glide path into the post-MTP period.
    - Activities required by the MTP must continue as core functions, but they are not strategies by themselves
    - In budget planning, the Board should distinguish between funds that have been allocated and those that have not (regardless of whether they are currently earned or unearned)
    - Unallocated funds can (i) be assigned to meet near-term needs or (ii) be invested in long-range strategies, with the understanding that funds spent on immediate needs will not be available for long-range strategic investment.

Candidate Strategies

The Board developed a set of candidate strategies that will be subjected to rigorous "pressure testing" by the Strategy Workgroup. Each candidate strategy was constructed in three parts:

- Diagnosis
    - Identify the critical driver(s) of success or failure in one or more social determinants of health
        - May be a persistent obstacle
        - May be an unrealized opportunity
- Distinct Advantage
    - Identify an advantage that NCACH possesses (or could possess) that is directly relevant to the diagnosis
        - Is there a unique skill or capacity NCACH possesses?
        - What is NCACH able to do that no one else can?
        - Is there a distinct point of leverage that NCACH can exploit?
- Policy
    - Identify a policy that uses NCACH's distinct advantage(s) to address the diagnosis

Candidate Strategies Specified by the Board

Candidate Strategy 1: Housing

- **Diagnosis:** Lack of housing stock and capacity due to a lack of incentive funds for capital investments in housing
- **Distinct NCACH Advantage(s)**:
    - Ability to leverage current transformation project funds for matching grants
    - Resources to gather the data needed to evaluate where this work would be most beneficial
    - Capacity to research evidence-based approaches
    - Ability to convene the correct partners

- **Policy:** Leverage current MTP funds to bring in matching dollars and bring partners together to develop a joint grant processes.
    - This model would require those agencies to have an operational plan and funding stream to make the work sustainable.

Candidate Strategy 2: Respite Housing

- **Diagnosis:** The region lacks an articulated strategy on how to create respite housing for those individuals who are interacting with healthcare and have no place to transition into.
- **Distinct NCACH Advantage(s):**
    - Multi-Sector Convening group that involves both healthcare and community-based partners.
        - Partners have the relationships and data available to identify and connect with those individuals who need these services.
    - Expertise in grantsmanship and raising funds.
- **Policy:** Organize and convene the appropriate entities to identify a model that can be utilized in the region and play a leadership role in securing funding.

Candidate Strategy 3: Transportation

- **Diagnosis** The regional transportation system is deficient due to underfunding, lack of cost effectiveness, and lack of a regional vision.
- **Distinct NCACH Advantage(s):**
    - Ability to act as a convener.
    - Capacity to develop models to address problems and replicate those models.
    - Ability to act as a funder.

  Policy: Convene appropriate subject matter experts to assess regional needs and opportunities in order to develop a viable model (including identifying capacity and funding).

Candidate Strategy 4: Community Based Care Coordination Expansion

- **Diagnosis:** Many residents of the region live in poverty and are unable to access the available supports to help them address their social determinants of health.
- **Distinct Advantage(s):**
    - Knowledge and expertise related to accessing supports
        - Already developing a model (Pathways Hub) that provides care coordination to patients.
- **Policy:** Review opportunities to expand care coordination strategies to additional populations and develop a team of navigators in the region to connect people to the supports they need.

Strategy 5: Community Information Exchange

- **Diagnosis:** Information on services in our region is fragmented and when an individual is referred to services, it is hard to ensure that connection was made and get confirmation that a positive outcome occurred.
- **Distinct Advantage(s):**
    - Funding that could be used to start a better system for connecting patients to social service providers.
    - Expertise and experience in this issue.
    - Ability to bring both payers and providers to the table.
- **Policy:** Utilize the current structure of the ACH to bring the appropriate individuals together to evaluate to create a CIE and develop the process to make this system sustainable in the future.

Candidate Strategy 6: Leverage Funding for SDOH Work

- **Diagnosis:** Partners currently do not have the necessary processes, expertise, or capacity to identify available funding streams and successfully pursue them.
- **Distinct Advantage(s):**
    - Expertise in grantsmanship and raising funds.
    - Ability to convene partners in the region.

  Policy: Establish clearinghouse for grants coming into this region and provide technical assistance to partners to help them apply for funds and maximize their impact.
    - Could include developing a funders roundtable.

Candidate Strategy 7: Addressing Adverse Childhood Experiences

- **Diagnosis:** It is hard to truly improve the social determinants of health if we are not first to identify and address adverse childhood experiences (ACEs).
- **Distinct Advantage(s):**
    - Expertise in this area.
    - Ability to bring the appropriate partners together.
    - Funds that could be used to initiate the work.
- **Policy:** Develop and steer implementation of a model for addressing ACEs via an evidence-based program like home visiting.

Proposed Action ▶ Because there may be promising strategies that were not identified on October 7th, Board members and staff should be encouraged to submit additional candidates using the format presented above. If additional strategies emerge during the Strategy Workgroup's work, they also should be considered.

Proposed Action ▶ The Strategy Workgroup should evaluate candidate strategies by assessing the following:

- The degree to which they can satisfy the five Board-selected criteria
- The evidence base for (and against) the identified diagnosis and proposed policy
- The practical viability of the proposed policy, including . . .
    - The clarity and feasibility of the presumed mechanisms of action
    - The availability of required expertise
    - The business case for the strategy (if applicable)

Next Steps

Strategy Workgroup

The Board agreed to create a workgroup and charge it with evaluating candidate strategies, drafting documents, etc. The Board did not have time to determine how the workgroup should be constituted or what its specific charges should be.

Unresolved questions include:

- Who should sit on the workgroup.
    - Multiple Board members advocated for the inclusion of SDoH domain experts
- How long the workgroup should operate and what its pace of work should be
    - There was disagreement about urgency.
        - Some Board members felt that strategic investments need to be initiated early in 2020, meaning that the workgroup should complete its work quickly.
        - Others argued that there is no rush and that a more deliberate pace would be appropriate, given the complexity and importance of the subject.
- What the workgroup's rules of operation should be.
- Whether it would be better to form multiple workgroups, each focused on a specific domain.

Proposed Action ▶ The Board should . . .

- Select members for the Strategy Workgroup
    - Or multiple workgroups if that method is adopted
- Give the workgroup a charge, including
    - An overall deadline (if any)
    - A schedule for reporting to the Board
    - Guidelines for developing business cases, evaluating evidence, etc.
    - Rules for assessment, deliberation, and voting

- Define staff responsibilities vis à vis the workgroup
    - Because workgroup members can't be expected to devote large amounts of time to the work, most heavy lifting will presumably fall to the staff, and those expectations should be defined.
    - Potential responsibilities include . . .
        - Researching evidence
        - Researching implementation requirements
        - Developing financial models
        - Preparing documents and reports

North Central Accountable Community of Health

Governing Board Meeting

Strategic Planning Update

October Board Retreat Strategic Planning Discussion

- Board members focused on the following items:
  - Discussing key themes of NCACH Mission/Vision
  - Identifying criteria to apply to Candidate Strategies
  - Developing potential Candidate Strategies

- The retreat did not allow time to dig into next steps of the Strategy Workgroup. This still needs to be determined by the Board.

NCACH Mission/Vision – Key Takeaways

- At its July retreat, the Board sketched a preliminary mission statement:

  "A regional coalition for all community health influencers, primarily intended to enable action on the social determinants of health and the sustainability of a well-functioning rural system of care."

- The Board revisited the statement on October 7th:
  - There was agreement that facilitating action on the social determinants of health (SDoH) should be central to NCACH's mission.
  - Discussion focused on whether "contributing to the sustainability of the rural system of care" should be an equivalently weighted goal or whether it should be seen as an *effect* of achieving success in addressing SDoH. The group arrived at a rough consensus in favor of the latter.

Criteria Adopted by Board

- Board discussed 12 proposed criteria for evaluating any future strategies of the organization
- 5 criteria were selected

Rank	Proposed Criteria
1	To make a meaningful impact on the social determinants of health and health equity
2	To promote sustainable change, rather than fleeting investments
3	To connect partners and encourage information sharing
5	To strengthen the engagement of marginalized groups
6	To be developed into a region wide agenda

Criteria Adopted by Board → Vision

- In selecting five criteria (and *not choosing* seven others), the Board has identified the following guiding principle:
    - North Central ACH is dedicated to developing a region-wide agenda focused on the social determinants of health and health equity. It prioritizes promoting sustainable change, rather than fleeting investments, and seeks to connect partners, increase information sharing, and strengthen the engagement of marginalized populations.
- These criteria should inform the evaluation and selection of strategies for NCACH to focus on, which will ultimately shape NCACH's future mission and vision.

Candidate Strategies

- Board identified 7 Candidate Strategies
- Focus Areas include *(details in report)*:
  - Housing, Transportation, Community Based Care Coordination, Community Information Exchange, Grant Funding, and Adverse Childhood Experiences
- Each candidate strategy was constructed in 3 parts:
  - Diagnosis
  - Distinct Advantage
  - Policy

Candidate Strategies - *Proposed Action* ▶

1. Board members and staff should be encouraged to submit additional candidates using the format presented.
    - If additional strategies emerge during the Strategy Workgroup's work, they also should be considered.

2. The Strategy Workgroup should evaluate candidate strategies
    - The degree to which they can satisfy the five Board-selected criteria
    - The evidence base for (and against) the identified diagnosis and proposed policy
    - The practical viability of the proposed policy

Next Steps - Strategy Workgroup

1. The Board agreed to create a workgroup and charge it with evaluating candidate strategies, drafting documents, etc.

2. The Board did not determine how the workgroup should be constituted or what its specific charge should be.

Strategy Workgroup – Remaining Questions

Questions for the Board to discuss:

1. Who should sit on the workgroup?
2. How long should the workgroup operate and what should its pace of work be?
3. What should the workgroup's rules of operation be?
4. Would it be better to form multiple workgroups, each focused on a specific focus area?

Strategy Workgroup - *Proposed Action ▶ The Board Should….*

1. Select members for the Strategy Workgroup
   - Or multiple workgroups if that method is adopted
2. Give the workgroup a charge, including
   - An overall deadline (if any)
   - A schedule for reporting to the Board
   - Guidelines for developing business cases, evaluating evidence, etc.
   - Rules for assessment, deliberation, and voting
3. Define staff responsibilities vis à vis the workgroup
   - Most heavy lifting will presumably fall to the staff, and those expectations should be defined.
   - Potential responsibilities include . . .
     - Researching evidence
     - Researching implementation requirements
     - Developing financial models
     - Preparing documents and reports

North Central Accountable Community of Health

Board Decision Form

TOPIC: *2019 Opioid Project Plan Strategies*

PURPOSE: *Allocate remaining 2019 Opioid Project funding*

BOARD ACTION:

☐ Information Only

☑ Board Motion to approve/disapprove

BACKGROUND:

Within the Board approved 2019 Opioid Project Plan, there was $33,000 of unallocated funding, reserved for unexpected initiatives. In addition to the unallocated funding, the Opioid Project is currently $10,826 under budget.

Through discussion during the August Opioid Workgroup meeting, a need was identified to provide high opioid prescribers with one-on-one technical assistance to reduce their prescribing to within recommended guidelines. Based on the discussion, Physician & Healthcare Consulting (Dr. Julie Rickard) submitted a proposal to perform an assessment to verify the need for this type of technical assistance, and if there is an indicated need, provide education, outreach, and coaching to high-volume prescribers.

During the September Governing Board meeting, the Board requested that staff conduct the needs assessment prior to approving the funding allocation. Based on claims data recently received from the Health Care Authority (HCA), the NCACH region includes:

- 31 prescribers who have 3 or more patients with >90 Morphine milligram equivalents/day. (measurement period: July 2018 – June 2019)
- 20 prescribers who have 5 or more opioid naïve patients 20 years and younger who received more than a 3 day supply. (measurement period: Oct 2018 – June 2019)
- 34 prescribers who have 5 or more opioid naïve patients 21 years+ who received more than a 7 day supply. (Oct 2018 – June 2019)

The 78 unique prescribers who fall into one or more of the above criteria demonstrate a need for technical assistance.

Attachments for the Board:

- Proposal from Physician & Healthcare Consulting
- Resume of Dr. Julie Rickard

PROPOSAL:
Motion to allocate **up to** $44,000 to contract with Physician & Healthcare Consulting to provide education, outreach, and coaching to high-volume opioid prescribers to help them identify issues contributing to their prescribing habits and get their prescribing practices more normalized relative to their peers.

Note: Dr. Rickard's original proposal included a needs assessment. Since the assessment has now been completed, funding would solely support outreach, education and coaching activities.

IMPACT/OPPORTUNITY (fiscal and programmatic):
In May, NCACH organized a conference for dentists which included best practices around opioid prescribing. To date, however, NCACH has not provided targeted technical assistance directly addressing opioid prescribing. Ensuring that providers are following prescribing guidelines would support efforts of our Whole Person Care Collaborative and Transitional Care and Diversion Interventions Workgroup partners.

Through targeted technical assistance, we have an opportunity to positively impact prescribing practices for providers who fall outside of prescribing guidelines. Because not all prescribers may be willing to accept coaching, sensitive outreach will be critical. To promote use of funds on education and coaching (and not just outreach), the contract will be structured to incentivize time spent on coaching.

The contract will be an up to amount rather than a predetermined amount. If there is limited engagement by prescribers, the funds will not be fully utilized. In addition, NCACH staff will meet with the consultant on a monthly basis to review outreach attempts, coaching engagement, and coaching completion. Upon contract execution, metrics will be developed to track success in engaging prescribers in coaching, coaching completion, and changes in prescribing patterns.

If funded, the Opioid Workgroup will remain within its planned budget of $300,000 for 2019 (though some of the funds will be expended in 2020).

TIMELINE:
NCACH staff will contract for this work soon after approval by the Governing Board. Given the sensitive nature of this work, it may take time to build relationships with high prescribers and get them to be open to coaching. Once engaged, it is estimated that the coaching time required will be 5-10 hours per provider. Including time for outreach and engagement, we estimate that this contract would provide for 10 hours of coaching for approximately 15 prescribers. While it is difficult to predict, it is estimated that the coaching will be completed in ~6 months with additional follow-up on prescribing patterns for those who received technical assistance in order to gauge success.

- December – Contract development and execution
- January – Launch initiative
- January – June – Outreach, education, and coaching provided; monthly meetings with consultant and NCACH staff.
- July-December – Tracking and reporting prescribing patterns of those that received coaching.

RECOMMENDATION:
NCACH staff (WPCC Manager, TCDI Project Manager, and Opioid Project Manager) along with the Opioid Workgroup recommend supporting the allocation of funding for education, outreach, and coaching targeted towards high opioid prescribers.

Submitted By:	Regional Opioid Stakeholders Workgroup
Submitted Date:	11/04/2019
Staff Sponsor:	Christal Eshelman

North Central Accountable Community of Health

Board Decision Form

TOPIC: Revision to the WPCC Stage 2 Funding Framework

PURPOSE: To adjust the funding framework to meet the evolving needs of the WPCC Learning Community.

BOARD ACTION:

- ☐ Information Only
- ☑ Board Motion to approve/disapprove

BACKGROUND:

In July 2018, the NCACH Governing Board approved the WPCC Stage 2 funding. The framework for the funding included a fixed and variable portion. The variable portion was to allow for organizations to voluntarily participate in the learning activities the WPCC organized. Recognizing the time commitment involved, and the fact that provider organizations already feel stretched thin, funding is primarily intended to support practice team involvement in the live learning sessions and improvement activities in their setting to help compensate for lost time with patients.

The Stage 2 Variable portion stated:
The variable portion of funding will be paid to each organization based on participation in each learning activity at $10,000 per activity per team provided the following conditions are met:

- For each completed learning activity, teams will be scored according to the assessment scale on the following page. Each team must progress to at least level 2.5 by the conclusion of the learning activity in order to receive funding for the activity. This will require attendance, active participation, engagement in improvement activities in the workplace, and reporting of progress through the Web Portal.
- Disbursement of variable funding
  Variable components will be paid within 60-90 days for all learning activities that concluded in the prior quarter, provided participation was satisfactory (as described above).

As the WPCC implementation activities have become more complex, the learning activities have also evolved from capacity building learning activities lasting 2 – 4 months into a more in-depth Population Health Management Learning and Action Network (LAN) that will last one year. Due to the evolution and extension of this new learning activity, the funding framework should be consistent with previous learning activities in order to compensate fairly.

PROPOSAL: Adjust the variable portion of funding so that each organization participating in a learning activity lasting about 1 quarter (2-4 months) is compensated $10,000 per team, and each organization participating in a year-long learning activity is compensated $10,000 per quarter per team, provided they meet participation requirements.
IMPACT/OPPORTUNITY (fiscal and programmatic): By creating a year-long LAN, we are creating an opportunity for clinical teams to focus on the implementation of population health management skills which would assist organizations as they prepare for value-based payment. The time commitment and homework for the year-long LAN is comparable to four shorter learning activities, therefore there would be no impact to the WPCC budget. We seek to compensate our partners fairly.
TIMELINE: The revision for this payment model would start immediately and continue for the duration of the Medicaid Transformation Project.
RECOMMENDATION: Motion to approve the proposed revision to the variable portion of the Stage 2 funding framework for WPCC Learning Community members to include quarterly payments for a year-long learning activity.

Submitted By:	Whole Person Care Collaborative
Submitted Date:	11/04/2019
Staff Sponsor:	Wendy Brzezny MN, RN

North Central Accountable Community of Health

Board Decision Form

TOPIC: *Public Health Seattle King County (PHSKC)*

PURPOSE: *To increase the budgeted amount for Public Health Seattle King County (PHSKC) contract*

BOARD ACTION:

☐ Information Only

☑ Board Motion to approve/disapprove

BACKGROUND:

NCACH began contracting with PHSKC in mid-2018 for data analytic support, including access to All-Payer Claims Database (APCD) data to examine populations and patterns of access, cost, quality/performance, and utilization of care.

The 2019 Budget approved by the Board included $24,000 for data analytics services from Public Health Seattle King County (PHSKC). In our monthly financial statements, this line item appears under the FE Portal Account Expenses, under Operations.

To date, NCACH staff submitted two special data requests leveraging PHSKC's access to the APCD in order to inform MTP work in our region. During Q1 of 2019, PHSKC analyzed zip-code level data linked to Emergency Department utilization in order to inform the Pathways HUB expansion plan. In Q3, PHSKC developed zip-code level population health profiles to provide context to the Population Health Learning & Action Network being offered to members of the WPCC.

Based on expense projections for these special data requests, the $24,000 budgeted amount will be exceeded.

PROPOSAL: Motion to increase the 2019 budgeted amount for the PHSKC contract by $16,000 (from $24,000 to $40,000) to cover data analytic services through the end of 2019 and comply with the Board's budget deviation policy.

IMPACT/OPPORTUNITY (fiscal and programmatic):

Per our Budget Deviation Policy, the NCACH Executive Director (ED) is authorized to deviate up to 10% or $50,000, whichever is less, from any spending decision or budget allocation made by the Governing Board without further action by the Board. This amounts to $2,400 in the case of the PHSKC budgeted line item.

There is a significant lag in King County's contracting and invoicing process. The $4,215 (18%) reflected in the financial statements for *Public Health Seattle King County (Data)* represent expenses paid in May 2019 for services rendered in 2018.

PHSKC sent NCACH an invoice on 10/11/19 for $19,779 (for services rendered Jan-Jun 2019), and an estimate of $15,686 for Q3 via email. Staff do not anticipate making any significant special requests in Q4. Increasing the budgeted line item will comply with the Budget Deviation Policy given what we are projecting for the year (and assuming that we are invoiced in a timely fashion).

Note that increasing this budgeted line item will not impact NCACH's bottom line, since projected expenses for program evaluation services ($120,000) are anticipated to come in far below budget.

TIMELINE: *Assuming the Board approves this motion, changes would be reflected in the November financial statements.*

RECOMMENDATION: Staff recommends approving the above motion/proposal.

Submitted By:	NCACH Leadership
Submitted Date:	11/04/2019
Staff Sponsor:	Caroline Tillier